



SCHOOL OF
MEDICINE

Investigations into Assessing Mindfulness in Primary Care: The State of the Science

Dr. Isabel Roth, DrPH, MS

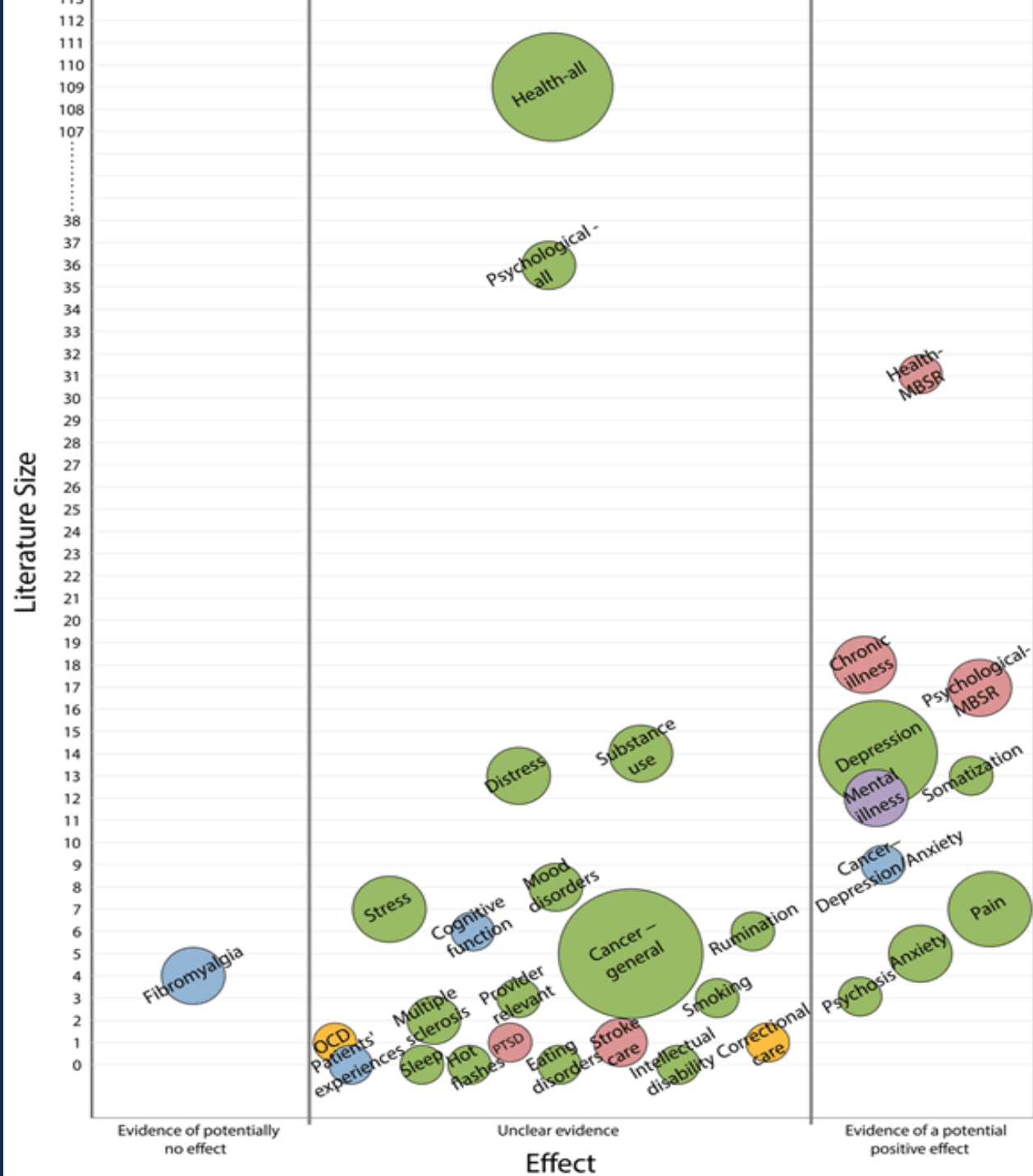
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Program on Integrative Medicine

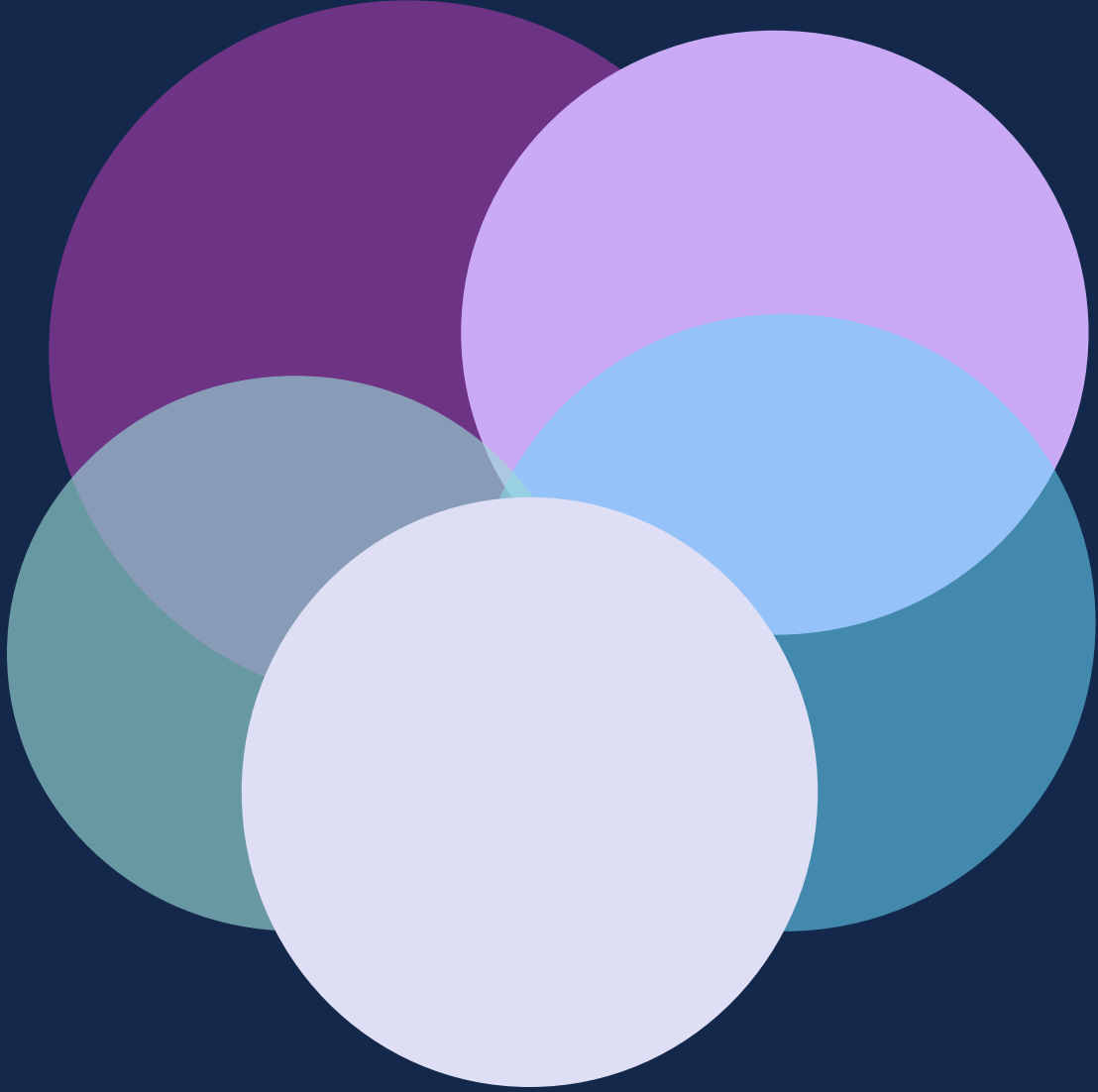
Department of Physical Medicine and Rehabilitation

