Mobile Health for Mental Health (MH2™) Using Technology to Improve Delivery of Mental Health Care

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OBJECTIVES

• To describe the feasibility and acceptability of MH2™ (Mobile Health for Mental Health), a web-based mobile health app developed to optimize stimulant medication treatment of children with ADHD.

• To describe pilot study in progress to 1) adapt MH2™ for use in a general pediatric clinic and 2) test its feasibility and acceptability using a mixed-methods proof of concept study design.

• Improving quality of child mental health care is national priority area

• ADHD affects 3-9% of U.S. children and is debilitating, chronic, and costly

• Most children & adolescents with ADHD treated by primary care

• Poor adherence to ADHD treatment guidelines in primary care

• National Quality Strategy: promote person-centered care, patient-provider communication and adherence to recommended care processes

• AACAP’s Back to Project Future initiative: Goal 5: Role of CAPs as educators and collaborators with child serving systems of care; Goal 8: Incorporate evolving technological advances into clinical practice (incl e-health)

Potential for High Public Health Impact

• Facilitate accurate reporting by parent and teacher

• Support clinician documentation of meeting treatment recommendations

• Improve quality of patient-provider communication

• Increase efficiency of health care visits

• Reduce child exposure to ineffective medication or side effects

• Facilitate collaboration with primary care and reduce reliance on CAP

• Currently also in Spanish; adaptable to additional languages

SIGNIFICANCE

INITIAL PILOT

Using a proof of concept study design, app feasibility will be assessed through the first three follow-up medication visits.

Study site: UCLA Pediatric Continuity Care Clinic (LA) – pediatric resident clinic

Study design: Proof of concept

Inclusion Criteria: ADHD diagnosis, age 5-11 yrs, first-time stimulant medication prescription or restart after significant gap in treatment, Spanish or English

Data sources: 1) after-visit parent surveys; and 2) time-stamped data from the app’s user activity log

Time points: (4 total): baseline, f/u med visits 1, 2, 3

Time intervals (3 total): T1: baseline-f/u med visit 1, T2: f/u med visit 1-2, T3: f/u med visit 2-3

Subject recruitment and data collection underway. Anticipated sample size: 12-24 parent-child dyads

CONCLUSIONS

FUTURE DIRECTIONS

• Improve outreach to pediatrics for both subject recruitment and feedback on how to make app more effective in pediatric setting – creating outreach "toolkit"

• Optimize parent interface to reduce user fatigue (e.g. ask certain questions more or less often)

• Make app more flexible (e.g. allow provider or parent to adjust med dosage between visits)

• Allow provider to view real-time metrics between visit, or have app alert provider between visits for "red flags" (e.g. med compliance drops below certain level), dangerous side effect reported, etc.

REFERENCES


STUDIES FUNDING

Studies funded by: UCLA CTsi (ULTR000124); UCLA Council on Research and the Faculty Grants Program (ULTR000124); Behavioral Health Centers of Excellence for California (S88612); Code for the Mission; UCLA Offices of Information Technology and Intellectual Property. Pilot study in pediatric clinic funded by AACAP Pilot Research Award for Attention Disorders, supported by AACAP’s Elaine Schlissler Lewis Fund.