Distribution Statement

Distribution A: Public Release.

The views presented here are those of the author and are not to be construed as official or reflecting the views of the Uniformed Services University of the Health Sciences, the Department of Defense or the U.S. Government.

Low-Intensity Cognitive Behavioral Therapy in Group Telebehavioral Health Format for Depressive Disorders Treatment in Primary Care

Carla J. Graham, Nicole Morris, Katherine G. Whatley

Uniformed Services University of the Health Sciences

Copyright Acknowledgement Statement

"The author(s) hereby certify that the use of any original work by another author or copyrighted material used in the DNP project entitled:

Low-Intensity Cognitive Behavioral Therapy in Group Telebehavioral Health Format for Depressive Disorders Treatment in Primary Care

is either appropriately cited within the manuscript or used with formal written permission of copyright release by the owner of the original work."

LCDR Carla J. Graham, DNP, PMHNP-BC
Daniel K. Inouye Graduate School of Nursing
Uniformed Services University
[redacted]

LT Nicole Morris, DNP, PMHNP-BC
Daniel K. Inouye Graduate School of Nursing
Uniformed Services University
[redacted]

LT Katherine G. Whatley, DNP, FNP-BC, WHNP-BC
Daniel K. Inouye Graduate School of Nursing
Uniformed Services University
[redacted]

Disclaimer

The views expressed in the paper are those of the authors and do not necessarily reflect the official policy or position of the Uniformed Services University, Department of the Navy, the Department of Defense, or the United States Government. There are no financial relationships that exist between the authors and a commercial entity.

We are military service members. This work was prepared as part of our official duties. Title 17, USC, 105 provides that 'Copyright protection under this title is not available for any work of the U.S. Government.' Title 17, USC 101 defines a U.S. Government work as a work prepared by a military service member of employee of the U.S. Government as part of that person's official duties.

Abstract

Project Site: Naval Medical Center Camp Lejeune

Project Title: Low-Intensity Cognitive Behavioral Therapy in Group Telebehavioral Health Format for Depressive Disorders Treatment in Primary Care

Authors: Graham, C.J., Morris, N., & Whatley, K.G.

Background or Problem/Issue: Depressive disorders account for significant healthcare utilization and disability. Military Health System (MHS) facilities are not adequately matched with resources for sufficient accessibility of mental health (MH) services. Barriers to the availability of MH resources are a chief concern and facilitating greater access to MH evidence-based treatments supports all seven critical initiatives of the MHS Quadruple Aim.

Clinical Question or Purpose: In patients diagnosed with depressive disorders, what is the effect of Low-Intensity Cognitive Behavioral Therapy (LiCBT), utilized in the primary care setting in a group telebehavioral health (TBH) format, on depressive symptom reduction, patient satisfaction, and use of civilian network services over six weeks?

Project Design: Implemented and evaluated the effectiveness of six weekly, one-hour LiCBT Group TBH sessions used as an augmentation to current treatment for mild to moderate depression for twelve primary care patients with depressive disorders. The Patient Health Questionnaire-9 (PHQ-9) and patient satisfaction questionnaire results were measured. Developed a program manual to outline implementation steps for future dissemination and sustainment.

Analysis of the Results: Significant reduction in PHQ-9 scores from pre-session (median 10.5, IQR 7.5-12.0) to post-session (median 7.0, IQR 4.0-9.3) and 100% patient satisfaction. Nine patients (75%) did not seek MH services in the civilian network following LiCBT Group TBH, two (17%) were unable to be reached for follow-up, and one (8%) utilized civilian services. Summary level data suggest that 36.9-58.5% of patients seeking MH care sought treatment at civilian facilities in 2020, which increased slightly to 39.1-64.3% in 2021. Active-duty patients seek civilian services less frequently, with 12.7-14.6% seeking treatment outside the hospital in 2020 and 17.4-21.1% in 2021.

Organizational Impact/Implications for Practice: The LiCBT program in group TBH format is a feasible and effective treatment for decreasing severity of depressive symptoms, while achieving patient satisfaction, and has the potential to significantly increase access to care, thus contributing to improved service member functioning and military readiness.

Contents

Low-Intensity Cognitive Behavioral Therapy in Group Telebehavioral Health Format for Depressive Disorders Treatment in Primary Care

Depressive disorders, including but not limited to major depressive disorder (MDD), depressive disorder with seasonal patterns, and persistent depressive disorder, are a leading cause of disability worldwide. They affect an estimated 4.4% of the global population and are associated with increased mortality risk, severe functional impairment, and significant economic impact (World Health Organization, 2017). Unfortunately, the United States (U.S.) active-duty military members are not immune (National Alliance on Mental Illness, 2019). Depressive disorders are the second leading mental health disorder among military personnel, affecting 22% of service members and increasing the need for psychiatric-mental health resources (Stahlman & Oetting, 2018). Current research demonstrates that the combination of multiple components, including low-intensity cognitive behavioral therapy (LiCBT) (Bennett-Levy et al., 2014; Naeem et al., 2017), delivered via telebehavioral health (TBH) (Banbury et al., 2018; Barrera et al., 2017; Haller et al., 2019; Lawn et al., 2019), in a group delivery format (Banbury et al., 2018; Rollman et al., 2017; Schuster et al., 2018; Williams et al., 2018) is an appropriate treatment option for depressive symptom reduction. This project focused on implementing and evaluating a six-week LiCBT group therapy program, delivered via TBH, for patients with depressive disorders in the primary care setting at Naval Medical Center Camp Lejeune (NMCCL).

Problem Synthesis

Within U.S. adults aged 18 years and older in 2017, an estimated 17.3 million (7.1%) people had at least one depressive disorder. Of adults with depressive disorders, 63.8% had a severe impairment, often causing lost workplace productivity. An estimated 65% of people received combined care by a health professional and medication treatment (National Institute of

Mental Health, 2019). The total economic burden of MDD, a single type of depressive disorder, is estimated at $210.5 billion per year (Center for Workplace Mental Health, American Psychiatric Association Foundation, n.d.).

Depressive disorders' high prevalence and detrimental impacts negatively affect military personnel. In 2016, mental health disorders accounted for the highest number of hospital bed days and the third-highest number of medical encounters for service members, resulting in burdens on the mission through lost productivity (Stahlman & Oetting, 2018). From 2007 to 2016, the second leading cause of all mental health disorder diagnoses was depressive disorders, totaling 281,829 cases. In 2017, there were 375,424 'direct care' outpatient encounters for active-duty depressive disorder patients, provided through military treatment facilities within the MHS; yet, there were 92,341 additional 'purchased care' encounters received from Tricare-authorized civilian facilities outside the MHS (Psychological Health Center of Excellence, 2018; Wooten et al., 2018). MHS facilities are not adequately matched with resources for sufficient accessibility of mental healthcare services (Wooten et al., 2018).

With depressive disorders accounting for significant healthcare utilization and disability in military service (Stahlman & Oetting, 2018), barriers to the availability of mental healthcare resources are a chief concern (Kantor et al., 2017). A study of 520 Department of Defense psychological health providers found that 49% of providers reported following up on their patients less frequently than desired due to heavy caseloads, and a fifth of providers saw MDD patients for less than eight sessions (Hepner et al., 2018). From patients' perspectives, significant barriers to care include a lack of finances, time, support from work (Kantor et al., 2017), and confidentiality, since they often require a commander's permission to attend medical appointments during work (Wooten et al., 2018).

Relevance to Military Nursing

The adverse sequelae of depressive disorders on productivity and overall health of service members challenge military operational readiness and the achievement of the MHS Quadruple Aim of increased readiness, better health, better care, and lower cost. The top priority is programs that extend the needed mental healthcare to service members, improving health and military readiness. Targeting barriers to care supports all seven critical initiatives of the MHS Quadruple Aim that include: improving deployability, expanding medical force readiness, encouraging healthy mental health behaviors, optimizing access to mental healthcare, improving the quality of mental healthcare to meet needs, achieving zero harm, and enriching the effectiveness and efficiency of mental health services (Defense Health Agency, 2019).

Clinical Question

In patients diagnosed with depressive disorders (P), what is the effect of LiCBT, utilized in the primary care setting in a group TBH format (I), on depressive symptom reduction, patient satisfaction, and use of civilian network services (O) over six weeks (T)?

Search Strategy/Results

We utilized the following databases for our literature search: PubMed Legacy and the Cumulative Index to Nursing and Allied Health Literature (CINAHL), using search terms guided by our clinical question. These search terms included “low-intensity CBT” OR “depression AND low-intensity CBT AND group therapy” OR “depression AND primary care” OR “telehealth intervention AND depression” OR “telehealth CBT” OR “telehealth depression” OR “telehealth AND depression AND primary care” OR “low-intensity CBT group therapy for depression.” Searches were limited to full text, peer-reviewed articles published within the last five years. These searches yielded a total of 684 studies for screening, with 606 remaining after removing

duplicates. Studies included during screening addressed LiCBT in group format for depression, LiCBT for depression via telephonic delivery, depression and group therapy, TBH interventions, and TBH CBT. Studies excluded during screening did not address depression, LiCBT, telephonic delivery, depression combined with group therapy, TBH CBT; or addressed medical conditions in conjunction with depression, other medical disorders (e.g., type two diabetes, cancer, irritable bowel syndrome), other mental health disorders (e.g., PTSD, psychosis, bipolar, panic disorder, anxiety), mobile app or internet-based interventions, pharmacist-led interventions, chronic pain interventions, rehabilitation interventions, or prolonged exposure. After title and abstract screening using the above-set criteria, 74 articles remained for full-text review. During the full-text review, 66 were further excluded for the following reasons: wrong interventions (36), wrong patient populations (10), wrong settings (10), and poor study designs (10), leaving a total of eight studies that we appraised using the Johns Hopkins Nursing Quality of Evidence-Based Practice (EBP) Tool and included in the solution synthesis, as seen in Appendices A and B.

Solution Synthesis

Mental health professionals are often a scarce resource in the primary care setting. Extending traditional in-person, one-to-one, high-intensity psychotherapy to all patients with depressive disorders may not be feasible in the primary care setting. To facilitate greater access to mental health evidence-based treatments, novel approaches with lower intensity interventions are needed with the goal of achieving similar outcomes as in-person, one-to-one high-intensity psychotherapy. ‘Low intensity’ refers to lower usage of therapist time or usage in a cost-effective way, such as in a group cognitive-behavioral therapy (CBT) context. The primary purpose of Low Intensity CBT (LiCBT) is to increase access to evidence-based psychological therapies and enhance mental health and wellbeing of patients seen in the primary care setting.

Individual and group formats can be used to deliver LiCBT. Naeem et al. (2017) demonstrated that LiCBT delivered via the traditional face-to-face method is a feasible and effective method for reducing depressive symptoms in a brief six to ten session duration. LiCBT has been shown to improve depressive severity, measured by the Patient Health Questionnaire (PHQ-9); improve functional disability; and produce economic gains to the system (Naeem et al., 2017). In a randomized controlled trial, Williams et al. (2018) found LiCBT-based therapy delivered in a group setting improved depressive symptoms. Other benefits were cost-effectiveness, patient satisfaction rates, and the ability for patients to maintain improvements after therapy completion (Rollman et al., 2018; Schuster et al., 2018; Williams et al., 2018).

There is also increasing literature evidence supporting LiCBT as a telehealth intervention (Banbury et al., 2018; Barrera et al., 2017; Haller et al., 2019; Lawn et al., 2019). LiCBT telephone-based therapy replicates recovery rates and clinical outcomes experienced in other settings, e.g., one-to-one high-intensity psychotherapy (Lawn et al., 2019), can easily be tailored to patient needs (Barrera et al., 2017), eliminates the need for traveling (Haller et al., 2019), and promotes a level of confidentiality because it does not require the patient to disclose participation (Haller et al., 2019). Additionally, one systematic review evaluated the addition of health professional-led group videoconferencing as a supplementary component to LiCBT (Banbury et al., 2018). Results supported the feasibility, acceptability, and efficacy of home-based videoconferencing groups at overcoming barriers for attending face-to-face groups, such as fear of meeting new people, travel distance, lack of time, and inconvenience (Banbury et al., 2018).

In summary, current empirical evidence demonstrates that the combination of multiple components, including LiCBT (Bennett-Levy et al., 2014; Naeem et al., 2017), delivered via TBH (Banbury et al., 2018; Barrera et al., 2017; Haller et al., 2019; Lawn et al., 2019), in a

group delivery format (Banbury et al., 2018; Rollman et al., 2017; Schuster et al., 2018; Williams et al., 2018) is a feasible, acceptable, and effective treatment option for depressive symptom reduction and reducing barriers to mental healthcare. Military primary care clinics provide wellness care across the health spectrum and are the prime setting to implement a group TBH program for the reduction of depressive symptoms. To date, this evidence-based project is the first initiative to achieve MHS goals related to improved access, cost quality, and readiness.

Focus Areas

The first focus area for our project was to identify an evidence-based LiCBT program that could be delivered in group format via TBH and used as an augmentation to current treatment for mild to moderate depression in active-duty service members receiving care at an NMCCL primary care clinic. The second focus area was implementing this program to decrease depressive disorder severity, improve patient satisfaction with depressive disorder treatment, and decrease civilian network purchases for depressive disorder treatment. Our third focus area was to evaluate the said program and disseminate findings and lessons learned.

Business Case Analysis

According to the most recent data from the Psychological Health Center of Excellence (2018), there were 50,761 direct care patients diagnosed with depressive disorders who received a total of 375,424 direct care outpatient encounters for depressive disorder treatment in 2017. There were 15,744 purchased care patients diagnosed with depressive disorders who received a total of 92,341 purchased care outpatient encounters for depressive disorder treatment in 2017. Additionally, the approximate cost for one, one-hour, 1:1 CBT session is $100 or more (Anxiety and Depressive Association of America, 2020). If one hour of outpatient purchased care, at the cost of $100/hr, were recaptured per purchased care patient through increasing access to care, an

estimated total of $1,574,400 could be saved. This is in addition to the $6,600 saved by treating twelve patients for the price of one in six sessions, utilizing the group TBH approach.

Organizing Framework

The organizing framework chosen for this project was the five-step Clinical Scholar Model. This model is based on the principles expressed in the Clinical Scholarship resource paper (Clinical Scholarship Task Force, 1999) published by Sigma Theta Tau International (Melnyk & Fineout-Overholt, 2019). We selected this model because it provides a straightforward and sustainable framework for evaluating an evidence-based solution on a smaller trial population with the intent of future, more comprehensive implementation and dissemination.

The five steps of the Clinical Scholar Model include observation, analysis, synthesis, application/evaluation, and dissemination. The observation step guided us in determining the significance of the problem, key stakeholders, and the outcome of interest. The analysis step guided us in analyzing and critiquing internal and external evidence surrounding the problem of depression in the military, barriers to appropriate care, and the proposed solution of LiCBT Group TBH. We then synthesized the evidence to assess completeness and adequacy. Evidence was determined to be complete and adequate, and we implemented a project applying LiCBT Group TBH to a pilot unit at NMCCL. We monitored this pilot unit and evaluated outcomes to determine efficacy, benefits, and feasibility of broader implementation. Finally, in the dissemination step, we disseminated findings and lessons learned (Melnyk & Fineout-Overholt, 2019).

Project Design

General Approach

This project was a program evaluation of LiCBT for depressive disorders, delivered in group TBH format, utilized as therapy augmentation to the current 'status quo' of: receiving medication through a primary care manager (PCM) without mental health therapy, referral for 1:1 mental health therapy, or purchased care within the civilian network for mental health therapy. It was designed to augment the current status of utilizing 1:1 therapy as the sole treatment option for depressive disorder therapy and the gaps in care that this creates.

Setting and Population

The setting was NMCCL, which consists of more than 2,500 staff, including PCM, specialty physicians, and other healthcare professionals, and provides services to approximately 60,000 beneficiaries, composed of active-duty service members, veterans, and family members (Military Health System Communications Office, 2020). This evidence-based project was designed to include eight to 12 patients in the primary care setting at NMCCL, who were diagnosed with depressive disorders. All participating patients had an assigned PCM at the implementation site and met the inclusion criteria of PHQ-9 scores being 0-14, demonstrating only mild to moderate depression. Exclusion criteria included severe depression with PHQ-9 of 15 or above, anxiety disorders, bipolar disorders, schizoaffective disorder, current substance use disorders, psychotic conditions, and severe psychiatric conditions for which this treatment modality would be inappropriate such as suicidal ideation/suicidality or current risk of harm to self or others (Barrera et al., 2017; Naeem et al., 2017; Rollman et al., 2018; Schuster et al. 2018).

Procedural Steps with Timeline

As outlined in Appendix D, the first phase was completed by July 31, 2021, and it included the first three steps of our selected EBP model: Observation, Analysis, and Synthesis.

