AHRQ Webinar on Improving Diagnosis and Treatment of Adult Depression Through Digital Healthcare
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Patient Outcomes Reporting for Timely Assessments of Life with Depression: PORTAL-Depression

QUESTION: This presentation is quite timely as we are developing a Depression Care Model. What is the preferred depression assessment for pediatrics? This is a contentious topic for many. What safety plan was utilized when question #9 was activated for suicidal ideation? Or outside of this study? Does your study also embody the interventions utilized per score or risk profile?

ANSWER: For pediatrics, we are using the PHQ2/9A for adolescents 12+. I'm not a pediatrician and it can be quite complicated in younger ages. We are not doing suicide assessments because of the potential liability. There are ways of sending automated responses for patients with certain responses to go to the ER etc. However, this was outside of our study as we did not triage interventions

QUESTION: Do you see social determinants of health (SDOH) being implemented in population health management to identify individuals who have a lack of engagement and to keep these individuals engaged? Or is there something more clinical to identify individuals who would benefit from this sort of case management?

ANSWER: I see SDOH as another tool to help clue the system into who may be at higher need for engagement. I think there are other clues like no shows, cancellations, missed calls, and lots of messages via the portal, or urgent care and Emergency Room use.

QUESTION: During population screening and monitoring, are there any items that might require immediate follow-up (e.g., suicidal ideation)? If so, what is the step for managing follow-up?

ANSWER: There were some questions about passive suicidal ideation, but not active. The exact questions varied between patients because it was an adaptive test. For processes going forward, we are moving back to the PHQ2 only for the portal, and then eventually PHQ8, and maybe 9 +CSRSS, if the legal department agrees with the workflow. Plans for follow-up will be automated messages back to patients if high risk for suicide.

Question: What was the attitude of primary care physicians (PCPs) to this intervention?

Answer: We surveyed PCPs and their attitudes evolved over time. Providers were very enthusiastic about depression screening, but there were concerns about additional burden. 40% of providers in the first year expressed overburden concerns early on. During the monitoring trial during the next year, 60% of the PCPs said they were no longer concerned about over-burden.

Question: What changes to the healthcare system are needed to incorporate this type of system into clinical practice?

Answer: The major driver would be a change in quality measures and how our healthcare systems are judged in terms of quality and care. I'm very excited that depression screening and follow-up is becoming one of the primary quality measures for insurers, but that is only for new cases of depression. For all patients struggling with depression, and not getting adequate care or follow up, that depression remission factor isn't a focus. The movement to accountable care organizations and population-based health are important. We need more savvy and thoughtful ways to engage patients, as inadequately treated depression is a huge driver of expensive healthcare utilization.

Carolyn Turvey, PhD, MS
University of Iowa College of Medicine; Veterans Rural Health Resource Center- Iowa City
Development of a Targeted Patient Portal Intervention to Improve Depression Treatment Adherence, Satisfaction, and Outcomes

QUESTION: In what ways can clinicians work with patient portals to enhance their treatment alliance with patients?

ANSWER: It's important to talk with patients about appropriate uses of secure messaging and explain why they would use this feature. Also, when it comes to patient notes, it's beneficial to talk about the problems you're working on and to also document the patient's strengths in addressing their problems to keep them from feeling disempowered.

QUESTION: What are some innovative uses of secure messaging in depression care? How can organizations manage clinician workload burden?

ANSWER: Not having secure messaging tied to visits, but to also use it between visit check-ins or assessments to help better time when those visits occur. A 6-month follow ups for depression isn't adequate for some individuals. Having some sort of assessment or check-in between visits could be useful, though different levels of professionals may have to look at the assessments, which gets into provider burden. Getting creative about treatment models may help with secure messaging and providers can also send out resources such as popular health apps via the portal. Providers should talk with patients during the first visit about portals and set clear expectations about use and turnaround time.

QUESTION: How can the electronic capture of patient-reported outcomes enhance alliance and treatment of patients with chronic serious mental illness?

ANSWER: There was a meta-analysis done on long-term measurement-based care which found that you must share a copy of the assessment with both the patient and the provider, and that there should be a discussion about what occurred in the assessment (improvement or no improvement). This seems straight-forward, but patients almost never receive information about who if anyone is reviewing their assessments. In our study, patients can see their trajectory over time via their patient portals. It helps their memory, provides a better sense of what depression mean, and allows for patient empowerment. One study participant said that even though they may not feel much better, they trust providers more because they have access to and discuss these assessments.

Adrian Aguilera, PhD
University of California, Berkeley; University of California, San Francisco
Improving Diabetes and Depression Self-management Via Adaptive Mobile Messaging

QUESTION: Why didn't you use a wearable device to track steps more accurately?

ANSWER: We did consider using them, but we wanted to make our findings as generalizable as possible. People who use these devices will wear them for a certain period and then stop use. Also, they are not as accessible to everyone; we chose to use cell phones because they are more widely used. We err on the side of generalizability and applicability to make sure these interventions can be implemented in the real world.

QUESTION: Do you tailor the motivational messages to individual's situation? For example, what if they don't have family?

ANSWER: We do limit social messages if requested.

QUESTION: You mentioned the study was still in progress. What are the next steps, and do you see expansion of the study into specific devices and/or other subpopulations?

ANSWER: We do hope to expand, but it will all be dependent on our outcomes

QUESTION: How are treatment plans changing through portal use?

ANSWER: The key for us is to use it for identification of cases and communication.

QUESTION: What factors are related to engagement with the messaging program?

ANSWER: One of the most important factors is having a sense of connection with providers; we want to avoid one-way interventions without providing a sense of purpose and where the data goes. We feel that people from the clinic will engage more because they have a sense that the clinic is involved. We are also sharing summary data with the providers so they can see a history of physical activity and other data over the past few months. The key is to connect the data and intervention to ongoing care.

Reference: This document captures the questions and answers presented during the AHRQ Webinar on Improving Diagnosis and Treatment of Adult Depression Through Digital Healthcare. A recording of the Webinar may be accessed here: https://digital.ahrq.gov/events/ahrq-webinar-improving-diagnosis-and-treatment-adult-depression-through-digital-healthcare.