

E-Care @ Home

WP1: User Requirements and Specification

D1.1.20-Clinicians Needs and ongoing usability Assessments

NB. Files are of a confidential nature. These assessments contain actual clinician interviews which are not to be distributed or reprinted in any way or for any purpose.

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| Deliverable id | D1.1.20-v1  |
| Document name | Clinicians Needs assessments |
| Date | 18. 09.2013 |

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| COVER AND CONTROL PAGE OF DOCUMENT |
| Project number: | 600451 |
| Project name: | E Care@Home |
| Document id: | D1.1.20 |
| Document name: | Clinicians Needs assessments |
| Dissemination level\* | Consortium  |
| Version: | 1.0 |
| Date: | 10.09.2013 |
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| ABSTRACT |
| Report on clinician consultations conducted at In-Geest PLEASE NOTE: these assessments, contain actual clinician interviews which are not to be distributed or reprinted in any way or for any purpose. |
| KEYWORDS |
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| --- | --- | --- | --- | --- |
| VER. | DATE | STATUS, CHANGES | FROM | REVIEW |
| 1.0 | 10.09.2013 | First draft  | The Alloy/In-Geest |  |
|  |  |  |  |  |

1. Overview:

This doc provides written summaries of all the need assessment interviews that have taken place with several clinicians (N=20) working at GGZinGeest in the period from February to September 2013. It starts off with a patient philosophy of Ingeest (paragraph 2.1), to illustrate the norms and values that are inherent to their perspective on dealing with patients and that are considered of importance in the adoption of the system. The remainder of chapter 2 provides summaries of specific need assessments and workshops with clinicians at Ingeest. At the end of the document, the conclusion lists a top 5 of clinical priorities for the system, which have been put together by a clinician/researcher of the ecare@home project group (Josien Schuurmans) who was involved in the need assessment interviews. It also states a list of ‘do’s and don’ts’ based on our assessments.

2) Clinician need assessment interviews

2.1 Patient philosophy for the ecare@home project (from the perspective of Ingeest)

Older mental health care patients are not all that different from people not suffering from a mental health disorder. People are not patients 24/7. They are also someone with their own likes and dislikes, their own quirks and habits just like anybody else, they have different roles (grandmother/father, mother/father, friend, lover, someone’s caretaker) and different needs. Not all patients are equally crippled by their disorder. A lot of people over 60 with a mental health disorder still work (sometimes volunteer work, especially after the age of retirement-65-). Not all patients in the AAL project will have a partner or a child who is looking after their needs. The word ‘care taker’ (or informal carer as stated in the proposal) does not necessarily apply to the people close to the patient, who we will also involve in the project. Significant other is a term that is more suitable. In a lot of cases, people may even mostly tend to their partner’s needs in stead of vice versa, the partner may be affected by physical illness and/or dementia and the ‘patient’ may be the primary caretaker. Patients may still have an active structural role in looking after their grandchildren.

Being in any kind of care, whether it be by chatting with a health care professional over the internet, by registering symptoms, or by having a sensor attached monitoring your heart rate or skin conductance, can make people be more aware of the fact that there is something wrong with them. This is not necessarily beneficial. It can make people feel worse about themselves, less independent, less healthy. This, in turn, can have an adverse effect on treatment fidelity (in order to maintain a sense of autonomy and/or health, people choose not to follow the good doctor\*’s advice, whether it be to take their medication on time, or to fill in the life chart every day). Although treatment fidelity is an important goal, it is also crucial for people involved in the care for mental health care patients to realise that this need for autonomy and the need to not focus solely on their disorder is essentially a good thing. It is healthy. We are all head strong when it comes to decisions that affect our daily life. It is called being an independent, adult person. We have a right to make ‘bad’ decisions regarding our own lives. In effect, people who completely and willingly submit to everything that we prescribe, are the people who suffer most, and will do anything to get better. Some might even argue that people who always comply and easily submit to any suggestion the ‘doctor’ makes may be incapable of making decisions for themselves.