During these first steps, we identified our problem of interest, depression in the military; the key stakeholders; and the outcomes we needed to measure. We also completed a literature review of the latest evidence-based solutions for our problem of interest, and we critiqued and appraised this literature. This enabled us to select LiCBT Group TBH as an evidence-based solution that addressed the problem of depressive symptoms and barriers to care (see Appendices A and B). We then synthesized evidence to identify our project's independent and dependent variables (see Appendix C); developed a business case analysis to assess feasibility, risk/benefit, and cost/benefit of implementation (see Appendix D); and created a project timeline to guide project implementation (see Appendix E).

Our next phase was Application & Evaluation, which we projected to be completed by February 28, 2022. Before project implementation, we sought institutional review board (IRB) and privacy board reviews and conducted informational sessions with NMCCL leadership and stakeholders to gain site access and secure their engagement. We also secured local clinical supervision and clinical oversight of our project by a qualified mental health provider, specifically the Integrated Behavioral Health Consultant (IBHC) provider in the primary care setting.

During the Application step of this phase, we conducted education sessions with NMCCL primary care clinic staff to inform them of project goals and processes for screenings and referrals to LiCBT Group TBH. By September 30, 2021, 12 patients were screened and referred to participate in the LiCBT Group TBH, with the help of PCM's and the IBHC. In collaboration with the IBHC, we conducted an initial assessment phone call with each interested patient to confirm eligibility and further provide details regarding program logistical details, weekly expectations, and schedule. We provided the primary care clinic and clinical supervisor's contact

information to project participants for any program questions. We also provided the local mental health clinic contact information and the national suicide helpline to all project participants. By December 31, 2021, six weekly, one-hour LiCBT Group TBH sessions with the eligible 12 patients were completed. We monitored attendance at each session to track sustained engagement of patients, and PHQ-9 evaluations were administered prior to the therapy program and at the final session. Patient satisfaction metrics were administered per facility protocol to assess overall patient satisfaction post-treatment.

During the Evaluation step, completed in March 2022, we analyzed and evaluated the patients' pre-and post-PHQ-9 evaluation scores, satisfaction scores, and attendance rates throughout the six-week program. We followed up with patients three months post-LiCBT Group TBH participation and assessed their individual use of civilian network mental healthcare services. We also compared the percentage of NMCCL patients seeking behavioral health services in the civilian network versus at NMCCL in 2020, pre-project implementation versus 2021, post-project implementation. During the final phase of Dissemination, which we project to be completed by May 21, 2022, we will develop and present our project results to local stakeholders and academic leadership. We also created a program manual to make available to local clinic leadership, outlining our project implementation instructions and future recommendations for sustainment.

Data Analysis Plan

The data analysis plan included one independent variable, LiCBT Group TBH, and four dependent variables. The first dependent variable, depressive severity, was measured using the PHQ-9 before and after LiCBT Group TBH program participation, assessing symptom reduction and/or decline in the depressive disorder severity category. Treatment response, defined as a

reduction in depressive symptoms severity of 50% or more as measured by the PHQ-9, was the preferable method for comparing treatment outcomes for statistical significance (Coley et al., 2020). The second dependent variable, patient satisfaction with treatment, was obtained post-treatment from the local facility's questionnaires that are routinely used to measure satisfaction with care received. The third dependent variable was the percentage of patients seeking behavioral health services in the civilian network for depressive services following LiCBT Group TBH involvement. Three months following treatment, we determined if civilian network services were received by contacting the patients telephonically. The last measure was the percentage of NMCCL patients seeking behavioral health services in the civilian network versus NMCCL from 2020 to 2021.

Potential Barriers and Dissemination Plan

The most common barriers related to the implementation of EBP included staff shortages, lack of organizational leadership buy-in, patient decompensation, and resistance to change by staff. We affirmed that lack of staff was not an issue as we performed the Application step. We anticipated the most likely barrier would be 'resistance to change by staff.' A solution for dealing with resistance was to encourage early staff engagement with the project. NMCCL key stakeholders were engaged and onboard with the implementation of this project.

To mitigate potential patient safety issues, only patients with mild to moderate PHQ-9 scores were considered for participation in the LiCBT Group TBH program. A safety plan was in place for each patient, and pre-and post-safety checks were performed in each group. No safety issues were encountered, however we were prepared to follow local clinic safety procedures, provide patients with the local mental health clinic's contact information, and encourage them to seek follow-up care, should any of the participating patients have experienced distress during any

of the sessions. We would have also informed their PCM of these steps. All our interactions with participating patients were supervised by our local clinical supervisor who was a mental health provider on staff at the primary care clinic.

The goal of dissemination was to share the project results with providers and patients to improve patient outcomes (White et al., 2019). This phase was imperative for moving evidence into practice. Occurring at multiple levels, the first dissemination area was internal with NMCCL clinical and administrative staff. Presentations at clinical or grand rounds were accomplished through group presentations. Poster and podium presentations were presented at the NMCCL 2022 Research Symposium. External dissemination for this project included a poster and podium presentation at USUHS, a poster and podium presentation at the Tri Service Nursing Research Program's 2022 Research and EBP Dissemination Course, presentation at Defense Health Agency's Nurses Week 2022 Continuing Education Forum, and journal submission for publication.

Sustainability was accomplished in many ways. Creating and developing partnerships was started at the beginning of the EBP implementation. A significant step in ensuring the sustainability of this project was to involve key project users, stakeholders, and the organization in project development, delivery, and evaluation. Finally, we aligned the project goals with the organizational mission to avoid mission drift. We made certain that the project supports the MHS Quadruple Aim to ensure sustainability and enhance mission readiness.

HIPAA Concerns and Ethical Considerations

Doctors of Nursing Practice are responsible for conducting scholarly projects and translation work that follow ethical guidelines regarding protection of project participants. Our team sought to follow three core ethical principles outlined in the *Belmont Report*: (1) Seek to

practice beneficence, (2) to practice nonmaleficence, and (3) to protect and promote justice. Within the work of translation, the intent is to apply evidence to improve outcomes (U.S. Department of Health and Human Services, 1976).

All personal identifying information (PII) and protected health information (PHI) was kept in the Armed Forces Health Longitudinal Technology Application (AHLTA), the military's electronic health record and clinical information system, which provides secure electronic access to the patient's comprehensive medical records. Our group de-identified the data using a project code number to track and compare the patients' pre-and post- PHQ-9 scores, depression category, and satisfaction scores. Results were reported in aggregates to protect patient privacy. All de-identified data and statistical analyses were only accessible to project team members and our clinical and academic supervisors. They were saved on password-protected, common access card (CAC) controlled government computers. The LiCBT groups were performed using MHS Video Connect and the video teleconferencing equipment approved at NMCCL. Ongoing communication with the NMCCL IRB and careful adherence to procedures and policies were critical to fulfilling our obligations to protect individuals in our care (White et al., 2019).

Project Results

Twelve patients were enrolled in the LiCBT Group TBH program. Patients were all female, and the majority were Caucasian (67%) with a median age of 25.0 years (Table 1). Most patients were civilian beneficiaries (83%) and diagnosed with an adjustment disorder with depressed mood (67%). Half of the patients did not have a Mental Health Clinic (MHC) referral but worked with the IBHC in the primary care setting. Of the six planned group sessions, four patients (33%) attended most or all of the sessions, while another four (33%) attended no sessions (Table 2).

Pre-session PHQ-9 scores were predominately moderate (67%) and mild (25%). There was a significant reduction in PHQ-9 scores from pre-session (median 10.5, IQR 7.5-12.0) to post-session (median 7.0, IQR 4.0-9.3, Figure 1). Post-session PHQ-9 scores were predominately minimal (42%) and mild (33%, Table 2). Post-session scores were unable to be obtained from two patients (17%).

Eight patients completed the post-treatment questionnaire. All patients were satisfied with their care and would recommend the treatment to someone else (100%, Table 2). Some patients reported that the sessions "definitely helped" and that the telehealth aspect was "less stressful" in open-ended comments (Table 3). Suggestions included holding sessions "later in the afternoon" and holding longer sessions. One patient indicated that she preferred a different therapeutic modality but would still recommend the program to others.

Of the enrolled patients, nine (75%) did not seek behavioral health services in the civilian network following LiCBT Group TBH, two (17%) dropped out or were otherwise unable to be reached for follow-up, and one (8%) utilized civilian services. Summary level data suggest that 36.9-58.5% of patients seeking mental healthcare sought treatment at civilian behavioral health services in 2020, which increased slightly to 39.1-64.3% in 2021. Active-duty patients seek civilian services less frequently, with 12.7-14.6% seeking treatment outside the hospital in 2020 and 17.4-21.1% in 2021.

Table 1. Patient Characteristics

Patient Characteristics

Characteristic		N=12
Age		25.0 [22.5-39.0]

Gender	*Female*	12 (100.0)
Race/Ethnicity	*Caucasian*	8 (66.7)
	Hispanic	2 (16.7)
	African American	1 (8.3)
	Other	1 (8.3)
Duty Status	*Civilian*	10 (83.3)
	Active Duty	1 (8.3)
	Retired	1 (8.3)
Diagnosis	*Adjustment Disorder w/ Depressed Mood*	8 (66.7)
	Major Depressive Disorder, Recurrent	2 (16.7)
	Depression	1 (8.3)
	Postpartum Depression	1 (8.3)
MHC Referral	*Active Patient*	3 (25.0)
	Active Referral	3 (25.0)
	No Referral, but working with IBHC	6 (50.0)

MHC = Mental Health Clinic; IBHC = Integrated Behavioral Health Consultant. Data reported in N(%) and Median [Q1-Q3].

Table 2. Sessions and Patient Outcomes

Sessions and Patient Outcomes

Session and Outcome Characteristics		N=12
Sessions (No.)		3.0 [0.0-6.0]
Session Attendance	*None (0 Sessions)*	4 (33.3)
	Partial (1-4 Sessions)	4 (33.3)
	Most/All (5-6 Sessions)	4 (33.3)
Pre-session PHQ-9		10.5 [7.5-12.0]
Pre-session PHQ-9 Category	*Minimal*	1 (8.3)
	Mild	3 (25.0)
	Moderate	8 (66.7)
	Moderate Severe	0 (0)
Post-session PHQ-9 (N=10)		7.0 [4.0-9.3]
Post-session PHQ-9 Category	*Minimal*	5 (41.7)
	Mild	4 (33.3)
	Moderate	0 (0)
	Moderate Severe	1 (8.3)

	Missing	2 (16.7)
PHQ-9 Difference (Post-Pre)		4.0 [1.8-5.3]
Satisfaction (N=8)		8 (100.0)
Would Recommend (N=8)		8 (100.0)

Data reported in N(%) and Median [Q1-Q3].

Figure 1. Pre- and post-session PHQ-9 scores. Post PHQ-9 scores were significantly lower than pre-session (p=.027).

Pre- and Post-Session PHQ-9 Scores

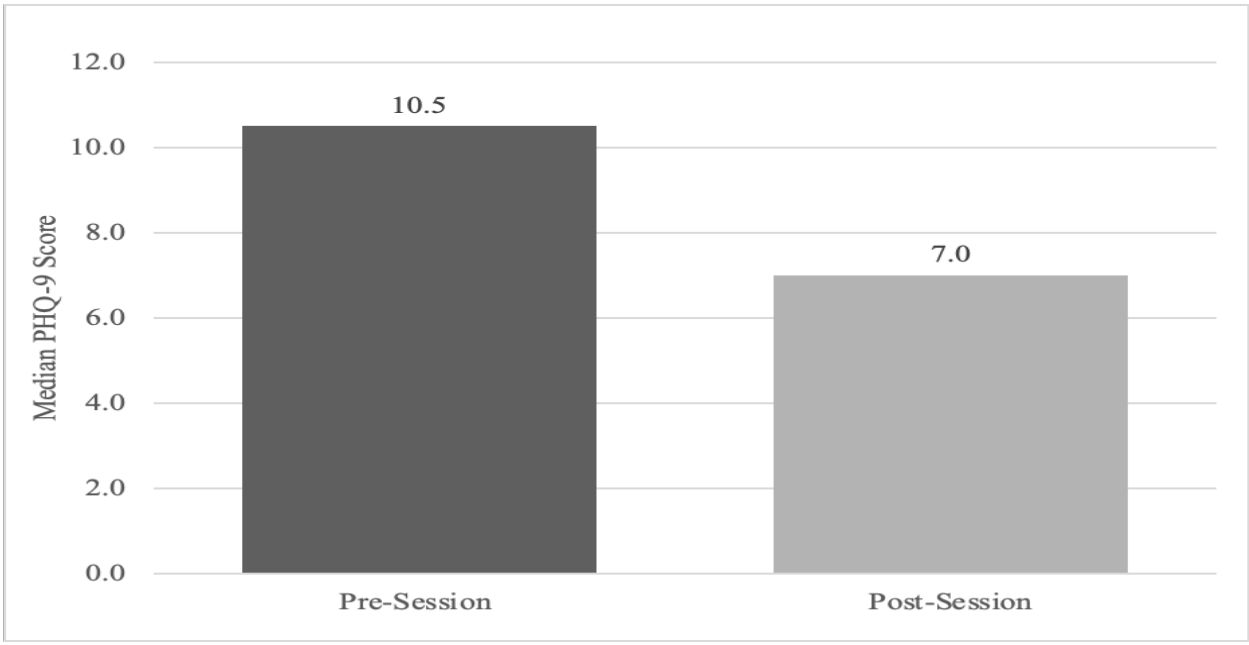


Table 3. Patient Feedback (Open Ended)

Patient Feedback (Open Ended)

Open-Ended Patient Feedback

Telehealth aspect made it "less stressful," “once per week was good, it didn’t conflict with anything else.”
Middle of the week timing was "not convenient" and would have liked "later in the afternoon"
Would have preferred different therapeutic modality, did not feel "learning and doing it myself" worked best
Would have preferred longer groups (>45min-1hr) and longer than 6 weeks, would have preferred Microsoft Teams as the virtual platform, "definitely helped me"/"invaluable to me"
MHS was "user friendly"
“Absolutely” satisfied with the overall experience
The group “felt like a lecture but not in a bad way”
“It worked out well with my schedule”

Statistical Analysis of the Results

Data were analyzed using SPSS 28.0 (Armonk NY, IBM Corp.). Numerical variables were reported in medians and interquartile ranges, while categorical variables were reported in counts and frequencies. The difference in PHQ-9 scores were analyzed with the Wilcoxon signed-rank test, while the correlation between PHQ-9 scores and the number of sessions attended were analyzed using a Spearman’s rank correlation. P-values less than 0.05 were considered significant.

Organizational Impact and Implications to Practice & Policy

We reviewed the evidence of feasibility, acceptability, effectiveness, and implementation of LiCBT in group format for depression, LiCBT for depression via telephonic delivery, depression and group therapy, TBH interventions, and TBH CBT. Eight studies met our inclusion criteria. Based on our literature review prior to study implementation, evidence indicated that these interventions were individually feasible, acceptable, and effective. Still, it was difficult to draw conclusions on the combination of these multiple components as an effective treatment option for depressive symptom reduction.

The focus of our evidence-based project was to identify if the LiCBT program could be delivered in group format via TBH and used as an augmentation to current treatment for mild to moderate depression in patients receiving care at an NMCCL primary care clinic. Other foci were to decrease depressive disorder severity, improve patient satisfaction with depressive disorder treatment, and decrease civilian network purchases for depressive disorder treatment. Lastly, we aimed to evaluate the LiCBT Group TBH program and disseminate findings and lessons learned.

Consistent with evidence-based research, we found that implementing a LiCBT Group TBH program within the primary care setting effectively decreases depressive disorder severity, as evidenced by PHQ-9 scores. We also found that the patients widely accepted the program per the patient satisfaction questionnaires, and only one (8%) patient sought behavioral health services in the civilian network for depressive services following LiCBT Group TBH. A strong recommendation for future practice at NMCCL is to adopt the LiCBT Group TBH program into the primary care settings, made easily accessible through our program manual. This clinical practice change provides the opportunity for sustainment and meets the requirements of the MHS Quadruple Aim of increased readiness, better health, better care, and lower cost.

Future Directions for Research and Practice

The sample size for this project was small, limiting the evaluation of the program's generalizability. Future evaluation should focus on a more comprehensive array of demographic variables, such as a larger sample size, inclusion of all genders, and age diversity. With the goal to improve cost-effectiveness, another recommendation for future research is to further evaluate civilian network purchases for depressive disorder treatment. Lastly, a future direction for practice is to incorporate LiCBT Group TBH into other NMCCL settings, such as medical and mental health clinics. LiCBT Group TBH has the potential to improve overall health and productivity, thereby benefiting both the patient and the military mission.

Conclusion

Depressive disorders significantly impact military personnel and operational readiness, but current practices cannot meet the demand for treatment. This EBP project demonstrated that the implementation of a LiCBT program in group TBH format is feasible in the military healthcare setting, and an effective treatment for decreasing depressive symptom severity and achieving patient satisfaction. In alliance with the seven critical initiatives of the MHS Quadruple Aim, continuation of this program and implementation in more expansive areas would improve access to care and decrease outpatient purchased care, totaling over $1.5 million in cost savings.

