California HealthCare Foundation

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Issue Brief

Tapping into Digitized Behavioral Therapy:
Lessons from the Safety Net

Two common conditions that are frequently seen in California's safety-net clinics are depression and chronic pain. Both are associated with co-morbidity and impairment that drive over-utilization in behavioral health and primary care settings. Unfortunately, a shortage of behavioral health providers is a significant barrier to the timely treatment of depression and chronic pain, particularly in the health care safety net. As the Medicaid expansion increases stress on workforce capacity, clinics are in need of creative and cost-effective solutions to address the behavioral health needs of their patients.

One potential solution is the use of computerized cognitive behavioral therapy (CCBT) as an alternative to face-to-face visits for depression or for chronic pain. It is available on a variety of platforms, including online and via hand-held devices. CCBT is based on cognitive behavioral therapy, an evidenced-based treatment regimen that has been used in various forms to address the needs of a broad range of populations and conditions. Because the approach lends itself to a degree of standardization, the development of computer-assisted methods of providing interaction has shown promise in making therapy widely accessible.

To learn more about the usefulness of CCBT in the safety net, the California HealthCare Foundation funded two initiatives to test and evaluate the technology in a number of settings, with a specific focus on the process of clinical and administrative implementation. One pilot focused on depression, and the other on chronic pain. Each of the projects encountered significant challenges.

This issue brief summarizes the findings of both evaluations, offers feedback from staff and patients, and discusses implications for successfully using CCBT in the safety net in the future.

Two Pilot Programs

California Institute for Behavioral Health Solutions (CIBHS) and Beating the Blues (BtB), *evaluated by Erika Van Burren*

BtB is a series of eight 50-minute CCBT sessions that use video vignettes designed for adults with mild-to-moderate depression. Its developer is Philadelphia-based U Squared Interactive. BtB administers the Patient Health Questionnaire (PHQ-9) to assess depression and the Generalized Anxiety Disorder (GAD) scale to assess anxiety. Both are

recognized as reliable screening tools. The user receives an email after each session summarizing what was covered, recommended activities for the week, and an overview of what would be covered during the next session.

Evaluation design. Objectives included exploration of the on-boarding, training, and implementation strategies used; barriers and successes encountered during implementation; the uptake and completion rate of service users; and perceptions of the program by users and staff. A final objective of the evaluation was to assess changes in short-term participant outcomes based on changes in symptom ratings on the PHQ-9 from baseline to following participation in the fourth session of the program.

Implementation. Community clinics in two counties, San Joaquin and Modoc, were selected for implementation. A site-based coordinator, helper, and program administrator were identified in each county. The site-based coordinator provided internal high-level oversight of the program, and ensured that implementation strategies were integrated into the regular course of business or that new structures were created to support implementation. The helper had a hands-on role in following up with referred participants to orient them to the BtB program and provide ongoing in-person, phone, and email assistance. The program administrator was responsible for creating user accounts and facilitating technical access to the BtB platform. Trainings were conducted to orient involved staff to the BtB system and HIPAA compliance requirements.

Enrollment. Despite thoughtful patient identification and referral, fewer than 20% (*n*=19) of the targeted 50 referrals per site were obtained, and only 26% (*n*=5) of those referrals progressed to the second of eight total sessions. No one progressed far enough to complete the satisfaction survey and receive the incentive. Due to the low number of referrals and early drop-off in participation, neither consumer satisfaction data nor depression screening data were available to include in the project evaluation.

San Francisco Health Plan (SFHP) and ReThink Pain, *evaluated by Informing Change*

ReThink Pain is a CCBT program designed by Empower Interactive for chronic pain patients in the safety-net population. It offers a non-medication alternative for pain patients, many of whom struggle with over-reliance on prescription drugs. ReThink Pain was designed as an e-learning program, consisting of 12 lessons with educational information and interactive exercises. It includes videos demonstrating a patient character's approach to handling his/her pain in various situations commonly encountered by chronic pain patients. San Francisco Health Plan helped to recruit five clinics with a total of 10 sites—all in San Francisco—to participate in the pilot. Together, the clinics care for more than 1,800 patients with chronic pain.

Evaluation design. The evaluation was originally designed to assess patient outcomes and lessons learned from implementation, but because the patient uptake was lower than expected, the focus of the evaluation shifted to understanding the challenges encountered and identifying recommendations for future implementation of CCBT.

Implementation. Empower Interactive provided a training on ReThink Pain at each of the five participating clinics. Some clinics shifted the registration and patient follow-up to their behavioral health teams, while others used volunteers or interns to recruit and register patients. Patient screening was used to identify appropriate participants in some settings, while others conducted a more general outreach.