Therefore, promoting *self-*management is key to good mental health. This means that it is vital for the patient to stay in charge of the decision making, whether it be to make an appointment with their doctor because they are not sleeping well, or to alert someone in case of crisis. Only in cases where the patient lacks the capacity to make sound decisions (for instance, due to a manic episode or psychosis), we may want to intervene without the patient’s ‘go-ahead’. Even then, we preferably want to have some contract with the patient (made in a period of relatively good mental health) stating in what cases someone else (for example the partner) may intervene without alerting the patient first. This is not only our philosophy in dealing with patients, it is also against the law to obtain information from people involved with the patient, without their knowledge or consent, or to give information, even to parents, children, partners, on someone’s treatment without their consent. Even if patients willingly give their consent to discuss every detail of their treatment with, for instance, their children, we will still be reluctant to do so, and strive not to do so, without the patient being present and being able to listen to the conversation. This is not merely out of respect for the patient as an independent person, but also because we do not know what motives might be involved in the patient’s willingness to share all information with their significant others. This may arise from the fact that they are dependent on them and do not wish to aggravate the people they want to be able to count on in times of need. Sharing details of what has been said with significant others may not always facilitate treatment. Treatment effectiveness in mental health care is at least partly rooted in the exclusively private nature of the treatment. You can say anything to your doctor, as long as you know he won’t tell anybody else.Therefore; in trying to facilitate all kinds of aspects of care through e-health care solutions, it is important that we do not lose sight of the patient’s need to make their own decisions and that we do not sidetrack the patient (for example by making an appointment with their doctor on the basis of certain observations made on a questionnaire, without the patient having to make this decision).

\* N.B. The word doctor is used in a broad sense here; it means any mental health care professional involved with the patient.

2.2 First round of individual need assessments/need assessment workshops

(February-May 2013);

Priorities for the tablet that came up during the first meetings with clinicians

-The life chart is a key method in the treatment of recurrent mood disorders to monitor and track symptom changes and identify triggers. The system should incorporate a digital form of the life chart.

-the system should enable different forms of contact, such as e-mailing and video-calling with the clinician, but it should be very clear at what times the clinician will be available to address the e-mails or respond to video-calling, as there will be many times when the primary clinician can not respond directly.

-the system should hold information on what to do and who to address in case of crisis. (could partly be based on the signal plan)

-the system should run smoothly and preferably be able to interact with the electronic patient records. Clinicians do not have time to enter data from the system in the electronic patient records (no extra administrative hassles).

- it should also be possible to administer other questionnaires than the life chart technique to assess mood changes, sleep, alcohol use, etc.

-the tablet should contain information on; the dynamics of the specific disorder, the medication (effectiveness, side effects and interaction effects), patient groups that the client can join, social activities the patient may want to be involved in.

-clients should not be side-tracked by automatic signals to the clinician or to a partner or relative unless the patient is severely unstable. Self-management and promoting awareness and patient responsibility is key and should be the focus throughout. The signal plan and treatment plan contain info on when we are allowed to act on for example a distressed call from a relative.

- in order to promote self-awareness, patients should be able to keep track of their own med levels in the blood stream (e.g. lithium levels), these should be made available to the patient and be visible in a table or graph for easy interpretation.

2.2 Interviews amongst 4 clinician’s on the daily hassles of their job

- having to look up different codes and having to go through too may steps in the electronic patient records to register the time you spend on each patient. Why could this not be automatically linked to your work notes on the conversation you have with a patient?