UNC School of Medicine

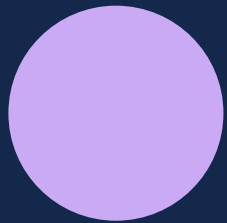




Hempel, 2014.
Evidence Map of
Mindfulness

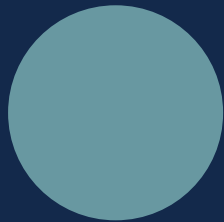


**MBSR
Group Visits**



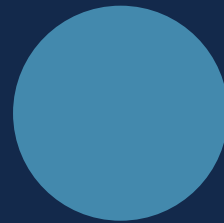
**Dr. Natalia
Morone**

**MINDFUL-PC
MINDFUL-OBOT**



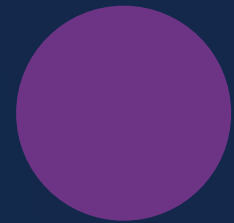
**Dr. Zev
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**Integrative
Medical
Group Visits**



**Dr. Isabel
Roth**

**Health
Insurance
Coverage**



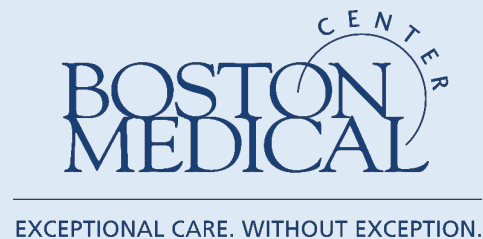
Dr. Eric Loucks

Embedding Adapted MBSR into Primary Care

Natalia E. Morone, MD, MS

Associate Professor of Medicine

Boston University, Boston Medical Center



Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians

Amir Qaseem, MD, PhD, MHA; Timothy J. Wilt, MD, MPH; Robert M. McLean, MD; and Mary Ann Forciea, MD; for the Clinical Guidelines Committee of the American College of Physicians*

Description: The American College of Physicians (ACP) developed this guideline to present the evidence and provide clinical recommendations on noninvasive treatment of low back pain.

Methods: Using the ACP grading system, the committee based these recommendations on a systematic review of randomized, controlled trials and systematic reviews published through April 2015 on noninvasive pharmacologic and nonpharmacologic treatments for low back pain. Updated searches were performed through November 2016. Clinical outcomes evaluated included reduction or elimination of low back pain, improvement in back-specific and overall function, improvement in health-related quality of life, reduction in work disability, and return to work.

muscle relaxants (moderate-quality evidence). (Grade: strong recommendation)

Recommendation 2: *For patients with chronic low back pain, clinicians and patients should initially select nonpharmacologic treatment with exercise, multidisciplinary rehabilitation, acupuncture, mindfulness-based stress reduction (moderate-quality evidence), tai chi, yoga, motor control exercise, progressive relaxation, electromyography biofeedback, low-level laser therapy, operant therapy, cognitive behavioral therapy, or spinal manipulation (low-quality evidence). (Grade: strong recommendation)*

Recommendation 2: For patients with CLBP ...initially select nonpharmacologic treatment...**mindfulness-based stress reduction** (moderate-quality evidence)

Barriers to clinical uptake

- Underutilized as not woven into outpatient clinical setting
- Not routinely reimbursed by health insurance companies for cLBP
- Lack of interaction and communication between primary care providers and mindfulness instructors

Morone NE, et al. *JAMA Intern Med.* 2016;176(3):329-337.

Cherkin DC, et al. *JAMA.* 2016;315(12):1240-1249.

Qaseem A, Wilt TJ, McLean RM, Forcica MA, Clinical Guidelines Committee of the American College of P.
Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the
American College of Physicians. *Ann Intern Med.* 2017;166(7):514-530.

- 25-question survey based on Interprofessional Education Collaborative's Core Competencies
- Administered to:
Licensed Primary Care Provider (Family Medicine or Internal Medicine, Pittsburgh PA, Boston MA, Chapel Hill NC, or Worcester MA)

Table 2. Predictors of patient referral to Mindfulness-Based Stress Reduction programs (n=83)				
Characteristic	Unadjusted		Adjusted	
	Odds Ratio (95% CI)	P-value	Odds Ratio (95% CI)	P-value
Age, No. (%)		0.08		0.04*
51 and older	<i>reference</i>		<i>reference</i>	
50 and younger	2.5 (0.91, 10)		3.3 (1.03, 9.09)	
Familiarity with Mindfulness-Based Stress Reduction Programs (MBSR), No. (%)		0.11		0.03*
A little bit & Somewhat	<i>reference</i>		<i>reference</i>	
Quite a bit & Very much	2.9 (0.8, 11.7)		5.1 (1.1, 22.5)	
Practice Mindfulness Meditation, No. (%)		0.24		0.08
No	<i>reference</i>		<i>reference</i>	
Yes	0.57 (0.2, 1.47)		0.4 (0.14, 1.1)	
<i>*p-value < 0.05</i>				

Table 2. Predictors of patient referral to MBSR programs. Age younger than 50 years old and greater familiarity with MBSR were significantly associated with referrals to MBSR.

OPTIMUM

Pragmatic Clinical Trial

Optimizing Pain Treatment in Medical Settings Using Mindfulness

Summary

A pragmatic clinical trial integrating a telehealth group-based adapted mindfulness stress reduction program into primary care settings for persons with chronic low back pain

Study design

Pragmatic randomized controlled trial



One year follow-up

Population



450 patients with chronic low back pain ≥ 18 years of age



Three healthcare systems: Boston Medical Center, UPMC, North Carolina (Internal or Family Med)

Comparison



Intervention group

225 participate in 8-week adapted Mindfulness Based Stress Reduction program



Control group

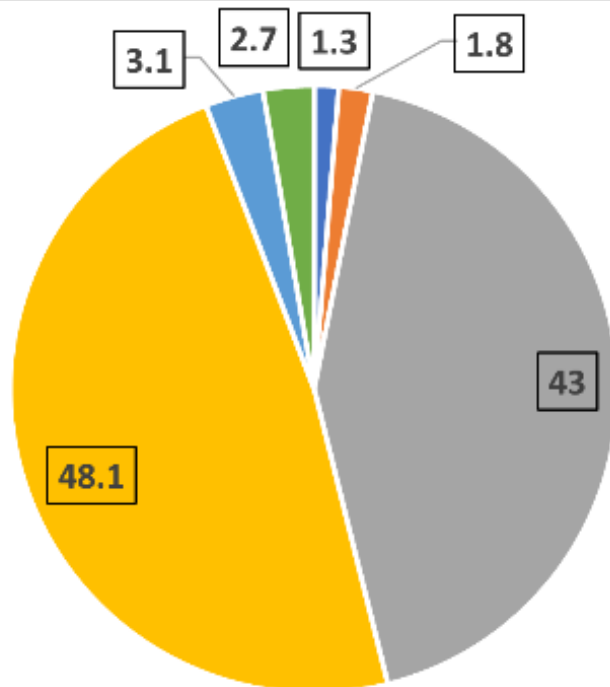
225 receive usual primary care

Outcomes

Mindfulness vs Usual Care	Baseline	w8	m6	m12
Pain Intensity & Pain Interference (PEG, Primary Outcome)				
Psychological function				
Physical function				
Healthcare utilization				
Pain medication/opioid use				

Proportion of Recruited Participants Categorized By Self-Identified Race

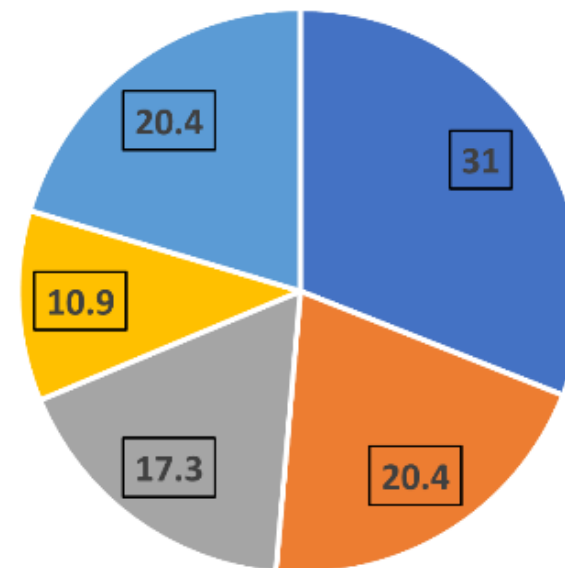
- American Indian / Alaskan Native (1.3%)
- Asian (1.8%)
- Black/African American (43%)
- White (48.1%)
- More Than One Race (3.1%)
- Unkown/Not Reported (2.7%)



N=451

Proportion of Recruited Participants Categorized By Annual Income Bracket

- Less than \$25,000 (31%)
- Between \$25,000 to \$50,000 (20.4%)
- Between \$50,000 to \$100,000 (17.3%)
- \$100,000 and Above (10.9%)
- Prefer Not to Answer (20.4%)