References

American Nurses Association. (2016). *Position statement*. https://www.nursingworld.org/~4af078/globalassets/docs/ana/ethics/ethics-and-human-rights-protecting-and-promoting-final-formatted-20161130.pdf

Anxiety and Depression Association of America. (2020). *Low-cost treatment.* https://adaa.org/finding-help/treatment/low-cost-treatment

Banbury, A., Parkinson, L., Nancarrow, S., Dart, J., & Gray, L. (2018). Telehealth interventions delivering home-based support group videoconferencing: Systematic review. *Journal of Medical Internet Research*, *20*(2), 28. 10.2196/jmir.8090

Barrera, T. L., Cummings, J. P., Armento, M., Cully, J. A., Bush Amspoker, A., Wilson, N. L., Mallen, M. J., Shrestha, S., Kunik, M. E., & Stanley, M. A. (2017). Telephone-delivered cognitive-behavioral therapy for older, rural veterans with depression and anxiety in home-based primary care. *Clinical Gerontologist*, *40*(2), 114–123. https://doi.org/10.1080/07317115.2016.1254133

Bennett-Levy, J., Richards, D., Farrand, P., Griffiths, D. K., Klein, B., Proudfoot, J., & Ritterband, L. (2014). *Oxford guide to low-intensity CBT interventions*. OUP Oxford.

Center for Workplace Mental Health, American Psychiatric Association Foundation. (n.d.). *Quantifying the cost of depression.* http://www.workplacementalhealth.org/Mental-Health-Topics/Depression/Quantifying-the-Cost-of-Depression

Clinical Scholarship Task Force. (1999). *Clinical scholarship resource paper.* https://www.sigmanursing.org/docs/default-source/position-papers/clinical_scholarship_paper.pdf

Coley, R. Y., Boggs, J. M., Beck. A., Hartzler, A. L., & Simon, G. E. (2020). Defining success in measurement-based care for depression: A comparison of common metrics. *Psychiatric Services, 71*(4), 312-318. 10.1176/appi.ps.201900295

Defense Health Agency. (2019, February). *Quadruple aim performance process.* [PowerPoint slides]. https://webcache.googleusercontent.com/search?q=cache:kwTCFahjhuAJ:https://health.mil/Reference-Center/Presentations/2019/02/11/Quadruple-Aim-Performance-Process-Transforming-Performance-Improvement+&cd=1&hl=en&ct=clnk&gl=us&client=safari

Haller, E., Besson, N., & Watzke, B. (2019). "Unrigging the support wheels" - A qualitative study on patients' experiences with and perspectives on low-intensity CBT. *BMC Health Services Research*, *19*(1), 686. https://doi.org/10.1186/s12913-019-4495-1

Harvard Business Review Press. (2011). *Pocket mentor: Developing a business case.* Harvard Business Review Press.

Hepner, K. A., Farris, C., Farmer, C. M., Iyiewuare, P. O., Tanielian, T., Wilks, A., Robbins, M., Paddock, S. M., & Pincus, H. A. (2018). Delivering clinical practice guideline-concordant care for PTSD and major depression in military treatment facilities. *Rand Health Quarterly*, *7*(3), 3. https://doi.org/10.7249/RR1692

Inspector General U.S. Department of Defense. (2020). *Evaluation of access to mental health care in the Department of Defense*. https://media.defense.gov/2020/Aug/12/2002475605/-1/-1/1/DODIG-2020-112_REDACTED.PDF

Kantor, V., Knefel, M., & Lueger-Schuster B. (2017). Perceived barriers and facilitators of mental health service utilization in adult trauma survivors: A systematic review. *Clinical*

Psychology Review, *52*, 52–68. https://doi.org/10.1016/j.cpr.2016.12.001

Lawn, S., Huang, N., Zabeen, S., Smith, D., Battersby, M., Redpath, P., & Fairweather-Schmidt, K. (2019). Outcomes of telephone-delivered low-intensity cognitive behaviour therapy (LiCBT) to community dwelling Australians with a recent hospital admission due to depression or anxiety: MindStep™. *BMC Psychiatry*, *19*(2). https://doi.org/10.1186/s12888-018-1987-1

Melnyk, B.M., & Fineout-Overholt, E. (2019). *Evidence-based practice in nursing and healthcare* (4th ed). Wolters-Kluwer.

Military Health System Communications Office. (August 2020). *Naval Medical Center Camp Lejeune among best of the best.* https://www.health.mil/News/Articles/2020/08/13/Naval-Medical-Center-Camp-Lejeune-among-best-of-the-best

Naeem, F., Pikard, J., Rao, S., Ayub, M., & Munshi, T. (2017). Is it possible to provide low-intensity cognitive behavioral treatment (CBT Lite) in Canada without additional costs to the health system? First-year evaluation of a pilot CBT Lite program. *International Journal of Mental Health*, *46*(4), 253–268. https://doi.org/10.1080/00207411.2017.1345039

National Alliance on Mental Illness. (2019, September). *Mental health by the numbers.* https://www.nami.org/learn-more/mental-health-by-the-numbers

National Institute of Mental Health. (2019, February). *Major depression.* https://www.nimh.nih.gov/health/statistics/major-depression.shtml

Naval Medical Center Camp Lejeune. (2020). *Clinic measure values overtime for Camp Lejeune.*

Privacy Boards and the HIPAA Privacy Rule. (2004 July 12). U.S. Department of Health and

Human Services National Institutes of Health. https://privacyruleandresearch.nih.gov/privacy_boards_hipaa_privacy_rule.asp

Psychological Health Center of Excellence (2018, December). *Outpatient utilization of mental health care among service members: 2005-2017.* https://www.pdhealth.mil/utilization_outpatient

Rollman, B., Belnap, B., Mazumdar, S., Abebe, K., Karp, J., Lenze, E., Schulberg, H., Rollman, B. L., Belnap, B. H., Abebe, K. Z., Karp, J. F., Lenze, E. J., & Schulberg, H. C. (2017). Telephone-delivered stepped collaborative care for treating anxiety in primary care: A randomized controlled trial. *Journal of General Internal Medicine*, *32*(3), 245–255. 10.1007/s11606-016-3873-1

Schuster R., Fichtenbauer I., Sparr, V.M., Berger, T., & Laireiter, A.R. (2018). Feasibility of a blended group treatment (bGT) for major depression: Uncontrolled interventional study in a university setting. *BMJ Open*; 8:e018412. 10.1136/bmjopen-2017-018412

Stahlman, S., & Oetting, A. A. (2018, March). *Mental health disorders and mental health problems, active component, U.S. Armed Forces, 2007–2016.* https://health.mil/Military-Health-Topics/Combat-Support/Armed-Forces-Health-Surveillance-Branch/Reports-and-Publications/Medical-Surveillance-Monthly-Report

Sylvia, M. L., & Terhaar, M. F. (2014). *Clinical analytics and data management for the DNP.* Springer Publishing Company.

Theriault, F. L., Gardner, W., Momoli, F., Garber, B. G., Kingsbury, M., Clayborne, Z., & Colman, I. (2020). Mental health service use in depressed military personnel: A systematic review. *Military Medicine*, *185*(7-8), e1255-e1262. 10.1093/milmed/usaa015

Watzke, B., Haller, E., Steinmann, M., Heddaeus, D., Härter, M., König, H. H., Wegscheider, K.,

& Rosemann, T. (2017). Effectiveness and cost-effectiveness of telephone-based cognitive-behavioural therapy in primary care: Study protocol of TIDe – telephone intervention for depression. *BMC Psychiatry*, *17*, 263. https://doi.org/10.1186/s12888-017-1429-5

White, K. M., Dudley-Brown, S., & Terhaar, M. F. (2019). *Translation of Evidence into Nursing and Healthcare* (Third ed). New York, NY: Springer Publishing.

Williams, C., McClay, C. A., Matthews, L., McConnachie, A., Haig, C., Walker, A., & Morrison, J. (2018). Community-based group guided self-help intervention for low mood and stress: Randomised controlled trial. *The British Journal of Psychiatry, 212*(2), 88–95. https://doi.org/10.1192/bjp.2017.18

Wooten, N. R., Brittingham, J. A., Pitner, R. O., Tavakoli, A. S., Jeffery, D. D., & Haddock, K. S. (2018). Purchased behavioral health care received by military health system beneficiaries in civilian medical facilities, 2000-2014. *Military Medicine*, *183*(7-8), e278–e290. https://doi.org/10.1093/milmed/usx101

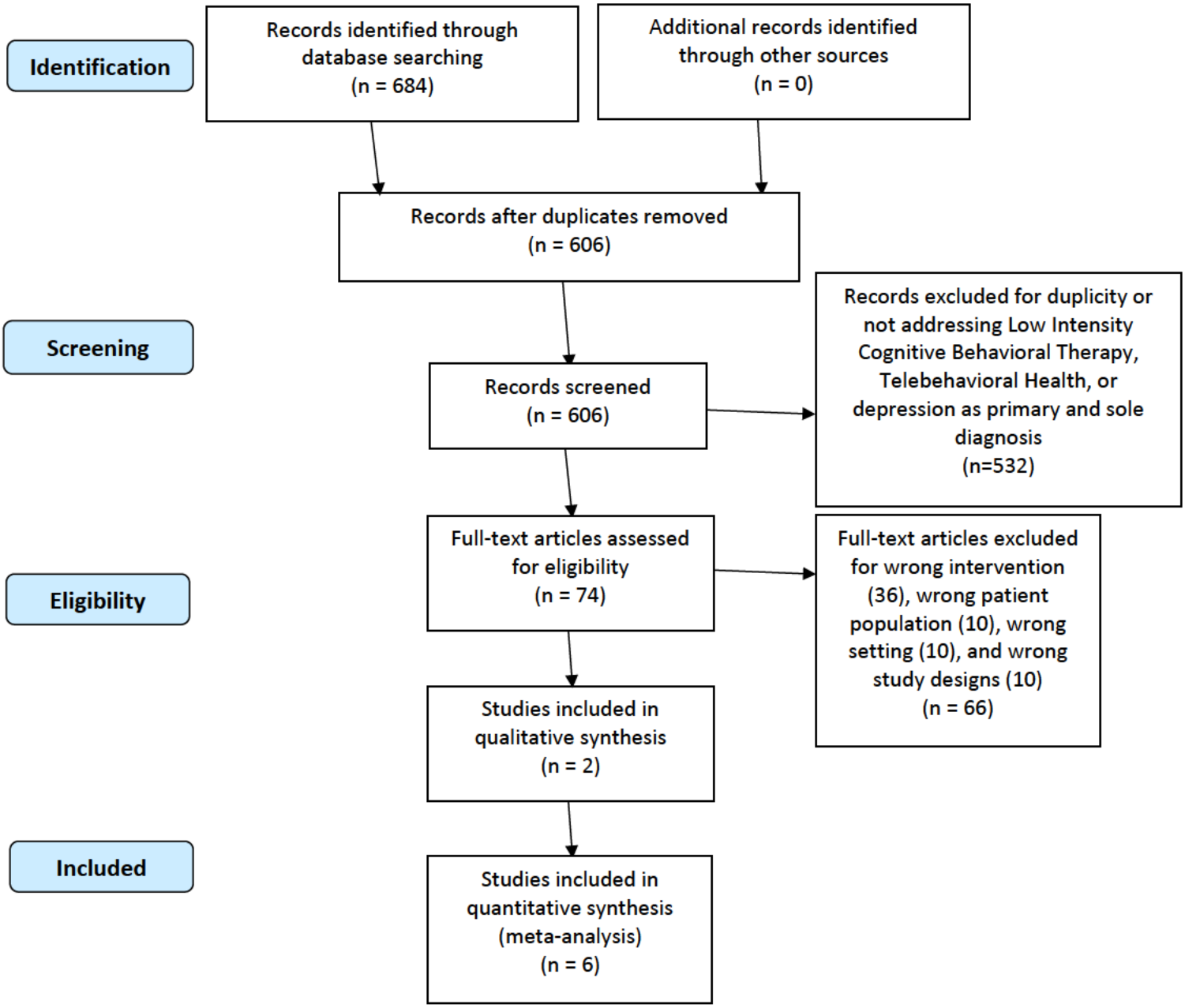
World Health Organization. (2017). Depression and other common mental disorders: Global health estimates. *Geneva: World Health Organization.* License: CC BY-NC-SA 3.0 IGO. https://apps.who.int/iris/bitstream/handle/10665/254610/WHO-MSD-MER-2017.2-eng.pdf

U.S. Department of Health and Human Services. (1976). *The Belmont Report*. https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/index.html

Appendix A

Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Diagram

PRISMA 2009 Flow Diagram



From: Moher D, L berati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *P*referred *R*eporting *I*tems for *S*ystematic Reviews and *M*eta-*A*nalyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

Appendix B

Evidence for the Solution

Table 1

Evidence Table

1st Author Name & Publication Year	Study Purpose/Aims	Research Questions/ Hypotheses	Study Design	Total Sample Size (initially & at end)	Sampling Plan	Independent Variables & Level of Measurement	Dependent Variables and Level of Measurement	Statistical Analyses: What tests were used for which research questions?	Results	Strengths (how promoted internal/external validity)	Weaknesses (biases, threats to internal/external validity)	LEVEL OF EVIDENCE - using JHNEBP tool (Strength and Quality)
1. Schuster et al. (2018)	The study aimed to: 1. Apply a developed blended group intervention to a sample of clinically depressed adults. 2. Evaluate its usefulness in a structured and standardized way. 3. Analyze system usage and corresponding changes over time. 4. Assess participants' appraisals of the new format.	N/A	Patient-centered uncontrolled interventional study	Initial Sample: n=88 Final Sample: n=26	Study was advertised online and by handing out flyers in public health centers and populated public areas, such as urban pedestrian areas in Vienna, Austria. All those interested were invited to visit the study web page and to fill out an online participation form. Recruitment ended after sufficient participants had been acquired. Two independent psychologists then conducted the diagnostic interviews to account for inclusion and exclusion criteria. **Inclusion Criteria:** (n=26) aged between 18 and 65 years; familiar with the use of personal computers; suffering from mild to moderate levels of major depression and/or dysthymia and/or mild to moderate comorbid anxiety. **Exclusion Criteria:** (n= 62), no reply to participation	The treatment compromised a **7-week low-intensity CBT-based (LiCBT)** psychoeducation and self-management **group intervention**, in which personal sessions (90 min) alternated with online exercises and remote therapist feedback. The theoretical basis for the low-threshold CBT intervention was based upon acceptance, mindfulness, self-management, and resource-oriented psychotherapy principles. The blended format included face-to-face sessions, complemented with online multimedia presentations and a platform featuring videos, online worksheets, an unguided group chat, and remote therapist-patient communication. The intervention focused on the reduction of depressive symptoms and	**Primary Outcome:** 1. Depression by use of the Center for Epidemiological Studies-Depression (CES-D) scale Level of Measurement: Interval **Secondary Outcomes:** 2. Psychological distress by use of the 12-item General Health Questionnaire (GHQ-12) 3. Personal resources by the German Questionnaire for the Assessment of Resources and Self-Management Abilities (FERUS) 4. Mindfulness states by the Mindful Attention Awareness Scale (MAAS) Level of Measurement: Interval	Power analysis was carried out a priori using G*Power,62, resulting in an estimated sample size of n=22, for a conservative medium within-subjects effect size of d=0.65 (alpha-error α=0.05, power β=0.90). Intention to treat (ITT) using linear mixed models. Reliable change indexes (RCI) for individual pre differences and follow-up differences. T-tests calculated differences in appraisals of intervention elements and the process aspects paired t-tests were applied.	All outcome measures indicated significant changes, and effect sizes were large to very large. For the primary outcome measure CES-D, a statistically significant reduction of self-reported depressive symptoms was found. Regarding secondary outcomes measures, self-reported psychological distress, assessed by the GHQ-12, significantly decreased. Personal resources (FERUS) significantly increased, as well as the frequency of mindful states (MAAS). Patients were followed up with after 3 months. At follow-up, 70% of patients exhibited Clinically Significant Improvement (CSI)	This is the first clinical study on blended group therapy (bGT) for depression. Additionally, this is the first study to apply standardized measures of client satisfaction and system usability in bGT. Lastly, it provides a detailed view on participants' appraisals of the new format.	The sample size was limited by participants who reported high comorbidity. The uncontrolled study design and the university setting restricted the interpretability of results	Level II

					letter; suffering from severe depression (≥7 criteria, including main symptoms), severe anxiety disorder, bipolar disorder, schizoaffective disorder, severe psychiatric and psychotic conditions, substance abuse, suicidal ideation; exhibited low-German language and/or computer skills; currently undergoing psychotherapy.	aimed at increasing personal resources and self-management abilities. Level of Measurement: Nominal	**Client Satisfaction and System Usability:** 5. Usability of online and multimedia elements by System Usability Scale (SUS) 6. Overall satisfaction with the treatment by the German version (ZUF-8) of the Client Satisfaction Questionnaire (CSQ-8) Level of Measurement: Interval **Appraisal of New Media Elements, Applicability and Process Aspects:** 7. Self-designed questionnaire (55 items) at post-treatment Level of Measurement: Interval		for depressive symptoms and CSI for general health was observed in 75%. Treatment satisfaction was high, and 69% ranked computer and multimedia use as a therapeutic factor. Participants described treatment intensification as an important advantage of the blended format. Half of the patients (48%) would have preferred more time for personal exchange. The majority (84%) stated that they would not leave out computer support and that this support has the potential to improve (80%) and intensify group therapy (72%). Lastly, 48% of patients expressed a desire for more group interaction and discussion time.			
2. Lawn et al. (2019)	The study aimed to assess: 1. The feasibility and acceptability of MindStep™, a	1. What is the recovery, reliable improvement, and reliable recovery rates	Prospective observational study	Initial Sample: n=867 Final Sample: n=680	Participants were screened via an initial interview, from referrals that came from six private health funds. These health funds identified n=867	**Up to six individual, telephone-delivered, low-intensity cognitive behavior (LiCBT) therapy sessions, delivered over 6-8 weeks** with 1, 3 and 6	1. Depression and anxiety. Measured by PHQ-9 and GAD-7 collected at each contact. The study used quantitative	**Pearson's chi-square test** showed a significant association between PHQ-9	The effect size of 1.03 for depression meant that, on average, those undergoing therapy would improve their	A key strength of this study is that the findings provide essential precursors	1. The use of the single imputation method, last observation carried forward (LOCF). This approach misses	Level II