* similar; having to go through many steps to register someone’s diagnosis.
* Having to call GP’s or other doctors involved with the patient on numerous occasions because they are unavailable and do not return our calls.
* Having to send a formatted letter (sent back and forth to us by the secretary who wants to make sure the letter is in order) everytime we wish to keep the GP informed on the status of the treatment of their patient.
* Having to reinvent the wheel everytime we feel that a patient needs more social or other activities or if a patient asks us about a particular activity. (finding out through different channels what activities are available near the patient’s home).
* Getting people involved with services that they could use to make things easier, but do not use because they do not know of their existence or do not know how to apply; f.i. special care taxis (connexion, valys).
* Slow computers…
* People not showing up for appointments, canceling appointments or not showing up on time and then having to call them to reschedule.
* People not doing their homework assignments for therapy because they ‘forgot’, or left it at home.
* having to call the patient about their lab results (on several occasions sometimes because client is not at home).
* It would be great if the patient’s lab results could be entered into f.e. an excel sheet automatically (possibility of graphs displaying lithium levels in the blood stream).
* Lab forms are standard for most patients but still the psychiatrist needs to order it for every individual patient everytime. Could standard lab forms be distributed to the patient through the tablet?
* Medication overview readily available for both patient and physician. Push messages from GP/other specialties to tablet; alerts for checking interaction effects.
* Some sort of time management tool for clinicians; a lot of clinicians find it difficult to make sure that they have enough time to; write letters, write psychological reports, call people etc.etc. in between appointments with clients (let alone having enough time to lunch properly).
* Being able to finish one task without the next client presenting him/herself for an appointment. Perhaps through videoconferencing start time of conversation can be more flexible for clinicians.

**2.3 Need assessment interview with/presentation for clinicians/researchers working for the research and innovation unit of older adults at Ingeest 22/8**

Present: Eric van Exel (psychiatrist), Didi Rhebergen (psychiatrist), XX (attending in training), Anna Paauw (research assistant), Nicole Korten (PhD student/ psychologist) Sigfried Schouws (clinical neuropsychologist), Annemieke Dols (psychiater) and Max Stek (professor, psychiatrist).

*First impressions;*

The reaction to our plans in general is a bit stand-offish. Instead of coming up with suggestions or ideas, initial responses are reluctant; such as “frankly, I do not see this working…’, when prompted to illuminate; what aspects of the plan (in this case the plans for the life chart plus) or why he/she does not see this working or what would work; ‘I don’t know, but on a gut level I just think that it won’t work that way’. On a different note; ‘we are already video calling in a different project and there are all sorts of notes on this topic, can’t you read those..’

*Interpretation;* However, this is informative. As I half suspected some of the clinicians are not too motivated for yet something else that would change and maybe complicate the way they work. The clinic is about to move to a different location, which will entail a lot of changes in the way we work now, in every aspect; chambers will have to be booked through a different system, nobody will have their own office or work place, even print assignments are handled differently (personal code access) etc. etc. Furthermore, in the last few weeks clinicians have been confronted with al lot of extra administrative work that has to be done in order to keep the insurance companies happy. Therefore, if we want our project to be successfully accepted, it is key to ensure that the system will facilitate some of the treatment processes for the clinician as well as the patient. The system should work flawlessly and not create another administrative hassle.