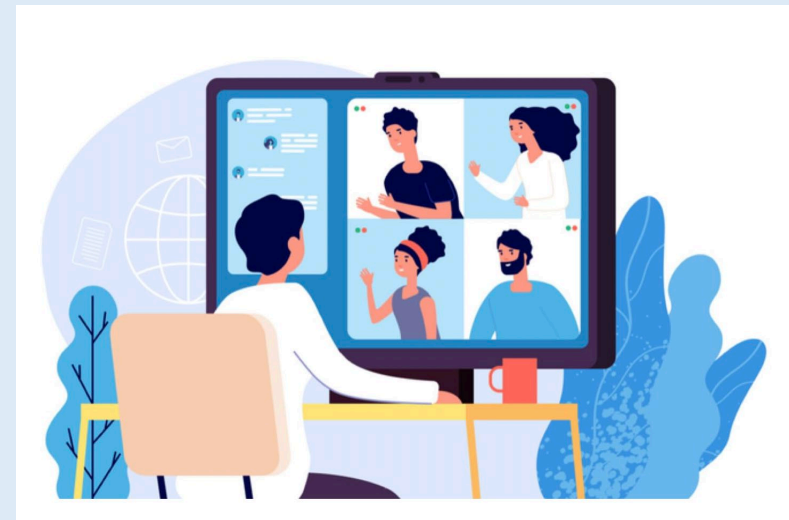


Primary Hypothesis

Patients in OPTIMUM will have significantly **improved pain intensity and interference as measured by the PEG composite score** at completion of the program and 6- and 12-months later, as compared to PCP Usual Care.

OPTIMUM: clinical pain management program

- Modeled on the Mindfulness-based Stress Reduction Program
- 8-weekly 90 minutes sessions, group-based
- Delivered in primary care through a telehealth medical group visit model



Medical Group Visits Improve

- Access and amount of time with a clinician
- Patient satisfaction
- Health services utilization (ED visits, repeat admissions)
- Medication adherence
- Health behaviors (BP, dietary modifications, exercise)
- Quality of life
- Disease-specific outcomes

Jaber et al, 2006; Cramer et al, 2013; Berman et al, 2004;
La Cour & Peterson 2015; Tsao 2007, Vickers et al.2012

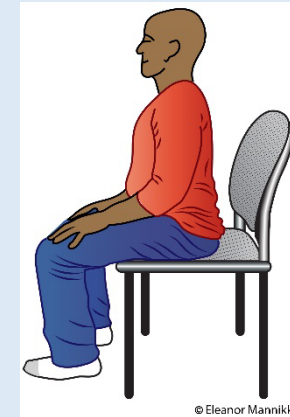
Patient signs into group Zoom with mindfulness instructor, primary care provider, and other patients



Patient meets with provider for brief check-in via breakout room



Patient returns to full group and participates in mindfulness program



Mean count of sessions attended (8 sessions offered)

Site	Sessions
Boston Medical Center (Internal Medicine)	4.5
University of Pittsburgh (Internal Medicine)	5.0
UNC-Chapel Hill (Family Medicine)	4.3

Conclusions

MBSR is recommended as first line therapy for chronic low back pain

Barriers to integrating into primary care

Group medical visit a promising model

Providers part of the program

Implementation and dissemination

OPTIMUM Team

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NCCIH Program Officer Dr. Wendy Weber



Thank You



Implementing Mindfulness Groups in Primary Care



Center for Mindfulness and Compassion

Zev Schuman-Olivier, MD

Founding Center Director, Center for Mindfulness and Compassion

Associate Professor, Department of Psychiatry

Harvard Medical School, Cambridge Health Alliance

Disclosures

- We have no conflicts of interest to disclose.


*The Arthur
Vining Davis
Foundations*



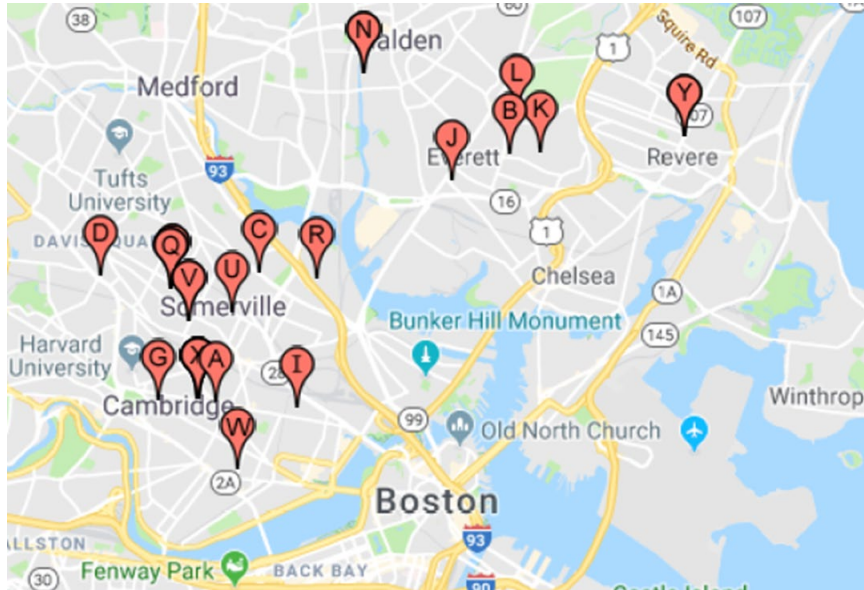
**SO
BC** | Science
Of
Behavior
Change

THE ARNOLD P.
GOLD
FOUNDATION
Keeping Healthcare Human

 **CHA**
Cambridge
Health Alliance

NIH  National Center for
Complementary and
Integrative Health

Mindfulness Training for Primary Care (MTPC)



- 8-week groups for primary care patients across 11 primary care sites
- Mindful Behavior Change curriculum designed to enhance chronic illness self-management, reduce stress, anxiety, and depression, while motivating behavior change.
- Referral-based
- Insurance-reimbursable
- Trauma-Informed

Setting up System-Wide Project

- Study US mindfulness centers (AMCAMS)
- Organizational Change Stakeholder Analysis
- Connecting Goals of Clinicians and Leadership
- Focusing on What Matters to the Institution
 - Patient-Centered Medical Home Expansion
 - Equity for Minoritized Populations
 - Waiver Metrics
 - Access to Behavioral Health Care

Training Group Leaders

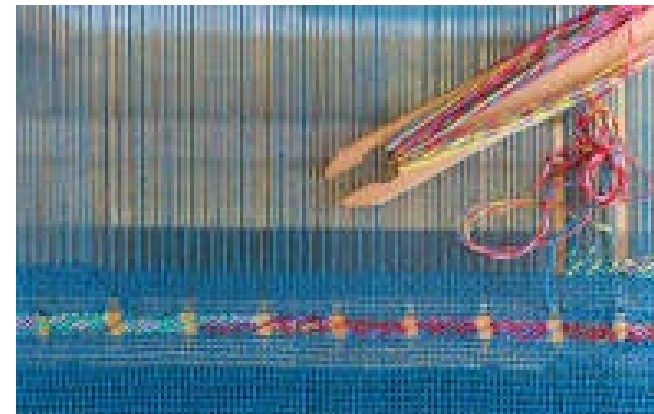
- All group leaders completed the following:
 - 1) Free 8-week MBSR course (27 h) (~30), 50% CHA discount for 4 years (~30)
 - 2) Weekly practicum during this MBSR course (8 h total)
 - a. UMass CFM senior teacher trainers with 44 years of combined teaching experience (~30+~30 potential group leaders]
 - 3) 40 hours of intensive MTPC-specific training that focused on core goals of Mindful Behavior Change (MBC) curriculum (~24GL current):
 - a. MBI Inquiry (components from MBSR/ MBCT/ MSC)
 - b. Attitudinal components of being a group leader
 - c. Trauma-informed
 - d. Mindful Behavior Change and Warm Mindfulness components

Studies on MTPC were conducted with groups co-led in pairs by licensed mental health clinicians (psychologist, clinical social worker, or psychiatrist) (12) and primary care physicians (3).