	LiCBT intervention delivered telephonically, in the Australian private health system 2. Whether MindStep™ can achieve benchmark recovery rates of > 50% in people with recent mental health hospital admission	of MindStep? How do they compare with the UK IAPT benchmark? 2. What is the enrollment, completion, drop out, and step-up rates? 3. Is there an optimal number of sessions to maximize recovery rates? 4. Do clients with varying initial symptom severity experience any differences in their recovery rates? If so, what are the implications for future program selection criteria? 5. Are the recovery rates relatively consistent across coaches? 6. Were clients satisfied with MindStep?			individuals as eligible for the program following an acute hospital admission for anxiety and/or depression, confirmed by the member's claims data and ICD-10 codes, and referred them to MindStep (telephone-delivered LiCBT). Of the n=867 initially referred, n=94 declined treatment and n=16 did not attend initial assessment. Following the initial assessment of n=757 individuals, n=29 were "not suitable"(i.e. client had complex or multi-morbid mental health conditions and deemed unsuitable for MindStep), n=18 declined treatment, n=30 dropped out, and n=680 entered treatment.	month follow ups to monitor improvement maintenance Level of Measurement: Nominal	methods to compare pre-post treatment clinical measures (N = 680) using Patient Health Questionnaire (PHQ-9) and the Generalized Anxiety Disorder (GAD-7). Level of Measurement: Interval 2. This study also included in-depth interviews with participants (N = 14) and coaches (N = 4), post-treatment, to determine the feasibility and acceptability of the program. Level of Measurement: Nominal	symptom severity and associated recovery status with a small effect size for those who were at initial caseness (N = 247). Pearson's chi-square test showed that there was a strong association between clients' PHQ-9 symptom severity and reliable improvement in their scores (N = 343, $\chi2 = 67.71$, Cramer's V= 0.44, $p < 0.001$). Similarly, the test showed that there was a fairly strong association between clients' GAD-7 symptom severity and their reliable improvement (N = 362, $\chi2 = 63.83$, Cramer's V = 0.42, $p < 0.001$). **Paired samples T-test** showed significant difference between the pre-intervention and post follow-up PHQ-9 scores (pre-score = 10.91, post-score = 4.32, mean difference = 6.59,	score by + 1.03 standard deviation units at post-treatment. This is equivalent to moving from the 50th percentile to the 85th percentile in terms of improvement (reduction) in PHQ scores. PHQ-9 scores improved by + 0.88 standard deviation units (50th percentile → 81st percentile) at post-treatment. GAD-7 scores improved by + 0.82 standard deviation units (50th percentile → 79th percentile). The recovery rate was 60% (95% CI: 55–65%) and reliable recovery, 56% (51–61%). Similarly, the test showed that there was a fairly strong association between clients' GAD-7 symptom severity and their reliable improvement (N = 362, $\chi2 = 63.83$, Cramer's V = 0.42, $p < 0.001$). Clients assessed with 'moderate anxiety' (81.0%, N = 94) and 'severe anxiety' (86.2%, N = 56) showed the most reduction in their GAD-7 scores.	to high-quality clinical trials.	the informative properties of missingness and does not account for error in imputed values. However, the authors included LOCF findings to provide an opportunity for comparison with other missing data techniques- namely multiple imputation and complete case analysis. 2. Absence of control group 3. Use of self-reported PHQ-9 and GAD-7 for determining clinical levels of depression and anxiety, as these do not formally diagnose patients	

								p < 0.001) and GAD-7 scores (pre-score = 9.14, post-score = 3.68, mean difference = 5.46, p < 0.001). Fishers' exact test showed that coach C had the highest enrollment rate (92.2%, p = 0.001) but, interestingly, the lowest recovery rate (31.6%, p = 0.003). There was no significant difference between other coaches' performance				
3. Naeem et al. (2017)	This study aimed to improve access to psychological therapies in order to increase the provision of the evidence-based treatments (low-intensity CBT in this example) for common mental disorders, i.e. depression, by the frontline community health professionals.	N/A	Prospective, longitudinal, observational study	Initial Sample: n=53 Final Sample: n = 47	Participants from Kingston, Ontario, Canada were screened between May 1, 2015 and June 1, 2016 from referrals that came from the transitional case management (TCM) services, crisis teams, and primary care providers. **Inclusion Criteria:** mild to moderate degree of depression or an anxiety-related disorder **Exclusion Criteria:** severe personality disorder, severe drug or alcohol dependence, psychotic illnesses, severe developmental disability, and those with a high level of risk to self or others.	**Six to ten individual, in-person, low-intensity cognitive behavioral treatment (LiCBT) sessions of 60 minutes delivered weekly** Level of Measurement: Nominal	Depression. Measured by Hospital Anxiety and Depression Scale (HADS), Clinical Outcomes in Routine Evaluations (CORE), and WHO Disability Scale (WHO-DAS 2). Participants were seen for 6 to 10 sessions and self-rating clinical measures were collected at every contact with the participants. Level of Measurement: Nominal and Interval	Measures included Hospital Anxiety and Depression Scale (HADS), Clinical Outcomes in Routine Evaluations (CORE), and WHO Disability Scale (WHO-DAS 2). Clients were asked to complete these assessments at every session. Statistical analyses were carried out using SPSS v22. Both **parametric and non-parametric tests** were conducted as appropriate. **Chi-**	Data from the last available session was used for an individual's post-treatment score. Mean difference in CORE scores was 20.6 (95% CI: 14.7-26.6, p-value=0.000). Mean difference HADS-Depression subscale score was 4.5 (95% CI: 3.4-5.5, p-value=0.000). Mean difference in HADS-Anxiety subscale scores was 5.0 (95% CI: 4.0-6.0, p-value= 0.000). Mean difference in WHO-DAS 2 scores was 7.1 (95% CI: 4.6-9.6, p-value=0.000). There	Results of this observational prospective cohort study have considerable consequences for the dissemination of evidence-based psychological treatment to routine practice. Consequently, the authors can make some reasonable assumptions about the extent to which low-intensity CBT provided can be effective. The CBT Lite program was not just feasible, but it also showed improvement in clinical measures, as well as improved	Caution is warranted in generalizing these results in light of the limitations due to methodology, i.e., use of prospective, non-controlled design, a small number of clients, lack of standardized diagnostic interviews.	Level II

								square and t-test were used to compare variables at baseline and to explore post-treatment effect. Clinical outcomes were assessed by comparing initial assessment, post-treatment, and follow-up scores on symptom measures for all clients who are considered to have started treatment (operationalized as those who attended at least one session). Data from the last available session was used for an individual's post-treatment score. In this way, it was possible to calculate clinical outcome in almost all clients.	was a statistically significant difference between the number of days worked in the past week at baseline [mean = 1.5 (SD = 1.6)], and at the end of the intervention [mean = 3.53(1.6)], p = 0.000.	disability and possibly net economic gains to the system.		
4. Williams et al. (2018)	This study aimed to: 1. Address the research gap by being the first intervention to explore low-intensity CBT classes for low mood and stress guided by self-help resources delivered in a community setting	**Primary question:** Does immediate access (IA) to the LLTTF classes result in an improvement in symptoms of depression at 6 months compared to a delayed access	Individually randomized design with delayed access control	Initial Sample: n=142 Final Sample: n=102	The pilot study showed that for those with a PHQ-9≥10 at baseline, the standard deviation of changes in PHQ-9 scores was 6.1. Based on a two-sample t-test, a sample size of 54 participants would be required for 90% power. In the pilot, follow-up data was available for 65% of participants, so they needed to randomize 84 participants with PHQ-9	Immediate enrollment vs. Delayed enrollment in Living Life to the Full Classes (**eight, weekly, 1.5 hour sessions in a LiCBT-based life-skills course delivered in a group setting**) (A pilot RCT demonstrated effective recruitment and adherence, and found improved levels of anxiety and depression 3-months after randomization.)	**Primary Outcome:** PHQ-9 Scores at 6 months Level of Measurement: Interval **Secondary Outcomes:** the Generalized Anxiety Disorder Scale (GAD-7), Hospital Anxiety and Depression Scale	Intention to treat basis using **linear regression models**. All analyses were carried out using R for Windows 3.0.2. P-values <0.05 were considered statistically significant. The study was powered to	1. At the 6-month follow-up, statistically significant between-group differences were observed for all outcome measures demonstrating that the LLTTF intervention was effective in improving symptoms of depression, anxiety, and social	1. First RCT to explore the effectiveness and cost-effectiveness of guided self-help CBT classes for depression delivered in a community setting. 2. Recruitment strategy ensured an adequate sample size of individuals with high baseline	1. Design could be improved by including a longer-term follow-up (≥12-months) to examine whether the positive findings at 6-months were maintained long-term would be valuable. 2. As a small academic trial, the resources available	Level I

	2. Compare the effectiveness of a community-based CBT self-help group intervention in improving symptoms of depression, anxiety and social function at 6-months	control (DA) group? **Secondary questions:** 1. Does immediate access to the LLTTF classes result in an improvement in anxiety and social function at 6 months, compared to DA. 2. Is the intervention cost-effective? 3. Is the intervention satisfactory to participants?			scores ≥10. They expected one third of participants to have PHQ-9<10 at baseline, so they aimed to randomize 126 participants in total. Specific inclusion and exclusion criteria not noted.	Level of Measurement: Nominal	(HADS) and the Work and Social Adjustment Scale (WSAS) at 6 months Level of Measurement: Interval **Client Satisfaction:** satisfaction was recorded using the client satisfaction questionnaire (CSQ-8) post treatment. The CSQ-8 is an 8-item questionnaire rated using a 4 point Likert scale. Level of Measurement: Interval	detect a clinically significant difference of 5.5 points on the PHQ-9 within the subgroup of participants with more severe depression (PHQ-9≥10) at baseline.	function. 2. A significant difference in favor of the IA group was observed for PHQ-9 (-3.64; 95% CI -6.06, -1.23; p=0.004) and GAD-7 (-2.83; 95%CI -5.03, -0.64, p=0.012). 3. A significant treatment effect was observed for participants with a baseline PHQ-9 ≥10 (n=86) (-5.37; 95%CI -8.33, -2.42, p<0.001), whereas those with baseline PHQ-9 ≤9 (n=18) showed no change at follow-up (1.15; 95%CI -3.33, 5.62, p=0.591) (p-value for interaction, 0.045). 4. The intervention was effective in improving symptoms of depression, anxiety and social function while being cost-neutral and available at an ICER below the NICE thresholds for funding.	PHQ-9 scores to allow for analysis of intervention effects on increasing severity of symptoms. 3. The role of a control group is to protect internal validity. A delayed access control achieves this. 4. No noticeable differences in demographic data were found between the IA and DA groups at baseline, or in rates of drop-out at 6 months. There were also no significant differences in age (p=0.97), gender (p=0.63), chronicity (p=0.33) or PHQ severity at eligibility (p=0.21) between completers and non-completers (those providing 6 month follow-up data vs drop-outs). 5)Recruitment methods reached a greater proportion of individuals who were unmarried (49.3%; 35% of Scottish adults are unmarried), had chronic symptoms of depression >2 years (80.9%), and were of non-white ethnic origin (8.5%; 3.3% of the Scottish	were insufficient to support separate staff for notifying participants of their allocation group, arranging treatment classes, supporting the delivery of classes, and collection of outcome data. 3. Men were underrepresented in the study (29.7% were male compared to 48% in the population)	

										population is non-White).		
5. Haller et al. (2019)	This study aimed to understand patients' experiences with the tel-CBT treatment, that might inform treatment conceptualization and dissemination.	1. Patients' evaluation of unique aspects of low-intensity and tel-CBT in order to better understand both the role of the guided self-help approach, the telephone as a delivery model, and their interplay 2. Little is known about predictors and mediators of change in tel-CBT; an explorative methodology regarding subjectively helpful treatment elements and processes can help to generate hypotheses about mechanisms of change in process outcome research	A qualitative study conducted alongside a randomized controlled trial (RCT) (Watzke et al., 2017) investigating tel-CBT compared to treatment as usual (TAU) in routine care	Initial Sample: n=14 Final Sample: n= 13	Due to organizational reasons the time frame for the interviews was restricted, implying that only patients of the RCT who had finished tel-CBT between October 2016 and February 2018 (i.e., whose termination of treatment took place in the previous 12 months before or within the interview period) could participate. Following a consecutive sampling strategy, all eligible patients (n = 14) were contacted and invited to participate in the interviews to describe their experiences with the intervention. One patient could not be reached, whereas all others were contactable and agreed to participate.	Semi-structured interviews consisting of 16 open-end, inductive questions, which revolved around the themes: the reason for starting tel-CBT and experience with the telephone as a therapy. These interviews followed an RCT (Watzke et al., 2017) where the IV consisted of **8-12 sessions of scheduled, individual, telephone-delivered, LiCBT-based treatments**, in addition to receiving a workbook which patients completed independently between sessions. Level of Measurement: Nominal	1. Expectations and fears towards the intervention 2. Aspects of guided self-help 3. Aspects of the telephone as a treatment delivery modality 4. Conclusion and implications for treatment pathway Level of Measurement: Nominal	Interview data were subjected to a qualitative content analysis and analyzed without prior knowledge of any trial outcomes to avoid any bias in interpretation. The Software MAXQDA 2018 (Verbi Software, 2017) was used to assist the qualitative content analysis. A sequential model of inductive and deductive development of categories was applied whereby a category can be understood as a conceptual assignment to text-based codes. The coding units referred to statements of participants that convey a meaningful message.	1. An initial underlying skepticism of whether this is achievable through a telephone-mediated therapy. 2. Initial face-to-face meeting with the therapist before beginning telephone-mediated therapy encouraged trust between the patient and therapist and made the therapy feel more personal. 3. Patients welcomed the close supervision and support from the therapist, particularly in the beginning phase of the treatment; but in the course of treatment, patients increasingly recognized the workbook as a therapeutic tool with personal relevance. 4. Concerning the cognitive behavioral principles, patients valued the solution-focused and pragmatic approach of the intervention 5. Continuity of the sessions and the regular interaction with the therapist were considered crucial for progressing in the therapy and for improving the mental	1. Reports tended to be homogeneous within the interviewed sample and repetitive within the individual interviews after completing the interview guide, which is indicative of data saturation. 2. Independent member of the study team was assigned as interviewer	1. The question remains as to whether or not researchers could reach saturation of the data obtained. Although the sample was broadly representative of the study participants of the RCT in terms of sociodemographic and clinical characteristics, patients who were not or only partially motivated for treatment due to their self-referral to the study were not able to be included. 2. Predominantly positive evaluation of the intervention might have been influenced by a socially desirable response style	Level III

									state 6. With no need for co-location, the therapy becomes independent of time and location, which makes it more adaptable to different lifestyles and suitable for people with demanding jobs or family commitments.			
6. Barrera et al. (2017)	This study aimed to evaluate the use of a telephone-delivered, modular, cognitive behavioral therapy (CBT) intervention for both late-life depression and anxiety delivered to rural, homebound Veterans.	N/A	Case Studies	Initial Sample: n= 10 Final Sample: n = 6	VA-HELPS investigators and staff met with Home-Based Primary Care (HBPC) staff in the Michael E. DeBakey Veterans Affairs Medical Center and by telephone to discuss the need for the intervention in their patient population and establish referral strategies. VA-HELPS staff met with interested patients in their homes to obtain informed consent and screen for elevated symptoms of depression and/or anxiety. **Inclusion Criteria:** Diagnosis of depression and/or anxiety **Exclusion Criteria:** Patients endorsing recent, active suicidal intent or untreated symptoms of mania, serious cognitive decline, psychosis, or substance abuse within the past month. Patients with (Geriatric Depression Scale—Short Form ≥ 5; or Generalized Anxiety Disorder-7 [GAD-7] ≥ 8) were excluded.	**Individual, telephone delivered, LiCBT, delivered over six to twelve sessions** augmented with a patient workbook for practicing skills in between sessions. Level of Measurement: Nominal	Depression and anxiety. Measured by PHQ-8 and GAD-7. Research assistants administered self-report measures to patients via telephone at baseline and three months post-treatment. Level of Measurement: Interval	Case 1: At 3-months PHQ-8 scores decreased from 14 to 10, with reductions in anhedonia, depressed mood, sleep difficulties, and negative feelings about himself. Overall severity of his anxiety remained unchanged, with GAD-7 scores of 9 at both time points. Case 2: At 3-months (post-treatment) his score on the GAD-7 decreased significantly, moving from the severe (17) into the moderate (11) range. PHQ-8 decreased slightly at posttreatment (16–14).	Veterans showed improvement in depression and/or anxiety symptoms following treatment as evidenced by decreased PHQ-8 and GAD-7 scores. Veterans also provided positive feedback regarding their experiences in this program. Results suggest that telephone-delivered, modular, CBT is acceptable to older adults and can be tailored to individual patient needs.	Consistent with previous studies, this study showed telephone delivery of CBT was satisfactory to the patients and helpful in overcoming logistical, financial, and time barriers to receiving in-person evidence-based care.	Generalizability to other patient populations is limited, as is true for all case series.	Level V