*Specific comments*

* Different people comment on the fact that there is a lot of work already being done in this domain; video calling has already been implemented in another trial at Ingeest, Nijmegen hospital has an ambulant gynaecological department that has implemented ICT appliances to help coordinate and support the delivery of care and is going to implement it in other parts of the clinic as well. X comments that there is a lot of research in Australia on video conferencing because of the fact that patients simply are too far away from a clinic to deliver care directly. The general advice is for us to try not to think of yet another way to do this if a lot of this knowledge has already been developed. We should be informed on all the possibilities and preferably act in consort with others (such as Ralph Kupka who is studying the life chart in a web based version), so we are not all trying to ‘reinvent the wheel’.
* *The psycho-education module:* opinions differ on what kind of info would need to be presented on the tablet. Person X (psychiatrist) would like to make sure that the info is in line with what we feel is the right info; such as the interaction of lithium with alcohol. When people just google this info, they come across faulty and potentially harmful information such as another patient saying that alcohol and lithium go along nicely. Psychiatrist Y disagrees, he thinks this is paternalistic and belittling. He feels that a lot of these kind of ICT projects tend to belittle people. People will google their questions anyway, there is no way to shield them from info that you disagree with as a clinician. Furthermore, it can be an important aspect of treatment to discuss their info searches with their psychiatrist or other health care professional. This should be everyone’s individual process. However, he agrees with psychiatrist X that it would be great if our own information leaflets at Ingeest would be provided on the tablet in a way that patients would be able to seek out the info they are looking for instead of having to go through lots of text that does not fit their question. Formal information leaflets could be provided alongside more personal info/stories such as the Stephen Fry video (The secret life of the manic-depressive). Psychiatrist Z comments that maybe info should be fitted to the needs of a specific patient; if alcohol use is an important problematic aspect the tablet should include more info on this particular topic, for instance. Psychiatrist X comments that another way of making info personal is by making video’s of specific sessions on psycho-education. However, this is also quite scary for the psychiatrist; what if you accidentally say the wrong thing? Some psychiatrists do not seem too keen on the idea, but acknowledge that the Alzheimer centre is now providing videotaped sessions to patients of the diagnostic outcome interview. Discussion remains open on whether you would like to make a script for such a video (to make sure you don’t falter) or if a natural recording would be better (more personal and real-life).
* *Life chart plus*. Y argues that it should be clear what goal we are trying to attain; are we trying to make a self-management system or a system that will help prevent relapse. (I do not really see that these aspects are mutually exclusive). W feels that alerts to the psychiatrist, to see the patient sooner if the life chart provides info that the patient is not doing well, would not work. He can’t explain why it would not work or what would work, it is just a gut feeling. X argues that preferably, alerts should be sent to the patient. Based on the ‘signal plan’ and the ‘treatment plan’ specific rules and contracts can be made with the patient to inform us when their partner/ relative is allowed to contact us directly after an alert or if we are allowed to contact the patient directly after a certain alert. X argues that a lot of patients are not motivated to work with the life chart continuously. She even feels that patients who do fill them in constantly are not very healthy (i.e. obsessive). Y argues that motivation is key here. He feels this will come down to the clinician trying to motivate the patient to fill in the life chart. I make another suggestion which might not entail a lot of motivational interviewing on the part of the therapist. At the end of the discussion, everyone agrees that making sure that you have a simple effective way of registering both mood and other factors (sleep, meds, activity levels) with easy-to-read graph or figure outcome helping the patient to see patterns, could be motivating in itself. However, it is key that the system really is simple and works flawlessly.
* *Video calling*. Y refers to another project on video calling at Ingeest, and says that it was and still is difficult to implement. He refers to notes on this topic from meetings that they have had with the senior researcher that is in charge; Gemma Nijboer. He does not feel any added value of the implementation of video calling. It takes him a lot more hassle than just picking up the phone and dialing the patient. He has to plug in a laptop to another socket (because the institute does not have wifi) every time he wants to do a videoconferencing session. Also the system had a lot of technical difficulties at first. A few changes have been made recently and he is hopeful that the system will work better in future. X comments that we should think of how we will deal with the fact that some of the patients in the trial do not have wifi in their homes.

**2.4 Need assessment interview (60 minutes)with/presentation for clinicians working for the outdoor older adult department at Ingeest, date 3/9.**

Present: Caroline Sonneberg (psychiatrist), Jeroen de Jong (geriatrician), Chris van Hout (geriatrician in training), Joanneke Sikkema (psychiatric nurse), XX (psychiatric nurse), Jacqueline Onrust (social worker), Eva (intern), Sanne van Hilten (GP in training).

*First impressions;*

Overall the attending clinicians are very interested in our plans and are very cooperative. They feel their patients would benefit from a platform that can provide them with information and help them gain more insight in their illness and alert their clients or family members when to take action. However, they do raise a few important concerns. Concerns regarding the platform center mainly on ethical concerns towards their patients; will this platform not compromise their autonomy and their right to privacy? Will it not be too belittling or maybe set off alerts when there really is no reason to be alarmed?

*Specific comments*

*Video-calling:*

All who are present can relate to the added value of video calling. Especially for crisis contacts (for example a patient calls you in between sessions because he/she is in distress). Added info from video calling could help assess the seriousness of the situation (being able to see someone’s expression, gestures, signs of psychosis e.g. looking around or seeming distracted by sounds or visual stimuli where none are present). It would also be easier to reassure the patient if they can see your expression. Also, it would be great to use video calling for family conference sessions where one or more of the family members can not be present at the facility. At the moment, clinicians use the speaker function on the phone for this, but it would work much better to actually be able to see the person you are talking to.