Weaving a Mindfulness-Based Program for Living Well with Chronic Illness and Enhancing Capacity for Self-Management and Health Behavior Change

- Section 1-4: Cultivating Mindfulness
- Section 5-8:
 - Kindness and Coping
 - Accessing Core Values and Aspiration
 - Living Well through Wise Action
 - Connection, Communication, Community
- 3 threads:
 - Warmth and Common Humanity
 - Interpersonal Mindfulness
 - Behavior Change

Warm
Mindfulness
Approach



Study Design

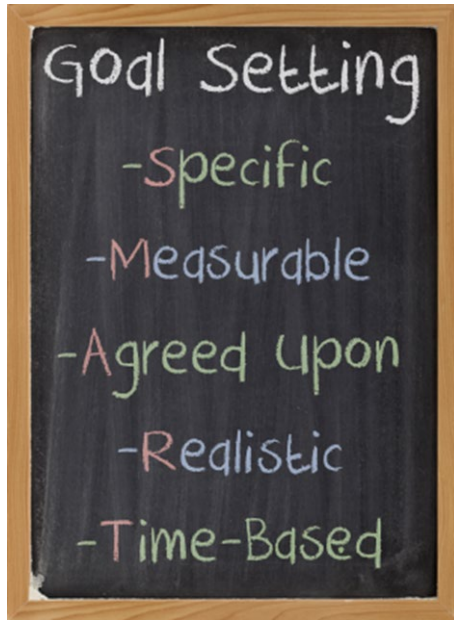
Randomized Comparative Effectiveness 8-week MTPC vs Low-Dose Mindfulness Comparator

Mindfulness Training for Primary Care (MTPC) (66% of participants)	Low Dose Comparator (LDC) (33% of participants)
<ul style="list-style-type: none">• Group program: MTPC groups are 2 hours long for 8 weeks + 7-hour day of silent practice• Co-located: Delivered by mental health clinicians/PCP in primary care• Insurance-reimbursed: Billed as group psychotherapy or medical group visits with ~ 9-12 patients	<ul style="list-style-type: none">• 60-minute introduction to mindfulness• Referral to community mindfulness resources (classes, top mobile apps, books, websites)• Called every 2 weeks and encouraged in mindfulness practice• Placed on a 6-month waitlist for group

Study Procedures & Assessments

STUDY GROUP	WEEK 0	WEEK 0-1	WEEK 1-4	WEEK 5-6	WEEK 7	WEEK 8-9
BOTH GROUPS	Informed Consent Session	Randomization			SMART GOAL VIDEO	
	T0 Surveys				T1 Surveys	T2 Surveys
	Mindfulness Orientation		Weekly Mindfulness Resource Diary Card Weekly Mindfulness Practice Diary Card			
INTERVENTION			MTPC Intervention			
COMPARATOR			MINDFUL-PC Staff Check-In (Every 2 weeks)			

Action Plan Initiation Survey



1. Please choose the category of your goal (choose one):

- Activity level/exercise
- Diet/eating/drinking
- Self-care practice
- Other ____

2. My Goal (be specific): _____

3. In the last two weeks, did you meet your goal?

Not met at all
Totally met

1

2

3

4

5

6

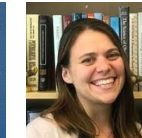
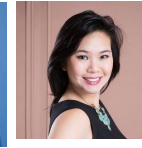
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Action Plan Initiation Results

Study 1(N=81): OR = 4.09, p=0.04

Study 2(N=136): OR=2.91, p=0.006

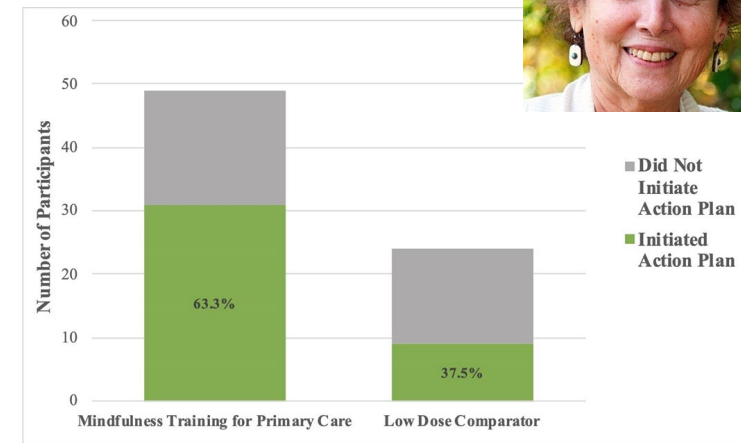
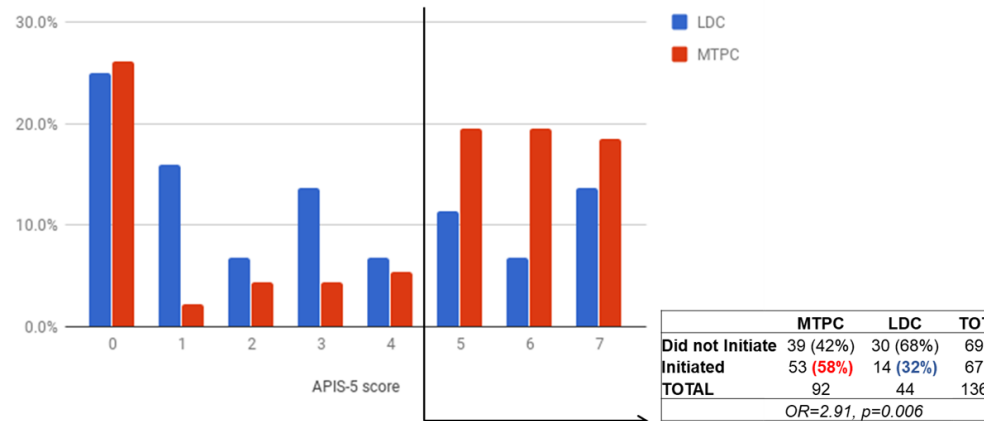
Study 3(N=73): OR=2.87, p=0.04



Study 2

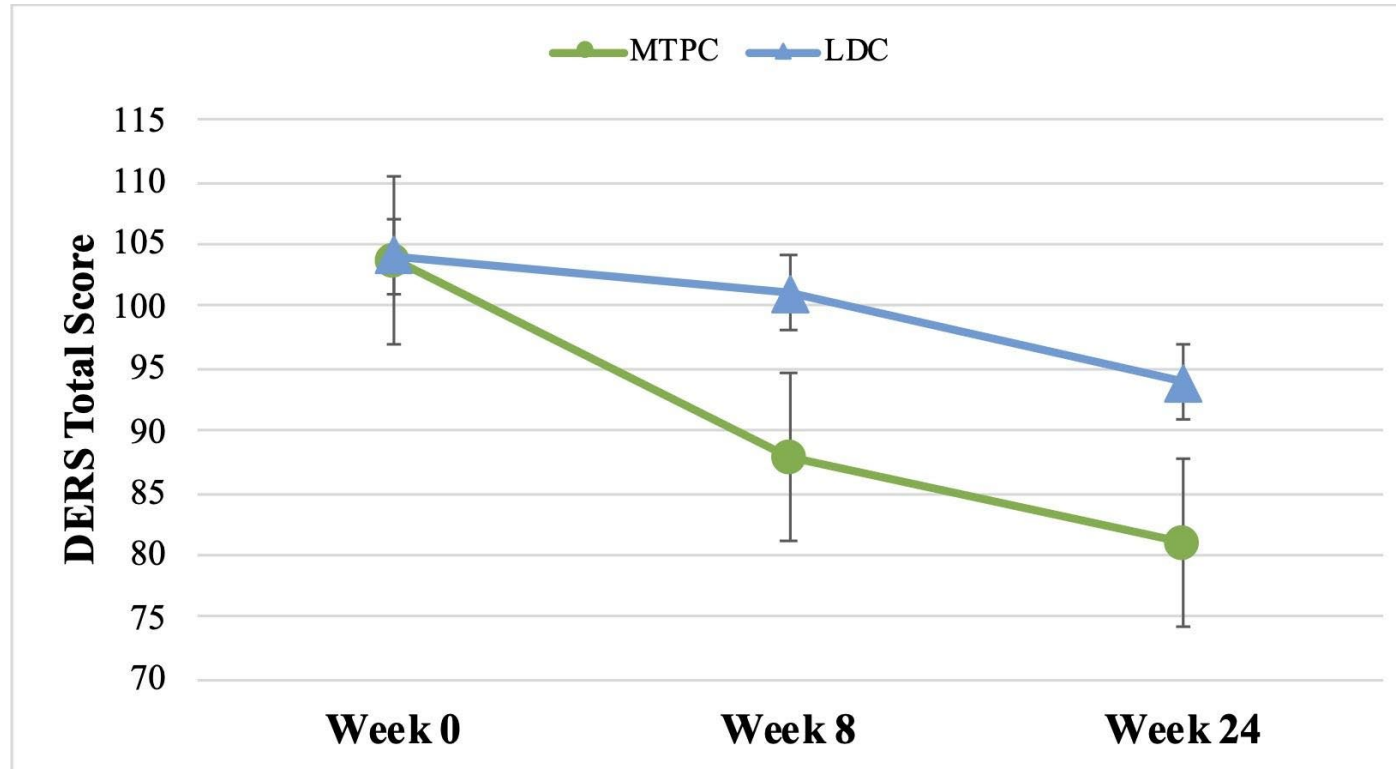
Study 3

Action Plan Initiation at 2 weeks (MTPC vs. LDC)