								Case 3: PHQ-8 scores moved from the moderate range (13) to below the cutoff for mild symptoms (2), with improvement in anhedonia, sleep, appetite, negative self-feelings, and concentration. His GAD-7 scores moved from the moderate (14) into the mild range (9), with improvements in amount of worry, ability to relax, and restlessness.				
7. Banbury et al. (2018)	This study aimed to review the literature to determine the feasibility, acceptability, effectiveness, and implementation of health professional-led group videoconferencing to provide education or social support or both, into the home setting.	N/A	A systematic review using mixed methods appraisal tool	Initial records identified: n=1634 Final records used: n=17	Publications were collected from January 2000 to March 2016 on videoconferencing group education and/or social support, in the home, between health professionals and groups of patients or consumers. The following electronic databases were searched: Academic Search, CINAHL with full-text, Health Source Consumer, Health Source Nursing, MEDLINE, Psychology and Behavioural Sciences Collection, PsycINFO, SocioIndex, PubMed, InfoRMIT, ProQuest, and Google Scholar. Databases included literature that	Health professional–led **group video-conferencing, providing education, social support, or both,** studied between January 2000 to March 2016 Level of Measurement: Nominal	**Feasibility** (For this study feasibility focuses on the installation and testing of equipment. It includes factors relating to the videoconferencing system, equipment, and its usability for participants and facilitators), **Acceptability** (relates to the extent to which the intervention is suitable, satisfying, or attractive to the participants), **Effectiveness** (concerns the interventions effect on participants' health status and/or health	Quality assessment of identified studies was completed using the Mixed Methods Appraisal Tool (MMAT), as 7 of the 14 included studies had used mixed-methods study designs. The analysis framework of the outcome terms of **feasibility, acceptability,** and **effectiveness** were often used in the included studies, but there were no consistent	Overall groups delivered by videoconference are feasible and potentially can improve the accessibility of group interventions. This may be particularly useful for those who live in rural areas, have limited mobility, are socially isolated, or fear meeting new people. Outcomes are similar to in-person groups. Overall, evidence indicated that group videoconferencing into the home was **feasible** and **acceptable.** Overall,	The objective was clearly stated. The inclusion criteria were stated. The exclusion criteria were stated. Study selection was described. Flow chart of study selection was provided. List of included studies was provided. It was reported that there were no known conflicts of interest.	Comparability of study findings was limited by the heterogeneity of the interventions, participants, and assessed outcomes. Sample sizes were small, which was a limitation for those studies reporting quantitative data.	Level II

					was peer-reviewed and gray literature. **Inclusion Criteria:** studies that were interventions that collected primary data directly from participants, which documented the use of group videoconferencing for patient education or social or mental health support into participants' homes. Intervention studies that were delivered by family practice, local primary care organizations, generalist community health services (including home nursing, counseling, allied health, and health education) and tertiary settings to the community to adults aged 18 years or older were included. **Exclusion Criteria:** studies that provided group education to youth or children, students, health professionals; were part of a virtual reality game; or did not enable participants to see and/or hear others in the group.		outcomes) and **Implementation** (the extent the intervention can be successfully and reliably delivered to participants as it is intended). Level of Measurement: Nominal	definitions. Telebehavioral health (TBH) literature was reviewed first to define the concepts of these terms. The additional overarching theme of implementation was also included to capture data regarding validity and reliability of delivering face-to-face programs in the videoconferencing context. The framework utilizes similar concepts identified by Hebert (2001), where system quality, user satisfaction, and individual impact conceptualize the structure-process-outcome of TBH variables. The overarching concepts are present in other models that are designed to guide planning and evaluation of TBH interventions. Content analysis compared subheading level data of the two groups with confirming and	evidence indicated the **effectiveness** of home-based videoconferencing groups which overcame known barriers for attending face-to-face groups, such as transportation, travel distance, lack of time, and inconvenience. Overall, evidence indicated that **implementation** of existing psychoeducational interventions reported good reliability and validity and were as effective as face-to-face interventions. In addition, many studies reported the ability to replicate group processes such as bonding, cohesiveness, and empathy.			

								contrasting results noted. Using two groups to compare results is intended to provide greater validity for quantitative data and trustworthiness for qualitative data.				
8. Rollman et al. (2018)	This study aimed to: 1. Examine the effectiveness of combining an internet support group (ISG) with an online computerized cognitive behavioral therapy (CCBT), provided via a collaborative care program for treating depression and anxiety, vs CCBT alone 2. Examine whether providing CCBT in this manner is more effective than usual care	Is combining an internet support group (ISG) with a care manager–guided computerized cognitive behavioral therapy (CCBT) program better at treating depression and anxiety than CCBT alone and better than primary care physicians' usual care for these conditions?	A 3-arm randomized clinical trial with blinded outcome assessments	Initial Sample: n= 2884 Final Sample: n = 704	Primary care physicians from 26 primary care practices in Pittsburgh, Pennsylvania, referred 2884 patients aged 18 to 75 years in response to an electronic medical record prompt from August 2012 to September 2014. Overall, 704 patients (24.4%) met all eligibility criteria and were randomized, using a computer-generated assignment sequence prepared in advance, to **CCBT alone** (n = 301), **CCBT+ISG** (n = 302), or **usual care** (n = 101). Group assignment was concealed until after baseline assessment. **Inclusion Criteria:** internet and email access and score of 10 or greater on either GAD-7 or PHQ-9 **Exclusion Criteria:** alcohol dependence, active suicidality, serious mental illness for which the program interventions would be inappropriate	**Internet support group (ISG) with an online, one-to-one computerized cognitive behavioral therapy (CCBT)**, provided via a collaborative care program for 6 months Level of Measurement: Nominal	Depression and anxiety via PROMIS Depression and Anxiety scales and SF-12 MCS scale at program completion, 3-month, 6-month, and 12-month follow-up Level of Measurement: Interval	The authors powered their trial to test their primary hypothesis that patients receiving CCBT+ISG will report 0.30 or greater effect size (ES) improvement from baseline at 6 months on the SF-12 Mental Health Composite Scale (MCS) vs CCBT alone. Assuming a **2-sample t test** to compare between-arm differences in 6-month improvements and 2-tailed α = .05, the authors needed 300 patients per arm to have 90% or greater power to detect a 0.30 ES difference in our primary outcome measure. The authors compared	**Intervention Engagement:** By 6 months, 504 of 603 patients (83.6%) with CCBT access had completed at least 1 session and 221 (36.7%) had completed all 8, and the mean sessions completed was 5.4, which was similar by randomization status. Overall, 228 of 302 patients (75.5%) in the CCBT+ISG arm logged into the ISG at least once, of whom 141 (61.8%) made at least 1 online comment or post (mean, 10.5; median, 3; range, 1-306). **Primary Hypothesis:** CCBT + ISG vs CBT Alone: At 6-month follow-up, patients in the CCBT + ISG and CCBT alone arms reported similar improvements on primary outcome measure (SF-12 MCS:	First trial to examine the effectiveness of incorporating either CCBT or an ISG into a collaborative care program for treating depression or anxiety in primary care. Report confirms the effectiveness of guided CCBT, highlights the critical importance of patient engagement with online interventions, and provides high-quality evidence about the limits and potential benefits of these emerging technologies.	This study has several limitations of which potentially affect the generalizability of the findings. First, the use of EMR generated prompts to promote identification of patients for study participation is limited to settings with systems capable of generating these alerts, clinician recognition of targeted conditions, and entry of the proper diagnostic codes into the EMR. Also, given the nature of the interventions, patients knew their treatment assignment, which could have biased their responses to our blinded assessors. Finally, study sites were not cluster randomized, and the same	Level I

									baseline sociodemographic and clinical characteristics by randomization status using t tests for continuous data and χ2 analyses for categorical data. They compared participants who withdrew from study participation by baseline covariates and analyzed time until withdrawal by study arm using Kaplan-Meier curves. Their linear mixed models for primary analyses assumed that data were missing at random and were robust to ignorable missingness assumptions. All reported P values are 2-tailed with significance levels at P ≤ .05, and all analyses were performed with SAS version 9.4 (SAS Institute).	ES,0.02; 95% CI, −0.17 to0.13) and on the PROMIS Depression and Anxiety scales that continued 6-months later. **Secondary Hypothesis:** CCBT Alone vs UC: Compared with patients in the UC arm, patients in the CCBT alone arm reported significant 6-month improvements on the PROMIS Depression and Anxiety scales but not the SF-12 MCS scale. However, these differences resolved 6 months later, as patients' symptoms in the UC arm improved. Again, significant treatment interactions was observed favoring CCBT for patients aged 35 to 59 years on the SF-12 MCS and PROMIS Depression and Anxiety for patients living alone on the PROMIS Depression and Anxiety scales, and for nonwhite patients on the PROMIS Depression scale. Moreover, patients reported improved 6-month SF-12 MCS (mean points, 0.80; 95% CI, 0.37-1.22), PROMIS Depression (mean		physicians cared for patients in all study arms.	

									points, 0.48; 95% CI, −0.76 to −0.19), and PROMIS Anxiety (mean points,0.48; 95%CI, −0.79 to −0.17) scores for each additional CCBT session completed, and per-protocol analyses revealed a similar pattern (PROMIS mood symptoms: patients who completed ≥4 sessions: ES, 0.41; 95% CI, 0.17- 0.65; patients who completed all 8 sessions: ES, 0.52; 95%CI,0.26-0.78). **Conclusion:** Although ISG did not produce any measurable benefit over CCBT alone, providing online CBT to patients with depression and anxiety receiving primary care via a centralized collaborative care program is an effective strategy for delivering mental health care at scale.			

Appendix C

Data Analysis

Table 1

Data Analysis Table

Population	Variable Name	Variable Description and Type of Measure	Data Source	Possible Range of Values	Level of Measurement	Time Frame for Collection	Statistical Test	Decision Rule
IV	Group depressive disorder telebehavioral health (TBH)	**Description:** Low-intensity CBT (LiCBT), utilized as treatment augmentation, in a group TBH format **Type:** Process measure	EHR (in consultation with local stakeholders / IBHC)	0 = before participation 1 = after participation	Nominal	October 2021 - November 2021 (6 weeks)	None	N/A
DV	Depressive disorder severity 1. PHQ-9 score difference before and after group depressive disorder TBH	1. **Description:** Symptom reduction in primary care patients diagnosed with depressive disorder; symptom measurement completed BEFORE and AFTER LiCBT Group TBH	1. EHR (PHQ-9)	1. 0-27	1. Interval	1. November 2021 (pre-treatment) and December 2021 (post-treatment)	1. Wilcoxon signed-rank test	1. Based on the literature, treatment response, defined as 50% or greater reduction in depressive disorder symptoms on

		Type: Outcome measure						the PHQ-9, is the preferable method for comparing treatment outcomes for statistical significance (Coley et al., 2020).
	DV	Patient satisfaction with treatment	**Description:** Based on the literature, a questionnaire designed to evaluate elements, including specific functions; satisfaction and perceived efficacy; perceived therapeutic factors; optimal blend, intensity, and duration; mode of delivery; and perceived (dis)advantages of group depressive disorder TBH (Schuster et al., 2018). **Type:** Outcome measure	Facility patient satisfaction questionnaire	Yes, no, neutral questions; Likert scales; and open-ended questions	Nominal / Ordinal	November 2021 (post-treatment)	Descriptive statistics	Questionnaires are an effective and efficient method for evaluating CBT TBH for depressive disorder treatment (Barrera et al., 2017; Schuster et al., 2018).

	DV	Civilian network care purchases	**Description:** % of patients seeking behavioral health services in civilian network for depressive services following LiCBT Group TBH **Type:** Outcome measure	Patient report via telephone and/or chart review	0 = No, did not receive behavioral health services in civilian network for depressive services 1 = Yes, did receive behavioral health services in civilian network for depressive services	Nominal	February 2022 (3 months following post-treatment)	McNemar's Test	Examine the difference in proportion for paired samples (e.g. if LiCBT Group TBH affected a patient's decision to receive or not receive behavioral health services in network for depressive services).
	DV	Civilian network care purchases	**Description:** % of NMCCL patients seeking behavioral health services in civilian network **Type:** Outcome measure	NMCCL access to care reports	Compare the % of NMCCL patients seeking behavioral health services in civilian network vs. NMCCL in 2020 pre-project implementation vs. 2021 post-project	Nominal / Ordinal	January-February 2022 once NMCCL access to care reports are generated	Phi Coefficient	Federal regulations establish access to care standards that apply to purchased care systems and establish that that wait time for specialty care appointments

					implementation .				, such as mental health, must not exceed 4 weeks (28 days). Specialty access to care reports in purchased care systems include only those patients who were able to obtain an appointment and considered the patient's first appointment (Inspector General U.S. Department of Defense, 2020).

Appendix D

Business Case Analysis

Table 1

Business Case Analysis Table

BUSINESS CASE with VALUE BASED CARE ASSESSMENT
Proposed Title for Project/Initiative/Opportunity to Improve
Low-Intensity Cognitive Behavioral Therapy (LiCBT) in Group Telebehavioral Health Format (TBH) for Depressive Disorders Treatment in Primary Care
Opportunity Statement
Depressive disorders are a leading cause of disability worldwide and are associated with increased mortality risk, severe functional impairment, and significant economic impact (National Institute of Mental Health, 2019). More specifically in relation to the military, depressive disorders are a leading cause of morbidity, an impediment to operational readiness, and cause a large gap in access to treatment (Stahlman & Oetting, 2018). Recently, Military Health System (MHS) beneficiaries' demand for health care has exceeded Military Treatment Facilities' (MTF) capacity, as evidenced by the increase in purchased care visits (outpatient, ED, and inpatient) related to depressive disorders (Psychological Health Center of Excellence, 2018; Wooten et al., 2018). Minimizing the treatment gap, by making mental health care more readily available for depressive disorders in the primary care setting, could decrease cost and contribute to a more medically ready and deployable force. Our proposed project aims to implement and evaluate evidence-based LiCBT using group TBH format, for patients with mild to moderate depressive disorders, as an augmentation to care received through the primary care clinic at Naval Medical Center Camp LeJeune (NMCCL).
Business Opportunity/Objectives
Macro- **1.** Optimizing access to mental health care **2.** Improving quality of mental health care to meet needs **3.** Enriching effectiveness and efficiency of mental health services **4.** Achieving zero harm **Micro-** **1.** Decrease depressive disorder severity **2.** Improve patient satisfaction with depressive disorder treatment **3.** Decrease civilian network purchases related to depressive disorders
Potential Impact of the Initiative/Project

The current treatment approach, for mild to moderate depressive disorders in primary care, is medication through the primary care manager (PCM) without mental health therapy, referral for 1:1 mental health therapy, or purchased care within the civilian network for mental health therapy. LiCBT in group TBH format, used as augmentation to the current treatment approach, has the potential to bring numerous benefits to NMCCL. In alignment with the MHS Quadruple Aim, some of these benefits include: encouraging healthy mental health behaviors, optimizing access to mental health care, improving the quality of mental health care to meet needs, achieving zero harm, and enriching the effectiveness and efficiency of mental health services.

