**MHRN Steering Committee Meeting**

**HCSRN Conference, Minneapolis MN**

**April 10th, 2018**

Today’s agenda about MHRN III

No project updates – please see updates in [GitHub,](https://github.com/MHResearchNetwork/MHRN-SC-Meeting-Spring-2018) they will also be posted on the [MHRN website](http://hcsrn.org/mhrn/en/)

**Announcements**

3 new MHRN-Affiliated projects funded or funding looks promising:

* PCORI Engagement Award led by Karen Coleman
* Opioid & Suicide proposal funded, led by Bobbi Jo Yarborough, first R01
* Developing analytic methods for complex dynamic treatment regimens, Susan Shortreed, first R01

**MHRN III Goals**

*[Refer to New Goals ppt slides on GitHub for summary]*

New – More focused on methods and on stakeholders

Implementation – what are the strategies/tools for working with HCS, and how do we measure it;

Zero Suicide is example of full circle project

**MHRN III Pilot Proposals**

*[Proposal summaries on GitHub]*

Today’s discussion not evaluative (which should move forward), more of how do we improve upon these. Take note that the Notice did not specify number of pilot projects. Consider other funding opportunities, portfolio balance, external partners, junior investigators, external consultants.

* ***Precision medicine for treatment-resistant depression (Brian Ahmedani)***

Which treatments are best match for individuals. AoU is not set up to evaluate this; more focused on etiology. No one better than MHRN to identify those with favorable/non-favorable Tx, focus on TRD. Will collect biospecimens. How do we get pts to participate? Patients will get genomics & survey data back. Suggestion to provide feedback soon to providers and pts including EHR data

Results reporting – AoU has committee to develop nationwide protocol for returning results

* ***Culturally responsive shared decision making for tx of depression (Karen Coleman/Ming Tai-Seale)***

Computational ethnography – feasibility pilot, test tool in PC, capture audio/visual data, ambient data, eye gazing, distance between people, etc. Big innovation is the technology.

Psychotherapy needs to move from data to theory to outcomes; having data on what actually happened in the encounter

* ***Employment & financial changes as risk factors for suicide attempt (Rob Penfold)***

May shape questions we ask, shape self-report data to give us a better signal; may identify unidentified risk, implications for treatment planning

IRB concerns – some experience with this and not a huge barrier

* ***Rapid assessment of ketamine-like drugs (Susan Shortreed)***

Drugs will be approved for TRD, add-on treatment; confounding by indication a major issue. What are appropriate analytic techniques? Challenge is to do rapid assessment. Studies on diffusion of new meds. Consider stakeholder engagement. HCS – have been discussions with formulary re: ketamine, rising from grass roots

* ***Clinical implementation of suicide risk algorithm (Bobbi Jo Yarborough)***

No literature about implementing tools we are developing; begin to ask Q’s on how SRS algorithm can be integrated into clinical workflow; perfect for pilot mechanism, not likely to be funded otherwise; Suggestions to include as stakeholder - administrators, I , and medical legal.

Run scenarios with key informants. Would it be like CV wizard with components or a composite score? Which components are actionable – focus on a few factors pt/provider can focus on. To what extent do you engage families? Important to consider – alert fatigue, how many will you identify with algorithm and what do we have available to deal with them, if turning it on, need to know when to turn it off – does doing the CSSR turn it off. How often is it refreshed?

Use PCORI patient engagement infrastructure.

HPI HCS leader priorities: Precision medicine, ketamine, and big data

***Action Item:*** Produce 1 paragraph description of each pilot proposal for distribution to HCS stakeholders.

**MHRN III Informatics**

*[see Informatics ppt slides on GitHub]*

Other PROs? Build PRO table in CESR format

Processes of care, how many best practice alerts, referrals, performance measures (collected but we haven’t tapped), look at care gaps, no shows another data area, video and email visits – how recorded, how many receiving care through alternate methods

**Stakeholder Engagement**

*[Refer to Stakeholder ppt slides on GitHub]*

Patient engagement a core value for MHRN III

Half-day training at MHRN NIMH Fall Meeting

Patient engagement workshop – member from each MHRN site

Involve parents, key system people?

Reassess MHRN organizational structure – who votes?

Meetings restructured to allow stakeholder engagement

***Action*** ***item:*** Email Karen Coleman if interested in engagement

**MHRN III Methods Core**

*[Refer to Methods ppt slides on GitHub]*

Foster methodological excellence – at state of the art plus one level up

New methods that address that challenges we are facing

How do you identify area where new methods are needed?

***Action*** ***item:*** Check with Rinad Beidas, ALACRITY Methods Core

**MHRN III Pragmatic Trial**

*[Refer to proposal on GitHub]*

Phase 1 – clinical effectiveness aims

Phase 2 – implementation phase

Bring in Autism Spectrum issues?

Ask patient stakeholders what outcomes are important to them

Look at mom/baby attachment, tie with well-child visits

**New MHRN Members**

*[Refer to Member ppt slides on GitHub]*

Should we have a code of conduct?

If there is a specific target group like PTSD, might want to engage with VA

New type of partners – investigator members (like UCSD researchers)

Computer science students – methods, training

We do already have PhD students who work with us – not systematic, more informal

Are a lot of training programs, but not training students to be very useful

**Summary/Wrap-Up**

* Circulate 1 paragraph plain language descriptions for pilot proposals for stakeholders
* Online survey for stakeholders
* mHealth SIG – keep discussions going for new SIG
* Continue to engage with external researchers (David Mohr would like to engage with MHRN)