

A Pilot Study of Video Telemedicine in the Assessment of Primary Care Patients With Anxiety and Depressive Disorders

Abstract

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OBJECTIVE

The results of many clinical trials are disappointing due to high placebo response rates. This could be due to a number of factors, including inappropriate patients being entered into the trial, and problems with the accuracy of the assessment process. Centralized raters could help to accelerate patient recruitment, and improve the quality of patients enrolled in trials by tapping into primary care physicians' practices via videoconferencing. The quality and reliability of assessments should also be improved by using a small group of highly trained and calibrated raters. The purpose of this study was to examine the feasibility of identifying and recruiting primary care patients for clinical trials, and to examine patient comfort, satisfaction, and adherence in a mock clinical trial using high-quality videoconferencing for screening and evaluations by remote centralized raters.

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METHOD

Patients with Major Depressive Disorder, Generalized Anxiety and Panic Disorder were identified in two primary care practices by waiting room screening with the self-report Patient Health Questionnaire (PHQ). Once consented, patients were interviewed remotely by well-trained raters using the high-quality videoconferencing. The first interview was a diagnostic interview containing the overview of the SCID and diagnostic questions from the PHQ; if qualified, the patient was asked to come back once a week for six weeks for follow-up evaluations (HAM-D, HAM-A, or Panic Disorder Severity Scale), as if they were in a therapeutic clinical trial. Patients received treatment as usual from their primary care physician. Patients completed a survey after their first and last remote assessment in which they were asked to rate their overall preferences for the videoconferencing process, their level of agreement with descriptions of various attributes of their experience, and to respond to three open-ended questions probing attitudes towards remote assessment.

RESULTS

Of the 45 patients enrolled, 80% completed the six-week study with no more than 2 missed appointments. Nine patients (20%) dropped out of the study because of personal issues or being lost to contact. Satisfaction and comfort levels of the participating patients using videoconferencing were very high, indicating that they would participate again and would not hesitate to recommend to others participation in clinical studies using videoconferencing. More than three quarters (77%) preferred videoconferencing, had no suggestions for improvements, or found no differences from face-to-face contact.

CONCLUSIONS

Patient acceptance of remote raters is high. Patients in primary care settings will enroll, participate and complete research protocols using 'virtual' interviews (videoconferencing). The impact of remote centralized ratings on signal detection in clinical trials must now be tested.

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Key Results

Patient Yield	# of Patients
Screening Patient Health Questionnaires [PHQs] completed	1,329
Patients screened positive on intake measure – [PHQ]	211 (16%)
Met entrance criteria	135
Patients agreeing to participate and sign informed consent	79
Patients passing secondary screen with SCID	45
Enrolled in study [6 visits]	45
Patients who completed study	36 (80%)

How does interviewing with videoconferencing differ from face to face visits? Are they as useful?	After First Assessment		After Last Assessment	
Videoconferencing as useful/preferred	64%		74%	
Preferred face-to-face	19%		12%	
Face-to-face more familiar/can feel mood/see hand gestures		16%		9%
Need a relationship established before videoconferencing		4%		3%

Patient Satisfaction Survey [N=104] Agreement rating from [1]=Very Unlikely to [5]=Very Likely	Agreement Rating Scale [1 – 5]
Would you participate in another study using this technology?	4.7
Would you be likely to recommend to a friend to participate in clinical studies using videoconferencing?	4.5

Videoconferencing Advantage: Selected* Representative Verbatims

“I felt more comfortable and easier to talk this way. I don’t think I would go if it were face-to-face.”
“It is better in one way. It is like you don’t have to face the person with your problems.”
“It made me more comfortable because I would be more uncomfortable face-to-face.”
“...just knowing that the interviewer is not actually in the room creates a degree of comfort. You don’t also feel so much like you are in the ‘hot seat’.”
“Sometimes it is hard to relate to someone so quickly in person. This helped me relate more quickly.”
“I would not have come if it was in a face-to-face interview – this way I felt much more relaxed and comfortable.”
“Less nervous using videoconferencing.” “I say they differ in the fact that I feel more privacy and more freedom in this video technology system.”
“I felt more comfortable. Face-to-face I know I would have had a problem. It’s hard enough for me when it’s a doctor I know.”
“Face-to-face is very difficult. Get things out off of your chest – the videoconferencing - it was very, very comfortable. I felt like I could say anything.”

* Unduplicated patient responses