Metrics

1. Decrease in PHQ-9 scores, showing symptom reduction and/or decline in depression severity category
    a. MHS Quadruple Aims: Improving quality of mental health care to meet needs, enriching effectiveness and efficiency of mental health services, and achieving zero harm
2. Positive Facility Patient Satisfaction Metrics
    a. MHS Quadruple Aims: Improving quality of mental health care to meet needs, enriching effectiveness and efficiency of mental health services, and achieving zero harm
3. Decrease in number of purchased care visits
    a. MHS Quadruple Aim: Optimizing access to mental health care with improved cost effectiveness

Alternatives (courses of action) chosen for Analysis

1. LiCBT in Group TBH Format: Current empirical evidence demonstrates that the combination of multiple components, including LiCBT (Bennett-Levy et al., 2014; Naeem et al., 2017), delivered via telebehavioral health (Banbury et al., 2018; Barrera et al., 2017; Haller et al., 2019; Lawn et al., 2019), in a group delivery format (Banbury et al., 2018; Rollman et al., 2017; Schuster et al., 2018; Williams et al., 2018), is a feasible, acceptable, and effective treatment intervention for the reduction of depressive symptoms.

2. LiCBT In-Person Group Format: LiCBT in-person group sessions of 60 minutes delivered weekly have been shown to be effective (Naeem et al., 2017).

3.*"Status Quo"*: Medication through PCM without mental health therapy, referral for 1:1 mental health therapy, or purchased care within civilian network for mental health therapy. While continuing the status quo is a reasonable alternative, the first two courses of action are more viable, efficient, and cost-effective for meeting the depressive disorder demand for needed services as evidenced by the analysis of alternatives outlined below.

Assumptions

1. Depressive disorders are a leading cause of morbidity in military personnel, an impediment to operational readiness in military organizations, and there is a large treatment gap for depressive disorders (Theriault et al., 2020).
2. The treatment gap is evidenced by the increasing number of purchased care visits (Wooten et al., 2018).
3. Caseloads preclude providers from seeing depressed patients as often as they would like (Hepner et al., 2018).
4. Timing (weekly), number of sessions (6-12), and length of sessions (1 hour) are standards of care (Barrera et al., 2017; Hepner et al., 2018; Lawn et al., 2019; Naeem et al., 2017).
5. Lack of treatment options (Kantor et al., 2017), provider shortages in MTFs, clinic hours only during duty hours, limited confidentiality (because service members need their commander's permission to attend medical appointments during duty hours), and military leadership's negative perceptions about behavioral health care are the major barriers to care identified by patients (Wooten et al., 2018).
6. 1:1 CBT sessions may cost $100 or more per hour (Anxiety and Depression Association of America, 2020).
7. LiCBT (Bennett-Levy et al., 2014; Naeem et al., 2017), telebehavioral health (Banbury et al., 2018; Barrera et al., 2017; Haller et al., 2019; Lawn et al., 2019), and group delivery formats (Banbury et al., 2018; Rollman et al., 2017; Schuster et al., 2018; Williams et al., 2018) are evidenced-based interventions for the reduction of depressive disorder symptoms.

Analysis of Alternatives

Alternative 1:	LiCBT in Group TBH Format

Pros	**Cons**
Benefits: Provides an alternative for patients who may otherwise, due to their low severity, "slip through the	**Expectations when benefits will be realized:** Some benefits will be realized immediately, such as encouraging healthy mental health behaviors and providing an alternative form of

cracks." Prevents decompensation of patients to critical levels. **Cost:** Overhead only **Cost saving/avoidance:** This project is expected to save the Command money by mitigating outpatient purchased care for depressive disorders. **Potential impact on other org. metrics**: Increase patient safety, increase patient satisfaction, increase access to mental health care, improve depressive symptoms, and decrease hospital admission rates to inpatient mental health. **Unquantifiable benefits or costs/business impact:** Decrease patient suffering, decrease patient stress and anxiety, and improve quality of life. Address patient barriers (e.g. travel time, time away from command, limited confidentiality). Potential to prevent susceptible patients' exposure to infectious diseases, especially during COVID-19 pandemic.	treatment to patients. However, other benefits may take months, such as increasing access to MHS appointments and decreasing purchased care visits. **Unquantifiable benefits or costs/business impact:** Technology/connections issues. Lack of face-to-face interaction. Unavailable space for privacy. Preference for individual therapy. Group format may prevent newcomers from joining.
Alternative 2:	LiCBT in Person Group Format
Pros	**Cons**
Benefits: Increase cost effectiveness, access to social support, and helps individuals develop communication and socialization skills. **Cost:** Overhead only **Cost saving/avoidance:** Cost savings is expected from decreased purchased care visits. **Potential impact on other org. metrics:** Increase patient safety, increase patient satisfaction, increase access to mental health care, improve depressive symptoms, and decrease hospital admission rates to inpatient mental health.	**Expectations when benefits will be realized:** Some benefits may be realized immediately, such as encouraging healthy mental health behaviors and providing an alternative form of treatment to patients. Other benefits may take months, such as increased access to mental health appointments and decreased purchased care visits. **Unquantifiable benefits or costs/business impact:** Does not address patient barriers (e.g. travel time, time away from command, limited confidentiality) and therefore may not increase patient satisfaction.
Alternative 3:	*"Status Quo"*: Medication through PCM without mental health therapy, referral for 1:1 mental health therapy, or purchased care within civilian network for mental health therapy
Pros	**Cons**
Benefits: Dedicated, one-on-one, individualized therapy sessions and/or ability for PCM to manage care without referral to mental health.	**Expectations when benefits will be realized:** According to the Inspector General's report, *Evaluation of Access to Mental Health Care in the Department of Defense* (2020), thousands of active-duty service members and their families have experienced delays in obtaining mental health care. The delays may have involved numerous members not being able to: (1) see the right provider at the right time, (2) obtain mental health care at all, or (3) receive timely follow-up treatment. Current access to outpatient mental health care at NMCCL is 45 days,

	which is beyond the standard and expected 28-day guideline (NMCCL, 2020). **Cost:** Increased due to purchased care cost. The current mental health care services are insufficient, the demand is too great to meet the need. **Cost saving/avoidance:** None. **Potential impact on other org. metrics:** Decrease in access to care and increase in inpatient mental health stays. **Unquantifiable benefits or costs/business impact:** Decrease in patient satisfaction.

Recommendation and Rationale

Recommendation

Conduct LiCBT for depressive disorders within a group TBH format in the primary care setting. Specifically, 6 weekly 1-hour group TBH sessions utilizing LiCBT with additional homework to be completed in-between sessions (also based on LiCBT theories/practices).

Rationale

The current empirical evidence demonstrates that the combination of multiple components, including LiCBT (Bennett-Levy et al., 2014; Naeem et al., 2017), delivered via telebehavioral health (Banbury et al., 2018; Barrera et al., 2017; Haller et al., 2019; Lawn et al., 2019), in a group delivery format (Banbury et al., 2018; Rollman et al., 2017; Schuster et al., 2018; Williams et al., 2018), is a feasible, acceptable, and effective treatment intervention for the reduction of depressive symptoms. Group TBH opportunities can address all of the assumptions listed above and reduce barriers to health care. Military primary care clinics are designed to provide wellness care across the health spectrum and serve as the one-stop-shop for all health care needs. Hence, this is the prime setting to implement a group telebehavioral health intervention for the reduction of depressive symptoms for active-duty personnel, especially during COVID-19 pandemic.

Value Based Care - Investment Required by the Organization and the Associated "VALUE" or $ GAINED

	According to the most recent data from the Psychological Health Center of Excellence (2018), there were 50,761 direct care patients diagnosed with depressive disorders who received a total of 375,424 direct care outpatient encounters for depressive disorder treatment in 2017. There were 15,744 purchased care patients diagnosed with depressive disorders who received a total of 92,341 purchased care outpatient encounters for depressive disorder treatment in 2017.

I. *Volume projection based on:*

Sum of direct and purchased care patients diagnosed with depressive disorder per year (2017)	**50,761** (direct care patients with depressive disorder) **15,744** (purchased care patients with depressive disorders)

Total	**66,505**

Approximate cost for 1, 1-hour, 1:1 CBT session is $100 or more (Anxiety and Depressive Association of America, 2020).

II. *Reimbursement calculated for:*

Recaptured purchased care outpatient encounters (Conservative estimation of recapture of 1 hour of outpatient purchased care, at the cost of $100/hr, per purchased care patient)	$ 1,574,400 est
Treating 12 patients for the price of 1 for 6 sessions	$6,600 est

III. *Costs:*

Variable Costs:

Supplies	$1000.00 est
Total	**$1,000 est**

Fixed Costs:

Labor	$ 0 (assuming cost of the therapy sessions is already accounted for in provider salaries since military providers work on a fixed salary)
Overhead (Use of facility, lights, computers, monitors, projectors, printers, etc.)	$ 2,000 est
Total	**$ 2,000 est**

IV. *Forecasted P&L statement:*

Revenues:

Recaptured purchased care mental health visits	$ 1,574,400 est
Treating 12 patients for the price of 1 for 6 sessions	$ 6,600 est
Total revenues	**$ 1,581,000 est**

Costs:

Variable costs	$1,000 est
Fixed costs	$2,000 est
Total costs	**$3,000 est**

PROJECTED PROFIT ***$ 1,578,000 est***

Risks and Mitigation Plan

Risks	**Plan**
1. Lack of buy-in and resistance to change from staff and leadership	1. Frequent communication with key stakeholders and mentors regarding project needs or concerns. Conduct staff education and address concerns.
2. Patient decompensation	2. Provide emergency contact numbers at the beginning of each session and ensure patients understand mental health safety is the priority. Patients will have an established primary care provider of record, from whom they receive regular follow-up care, as this program is designed to be *augmentation* to their current treatment. All psychotherapy clinical work will be supervised by an onsite clinical preceptor and clinic safety protocols will be followed, along with direct preceptor clinical supervision, in case of patient decompensation.
3. Technology/Connection issues	3. Maintain relationships with IT and utilize DOD-approved TBH phone application, if needed.
4. Failure to meet timeline and goals	4. Frequent communication with key stakeholders and mentors. Detailed project planning.
5. Program ineffective	5. Analyze metrics, and if warranted, provide recommendations for future project development, dissemination, and sustainment.

Implementation Plan			
Phase 1:	Observation, Analysis, and Synthesis		
Milestone Description:	Systematic review of literature will be completed in order to select and finalize a program curriculum.		
Deliverables		Due Date	Accountable Person
1. Identify problem, key stakeholders and outcome of interest 2. Systematic review of literature 3. Select and finalize LiCBT Group TBH Curriculum based on literature review 4. Identify independent and dependent variables to utilize for data analysis during Application & Evaluation 5. Develop Business Case Analysis to assess feasibility, risk/benefit, and cost/benefit of implementation		31JUL2021	LCDR Graham, LT Morris, LT Whatley
Resources Needed			
1. Laptops			
Expected Level of Benefit			
Thorough observation, analysis, and synthesis of the significance of the problem and the proposed solution will be needed to guide this evidence-based project.			
Phase 2:	Application and Evaluation		
Milestone Description:	Staff education will be conducted on project goals, clinical supervision, screenings, and referrals to LiCBT Group TBH.		

	Identify and confirm 8-12 patients, with the help of PCM's and Integrated Behavioral Health Care (IBHC) providers, willing to participate in LiCBT Group TBH. Patients must meet appropriate inclusion criteria (mild to moderate depression, score of 0-14, demonstrated by PHQ-9 scores) and fail to demonstrate any exclusion criteria (severe depression as identified by PHQ-9 scores, severe anxiety disorder as defined by GAD-7, bipolar disorder, schizoaffective disorder, severe psychiatric and psychotic conditions for which treatment would be inappropriate, substance abuse, suicidal ideation/suicidality, and those with a high level of risk to self or others) (Barrera et al., 2017; Naeem et al., 2017; Rollman et al., 2018; Schuster et al. 2018). Six weekly, one hour, LiCBT Group TBH sessions will be conducted with the eligible 8-12 patients identified who wish to engage in the project. PHQ-9 evaluations will be administered prior to the therapy program and at the final session. Post-treatment, patient satisfaction metrics will be administered per facility protocol to assess overall patient satisfaction. Engagement in treatment will be tracked through attendance rosters completed prior to each session. Civilian network care purchases will be measured via patient report, EMR review, and NMCCL access to care reports. PHQ-9 evaluation scores, patient satisfaction metrics, attendance sustainment, and civilian network care purchases will be recorded and analyzed to assess program efficacy.

Deliverables	Due Dates	Accountable Person
1. Provide education to staff and leadership about project goals, clinical supervision, screenings, and referrals through educational in-services 2. Secure TBH platform 3. Designate providers to assist coding/co-signing notes (e.g. clinical preceptors)	Deliverables 1 - 3: 31AUG2021	LCDR Graham, LT Morris, LT Whatley
4. Identify 8-12 patients to participate in program	Deliverable 4: 30SEP2021	
5. Conduct six, one-hour LiCBT Group TBH sessions under supervision of clinical preceptor 6. Provide pre and post-treatment PHQ-9 7. Provide post-treatment satisfaction metric per facility protocol 8. Track sustained engagement in treatment by monitoring attendance 9. Document in EMR with group template note following each group session in consultation with clinical supervisor/clinical preceptor	Deliverable 5 - 9: 4OCT-12NOV2021	
10. Follow up with patients 3 months post treatment to assess individual use of civilian network mental healthcare services	Deliverables 10-13: 28FEB2022	

11. Compare the % of NMCCL patients seeking behavioral health services in civilian network vs. NMCCL in 2020 pre-project implementation vs. 2021 post-project implementation 12. Data Analysis Table (organized document clearly demonstrating PHQ-9 scores, patient satisfaction results, attendance sustainment, and civilian network care purchases) 13. Determine efficacy, benefits, and feasibility for wider implementation		

Resources Needed

1. Time
2. Laptops with Excel
3. Access to electronic medical record (EMR)
4. Stakeholder engagement meetings
5. Staff education in-service resources (e.g. informational handout, audiovisual equipment)
6. Coordination with primary care and mental health Department Heads/Division Officers to schedule educational in-services regarding project goals, clinical supervision, screenings, and referrals
7. Assistance from PMH providers and primary care providers
8. Curriculum that was finalized in Phase 1 Observation, Analysis, and Synthesis
9. Assistance coding/co-signing notes
10. Group template from AHLTA
11. Metrics (PHQ-9, Facility Patient Satisfaction, Civilian Network Care Purchases)
12. Attendance Roster
13. Secure phone
14. NMCCL access to care reports

Expected Level of Benefit

This phase is the ultimate goal of the evidence-based project. Detailed planning and staff buy-in is crucial to the success of this project. Adequate time set aside for program curriculum finalization and staff education regarding project goals will ensure all key NMCCL stakeholders are educated about LiCBT Group TBH. Selection of appropriate patients will optimize patient safety and maximize program outcomes. Ensuring that it is implemented appropriately, and according to plan, is imperative to gaining accurate data for program efficacy. Pre and post PHQ-9 scores, Facility Patient Satisfaction Metrics, and Civilian Network Care Purchases will demonstrate program efficacy.

Phase 3:	Dissemination
Milestone Description:	A program manual will be developed to outline specific steps for future dissemination and sustainment.

Deliverables	Due Dates	Accountable Person
1. Develop program manual 2. Brief leadership on findings, if requested 3. Complete all project requirements for school presentation	31MAY2022	LCDR Graham, LT Morris, LT Whatley

Resources Needed

1. Time
2. Laptops
3. Completed data analysis
4. Program manual template

5. Printer with paper
Expected Level of Benefit
Dissemination and sustainment are important components of translation of evidence for change and innovative health care.

NOTE: Modified from Harvard Business Review Press. (2011). *Pocket mentor: Developing a business case.* Boston: Author (pp 82-85).