Gawande 2018, 2019, 2023

Study 3 Results



Between group effects at Week 8

$\beta = -12.98$, 95% CI [-23.3, -2.6] $d = -0.59$, $p = .01$

These effects held at Week 24

$\beta = -13.35$, 95% CI [-24.3, -2.4] $d = -0.61$, $p = .02$

Gawande 2023

Study 3 Results

DERS Subscales	β	<i>d</i>	<i>p</i>
<i>Nonacceptance</i>	3.12	0.55	0.036
Goal-directed behavior	3.48	0.82	< 0.001
Impulse control	0.47	0.11	0.687
Lack of emotional awareness	1.13	0.24	0.314
Emotional regulation strategies	4.99	0.74	0.001
Lack of emotional clarity	-0.18	-0.05	0.836

Accessibility

- Phase 1
 - 46% private, 52% subsidized/CMS, 2% other
 - 62% with less than \$40K annual income
 - 22% non-white race, 15% English 2nd language
- Phase 2
 - 45% private, 53% subsidized/CMS, 2% other
 - 29% with less than \$20K annual income
 - 23% non-white race, 17% English 2nd language

Mindful Mental Health Service

- 7,000+ referrals from CHA System w/in past 7 years
- Training Service with Advanced Clinical Mindfulness Fellows (Psychology, SW, Psychiatry) and Practicing Primary Care Providers
- Mindfulness Continuum (~25-30 groups per year)
 - Introduction to Mindfulness group (12 weeks)
 - Mindfulness-Based Cognitive Therapy (8 weeks)
 - Mindful Behavior Change [MH & MTPC] (8 weeks)
 - Strengthening Your Practice Alumni Groups (12 weeks)
 - Spanish and Portuguese MBC Groups (8 weeks)

Growth and Future of MMHS

- CHAMindWell
 - ~2,000 CHA patients in Community track
 - ~350 active in Connected track
 - >1,000 read mental wellness email newsletter/ mo
- Program for Alleviating and Reducing Trauma and Stress (PARTS)
 - First IFS Group-Based Clinical Service for PTSD



**Center for
Mindfulness
and Compassion**

Mindful Healthcare Scholars

- 12-month program starts June 13, 2024
- In-person launch workshop in the Boston area
 - 2 days, June 13-14; live online option will be available
- Monthly live online sessions with faculty and guest speakers
 - First Wednesday of each month for 1.5 hours
- Monthly small groups for practice, peer support, and project planning, 1 hour each month

<https://www.chacmc.org/scholars-program>

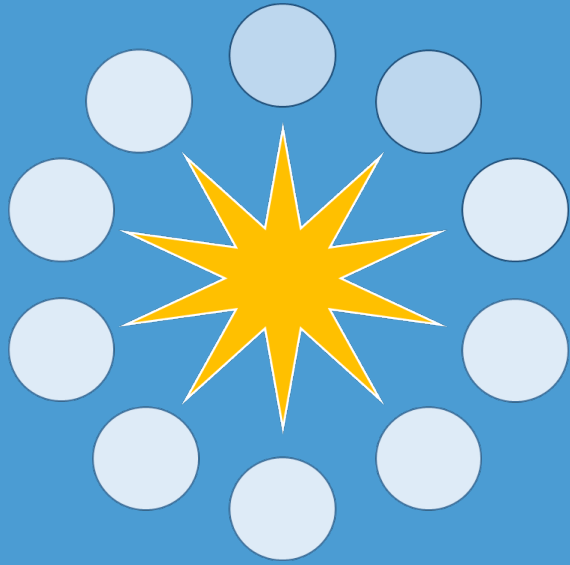
Center for Mindfulness and Compassion

The mission of the CHA Center for Mindfulness and Compassion (CMC) is to enhance health and well-being by integrating mindfulness and compassion into healthcare with a commitment to equity, inclusivity, accessibility, and diversity.

To cultivate mindfulness and compassion learning and practice in:

- Clinical Innovation
- Professional training
- Scientific research

www.chacmc.org



MAGIC: More Access to Group Integrative Care for Chronic Pain

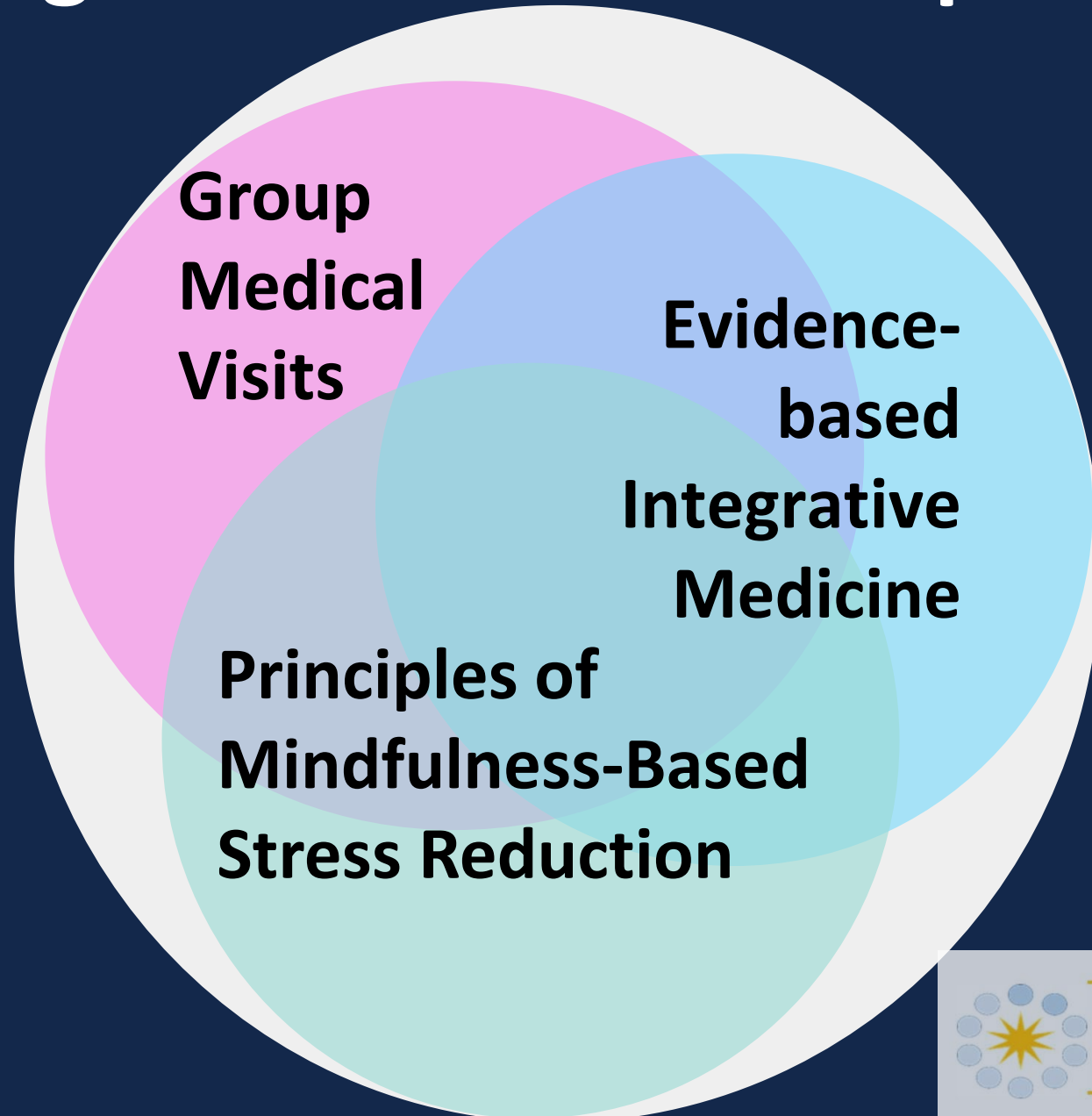
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Integrative Medical Group Visits

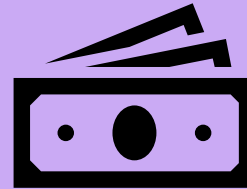


Quintuple Aim

Improve Population Health



Reduce Costs



Improve Patient Experience



Improve Provider Experience



Improve Health Equity



Components

- 9-week, structured curriculum
- Mindfulness is incorporated into every session
 - Also includes:
 - Chair yoga
 - Anti-inflammatory nutrition
 - Self-acupressure
 - Self-massage
 - Health education
- Led my primary care provider and mindfulness/yoga teacher/behavioral health provider
- Billable through standard billing codes (99213-99215)

What is covered in Integrative Medical Group Visits?