Enrollment. Despite the variety of strategies, all of the clinics experienced very limited success in signing up patients. Among all of the sites, only 21 patients had signed up in the first three months.

Findings in Common

Interviews with staff and feedback from patients in both pilot programs revealed a number of findings in common.

Target Population and Patient Motivation

BtB. Staff felt the program was not well suited for people with high levels of functional impairment, although they noted that there was initial consumer interest and ongoing enjoyment of the program by many referred individuals. One staff person in Modoc County specified that the program would be ideal for consumers who are: (1) relatively stable, receive medications, and have non-debilitating symptoms; (2) isolated, not eligible for higher levels of service intensity, or lack transportation; and (3) difficult to engage in talk-based therapy modalities because of verbal or cognitive impairments. However, other staff members gave less importance to such criteria, noting that consumer motivation and willingness

to commit to completing the program was a better indicator of fit.

Four of the seven staff interviewed referenced a lack of consumer motivation, commitment, or follow-through as a barrier to implementation, citing missed or rescheduled appointments and lack of time available to start the program.

Rethink pain. Staff noted that the patients selected for the pilot had too much functional impairment to benefit from it. The material presented in images and scenarios did not seem representative of their patient populations and did not reflect their lived experience, particularly with regard to ethnicity and socioeconomic status.

Also, patient motivation was a key challenge. The patient's only incentive was to better manage their pain without medication, which may not have been enough for many in this population. Clinicians noted the program was missing the social interaction elements that are typical in the in-person group meetings. While they recognized the difficulties in replicating this social interaction online, they thought it was an important part of pain management. They felt that ReThink Pain's group chat room was not sufficient to address this issue.

Technical Challenges and Computer Literacy

BtB. Both vendor and site-based staff identified technical issues and computer literacy as significant barriers for staff and consumers in accessing and using the system.

There are many "individuals who don't even have an email address, so for them to sit down, get into their email account, log into a specific URL, and then proceed with the program … that's quite a challenge itself."

— Staff member

In Modoc, internet service was described as very unreliable and the site coordinator identified the low bandwidth of the internet provider as contributing to frequent interruptions in service. Staff in both counties reported issues related to accessing the BtB system. Some consumers did not receive the authorization email giving them access after their account had been created; for others, the activation code within the email expired too quickly. For individuals most affected by such issues, web-based training and ongoing email technical assistance were not sufficient. These problems presented a barrier to consumer engagement by frustrating consumers and by decreasing buy-in to the system for staff.

Rethink pain. Many patients in the program had limited access to computers and low or no computer literacy. Although each clinic was given a laptop to use for the program, some had difficulty finding a secure space where patients could have some privacy to use the computer. Further, patients and staff who attempted to register themselves in the program often got stuck. Particular challenges were linking a patient with a clinician and requirements around public name, user name, and password.

Implementation, Workflow, and Provider Engagement

BtB. In both counties the implementation was beset with challenges including staffing shortages and competing project demands. Further, providers and staff felt there was insufficient guidance in best practices for facilitating adoption of the program. They noted that a program implementation manual would have helped the counties structure a protocol and optimize their chance for success. Several people suggested conducting structured site-based group sessions to provide face-to-face assistance in resolving computer and system access issues, as well as providing therapeutic support to patients moving through the modules. Two staff members felt implementation would have been more successful if they had involved clinicians in a more intentional way; they said this would have helped in working with specific patients and integrating the program into treatment planning processes.

Rethink pain. Overall, San Francisco Health Plan and Empower Interactive staff thought that getting clinics to adapt and fit the program into their workflow was an overwhelming challenge, especially given the concurrent changes they faced. At some clinics, staff cited the lack of an internal champion to motivate participation. Some providers were not motivated or could not successfully refer patients to the program, and several of the clinicians who did refer patients said that they did not know the current status of their enrolled patients. Staff also noted that, unlike some previous initiatives, the ReThink Pain project offered no incentives for providers or patients to involve themselves in the program.

Business Associate Agreements (BAA), Contracts, and Information Security Processes

BtB. Unanticipated contracting issues slowed implementation. Because the project required interacting with "covered entities" and "protected health information" (PHI) under HIPAA, BAA contracts were among the first items that needed to be created so that patient privacy was assured. In addition, the risk management departments at each county clinic, as well as at CIBHS, needed to be satisfied that all compliance issues would be addressed, appropriate insurance requirements put into place, and compliant file sharing, encryption, and the overall compliance framework established and communicated to each party.