Appendix E

Project Timeline

Table 1

Project Timeline

Project Year 1 (2021)												
Activity/Month	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**
USUHS VPR Submission and Approval	X	X	X									
Site IRB Submission and Approval				X	X	X	X	X	X	X		
Observation, Analysis, & Synthesis *Tasks:* 1. Identify problem, key stakeholders and outcome of interest 2. Systematic review of literature 3. Select and finalize Low Intensity Cognitive Behavioral Therapy (LiCBT) Group Telebehavioral Health (TBH) Curriculum based on literature review 4. Identify independent and dependent variables to utilize for data analysis during Application & Evaluation 5. Develop Business Case Analysis to assess feasibility, risk/benefit, and cost/benefit of implementation	X	X	X	X	X	X	X					
Application & Evaluation *Tasks:* 1. Provide education to staff and leadership about project goals, clinical supervision, screenings and referrals through educational in-services 2. Secure TBH platform 3. Designate providers to assist coding/co-signing notes (e.g., clinical preceptors)								X	X	X	X	X

Project Year 1 (2021)												
Activity/Month	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**
Application & Evaluation (Cont.) *Tasks:* 4. Identify and confirm 8-12 patients to participate in program 5. Conduct six, one-hour LiCBT Group TBH sessions under supervision of clinical preceptor 6. Provide pre- and post-treatment PHQ-9 7. Provide post-treatment satisfaction metric per facility protocol 8. Track sustained engagement in treatment by monitoring attendance 9. Document in EMR with group template note following each group session in consultation with clinical supervisor/clinical preceptor 10. Follow up with patients 3 months post treatment to assess individual use of civilian network mental healthcare services 11. Compare the % of NMCCL patients seeking behavioral health services in civilian network vs. NMCCL in 2020 pre-project implementation vs. 2021 post-project implementation 12. Data Analysis Table (organized document clearly demonstrating PHQ-9 scores, patient satisfaction results, attendance sustainment, and civilian network care purchases) 13. Determine efficacy, benefits, and feasibility for wider implementation								X	X	X	X	X
Dissemination *Tasks:* 1. Develop program manual 2. Brief leadership on finding 3. Seek out opportunities for external dissemination 4. Complete all project requirements for school presentation												X

Project Year 2 (2022)												
Activity/Month	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**AUG**	**SEP**	**OCT**	**NOV**	**DEC**
USUHS VPR Submission and Approval												
Site IRB Submission and Approval												
Observation, Analysis, and Synthesis												
Application and Evaluation	X	X										
Dissemination	X	X	X	X	X							

Appendix F

Forms Used in Data Collection

Table 1

Demographic Data

Session #	Patient Identification Number	Age	Sex	Rank/ Civilian	Ethnicity	Diagnosis	Referral to Mental Health Clinic?	PHQ-9 Initial	PHQ-9 Final	Number of Sessions Attended	Patient Satisfaction/ Recommendations	Use of Civilian Network Services Post LiCBT Group?
	1											
	2											
	3											
	4											
	5											
	6											
	7											
	8											
	9											
	10											
	11											
	12											

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Interactive Customer Evaluation (ICE) Comment Card Ratings

Overall Satisfaction Question

Were you satisfied with your overall experience?

Standard Scale Questions

Facility Appearance

Employee/Staff Attitude

Timeliness of Service

Quality of equipment and furnishings

Yes/No Questions

Did the product of service meet your needs?

Did you receive safe, competent, and professional care?

In general, I'm able to see my healthcare team when needed

After checking in, I was kept informed about how long I would have to wait for my appointment

I would recommend this facility/service to a TRICARE-eligible family member or friend.

Average and response counts for individuals do not include responses of N/A.

Standard Scale choices include: Excellent Good OK Poor Awful

DOCTOR OF NURSING PRACTICE PROJECT

DNP Project Clinical Question and Team Mentor (Committee Membership) Agreement Form

Graduation Year: 2022 **Phase 2 Site(s) Name:** Naval Medical Center Camp Lejeune

Name(s) of DNP Project Student Team:

1. LCDR Carla J. Graham	AGCNS ☐	FNP ☐	PMHNP ■	RNA ☐	WHNP ☐
2. LT Nicole Morris	AGCNS ☐	FNP ☐	PMHNP ■	RNA ☐	WHNP ☐
3. LT Katherine G. Whatley	AGCNS ☐	FNP ■	PMHNP ☐	RNA ☐	WHNP ☐
4.	AGCNS ☐	FNP ☐	PMHNP ☐	RNA ☐	WHNP ☐
5.	AGCNS ☐	FNP ☐	PMHNP ☐	RNA ☐	WHNP ☐
6.	AGCNS ☐	FNP ☐	PMHNP ☐	RNA ☐	WHNP ☐

The tentative title of the DNP Project Proposal for this student group is:

Low-Intensity Cognitive Behavioral Therapy in Group Telebehavioral Health Format for Depressive Disorders Treatment in Primary Care

Committee Approved DNP Project Clinical Question:

In patients diagnosed with depressive disorders, what is the effect of Low-Intensity Cognitive Behavioral Therapy (LiCBT), utilized in the primary care setting in a group telebehavioral health (TBH) format, on depressive symptom reduction, patient satisfaction, and use of civilian network services over six weeks?

Names of DNP Project Team Mentors:

I agree to serve as a member of the DNP Project Team (Team Mentors) for the above DNP Student Project Team. As a Project Team Mentor, I agree to the duties and responsibilities outlined within the DNP Project Manual which include but are not limited to the provision of consultation and guidance supporting the entire DNP project journey and to ensure the DNP project is of sufficient rigor and demonstrates doctoral level scholarship to meet the requirements for USUHS GSN graduation.

Senior Mentor (Chair):	Tarah Lewis	Signature:	LEWIS.TARAH.BRYANNE.1245508910 Digitally signed by LEWIS.TARAH.BRYANNE.1245508910 Date: 2020.12.17 19:19:14 -05'00'	Date:	12/17/20
Team Mentor (Member):	CDR Rob Kimberling, NC USN	Signature:	KIMBERLING.ROBERT.JOSEPH.1159551039 Digitally signed by KIMBERLING.ROBERT.JOSEPH.1159551039 Date: 2020.12.31 10:11:55 -05'00'	Date:	12/31/20
Team Mentor (Member):		Signature:		Date:	
Team Mentor (Member):		Signature:		Date:	

Form Version: 4 December 2020

Authors' Collaborative Institutional Training Initiative Program Certificates

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 1 OF 2
COURSEWORK REQUIREMENTS*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Carla Graham (ID: 9016085)
- **Institution Affiliation:** Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 603)
- **Institution Email:** carla.graham@usuhs.edu
- **Phone:** 2602735923

- **Curriculum Group:** OUSD P&R Human Research
- **Course Learner Group:** Biomedical Investigators and Research Study Team
- **Stage:** Stage 1 - Basic Course

- **Record ID:** 35987334
- **Completion Date:** 19-Mar-2020
- **Expiration Date:** 19-Mar-2023
- **Minimum Passing:** 80
- **Reported Score*:** 86

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
Module for Non-DoD Personnel Conducting Research Involving Human Subjects Supported by the DoD (ID: 16769)	18-Mar-2020	No Quiz
Belmont Report and Its Principles (ID: 1127)	18-Mar-2020	3/3 (100%)
History and Ethics of Human Subjects Research (ID: 498)	19-Mar-2020	4/5 (80%)
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	19-Mar-2020	5/5 (100%)
Informed Consent (ID: 3)	19-Mar-2020	5/5 (100%)
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	19-Mar-2020	4/4 (100%)
Records-Based Research (ID: 5)	19-Mar-2020	3/3 (100%)
Genetic Research in Human Populations (ID: 6)	19-Mar-2020	4/5 (80%)
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	19-Mar-2020	4/5 (80%)
Research Involving Prisoners (ID: 8)	19-Mar-2020	4/4 (100%)
Research Involving Children (ID: 9)	19-Mar-2020	3/3 (100%)
Research Involving Pregnant Women, Fetuses, and Neonates (ID: 10)	19-Mar-2020	3/3 (100%)
FDA-Regulated Research (ID: 12)	19-Mar-2020	5/5 (100%)
Recognizing and Reporting Unanticipated Problems Involving Risks to Subjects or Others in Biomedical Research (ID: 14777)	19-Mar-2020	5/5 (100%)
Research and HIPAA Privacy Protections (ID: 14)	19-Mar-2020	4/5 (80%)
Conflicts of Interest in Human Subjects Research (ID: 17464)	19-Mar-2020	5/5 (100%)
Defining Research with Human Subjects - SBE (ID: 491)	19-Mar-2020	4/5 (80%)
The Federal Regulations - SBE (ID: 502)	19-Mar-2020	4/5 (80%)
Assessing Risk - SBE (ID: 503)	19-Mar-2020	4/5 (80%)
Research in Public Elementary and Secondary Schools - SBE (ID: 508)	19-Mar-2020	4/5 (80%)
Internet-Based Research - SBE (ID: 510)	19-Mar-2020	5/5 (100%)
International Studies (ID: 971)	19-Mar-2020	2/3 (67%)
The IRB Member Module - 'What Every New IRB Member Needs to Know' (ID: 816)	19-Mar-2020	4/5 (80%)
Informed Consent and Confidentiality in Public Health Research (ID: 17639)	19-Mar-2020	1/5 (20%)
Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 912)	19-Mar-2020	No Quiz

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

Verify at: www.citiprogram.org/verify/?k28acbb4e-8563-40a7-bdf7-f618ffc27a6c-35987334

Collaborative Institutional Training Initiative (CITI Program)
Email: support@citiprogram.org
Phone: 888-529-5929
Web: https://www.citiprogram.org

Collaborative Institutional Training Initiative

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 2 OF 2
COURSEWORK TRANSCRIPT**

** NOTE: Scores on this Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the course were met.

- **Name:** Carla Graham (ID: 9016085)
- **Institution Affiliation:** Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 603)
- **Institution Email:** carla.graham@usuhs.edu
- **Phone:** 2602735923

- **Curriculum Group:** OUSD P&R Human Research
- **Course Learner Group:** Biomedical Investigators and Research Study Team
- **Stage:** Stage 1 - Basic Course

- **Record ID:** 35987334
- **Report Date:** 19-Mar-2020
- **Current Score**:** 86

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES	MOST RECENT	SCORE
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	19-Mar-2020	5/5 (100%)
Defining Research with Human Subjects - SBE (ID: 491)	19-Mar-2020	4/5 (80%)
Informed Consent (ID: 3)	19-Mar-2020	5/5 (100%)
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	19-Mar-2020	4/4 (100%)
The Federal Regulations - SBE (ID: 502)	19-Mar-2020	4/5 (80%)
Belmont Report and Its Principles (ID: 1127)	18-Mar-2020	3/3 (100%)
Assessing Risk - SBE (ID: 503)	19-Mar-2020	4/5 (80%)
Records-Based Research (ID: 5)	19-Mar-2020	3/3 (100%)
Genetic Research in Human Populations (ID: 6)	19-Mar-2020	4/5 (80%)
Research Involving Prisoners (ID: 8)	19-Mar-2020	4/4 (100%)
Research Involving Children (ID: 9)	19-Mar-2020	3/3 (100%)
Research Involving Pregnant Women, Fetuses, and Neonates (ID: 10)	19-Mar-2020	3/3 (100%)
FDA-Regulated Research (ID: 12)	19-Mar-2020	5/5 (100%)
Research in Public Elementary and Secondary Schools - SBE (ID: 508)	19-Mar-2020	4/5 (80%)
Research and HIPAA Privacy Protections (ID: 14)	19-Mar-2020	4/5 (80%)
Internet-Based Research - SBE (ID: 510)	19-Mar-2020	5/5 (100%)
History and Ethics of Human Subjects Research (ID: 498)	19-Mar-2020	4/5 (80%)
Recognizing and Reporting Unanticipated Problems Involving Risks to Subjects or Others in Biomedical Research (ID: 14777)	19-Mar-2020	5/5 (100%)
Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 912)	19-Mar-2020	No Quiz
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	19-Mar-2020	4/5 (80%)
International Studies (ID: 971)	19-Mar-2020	2/3 (67%)
The IRB Member Module - 'What Every New IRB Member Needs to Know' (ID: 816)	19-Mar-2020	4/5 (80%)
Informed Consent and Confidentiality in Public Health Research (ID: 17639)	19-Mar-2020	1/5 (20%)
Conflicts of Interest in Human Subjects Research (ID: 17464)	19-Mar-2020	5/5 (100%)
Module for Non-DoD Personnel Conducting Research Involving Human Subjects Supported by the DoD (ID: 16769)	18-Mar-2020	No Quiz

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

Verify at: www.citiprogram.org/verify/?k28acbb4e-8563-40a7-bdf7-f618ffc27a6c-35987334

Collaborative Institutional Training Initiative (CITI Program)
Email: support@citiprogram.org
Phone: 888-529-5929
Web: https://www.citiprogram.org

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 1 OF 2
COURSEWORK REQUIREMENTS*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Nicole Morris (ID: 9016861)
- **Institution Affiliation:** Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 603)
- **Institution Email:** nicole.morris@usuhs.edu
- **Phone:** 2403085809

- **Curriculum Group:** OUSD P&R Human Research
- **Course Learner Group:** Biomedical Investigators and Research Study Team
- **Stage:** Stage 1 - Basic Course

- **Record ID:** 35993234
- **Completion Date:** 19-Mar-2020
- **Expiration Date:** 19-Mar-2023
- **Minimum Passing:** 80
- **Reported Score*:** 97

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
Module for Non-DoD Personnel Conducting Research Involving Human Subjects Supported by the DoD (ID: 16769)	19-Mar-2020	No Quiz
Belmont Report and Its Principles (ID: 1127)	19-Mar-2020	3/3 (100%)
History and Ethics of Human Subjects Research (ID: 498)	19-Mar-2020	5/5 (100%)
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	19-Mar-2020	5/5 (100%)
Informed Consent (ID: 3)	19-Mar-2020	5/5 (100%)
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	19-Mar-2020	4/4 (100%)
Records-Based Research (ID: 5)	19-Mar-2020	3/3 (100%)
Genetic Research in Human Populations (ID: 6)	19-Mar-2020	5/5 (100%)
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	19-Mar-2020	5/5 (100%)
Research Involving Prisoners (ID: 8)	19-Mar-2020	4/4 (100%)
Research Involving Children (ID: 9)	19-Mar-2020	3/3 (100%)
Research Involving Pregnant Women, Fetuses, and Neonates (ID: 10)	19-Mar-2020	3/3 (100%)
FDA-Regulated Research (ID: 12)	19-Mar-2020	5/5 (100%)
Recognizing and Reporting Unanticipated Problems Involving Risks to Subjects or Others in Biomedical Research (ID: 14777)	19-Mar-2020	5/5 (100%)
Research and HIPAA Privacy Protections (ID: 14)	19-Mar-2020	5/5 (100%)
Conflicts of Interest in Human Subjects Research (ID: 17464)	19-Mar-2020	5/5 (100%)
Defining Research with Human Subjects - SBE (ID: 491)	19-Mar-2020	5/5 (100%)
The Federal Regulations - SBE (ID: 502)	19-Mar-2020	5/5 (100%)
Assessing Risk - SBE (ID: 503)	19-Mar-2020	5/5 (100%)
Research in Public Elementary and Secondary Schools - SBE (ID: 508)	19-Mar-2020	5/5 (100%)

Internet-Based Research - SBE (ID: 510)	19-Mar-2020	5/5 (100%)
International Studies (ID: 971)	19-Mar-2020	3/3 (100%)
The IRB Member Module - 'What Every New IRB Member Needs to Know' (ID: 816)	19-Mar-2020	5/5 (100%)
Informed Consent and Confidentiality in Public Health Research (ID: 17639)	19-Mar-2020	2/5 (40%)
Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 912)	19-Mar-2020	No Quiz

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

Verify at: www.citiprogram.org/verify/?ke77a904b-1252-411d-a3ba-1d3ae66b55e3-35993234

Collaborative Institutional Training Initiative (CITI Program)
Email: support@citiprogram.org
Phone: 888-529-5929
Web: https://www.citiprogram.org

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 2 OF 2
COURSEWORK TRANSCRIPT**

** NOTE: Scores on this Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the course were met.

- **Name:** Nicole Morris (ID: 9016861)
- **Institution Affiliation:** Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 603)
- **Institution Email:** nicole.morris@usuhs.edu
- **Phone:** 2403085809

- **Curriculum Group:** OUSD P&R Human Research
- **Course Learner Group:** Biomedical Investigators and Research Study Team
- **Stage:** Stage 1 - Basic Course

- **Record ID:** 35993234
- **Report Date:** 14-Jan-2022
- **Current Score**:** 97

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES	MOST RECENT	SCORE
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	19-Mar-2020	5/5 (100%)
Informed Consent (ID: 3)	19-Mar-2020	5/5 (100%)
Defining Research with Human Subjects - SBE (ID: 491)	19-Mar-2020	5/5 (100%)
The Federal Regulations - SBE (ID: 502)	19-Mar-2020	5/5 (100%)
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	19-Mar-2020	4/4 (100%)
Belmont Report and Its Principles (ID: 1127)	19-Mar-2020	3/3 (100%)
Records-Based Research (ID: 5)	19-Mar-2020	3/3 (100%)
Assessing Risk - SBE (ID: 503)	19-Mar-2020	5/5 (100%)
Genetic Research in Human Populations (ID: 6)	19-Mar-2020	5/5 (100%)
Research Involving Prisoners (ID: 8)	19-Mar-2020	4/4 (100%)
Research Involving Children (ID: 9)	19-Mar-2020	3/3 (100%)
Research Involving Pregnant Women, Fetuses, and Neonates (ID: 10)	19-Mar-2020	3/3 (100%)
FDA-Regulated Research (ID: 12)	19-Mar-2020	5/5 (100%)
Research in Public Elementary and Secondary Schools - SBE (ID: 508)	19-Mar-2020	5/5 (100%)
Research and HIPAA Privacy Protections (ID: 14)	19-Mar-2020	5/5 (100%)
Internet-Based Research - SBE (ID: 510)	19-Mar-2020	5/5 (100%)
History and Ethics of Human Subjects Research (ID: 498)	19-Mar-2020	5/5 (100%)
Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 912)	19-Mar-2020	No Quiz
Recognizing and Reporting Unanticipated Problems Involving Risks to Subjects or Others in Biomedical Research (ID: 14777)	19-Mar-2020	5/5 (100%)
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	19-Mar-2020	5/5 (100%)
International Studies (ID: 971)	19-Mar-2020	3/3 (100%)
Conflicts of Interest in Human Subjects Research (ID: 17464)	19-Mar-2020	5/5 (100%)
The IRB Member Module - 'What Every New IRB Member Needs to Know' (ID: 816)	19-Mar-2020	5/5 (100%)
Informed Consent and Confidentiality in Public Health Research (ID: 17639)	19-Mar-2020	2/5 (40%)
Module for Non-DoD Personnel Conducting Research Involving Human Subjects Supported by the DoD (ID: 16769)	19-Mar-2020	No Quiz