*The psycho-education module:* as with our previous clinician need assessment, opinions differ on what kind of info would need to be presented on the tablet. Person X (psychiatric nurse) would like to make sure that the info is contained (not too much info) and that the information presented is in line with what we feel is the right info so that people do not get upset from faulty information. She points out that patients already get upset from reading all the side effects in the medication leaflet and that it is a negative influence on treatment adherence. On the other hand, everyone present confirms that we are unable to shield patients from information that they can look up elsewhere on the web. Psychiatrist Y would like to be able to push info that is specific to the client’s needs to the tablet, whilst keeping the general info to a minimum. All clinicians present agree that it would be great if the tablet would hold specific info on meds; which tablets can you split into two halves for example. Which meds can you take with milk? Which ones should you just take with water?

Regarding video-taping psycho-educational sessions, the clinicians agree that this is the way of the future (Alzheimer centre is already videotaping the sessions reporting the results of their diagnostic evaluation back to the patient and family). It would be great for the client to be able to play back the session multiple times, since a lot of information is lost due to stress, short attention span, etc. However, they also have some hesitations. First of all, it is an extra strain on the clinician to say everything just right. Also, we can not control what happens to such a videotaped session once we hand it over to the client. He/she may show it to whomever and potentially damage themselves by doing so. (in light of the fact that patients may not always act in their own best interest because of their mental health problems).

*Life chart plus*.

A lot of clinicians feel that the life chart as it is does not add much to treatment. It is not difficult to fill in, but it does not in itself produce any insight into what goes wrong. That’s something you have to figure out through piecing all the info together with your clinician. Some clinicians use the life chart, others don’t really see the value. Clinicians agree that a ‘smart’ life chart with other apps attached would be a valuable addition to treatment.

Opinions differ on whether patients will be prone to assess their mood continuously. Especially when they are feeling ok, they probably won’t use it as much. Psychiatrist X agrees that people will fill it in at times when they are less stable, but her experience is that in cases where people wonder about their mood changes, it can really help them to fill in the life chart and they are motivated to do so.

One of the interns wonders if the life chart can also be accessed from an app on a client’s smartphone, as people will probably be more prone to fill in their mood and activities if they can do it anywhere at anytime. Most people won’t carry their tablet around everywhere they go.

Psychiatric Nurse Y wonders whether people are able to read graphs. They should be very simple to read, even for people with a lower education with no experience with graphs. With regard to setting off alerts, the geriatrician is concerned that the system will not unnecessarily worry patients and family members (or clinicians). This is a recurring topic in multiple assessments; how do we make sure that the system empowers people and promotes self-management in stead of actually adding to insecurity and worry. When is a shift in mood problematic?

*Social chart*

All clinicians feel that this would be great to have, but they are not so sure if organizations would be prone to push their info to the tablet and keep this up to date. Trying to keep this up to date ourselves would be very time-consuming. Websites by organizations offering activities are not kept up to date, so why would they be prone to do it for this system? What’s their interest in doing so?

*Friends and family portal;*

People do appreciate that the system will provide access to family members or friends as well, as they often play a role in keeping tabs on the patient’s health. The older adult department is used to involving family members in the treatment. They can spot changes in a patient’s behavior much quicker than we can. However, they do raise a few concerns. One of the nurses states that she has a patient where the children are so concerned, that she feels her patient’s relapses are often set off by them pressing him too hard and belittling him. Also, even though patients may feel it is okay to exchange all kinds of personal info regarding their treatment with others, clinicians often do not feel the same way. Sometimes people are too willing to share information, for the wrong reasons. That is why we don’t share every detail of therapy with significant others, even with the patient’s consent.

