# MIAMI Project:
## MIRECC Initiative on Antipsychotic Management Improvement

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# MIAMI Journey

- 1998-2000
  - Increased recognition of the metabolic effects of second-generation antipsychotic medications
- 2003
  - VA/DOD Clinical Practice Guideline for the Management of Diabetes Mellitus in Primary Care
- 2004
  - Consensus guidelines for physical health monitoring of patients with schizophrenia (Am J Psych, 2004)
  - ADA consensus conference on antipsychotic drugs and obesity and diabetes (Diabetes Care, 2004)
  - Updated VA/DOD Clinical Practice Guidelines for Management of Psychosis

# MIAMI Journey

- 2003-2008
  - Emerging evidence that despite the various guidelines, rates of metabolic monitoring were fairly low
- 2007 - VA OIG Report: Healthcare Inspection: Atypical Antipsychotic Medications and Diabetes Screening and Management. Recommendations included:
  - Implement and document weight reduction strategies
  - Improve treatment and documentation of interventions for elevated fasting blood glucose levels
  - Implement interventions to maintain blood pressures less than 140/90 for younger patients without diabetes who are prescribed atypical antipsychotic medications
  - Achieve target blood glucose levels for younger patients with diabetes who are prescribed atypical antipsychotic medication

# MIAMI Journey

- 2008 - VA Office of Mental Health Services: Report of the Workgroup on Atypical Antipsychotic Medications and Diabetes Screening and Management.
  - Assure access by primary care and mental health clinicians to guidance documents
  - Ensure mental health clinics are able to follow recommendations for monitoring of metabolic risk factors
  - Improve coordination of care between primary care and mental health for patients treated with antipsychotic medication
  - Improve referral of patients with identified metabolic risk factors to *MOVE!* or other wellness programs

# MIAMI Journey

- 2009 - MIAMI Project is funded: VA Office of Mental Health Services Initiative
- 2-year national program designed to implement recommendations from the Atypical Antipsychotics Workgroup
- Administered by the VISN 22 and 16 MIRECCs in conjunction with Mental Health QUERI
- Project Goals: improve monitoring for and management of physical health problems among veterans taking atypical antipsychotic medications
  - Improve adherence to guidelines around metabolic monitoring for antipsychotic medication
  - Decrease the number of veterans who are prescribed antipsychotic medications who are obese
  - Increase the use of weight interventions among veterans who are prescribed antipsychotic medications and are obese

# MIAMI Activities

- Develop and disseminate effective tools for implementing antipsychotic monitoring programs
- Educate champions who will go back to their facilities/VISNs and educate others
- Assist with implementation of metabolic monitoring/management at VA clinics
- Utilize VHS DSS and VA Corporate Data Warehouse to evaluate change in monitoring in VA

# MIAMI Resources: Practice Guidelines and Wellness Resources

- vaww.mirecc.va.gov/miamiproject/
  - Includes background information regarding MIAMI
- vaww.mirecc.va.gov/miamiproject/guidelines.asp
  - Clinical practice guidelines for obesity, diabetes, hypertension, dyslipidemia, and atypical antipsychotics
- vaww.mirecc.va.gov/miamiproject/resources.asp
  - EQUIP Wellness Manual
  - Food and Physical Activity Diary
  - BMI Chart

# MIAMI Resources: Educational Tools

- vaww.mirecc.va.gov/miamiproject/education.asp
  - Metabolic Monitoring and Management for Patients Taking Antipsychotic Medications: Guidance for VHA Primary Care Providers
  - A poster including essential information regarding metabolic monitoring and management
  - Educational slides to help promote awareness of the problem and educate other clinicians
  - Downloadable powerpoint presentations from 2010 MIAMI Conference

# MIAMI Resources: Technical Assistance Center (TAC)

- vaww.mirecc.va.gov/miamiproject/technical_assistance_center.asp
- Goal of center is to support sites implementing routine monitoring
- Located in Little Rock at CeMHOR
  - Monday thru Friday
  - 8:00-4:30
  - Phone: 1-888-357-1978
  - Email: vhalitmiamiproject@va.gov

# TAC Services

- Clinical consultations
  - Metabolic Effects of Antipsychotic Medications
  - Current Monitoring and Management Guidelines
- Advice about implementation strategies
  - General – how to get started, who to involve
  - Specific – how to manage a particular challenge at a specific site
- Advice re: wellness resources for individuals with SMI
  - Accessing programs
  - How they fit with monitoring/management programs
  - How to engage veterans in these programs