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

Verify at: www.citiprogram.org/verify/?ke77a904b-1252-411d-a3ba-1d3ae66b55e3-35993234

Collaborative Institutional Training Initiative (CITI Program)
Email: support@citiprogram.org
Phone: 888-529-5929
Web: https://www.citiprogram.org

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 1 OF 2
COURSEWORK REQUIREMENTS*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Katherine Whatley (ID: 9039008)
- **Institution Affiliation:** Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 603)
- **Institution Email:** katherine.whatley@usuhs.edu
- **Phone:** 9194546502

- **Curriculum Group:** OUSD P&R Human Research
- **Course Learner Group:** Biomedical Investigators and Research Study Team
- **Stage:** Stage 1 - Basic Course

- **Record ID:** 36123285
- **Completion Date:** 02-Apr-2020
- **Expiration Date:** 02-Apr-2023
- **Minimum Passing:** 80
- **Reported Score*:** 90

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
Module for Non-DoD Personnel Conducting Research Involving Human Subjects Supported by the DoD (ID: 16769)	31-Mar-2020	No Quiz
Belmont Report and Its Principles (ID: 1127)	31-Mar-2020	3/3 (100%)
History and Ethics of Human Subjects Research (ID: 498)	31-Mar-2020	4/5 (80%)
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	02-Apr-2020	5/5 (100%)
Informed Consent (ID: 3)	31-Mar-2020	4/5 (80%)
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	01-Apr-2020	4/4 (100%)
Records-Based Research (ID: 5)	01-Apr-2020	3/3 (100%)
Genetic Research in Human Populations (ID: 6)	01-Apr-2020	4/5 (80%)
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	01-Apr-2020	5/5 (100%)
Research Involving Prisoners (ID: 8)	01-Apr-2020	4/4 (100%)
Research Involving Children (ID: 9)	01-Apr-2020	3/3 (100%)
Research Involving Pregnant Women, Fetuses, and Neonates (ID: 10)	01-Apr-2020	3/3 (100%)
FDA-Regulated Research (ID: 12)	01-Apr-2020	4/5 (80%)
Recognizing and Reporting Unanticipated Problems Involving Risks to Subjects or Others in Biomedical Research (ID: 14777)	02-Apr-2020	5/5 (100%)
Research and HIPAA Privacy Protections (ID: 14)	01-Apr-2020	4/5 (80%)
Conflicts of Interest in Human Subjects Research (ID: 17464)	01-Apr-2020	4/5 (80%)
Defining Research with Human Subjects - SBE (ID: 491)	02-Apr-2020	4/5 (80%)
The Federal Regulations - SBE (ID: 502)	02-Apr-2020	5/5 (100%)
Assessing Risk - SBE (ID: 503)	02-Apr-2020	5/5 (100%)
Research in Public Elementary and Secondary Schools - SBE (ID: 508)	02-Apr-2020	4/5 (80%)
Internet-Based Research - SBE (ID: 510)	02-Apr-2020	4/5 (80%)
International Studies (ID: 971)	02-Apr-2020	3/3 (100%)
The IRB Member Module - 'What Every New IRB Member Needs to Know' (ID: 816)	02-Apr-2020	5/5 (100%)
Informed Consent and Confidentiality in Public Health Research (ID: 17639)	02-Apr-2020	4/5 (80%)
Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 912)	02-Apr-2020	No Quiz

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

Verify at: www.citiprogram.org/verify/?ked38857e-d1ae-4906-a6bc-e4f556bb1d22-36123285

Collaborative Institutional Training Initiative (CITI Program)
Email: support@citiprogram.org
Phone: 888-529-5929
Web: https://www.citiprogram.org

Collaborative Institutional Training Initiative
Collaborative Institutional Training Initiative
Collaborative Institutional Training Initiative

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 2 OF 2
COURSEWORK TRANSCRIPT**

** NOTE: Scores on this Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the course were met.

- **Name:** Katherine Whatley (ID: 9039008)
- **Institution Affiliation:** Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 603)
- **Institution Email:** katherine.whatley@usuhs.edu
- **Phone:** 9194546502

- **Curriculum Group:** OUSD P&R Human Research
- **Course Learner Group:** Biomedical Investigators and Research Study Team
- **Stage:** Stage 1 - Basic Course

- **Record ID:** 36123285
- **Report Date:** 17-Jan-2022
- **Current Score**:** 90

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES	MOST RECENT	SCORE
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	02-Apr-2020	5/5 (100%)
Informed Consent (ID: 3)	31-Mar-2020	4/5 (80%)
Defining Research with Human Subjects - SBE (ID: 491)	02-Apr-2020	4/5 (80%)
The Federal Regulations - SBE (ID: 502)	02-Apr-2020	5/5 (100%)
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	01-Apr-2020	4/4 (100%)
Belmont Report and Its Principles (ID: 1127)	31-Mar-2020	3/3 (100%)
Records-Based Research (ID: 5)	01-Apr-2020	3/3 (100%)
Assessing Risk - SBE (ID: 503)	02-Apr-2020	5/5 (100%)
Genetic Research in Human Populations (ID: 6)	01-Apr-2020	4/5 (80%)
Research Involving Prisoners (ID: 8)	01-Apr-2020	4/4 (100%)
Research Involving Children (ID: 9)	01-Apr-2020	3/3 (100%)
Research Involving Pregnant Women, Fetuses, and Neonates (ID: 10)	01-Apr-2020	3/3 (100%)
FDA-Regulated Research (ID: 12)	01-Apr-2020	4/5 (80%)
Research in Public Elementary and Secondary Schools - SBE (ID: 508)	02-Apr-2020	4/5 (80%)
Research and HIPAA Privacy Protections (ID: 14)	01-Apr-2020	4/5 (80%)
Internet-Based Research - SBE (ID: 510)	02-Apr-2020	4/5 (80%)
History and Ethics of Human Subjects Research (ID: 498)	31-Mar-2020	4/5 (80%)
Office of the Under Secretary of Defense (Personnel and Readiness) (ID: 912)	02-Apr-2020	No Quiz
Recognizing and Reporting Unanticipated Problems Involving Risks to Subjects or Others in Biomedical Research (ID: 14777)	02-Apr-2020	5/5 (100%)
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	01-Apr-2020	5/5 (100%)
International Studies (ID: 971)	02-Apr-2020	3/3 (100%)
Conflicts of Interest in Human Subjects Research (ID: 17464)	01-Apr-2020	4/5 (80%)
The IRB Member Module - 'What Every New IRB Member Needs to Know' (ID: 816)	02-Apr-2020	5/5 (100%)
Informed Consent and Confidentiality in Public Health Research (ID: 17639)	02-Apr-2020	4/5 (80%)
Module for Non-DoD Personnel Conducting Research Involving Human Subjects Supported by the DoD (ID: 16769)	31-Mar-2020	No Quiz

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

Verify at: www.citiprogram.org/verify/?ked38857e-d1ae-4906-a6bc-e4f556bb1d22-36123285

Collaborative Institutional Training Initiative (CITI Program)
Email: support@citiprogram.org
Phone: 888-529-5929
Web: https://www.citiprogram.org

USUHS FORM 3202N
DANIEL K. INOUYE GRADUATE SCHOOL OF NURSING
EVIDENCE-BASED PRACTICE/PERFORMANCE IMPROVEMENT PROPOSAL

VPR Date Stamp

Project Number: _____ (VPR will assign)

Project Title: Low-Intensity Cognitive Behavioral Therapy in Group Telebehavioral Health Format for Depressive Disorders Treatment in Primary Care

SECTION A: STUDENT POC INFORMATION

1. Name (Last, First, MI): **Graham, Carla, J.** Student E-mail: **carla.graham@usuhs.edu**
2. Home Address: [redacted] Cell Number: [redacted]

SECTION B: COMMITTEE CHAIR / SENIOR MENTOR INFORMATION

3. Name (Last, First, MI): **Lewis, Tarah, Bryanne**
4. Telephone: **301-295-1201** Fax: **301-295-1201** E-mail: **tarah.lewis@usuhs.edu**
5. USUHS Building/ Room No.: **Daniel K. Inouye Graduate School of Nursing RM 1034**

SECTION C: PROJECT INFORMATION

6. Attach the Abstract for the proposal, including the following sections: Site Location of the Project, Title, Authors, Background or Problem/Issue, Clinical Question/Purpose, Project Design, Anticipated Organizational Impact/Implications for Practice and also include the Proposed Timeline. Single space the abstract and use Times New Roman font, size 12.
7. Is this proposal related to an active research project of the Chair/Senior Mentor identified in Section B? ☐ Yes ☒ No
   If yes, complete below; if no, proceed to Part 8.
   Project Number: _____
   Project Title:
   Project Start Date: _____ Project End Date: _____
8. Anticipated period of performance: Project Start Date: **1/1/2021** Project End Date: **4/1/2022**
9. Performance Site(s): **Naval Medical Center Camp Lejeune**
10. Does this project involve any classified information? (Contact the USUHS Security Office for guidance) ☐ Yes ☒ No
11. Do you have a funding source for this project? ☐ Yes ☒ No ☐ NA
    If yes, specify the funding agency and the amount provided:

SECTION D: SIGNATURES

The following signatures attest to the validity of the above information:

Carla Graham — Digitally signed by Carla Graham Date: 2020.12.17 17:05:23 -05'00'
Student (Project Point of Contact for the Group) (Signature and Date)

LEWIS.TARAH.BRYANNE.1245508910 — Digitally signed by LEWIS.TARAH.BRYANNE.1245508910 Date: 2020.12.23 09:22:04 -05'00'
Chair/Senior Mentor (Signature and Date)

OWEN.REGINA.D.1253117423 — Digitally signed by OWEN.REGINA.D.1253117423 Date: 2021.03.02 06:37:39 -05'00'
Chair/Program Director (Signature and Date)

Chair/Program Director (Signature and Date)

SEIBERT.DIANE.C.1084932279 — Digitally signed by SEIBERT.DIANE.C.1084932279 Date: 2021.03.02 07:52:52 -05'00'
Associate Dean for Academic Affairs, GSN (Signature and Date)

DNP Project Director or PhD Director (Signature and Date)

WASSERMAN.JOAN.E.1551061066 — Digitally signed by WASSERMAN.JOAN.E.1551061066 Date: 2021.06.30 08:59:56 -04'00'
Associate Dean for Research, GSN (Signature and Date)

ROMANO.CAROL.A.1032050294 — Digitally signed by ROMANO.CAROL.A.1032050294 Date: 2021.06.30 10:58:40 -04'00'
Dean, DKI Graduate School of Nursing (Signature and Date)

In light of the above signatures, the project is approved.

BOJANOWSKI.LEODAYAN.ARPA.1458235860 — Digitally signed by BOJANOWSKI.LEODAYAN.ARPA.1458235860 Date: 2021.11.02 11:17:36 -04'00'
USUHS Vice President for Research Date

Appendix J

Naval Medical Center Camp Lejeune Institutional Review Board Letter of Determination

October 29, 2021

MEMORANDUM

From: Exempt Determination Official, Human Research Protection
To: Carla Jean Graham, USN, NMCCL

Subj: INSTITUTIONAL REVIEW BOARD REVIEW DETERMINATION

Ref: (a) NMCCL Human Research Protection Program (HRPP) Standard Operating Procedure (SOP), October 3, 2019
(b) DASD (HRP&O) Operating Instruction, 2019
(c) 32 CFR 219

Encl: (1) Institutional Review Board Determination Application

1. Per the reference, an administrative review of your application, "*Low-Intensity Cognitive Behavioral Therapy in Group Telebehavioral Health Format for Depressive Disorders Treatment in Primary Care*," was completed by the Exempt Determination Official (EDO).

2. After reviewing your application, the project described does not meet the criteria of activities subject to federal regulations at 32 CFR 219. Based on the materials submitted, it has been determined that IRB oversight is not required at this time.

3. Although IRB oversight is not required, all activities proposed in the submission should be conducted in a responsible and ethical manner, and held to standards required by your field and your responsibilities at Naval Medical Center Camp Lejeune.

4. This determination applies only to the activities described in the determination submission and does not apply should any changes be made. If changes are being considered and there are questions about whether IRB review is needed, please contact the IRB Administrator.

5. If you have any questions or concerns, please contact the IRB Administrator at (910)450-3013 or stephanie.l.dysonelms.ctr@mail.mil.

Respectfully,

HRPP Staff
NMCCL

Appendix K

Public Affairs Office Approval

NAVHOSPCAMLEJINST 5721.1B

AUTHORED WORKS APPROVAL SHEET

Author: LCDR Carla J. Graham, LT Nicole Morris, LT Katherine G. Whatley

Title: Low-Intensity Cognitive Behavioral Therapy in Group Telebehavioral Health Format for Depressive Disorders Treatment in Primary Care

Does the authored work involved potential or inherent controversy? YES/NO

Is the authored work likely to receive media coverage or publicity? YES/NO

Does the authored work address plans, policies, programs or operations of the DoD or the U.S. Government? YES/NO

DEPARTMENT HEAD ACTION:

1. ☒ Approved ☐ Disapproved.

2. ☐ Return to author for revision, discussion. 3. ☐ Recommend BUMED (MED-00P) review.

COMMENTS: Disclaimer added. Results powerpoint and poster submitted in conference with previously approved materials.

SIGNATUR[redacted] Kimberling DNP, FNP-C, CDR NC USN Date: 3/17/22

UPI: 1821406554

DIRECTORATE ACTION:

1. ☒ Approved ☐ Disapproved.

2. ☐ Return to author for revision, discussion. 3. ☐ Recommend BUMED (MED-00P) review.

COMMENTS: _____

SIGNATURE: [redacted] Date: 17 MAR 22

PUBLIC AFFAIRS ACTION:

1. ☒ Approved ☐ Disapproved.

2. ☐ Return to author for revision, discussion. 3. ☐ Recommend BUMED (MED-00P) review.

COMMENTS: Reviewed poster & PPT presentations. All disclaimers good.

SIGNATURE: [redacted] Date: 03/17/2022

DIRECTOR FOR PROFESSIONAL EDUCATION ACTION:

1. ☒ Approved ☐ Disapproved.

2. ☐ Return to author for revision, discussion. 3. ☐ Recommend BUMED (MED-00P) review.

COMMENTS: _____

SIGNATU[redacted] Date: 3/12/2022

COMMANDING OFFICER ACTION:

1. ☒ Approved ☐ Disapproved.

2. ☐ Return to author for revision, discussion. 3. ☐ Forward to BUMED (MED-00P) for review.

COMMENTS: _____

R. S. EWING
CAPT MC USN
COMMANDER
NMRTC CAMP LEJEUNE

SIGNATURE: [redacted] Date: 3/18/22

Appendix L

DOCTOR OF NURSING PRACTICE PROJECT
Completion Verification Form

The DNP Project titled: "Low-Intensity Cognitive Behavioral Therapy in Group Telebehavioral Health Format for Depressive Disorders Treatment in Primary Care"

was completed at Naval Medical Center Camp Lejeune by the following student(s):

(type student name)	*(signature)*	*(date)*
LCDR Carla J. Graham	[redacted]	07APR2022
LT Nicole Morris		07APR2022
LT Katherine G. Whatley		07APR2022

The DNP Practice Project Team verifies that the following components of the DNP project, accomplished by the above students, is of sufficient rigor and demonstrates doctoral level scholarship to meet the requirements for USUHS GSN graduation:

- Presentation to the DNP Project Team,
- Presentation of DNP project to the leadership at the Phase II Site,
- Abstract/Impact Statement *(Appendix I)*, and
- DNP Project Written Report.

Verified by:

(type name)	*(signature)*	*(date)*	
LCDR Tarah Lewis	[redacted]	12APR22	Senior Mentor
CDR Jane Abanes		11APR22	Team Mentor
			Team Mentor
CDR Robert Kimberling	KIMBERLING.ROBERT.JOSEPH.1159551039 Digitally signed by KIMBERLING.ROBERT.JOSEPH.1159551039 Date: 2022.04.08 09:06:36 -04'00'	8Apr2022	Team Mentor & Phase II Site Director