1. **Conclusion; summary, top 5 clinical priorities and do’s and don’ts.**

***Top 5 clinical priorities for functionalities of the ecare@home system***

1. **Usability** The system should have easy access for clinicians and the adoption of the system should not cost extra time and effort on the part of the clinician, it should facilitate treatment processes for the clinician as well as the patient, not complicate them.
2. **Life chart** to aid self-management: smarter version of the current life chart that would integrate both mood and a limited set (e.g. max 4-5) of other health domains (e.g. sleep, activity) and provide easy-to-read user feedback and perhaps set off alerts (directed towards the client).
3. **Information** relevant to your mental health: encompassing psycho-education, info on meds (desirable: short-cuts to information on courses, social activities offered by nearby institutions for older adults, options for patient groups or forums).
4. **Contact with care**: encompassing video conferencing to the health care portal, instant messaging to the health care portal, a crisis app
5. **Contact with others**: encompassing video conferencing to friends and family portal, instant messaging to the friends and family portal, (optional; social gaming with social contacts).

***Do’s and don’ts***

**Do:**

* Take measures to ensure smooth implementation of the system and discuss system requirements with the ICT department in an early stage, as experience shows that this can take quite a bit of time and effort.
* Consult other parties that are working on similar ict projects (such as a digital life chart or video calling) at an early stage to learn from their experiences.
* Make sure that the patient stays in charge of decisions regarding his/her treatment where this is feasible.
* Make sure that the privacy rights of the patient are protected; for this purpose the system should not be too ‘open’, for easy sharing of information regarding their illness with others (for example via facebook)
* Provide easy access to lab results and an overview of med levels in the blood stream, preferably in a graph or table that is easy to read and may be linked to other factors, such as alcohol use (this could be part of the ‘smart’ life chart)
* Make existing treatment plans or signal plans in the electronic patient records accessible within the system, to keep track of appointments made with the patient on how to act and who to involve in case of crisis.

**Don’t:**

* + Side-track the patient by directly sending alerts to the clinician, family members/significant others unless the situation warrants this approach (a crisis situation), even be vigilant to act in this manner with the patient’s consent.
	+ Expect too easily for the patient to take all decisions regarding privacy of information, (for example sharing info regarding treatment with ‘buddies’). Due to the nature of mental health disorders in general and specifically bipolar disorder, patients may be in a place where they are not capable to oversee the consequences of their decision. Our mental health care facility can not absolve itself from responsibility for the privacy of information regarding treatment merely by getting consent from the patient.
	+ Give unrealistic expectations to patients regarding reaction time and access to direct contact with their clinician at any given time; rules about when a video call is possible (and with whom) and on when their clinician will be able to respond to instant messaging should be made very clear.

**3.1 Clinician need/usability assessment at Ingeest on ecare@home, 11 feb 2014. 12-13 pm CET**

Present: Caroline Sonnenberg (head of the department for patient matters), Jessica Pijl (psychologist) Gert-Jan Kesseler (head of the department for logistic matters), Mirjam Beelen (nurse practitioner).

Absent: Annemieke Dols (called away on urgent patient matters)

Introduction of the ecare@home system and the work that has been done

Josien provides a short demo of the background of the project, target group, focus and the outcome of previous need assessments.

feedback: Caroline and Gert Jan suggest that the user assessments of the clients are probably biased since people that were selected to participate by clinicians tend to be healthier, younger, higher educated and therefore more computer savy than the overall patient group. There has been an enquiry among a random sample within the entire patient group being treated at our care facility, showing that only about 30% has any involvement in computers/ the internet. Furthermore, most people needed help from a family member or friend to actually be able to do anything (such as use e-mail, browse the net). There has been a short report on this enquiry, Gert-Jan will send this to me.

Psycho-education

The attending clinicians respond positively to the idea of providing a pdf or e-reader with access to the patient folders we use at Ingeest. They suggest that the communication department will probably be able to adjust the two column version to a one column version. Caroline and Gert Jan suggest that there should be different info ‘packages’ for different target groups; one for bipolar and one for depression for example, that could be pushed to the tablet. They also suggest to be selective on which info to provide to the patient on the tablet; not all the (general) folders that we distribute to the patient at the start of treatment, but rather only those that include specific info on their disorder and treatment. The tablet might also provide a few links to patient groups or other websites that we feel may be beneficial for those that seek more information.