# TAC Services

- Central repository for implementation tools
  - Sites can send tools to TAC to share with other sites
  - Distribution of “hardcopy” tools
- “Connector” between sites and between sites and experts

# Successful Strategies Shown to Help Implement Routine Monitoring for Metabolic Side Effects


**Richard R. Owen, MD**

**Mental Health Quality Enhancement Research Initiative (QUERI)**
**Center for Mental Healthcare & Outcomes Research**
**Central Arkansas Veterans Healthcare System**



# Overview

- Describe evidence for quality improvement (QI) strategies in general
- Describe evidence for strategies used to improve antipsychotic management
- Implications for implementation of recommendations for metabolic monitoring and management

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# QI Strategies – Overview

- Change Strategies
- Team Approach
- Evidence-Based Quality Improvement
- Lessons from QUERI
  - Formative Evaluation
  - Facilitation
- Integrate QI Efforts with System Priorities and Resources

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# Lessons from Research – Change Strategies

- Education
- Opinion Leaders
- Clinical Champions
- Academic Detailing
- Audit and Feedback
- Incentives or Sanctions

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# Lessons from Research

## Team-Based Quality Improvement

## Evidence-Based Quality Improvement

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# Theoretical Support for Team-Based Approach

| Theory | Application in *ASSIST* project |
|---|---|
| Interpersonal / Sociopsychological Theories (eg, Diffusion of Innovation, Social Influence Theory, Social Cognitive Theory) | Local opinion leaders use their influence to educate peers, encourage evidence-based care, and model targeted behaviors |
| Organizational Theories | Participation and support from organizational leadership is critical; resources offered to support team efforts |
| Complexity / Systems Theories | Functional capacity and impact of team (as a whole) may be greater than sum of its parts; exploit 'fuzzy boundaries' |

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# Characteristics of Successful Clinical QI Teams*

| Characteristics | Implications |
|---|---|
| View team goals to be part of the organization's key strategic goals | Ensure that team efforts align with broader org'l goals; provide regular updates on progress to senior leaders |
| View team leaders as competent, with clout to remove barriers to change | Ensure that team leaders have close connections to senior leaders and have a good understanding of clinical issues involved |
| Know one another's strengths / weaknesses, respect each other, may have worked together before | Include team members who have worked together in the past and who have good interpersonal skills |

*** Reference: Mills PD, Weeks WB. Joint Comm J on Qual Safety 2004;30:152-162. 'Successful' = achieved >20% sustained improvement on targeted clinical behavior.**

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# Total Quality Management (TQM) & Continuous Quality Improvement (CQI)

- Structured organizational process for involving personnel in planning and executing a continuous flow of improvements to provide quality health care
- Implement evidence-based practices
- Data-based
- Typically conducted based on intuition and anecdotes regarding strategies for changing organization and provider behavior

Shojania KG, Grimshaw JM: Evidence-based quality improvement: The state of the science. *Health Affairs.* 2005; 24: 138-50.

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# Evidence-Based Quality Improvement (EBQI)

- Explicit use of the best available evidence to inform decisions about the care of individual patients.
- Implement in routine practice the processes and outcomes of care established by the best available evidence.
- Tension between centralized & locally driven

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# Lessons from QUERI

## Formative Evaluation

## Facilitation

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# Research Approach to Implementation Lessons from QUERI

- Design multi-component interventions based on theory (behavior change, organizational change) and/or results from formative evaluation
- Conduct formative or process evaluation
  - identify determinants of care
  - tailor intervention design and implementation to local context
  - assess barriers to implementation
- Use external facilitation techniques
  - Identify and test new approaches and methods for overcoming barriers
- Conduct summative or impact evaluation

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# PARIHS Model*

**Successful implementation** of evidence is a function of the relation between:

- nature of the **evidence**
- **context** or environment in which the proposed change is to be implemented and,
- way or method by which the change is **facilitated**

* Promoting Action on Research Implementation in Health Servic
*[Kitson et al, 1998; 2002]*

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# PARIHS Model Conceptualization of Facilitation

- *Facilitators help QI teams understand what they need to change and how they need to change it in order to apply evidence to practice.*
  - An appointed role
  - Facilitator may be internal or external to the organization
  - Role is about helping and enabling rather than telling or persuading
  - Focus of facilitation can be narrow (eg, assistance with a specific task) or very broad in nature (eg, system redesign)
  - Broad range of facilitator roles is possible, with corresponding sk and attributes needed to fill role effectively

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# "Refined" Description of Facilitation Based on VA QUERI Experience*

*Facilitation is a process of interactive problem-solving and support to meet specific implementation goals, which occurs in the context of a recognized need for improvement and a supportive interpersonal relationship.*

- Content of facilitation and skills of facilitator may vary depending on project objectives

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* Stetler CB, et al. *Implementation Science* 2006; 1:23.