1. Group Orientation
2. Our reactions to **stress**
3. The importance of healthy **sleep**
4. **Food** and **movement** as medicine
5. Our bodies' response to **pain**
6. Our bodies and **inflammation**
7. Approaches to **depression** and challenging communications
8. Understanding the role of **food**
9. Goal-setting and Wellness Review

Structure of Telehealth IMGV

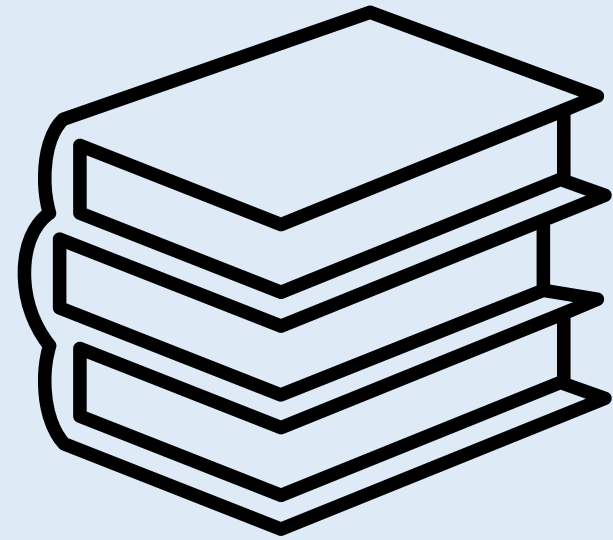
- Zoom room opens 15 minutes early
- Call patients who have not arrived, troubleshoot tech issues
- Begin at 3pm with opening 'Awareness of Breath Meditation'
- Physician leads check-in, with optional one-on-one breakout room
- Review home practice from previous week
- Discussion and didactic health topic
- Mind-body exercise (ex. Chair yoga, self-acupressure)
- Review home practice for coming week
- Recipe Demo
- Closing Poem



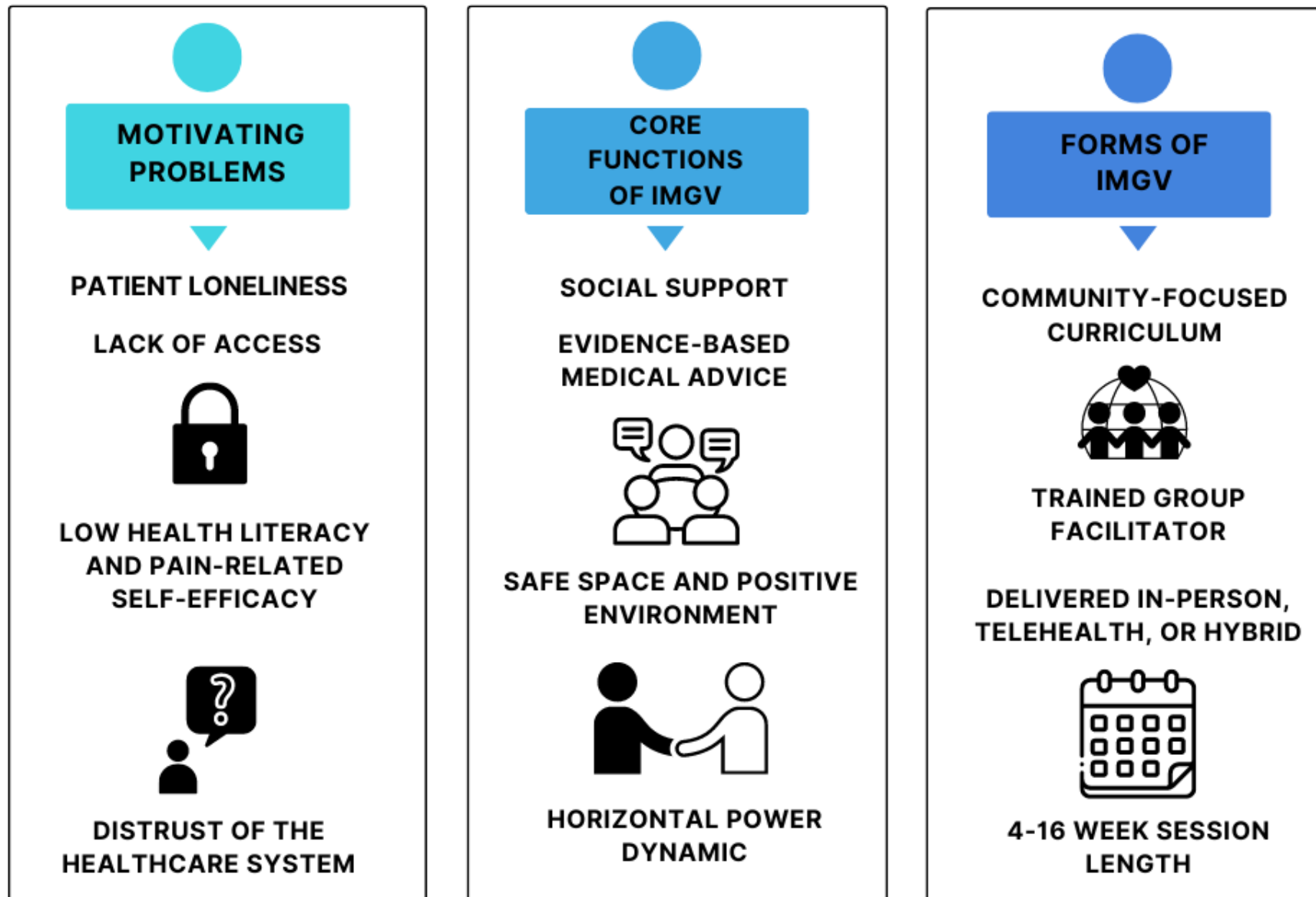
Interviews with National Stakeholders

Safety-net providers have been successfully implementing and delivering IMGVs for years. What can we learn from them?