Measures: log a reading

* Overall

The clinicians respond positively to the measures, the plus and minus poles for activity and mood and the current simplicity; less is more. Jessica feels that perhaps eating behaviour (too little vs too much) could be added, but Caroline suggests that people will probably not fill in more than these three measures; she also adds that these are the key measures for the life chart and it accurately reflects what she already monitors with patients. She adds that this type of likert scale has been proven to be useful for older adults. Gert Jan also agrees that keeping measures to a minimum is key.

* Log a reading: mood

Feedback all: The poles need more description; what does +5 and -5 mean and some description of values in between. Jessica suggests that for mood, this might be depicted in pictures rather than words (smileys). She warns that values should make clear that zero is not associated with the absence of mood; a flatline so to speak, but that it reflects neutral mood (not particularly good or bad).

* Log a reading: activity

Feedback all: clinicians are enthusiastic about the fact that this measure is also included as a bipolar measure; either too active or too passive. The poles and values in between need more description. It is suggested to also use pictures to this end; couch potato versus an overexerting running person for example.

* Log a reading: sleep

Feedback all: the current measure accurately reflects the essential info that is required for sleep. Whether it needs to have an alarm clock is debatable.

Life chart graphs

Clinicians respond positively to the overlayed view. They add that these should be interpreted in consort with the clinician. The ‘life chart’ could be the subject of conversations between patient and clinician. They feel that two measures is probably max; three measures displayed at once is too complicated for our target group. Same goes for lithium; an overlayed view of lithium over mood is desirable, but other measures should not be added, to avoid confusion. As far as wanting to adjust the look of the graph; clinicians feel that clients will only find this confusing. The outlook of the different measures adequately reflect the nature of the measures; sleep is displayed as a bar chart as these are fixed data, whereas mood fluctuates and therefore should be portrayed as a line. It is suggested that clinicians will prefer to work with a default look of the life chart. Having one or two alternative set-ups would be ok, but clinicians will not want to decide which one to use for every individual patient (adds to daily hassles).

Caroline suggests that the notes that people add to a certain reading (especially for a sudden peak or drop) should preferably be displayed within the life chart to help interpretation.

Caroline suggests that apart from portraying lithium levels, it would be great if the client could monitor their actual med use on the tablet (in the broadest sense; e.g. from date X, I am now using 125 mg of nortrilen daily). She does this on paper with patients. This should not be a complete overview of all meds, just of the ones the client uses for their mental disorder and it is not necessary that patients log whether or not they actually took their daily dose, it would just serve as an overview ofchanges in the dosage. This could then also be linked to mood for instance.

Clinician portal alerts

This is a difficult issue, and the debate had to be cut short due to time restraints. Clinicians feel that alerts should preferably be directed towards the patient, unless the patient is debilitated to such an extent that this is no longer possible. Alerts should not be triggered by a one-off reading. Mood values are different than blood pressure readings, which more or less have a fixed bandwith.

 Clinicians suggest that alerts should only be applied in certain stages (i.e. when it is already obvious that the patient is not doing too well). They feel that when the patients is very unstable, alerts may be directed towards the clinician. For example, when a patient is clearly becoming unstable and is so confused that he won’t be able to make a sound decision, appointments could be part of the signal plan that in those cases, alerts should be directed towards the clinician. However, it is also suggested that clients that are that unstable (i.e. they are incapable of contacting their clinician), will probably not be prone to log readings on the tablet at all.

Video calling

We did not have enough time to discuss this in depth. Clinicians agree that video calling should be appointment based and that the clinician is the one who makes the call, rather than the patient.

Instant messaging

Whether or not this adds anything to the communication with the patient is debatable, according to the attending clinicians. Caroline suggests that patients should be informed that for urgent matters, messaging is not the way to go. It may take a couple of days for the clinician to answer. However, it is discussed if that is the case, whether instant messaging will add anything or might simply be an extra communication portal that will lead to confusion. Caroline suggests that the messages should be sent to her regular outlook files from the instant messaging portal; but that is probably impossible since the privacy of patient data can not be ensured in that way. Also, if you would use your outlook account for patient communication, then why use a separate messaging box at all? The other option is to use an admin that will filter out the urgent matters from the instant messaging box; but again, this begs the question why a patient would use instant messaging to ask for a prescription when they could just as easily pick up the phone and tell the admin what they need.

