

Table 2 Interview themes with exemplar quotes

Theme	Exemplar quote(s)
General support for implementing digital therapeutics Supportive of offering digital therapeutics	<p>A lot of patients with substance use disorder or disorders show up, whether it's alcohol use disorder or opioid use disorder or any other sorts of substances, they're often showing up in primary care, they're showing up in urgent care, and saying "I don't know what to do, somebody help me." ... And so I think just having an extra tool in the toolbox to be able to refer patients back to and say that they can use this before they check into an urgent care or try to get seen, that they encourage them to start with that is also a great thing. (#11, care delivery leader)</p> <p>Just that we recognize that we will not be able to meet the demand for services through individual clinicians, and that we need more tools really to scale treatment and that digital tools are a great way to do that. And I think it provides a way to keep people engaged outside of sessions and to further accelerate treatment. (#13, care delivery leader)</p> <p>We use apps, frankly, for a lot of other diagnoses here as well—anxiety/depression, which oftentimes go along with substance use disorders. So I think [a digital therapeutic for SUD is] a very nice complement. (#9, care delivery leader)</p>
General implementation strategy and workflow recommendations Partnerships with dedicated teams, champions, and researchers aid implementation	<p>I think at the clinic what has worked well for me has been frequent meetings and support of the reSET and reSET-O researchers and the health coach. We have monthly meetings, and it's been really helpful for me to have that place to check in and have somebody outside of me tracking progress towards goals that we set or tweaking the rollout, what's working, what's not, how do we make this easier and more accessible. (#7, LICSW)</p> <p>Having a point person who's kind of the champion and can answer my questions, that's helpful for me. (#3, PCP)</p> <p>I think having time as a team to set aside and not have patient care and have like most of the team members there to kind of go through what this might look like, to experiment and roll something out, and then having follow up as a team where people can ask questions. (#2, PCP)</p>
Increase knowledge about new digital therapeutics among all primary care team members	<p>Clinicians notoriously need multiple mediums to get everyone on the same page, so it's a combination of large group announcements, huddle cards*, coming to the morning huddles and telling people and clinicians about this. (#10, PCP)</p> <p>I think perhaps having a huddle card, letting all staff know what is the reSET and reSET-O program, who do we offer it to, what it entails, how it can be helpful to the patients, which providers are part of it or who do we forward this information to once patients are interested? Maybe like a huddle card is going to be the best way to go about it, so that we have some reading material that we can always go back to and read if we need a little bit refresher, so that everybody is aware that something like this is available and we can offer. (#8, MA)</p> <p>*Huddle cards are documents that contain a concise written overview of treatments or clinic updates on a single page. Huddle cards are often presented at short team meetings called huddles</p>
Optimize workflows and access to information	<p>Providers would need to have some really good training on the use of the app and then how to get people signed up easily, because when people can't sign up easily, they just get frustrated. It needs to be user friendly. (#5, care delivery leader)</p> <p>And then it's very helpful to be able to have information that's easily accessible to share with patients, as well as for me to be able to refer back to easily. (#3, PCP)</p> <p>Actually we've set up a good process to be able to offer this to patients... Our internal standing order [in the electronic health record], for instance, to allow social work to be able to offer this to patients, I think that has gone well. (#12, care delivery leader)</p>

and characteristics of patients who might be offered the app and the supports they may need, which in turn would determine the ideal implementation strategies. For example, a digital therapeutic might be designed for patients with unhealthy alcohol use (likely a large population) or

eligibility may be limited to patients with a clinically recognized AUD diagnosis (likely a much smaller population); successful implementation for these unique target populations would likely require different implementation strategies and supports for app delivery.

Table 2 (continued)

Theme	Exemplar quote(s)
App design and target population will determine implementation needs The app's target population will determine implementation needs	I think a key question is if the app is designed and targeted for people who have alcohol use disorder versus just unhealthy alcohol use. If it's just unhealthy alcohol use, that's a huge population and there would need to be something that is completely self-directed and available on the Web, and we could suggest that people go there, because that volume of patients we couldn't manage anywhere near the way that we do people who have alcohol use disorder. [But] the population with a use disorder would benefit from having some staff who are supporting people in using the app and connecting to other care providers and supports if they are identifying a need and a desire for that. Because again, you're talking about a group of people who have a use disorder with a lot of morbidity associated with it and even a highly effective app is not likely to be effective in and of itself for most people. (#12, care delivery leader) I could see [an app offered for unhealthy alcohol use and AUD] being more available to more patients, but then you'd also need the staffing to support that if more and more patients were interested or providers were keeping it in mind more often, to recommend. (#7, LICSW)
Desire for flexibility in who to offer apps to (as opposed to strict eligibility requirements)	Frankly, in my opinion, if [the app is] tried and true ... for one kind of an addiction, why not the next? (#9, care delivery leader) There's definitely been situations where I'm glancing at a chart and I'm like oh, this person would be perfect for this, for reSET, and then I go in to check what substances they're using, and it's just alcohol. So there's a lot of people who aren't getting enrolled, who I think would benefit from it. (#6, LICSW) I tend to think of a lot of these apps and these different things that we offer to patients as things to try for coping. It's hard to see the downside of at least trying it out [using reSET for patients with AUD only]. It seems like a lot of what reSET is aiming for is in line with what we would also offer to somebody who is using alcohol in an unhealthy way or wanted to reduce their alcohol use. (#7, LICSW)
Messaging about the app should make it clear which patients are best suited	I think really having targeted information about which patients this would be useful for, what's the evidence behind it. (#10, PCP) Since we're offering [multiple apps for different conditions], we have to have really good knowledge about each one of those apps and what they do. (#8, MA)
Implementation adaptations for app-based AUD treatment may not need to be extensive Implementation of a digital therapeutic for AUD could be similar to implementation of a digital therapeutic for SUD	I think it would be a pretty similar workflow because again, there's kind of the screener tools that typically the MA's are using when a patient comes in for a visit. The PCP might talk to the patient and kind of introduce the idea of a digital therapeutic and then be referred or have some sort of handoff to a social worker. So I think it would be a very similar process, and I think a lot of what we're learning in the implementation of reSET and reSET-O could then be used as a foundation for implementing a new therapeutic for unhealthy alcohol use. (#15, implementation team member) Interviewer: Earlier you mentioned things like training, huddle cards, emails or announcements from partners in the delivery system. Are there any things related to those types of implementation strategies that might need to be changed? Participant: No, I think those work pretty well. (#13, care delivery leader) I'm also thinking in terms of follow up care. I think it would look the same—if I'm checking in with a patient with alcohol use disorder, it's going to be a pretty similar follow up to substance use disorder. (#1, LICSW)