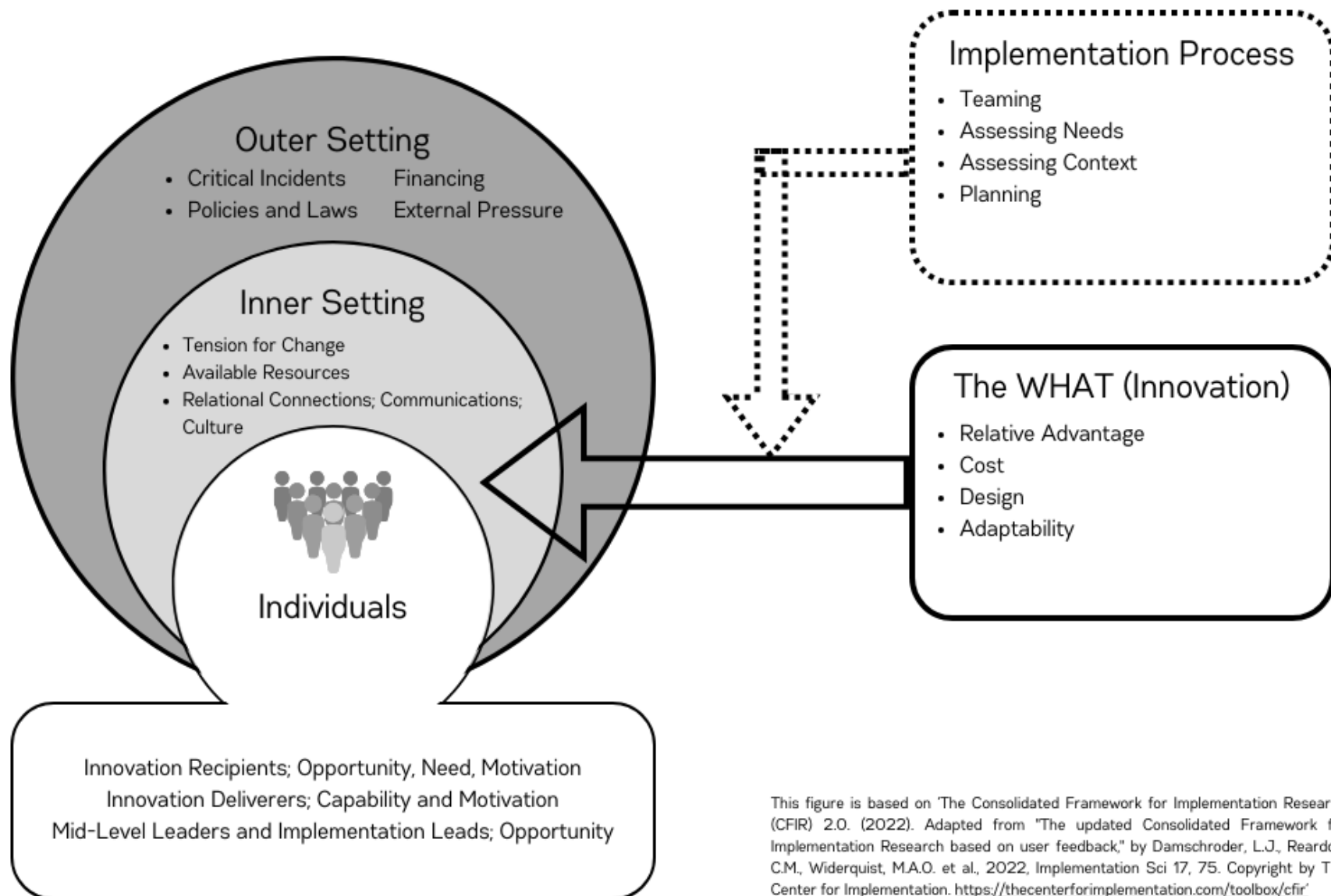
Systematic Review



Forms vs. Function of IMGV



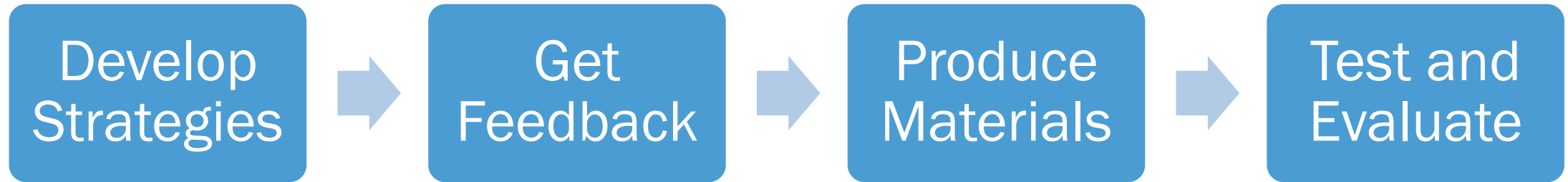
Themes from the Updated Consolidated Framework for Implementation Research



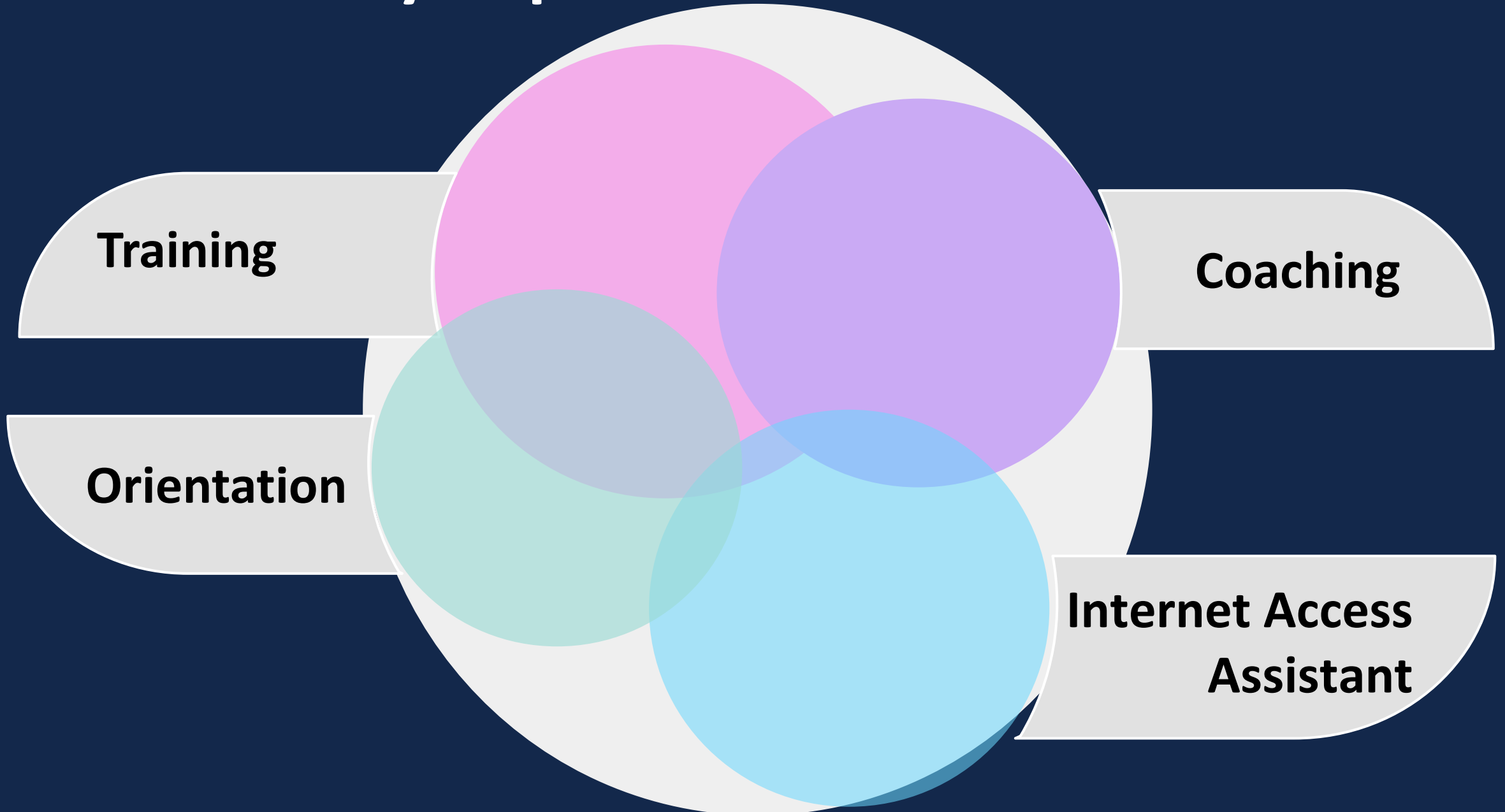
This figure is based on 'The Consolidated Framework for Implementation Research (CFIR) 2.0. (2022). Adapted from "The updated Consolidated Framework for Implementation Research based on user feedback," by Damschroder, L.J., Reardon, C.M., Widerquist, M.A.O. et al., 2022, Implementation Sci 17, 75. Copyright by The Center for Implementation. <https://thecenterforimplementation.com/toolbox/cfir/>

Aim 1: Analysis to Identify Strategies

From qualitative data to action



Key Implementation Strategies

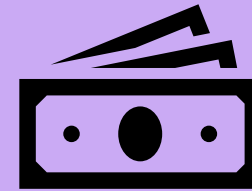


Ongoing Clinical Trial

**Pilot Feasibility at
Two FQHCs**



Evaluate Cost



**Evaluate patient
preceptions and
health outcomes**



**Assess Provider
and Staff
Perspectives**



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- Isabel Roth's contributions were supported by a K01 Career Development Award from the National Center for Complementary and Integrative Health (K01AT011578)
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 - Drs. Jennifer Leeman, Paula Gardiner, Shabbar Ranapurwala, Susan Gaylord, and Justin Trogdon

MBSR Health Insurance Coverage: If, How, and When?

