Nova Health AI
More time for Patient Care

Addressing the Use of Mobile Devices for Care

Why a Structured Check-In Helps More Than a Phone Could Ever "Hurt"

Executive Summary

A concern raised consistently in prospective client and stakeholder discussions deserves a direct, evidence-based answer: does putting more mobile-device contact between someone and their care team help their mental health, or harm it? Research does show that heavy, passive phone use, endless scrolling, algorithm-driven feeds, social comparison is linked to worse mental health outcomes, especially for people who are already vulnerable. That concern is legitimate, and Nova Insights takes it seriously.

But it describes a specific pattern of phone use, and it is not the pattern this platform uses. The distinction between passive, compulsive engagement and structured, protocol-driven outreach is exactly why the platform is a net mental-health benefit, not a risk, for the people it reaches, including some of the Veteran population's most vulnerable members: pregnant Veterans managing PTSD.

It Is a Different Kind of "On the Phone"

- **Someone reaching out to you, not you reaching for it.** The program sends a scheduled, purposeful check-in from the users own care/support team, the opposite of the compulsive, self-directed scrolling that drives most screen-time harm research.
- **Bounded and protocol-driven.** Each interaction has a defined start, a defined set of questions, and a defined end, not an infinite feed engineered to hold attention.
- **Never a substitute for human contact.** The system does not diagnose, counsel, or replace a clinician; it exists to get a user to a person faster, when it matters.

The Mental Health Case for the Program

- **Combats isolation in high risk windows.** When not in a clinical setting and in need of support, people are most likely to disengage from care; a scheduled check-in is a caring touchpoint during the very period isolation tends to take hold.
- **Surfaces decline before it becomes a crisis. Using our clients protocols and guidelines** Mental health status is tracked at every check-in. When responses trend toward concern, the system can escalate to providing relevant resources or escalates further to a support person, a person who decides what happens next, not a dead-end notification.
- **Demonstrated behavioral-health impact.** Among enrolled Veterans at VA facilities, substance-use relapse fell from 30% to 13%, and 30-day readmissions fell from an 11% rate to essentially none, direct evidence that structured monitoring changes real outcomes, not just paperwork.
- **Clear limits, clearly disclosed.** Every person on the program is told in writing that this is supplemental outreach, not an emergency system, and is directed to established support and emergency protocols for any crisis. Participation is voluntary and can end at any time.

Case in Point: Supporting Pregnant Veterans with PTSD

The clearest test of this model is also its most sensitive: pregnant Veterans managing post-traumatic stress disorder. A significant number of woman Veterans, including those who are pregnant, experience PTSD, which can complicate both their mental health and their maternity care. Engagement in regular

care and adherence to treatment plans are often difficult, especially given varied motivational factors and the need for sustained support between clinic visits, exactly the gap structured mobile outreach is designed to close.

Nova's team applied the same structured, protocol-driven model described above to this population. These Veterans received motivational messages twice weekly and well-being check-ins tailored to their individual treatment goals, no special app or device required. Automated assessments tracked symptoms of stress, anxiety, and depression, adapting follow-up based on responses. Crisis alerts and non-responses escalated automatically to clinicians, reinforcing safety for high-risk individuals rather than leaving a concerning response to sit unseen.

Across utilizations, demonstrated measurable improvement in mental health resilience, perceived support, and adherence to care protocols. Overall this approach produced:

- More consistent engagement with behavioral health services
- Faster provider intervention during emerging crises
- Enhanced care coordination and reduced clinical burden

> *It wasn't "more phone." It was structured connection delivered at the moments users were most likely to disengage, during one of the highest-risk life stages, for one of the highest-risk conditions.*

Built on Trust: Consent, Privacy, and Human Oversight by Design

The same governance discipline that makes this model clinically defensible is what makes it safe on a personal device. Every user enrolls voluntarily, with written informed consent that discloses the program's scope, its limits, and how their data is used, stored, and protected, in plain language, before participation begins.

- **Privacy and security by design:** data is encrypted in transit and at rest, access is limited on a need-to-know basis, and every access is logged and auditable.
- **Clinical authority stays with the clinician: based on clients protocols and guidelines** the system flags trends and escalates; it does not diagnose, prescribe, or intervene on its own.
- **Consent is ongoing, not one-time:** Users can modify or withdraw participation at any time, without penalty.

Conclusion

The risk is in how a phone is used, not that a phone is used. Unstructured, passive engagement can isolate; a scheduled, protocol-driven check-in from a user's own care team does the opposite, it keeps someone from falling through the cracks during the days they are most likely to. This program doesn't add to screen time; it uses two minutes they would spend on a device anyway to keep them connected to care.

Whether the population is a broader mental health cohort or general population, the evidence points in the same direction: structure, disclosure, and clinician oversight are what turn a mobile device from a source of risk into an instrument of care.