Rethink pain. A plan to market directly to patients through a partnership with the San Francisco Health Plan did not come to fruition. Originally, the SFHP was expected to send a mailing to pain patients about the program with a signup code for individuals to enroll themselves. The SFHP ultimately decided not to do the mailing based on privacy and security concerns. This limited the ability to reach the vast number of SFHP pain patients to those who could be contacted through the participating clinics.

Enduring Enthusiasm

BtB. Despite the poor results, staff noted some strengths of the program and its implementation. In San Joaquin, they saw the effects of persistence and engagement from staff, citing the clinic helper's willingness to push through the challenges, continuously call consumers, and positively engage with them. In general, staff across both sites felt that consumers were genuinely interested and wanted to participate, seeing the self-paced structure of the program as a strength. Modoc staff also mentioned the high quality of the BtB site and its content. At the close of the project, participating staff continued to endorse BtB as a cost-effective alternative to traditional therapy for their higher functioning consumers.

Rethink pain. Clinicians were pleased to offer the program to patients as "a new tool for how to think about their pain." They liked the fact that it enabled patients to work on managing their pain on their own. They saw it as one way to reduce the number of patients who would have to come to the clinic or group sessions to receive cognitive behavioral therapy. Clinicians said the content and curriculum were well thought out and liked the ability to monitor their patients' progress through the program (if there had been more uptake). They said it was especially well-suited for patients who are already engaged in, or interested in, managing their pain through non-medication approaches (such as participating in other cognitive behavioral therapy and/or attending a pain group).

Recommendations for Maximizing CCBT Success

The potential of CCBT programs excites clinics and addresses one of their key needs to provide alternatives for their patients. However, an obvious gap exists between clinics' interest in the programs and their ability to implement them successfully. Several suggestions for improvement emerged from evaluators' discussions with pilot participants.

Look for clinic readiness. Consider clinics with a senior leader and day-to-day champion of the program, dedicated implementation staff, enough resources and time for successful start-up, ability to integrate the program into clinic workflow, and previous success with technology applications.

An obvious gap exists between clinics' interest in the programs and their ability to implement them successfully.

Prepare the staff. Offer a more formal and regular external coaching approach to help clinic staff and patients, especially during the start-up phase of the program. Provide clinics with guidance or best practices for implementation, including which patients to target and how to integrate the program into regular clinic workflow. Ensure that the clinic has appropriate staffing for implementation, including a staff person who is available during open clinic hours to help patients register for and use the program.

Select appropriate patients. Assessment and data analytics tools may be useful in helping select patients who are most likely to benefit from using these programs. Identify and refer patients who have computer literacy, access to technology, reading skills, and enthusiasm for the therapy, as well as specific reasons to change their behavior.

Motivate patients to engage. Offer live coaching to remind and support patients to engage in the program. Use therapy groups to recruit participants and add a collaborative element that motivates users to complete the CCBT modules. Offer incentives for

patients to complete the program. Provide additional languages besides English. Consider applying motivational interviewing—a widely used and validated intervention strategy—in the orientation and ongoing outreach to participants.

Make the technology work for patients. Create a private place, such as a kiosk, where computers can be secured and patients can complete the program modules in private. Provide an iPad or other touchscreen device, which requires less computer literacy. Consider establishing patient access to computers in another setting, such as a hospital computer lab or a public library.

Help the providers. Include providers early in the development process to ensure their patient care needs are met. Offer incentives to sign up and support patient participation. Include a process for providers to track their enrolled patients' progress.

Build in compliance processes. Integrate contracts, insurance requirements, BAAs, and HIPAA compliance requirements into any project that requires interacting with protected health information from the first day. There needs to be a well-organized approach to training, securing PHI, tools to transmit the information, BAA templates, access to project-specific policies and procedures, and a robust compliance framework.

Keep improving. As more patients participate, collect information about their implementation experience to further fine-tune the specifics of the program. Learn what facilitates or inhibits progression through the program, and the extent to which patients are helped.

Conclusion

Although cognitive behavioral therapy is known to be an effective approach to behavioral health challenges, the adoption of computerized formats in the US has been slow. Questions remain about its efficacy and cost-effectiveness, as well as the best practice models for implementation—in particular with safety-net populations. The two CCBT pilots described above, while not successful in terms of patient participation or impact, offer useful guidance for safety-net organizations eager to help depression and chronic pain patients despite the shortage of providers. The specific barriers and challenges experienced at the various sites provide ample knowledge to improve upon future use of these and other CCBT programs in clinic settings.

About the Foundation

The California HealthCare Foundation (CHCF) is leading the way to better health care for all Californians, particularly those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

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