An Integrated Knowledge Translation (iKT)
Delphi Key Informant Analysis

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Director, Mindfulness Center at Brown University

Co-Authors:

Hannah E. Frank, Ariana Albanese, Shufang Sun, Frances Saadeh, Blair T. Johnson, A. Rani Elwy



Background and Rationale

- Hundreds of randomized controlled trials have evaluated Mindfulness-Based Stress Reduction (MBSR), but it remains largely not covered by health insurance in the United States.

Why Is This?

What is needed for MBSR
to be covered by health
insurance?

Specific Aims

To Identify:

1. Key questions to make decisions about **if, how, and when** MBSR should be covered by health insurance.
2. (A) **barriers** and (B) **facilitators** to understand and resolve for MBSR to be covered by health insurance.
3. Highest priority **evidence** needed to inform health insurance coverage decisions.

Methods

- Utilizing an integrated Knowledge Translation (iKT) approach, key informants (n=26) included health insurers, healthcare administrators, policymakers, clinicians, MBSR instructors, and MBSR students.
- An initial pool of items related to the study aims were generated through individual qualitative interviews.
- Through the Delphi process, participants rated, discussed, and re-rated each item's relevance.
- Items were required to reach a consensus of $\geq 80\%$ agreement to be retained for final inclusion.

Results – Demographics

Demographic Variable	Mean or N	SD or %
Age	46.9	13.5
Advisory board member primary role		
Clinician	4	15.4%
Government Policy Maker	6	23.1%
Healthcare Administrator	3	11.5%
Health Insurer and Healthcare Organization Representatives	4	15.4%
MBSR Instructor	4	15.4%
Patient / MBSR Student	5	19.2%
Race/ethnicity		
Black, non-Hispanic	2	7.7%
Hispanic	3	11.5%
Mixed race, non-Hispanic	1	3.8%
White, non-Hispanic	20	76.9%
Gender		
Female	15	57.7%
Male	11	42.3%

Demographic Variable	Mean or N	SD or %
Geographic Region		
Mid-Atlantic	6	23.1%
Midwest	2	7.7%
Northeast	11	42.3%
Southeast	2	7.7%
Southwest	2	7.7%
West	3	11.5%
Education level		
College degree	4	15.4%
Graduate degree	19	73.1%
Student	1	3.8%
Data missing	2	7.7%
Employment status		
Working full-time	21	80.8%
Working part-time	2	7.7%
Other: full-time student	1	3.8%
Data missing	2	7.7%

Results – Aim 1

Aim 1: Should [item] inform if, when and how MBSR is covered by health insurance?

Mean (SD)	Items meeting 80% cutoff in Round 3 (12.2% of initial items)
8.48 (0.75)	Research support demonstrating that MBSR works
7.81 (1.23)	MBSR not being harmful / having few side effects for people for whom it is appropriate
7.71 (1.42)	The extent to which MBSR can be clearly defined
7.52 (1.47)	MBSR's impact on health outcomes as demonstrated by standardized measures
7.48 (1.21)	MBSR teacher qualifications

Results – Aim 2a

Aim 2a: Is [item] a barrier / something that makes it harder for MBSR to be covered by health insurance?

Mean (SD)	Items meeting 80% cutoff in Round 3 (10.3% of initial items)
7.24 (1.42)	Perception that MBSR is not a medical treatment
7.04 (1.40)	Patient barriers to attending an 8-week MBSR course
7.00 (1.50)	Challenges with the potential delivery of a health service by a non-licensed provider (or need to develop a licensing process)

Results – Aim 2b

Aim 2b: Is [item] a facilitator / something that makes it easier for MBSR to be covered by health insurance?

Mean (SD)	Items meeting 80% cutoff in Round 3 (41.2% of initial items)
8.19 (0.93)	MBSR's potential for addressing common problems like depression and anxiety
8.05 (1.32)	Evidence that MBSR is effective at treating mental health and psychosomatic problems
8.00 (1.10)	The ability to deliver MBSR via telehealth
8.00 (1.14)	Buy-in of large professional groups providing this service (e.g., psychology and social work state or national groups)
7.95 (1.56)	MBSR being established as an intervention that works
7.95 (0.97)	Partnerships with reputable institutions to demonstrate effectiveness
7.86 (1.06)	The ability to demonstrate that MBSR is being delivered with fidelity (i.e., teachers deliver its core components)

Results – Aim 2b

Aim 2b: Is [item] a facilitator / something that makes it easier for MBSR to be covered by health insurance?

Mean (SD)	Items meeting 80% cutoff in Round 3 (41.2% of initial items)
7.76 (1.04)	National interest in evidence-based approaches that improve mental health outcomes
7.71 (1.19)	Positive public perceptions of mindfulness/MBSR
7.67 (1.24)	MBSR's standardized curriculum that can be used anywhere (i.e., replicability and scalability)
7.67 (1.39)	MBSR's ability to address stress broadly
7.57 (1.57)	Potentially lower out of pocket costs for MBSR than for therapy
7.48 (1.12)	Increased acknowledgement by insurers about the value of mindfulness-based interventions
7.44 (1.56)	Cost-effectiveness of MBSR
7.24 (2.10)	Minimal side effects of MBSR

Results – Aim 3

Aim 3: Should [item] be included in the systematic review protocol?

Mean (SD)	Items meeting 80% cutoff in Round 3 (44.2% of initial items)
8.29 (1.19)	Conditions that are effectively treated with MBSR
8.10 (1.22)	MBSR's impact on stress
8.00 (1.30)	MBSR's impact on PTSD/trauma symptoms
7.95 (1.24)	MBSR's impact on pain catastrophizing
7.90 (1.18)	MBSR's impact on pain symptoms
7.86 (1.32)	MBSR's impact on anxiety
7.86 (1.20)	MBSR's impact on chronic illness symptoms
7.81 (1.25)	MBSR's impact on quality of life
7.76 (1.26)	MBSR's impact on cardiometabolic risk
7.68 (1.55)	How MBSR compares to other interventions (comparative effectiveness)

Results – Aim 3

Aim 3: Should [item] be included in the systematic review protocol?

Mean (SD)	Items meeting 80% cutoff in Round 3 (44.2% of initial items)
7.67 (1.68)	Trajectory of symptom improvement following MBSR
7.67 (1.28)	Dose of MBSR (i.e., class length, home practice)
7.67 (1.20)	Mechanisms of MBSR (i.e., how and why it works)
7.64 (1.35)	Costs and potential savings (to insurance companies) associated with MBSR
7.62(1.32)	Long-term outcomes of MBSR (e.g., effect on quality of life)
7.62 (1.28)	MBSR's impact on depression symptoms
7.52 (1.08)	Extent to which MBSR reduces service utilization (e.g., hospital readmissions, avoidable emergency department use, doctor's appointments)
7.52 (1.83)	Comparisons between MBSR and other mindfulness-based interventions
7.48 (1.33)	How MBSR works in combination with other treatments (e.g., medication, therapy)

Strengths and Limitations

Strengths

- Use of iKT methods.
- The diversity of key informant perspectives.
- Use of the modified Delphi approach to systematically achieve consensus.

Limitations

- Certain participants in the Delphi discussion may have been less comfortable sharing their perspectives during group discussions and their thoughts may be less represented.
- Although we made efforts to recruit a diverse sample in terms of race/ethnicity and geographic region, increased diversity in these areas may have yielded different results.
- The advisory board represents a group of people who were sufficiently interested in MBSR to be willing to participate in ongoing meetings and surveys; there may be some opinions that are not represented by people unwilling to attend meetings on this topic.
- The sample size was not adequate to do stratified analyses by key informant type.

Interpretation

- Items selected for final inclusion from the Delphi rounds represent five priorities to consider in advancing MBSR health insurance coverage.
- These priorities include:
 1. Addressing the health impacts of MBSR.
 2. Considering the patient experience.
 3. Understanding costs.
 4. Assessing teacher fidelity to MBSR.
 5. The value of involvement with professional organizations.
- The first three priorities align with the policy-relevant “triple aim” (Berwick et al., *Health Affairs*, 2008) of improving health, improving individuals’ experiences of care, and reducing costs of care.

Conclusions

- Health insurance coverage of evidence-based mindfulness programs would reduce inequities in access to evidence-based care.
- The findings suggest several areas that would influence MBSR health insurance coverage, including:
 - Health impacts.
 - Patient experience.
 - Costs.
 - Teacher fidelity to the research-based program.
 - The value of involvement with professional organizations.
- These five areas are recommended priorities to focus on when working to advance MBSR health insurance coverage.

Thank You



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