In general, participants preferred flexible and inclusive eligibility criteria for digital therapeutics. Participants expressed feeling challenged when digital therapeutics had eligibility criteria that restricted its use to a specific population of patients which they perceived as unnecessarily narrow. One participant remarked,

One of the challenges we've come across so far... is that when patients present and they have alcohol use disorder, it has to be paired with another substance [for them to be eligible for reSET]. Which is really hard, because there are so many patients who have presented that have problems with alcohol use, they want support around it, and then we review and see—oh

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Implementation adaptations for app-based AUD treatment to accommodate high patient volume	
Simplify the workflow to accommodate higher volume	<p>We're already limited in how many people we can offer this to for other substance use, and if we look at people that have primary alcohol use disorder or alcohol use disorder alone, that population sort of dwarfs the overall other drug use disorder patient population who we currently can offer reSET and reSET-O to. So we would be even more challenged. Adaptation-wise, we probably would want to think about changing this a little bit so that it's even more easily administered to link people up. I kind of wonder about a virtual-only way of connecting patients with this. (#12, care delivery leader)</p> <p>I do think that alcohol use disorder is a lot more common than drug use disorder so there's potential for our system to be somewhat overwhelmed if we're getting lots and lots of information from patients who are in our panels who are using this and have alcohol use disorder. There's a potential for there to be basically information overload from that. (#4, PCP)</p>
Have a dedicated, centralized staff member to manage app-based care	<p>Ideally, we would be able to offer this with a completely remote or virtual implementation, or offering to connect the patient. Something like a centralized provider team that is able to offer patients the product, connect to it, and if it's useful, some ongoing monitoring with them. (#12, care delivery leader)</p> <p>I think what would be the most helpful is if there were one LICSW who is going to do this for multiple clinics and actually dedicate their time to that, it would be a way more successful program. Right now there's just way too many competing needs. (#6, LICSW)</p>
Provide opportunities for patients to access the app without going through a clinician	<p>Most patients are certainly familiar with being able to go on a smart phone and download an app and figure that piece out, so if that's something that is easily doable-I understand that might be necessary in terms of making it available for free, but the more that we can make it available to them, very easily accessible and without a lot of hoops to jump through. (#3, PCP)</p>
Implementation adaptations for app-based AUD treatment to accommodate variation in AUD severity, motivation to change, and treatment goals	
Different approaches are needed for patients with different AUD severity	<p>I think that for low-risk patients who I don't have a serious concern for withdrawal that may need medical intervention, [app-based treatment] could be an intriguing option. Again, I think it depends on the patient, if they're engaged, who this might work best for. (#10, PCP)</p>
Apps should allow for tailored goal setting (not just abstinence)	<p>I'd imagine you'd want to be able to offer that option [an app for patients who want to reduce but not stop drinking], right? And maybe different apps with different modules or guidance. Because I do think there's a number of patients where they're not ready to abstain completely, but it's kind of a risk reduction module so any reduction would be helpful. So I can see where there might be utility to do both. (#10, PCP)</p> <p>So I think from the clinic point of view it would be doing what we do now, goal setting, specific goals, and talking about motivation and barriers to reach those goals and lining that up with how they're using the app, like applying the concepts that they're learning in the app to actually work toward those goals. (#1, LICSW)</p>
Supportive of offering multiple apps for patients with AUD if there is good evidence to do so and it's clear when to use which app	<p>I personally like [having multiple digital therapeutic options] because then I'd be able to say "here are three things I can offer you that could potentially meet your needs." And then either based on my description, they can choose, or they can go in and see which one they prefer... I just feel there isn't one that's the perfect thing so being able to have more than one to choose from and go "yeah, out of all of them. I think that's the one that works for me the best." (#16, LICSW)</p> <p>I don't see a conflict [with offering multiple apps]. I just think that you would really need to make it clear like who goes where. If you have too many apps doing the same exact thing, like everyone with alcohol use has three different options, I think that's probably going to be confusing both for patients, just because I think that choosing something once you're at that point probably feels really overwhelming to begin with.... Otherwise you're probably going to have someone that you just pick your favorite app and everyone goes to the favorite app, right? (#2, PCP)</p>

PCP primary care provider, LICSW licensed independent social worker