Local institutions

This topic was not adressed.

Overall Impression; positive!

Nice lay out, simple, usable, not too complicated. Clinicians feel that this would definitely add something to their interaction with the patient (especially the ratings and the graphs).

Feedback Annemieke Dols (old-age psychiatrist, special interest bipolar disorder) on the presentation of screenshots.

1. Log a reading-mood: To A. it is a bit unclear how a bipolar client would rate his mood. She wonders if neutral (0) would be the ‘best’ mood for a bipolar patient. She has to get used to the idea that we have abandoned the life chart methodology that is more specific about whether someone rates him/herself as manic or depressed. After some discussion regarding why these types of clinical labels were abandoned (user assessments) she suggests that perhaps mood ratings could be clarified by adding tekst to the poles, similar to the activity and sleep ratings. Josien will look into appropriate lables.
2. Log a reading-activity: no comments, enthusiastic about the simplicity of the overall lay out for readings.
3. Log a reading; sleep. Annemieke suggests just depicting 15 minutes to the hour to simplify the clocks. She likes the idea of depicting shours of sleep and bed- wake-up time as a vertical bar that ‘floats’in the middle for normal bedtime hours that may float down when people sleep during the day or up when people go to bed really late at night.
4. Life chart; enthusiastic. Would like to be able as a clinician to shift between different overlays (2 or 3 readings at a time) and a different lay out (being able to change colours or bars to lines).
5. Alerts. Feels that the system should not give manic or depressed warnings based on mood or other readings. Is enthusiastic about the idea to direct patients toward their signal plan in case of an alert. Feels that a lot of thought should go into what kinds of alerts are set; for example not sleeping too well for 3 nights may not need any specific action, but not sleeping well for 10 nights in a row might.
6. Video calling. Is enthusiastic about the lay out of video calling and the simplicity of the controls.
7. Instant messaging. A. uses a separate mailbox for bipolar patients. This mailbox is screened by the secretary. Patients are aware of the fact that she does not read the messages directly and that their messages are screened and by whom. She discusses with patients what types of messages are fit fort his type of communication. However, she still finds that in practice, a lot of patients do not seem to grasp the idea that this type of communication is not fit to describe whole epistles of their life and what happened to them in between sessions. For example, something that warrants immediate action, such as a change in meds without consulting their doctor, might be embedded in a long message describing all sorts of problems or events. She still feels that we should somehow find a way to fit this type of communication into regular clinical practice and that e-mailing is not the way to do it. So she would want to use instant messaging, but through an admin and a lot of time and effort would have to go into managing patient’s expectations.
8. Crisis. A. tells me that the out of office hours crisis service is not as accessible to patients as you might think, because of a reason. We do not want patients calling us on weekends unless they are in such a state that they really need to see someone this instant. Other clinicians that do not know the patient, may give the wrong advice and the weekend crisis staff is really for emergencies only (acutely suicidal, psychotic, manic, needs hospitalization). So the idea is that people recieve an ‘alarm card’ from their clinician if the clinician feels that such a crisis may occur. The alarm card may have a limited expiration date (e.g. just for that specific weekend.) Even referring someone to the one who is on staff during office hours when your own clinician is not present might be troublesome. Other people do not know enough about the treatment plan and style of communication with a specific individual and may sometimes cause more harm than good. So again, unless someone is in an acute state of crisis, she prefers it when patients are not automatically put through to someone else. She would like the tablet to simply state the phone number and adress of our facility and nothing else.
9. Psycho-education. No comments. A. will screen the leaflets that I selected to see if there is anything missing.
10. Lithium. A. Dols would like to be able to push the entire excel sheet that she uses to record different blood levels over time (including kidney function etc., I sent an example to Chris and Gus) to the tablet. Her colleague C. Sonnenberg uses the same excel sheet. We need to look into the possibilities to do this and whether or not this might be tricky due to legislation for medical devices.