# Lessons from Research

## Integrate QI efforts with existing plans/resources

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# Integration of QI effort with other efforts/resources

- Align with service-level, facility, VISN, national strategic plans
- Capitalize on existing resources
  - Quality Management/Performance Improvement
  - System Redesign
- Connect to other experts/initiatives, e.g.,
  - Office of Quality & Performance – Clinical Practice Guidelines; Performance Measures
  - National Center for Health Promotion/Disease Preventi
  - Pharmacy Benefits Management Service
  - Patient-Centered Medical Home

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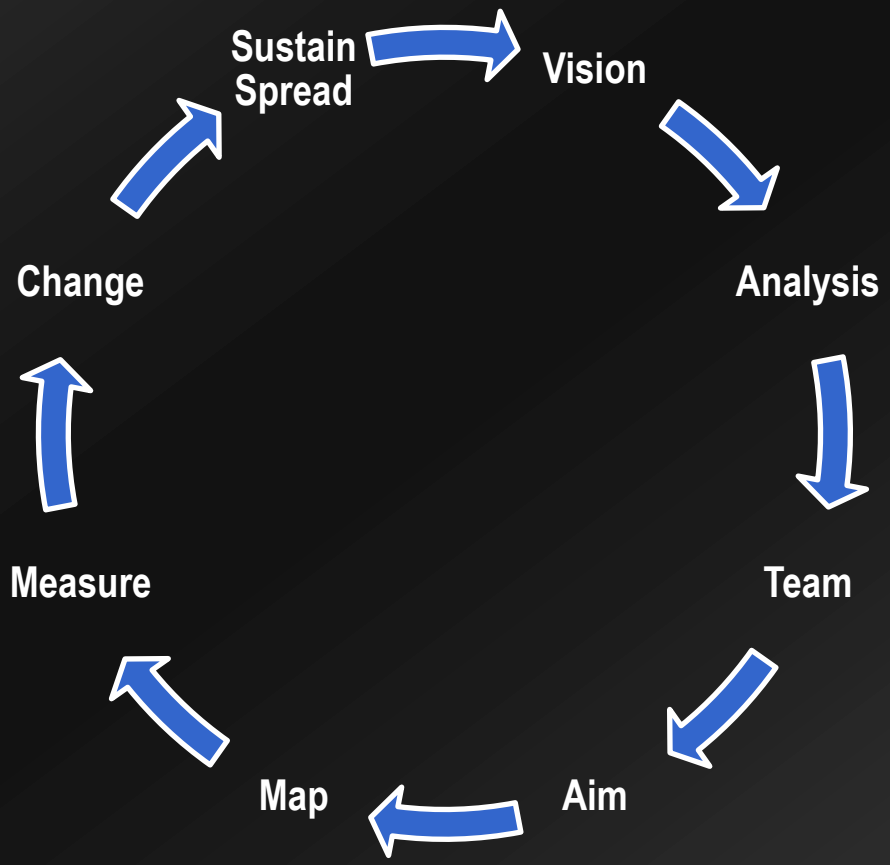
# Systems Redesign – “VA-TAMMCS”

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# Lessons from Research

## Studies of Strategies to Improve Metabolic Monitoring or Management:

## ASSIST and EQUIP studies

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# *A Study of Strategies to Improve Schizophrenia Treatment (ASSIST)*

- Objective: Increase adherence to recommendations for metabolic monitoring and appropriate antipsychotic dosing
- Evidence-Based Quality Improvement (EBQI) approach with external facilitation
- Two influence strategies with facilitation were compared:
  - Team QI (two sites)
  - Opinion leader with administrative support (two sites)
  - "Usual care" comparison – educational materials only (two sites)
- Richard Owen, PI, with Jeff Smith, Geoff Curran, and Teresa Hudson

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# ASSIST Tools

- Educational tools (for clinicians and patients)
- Clinical support tools
  - Pocket-sized booklet with dosing and side effect monitoring recommendations
  - CPRS clinical reminder for SE monitoring
- Performance monitoring tools (VISTA data)
  - Monthly site performance reports
  - Weekly provider-specific feedback on side effect monitoring

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# Barriers to Metabolic Monitoring (Formative Evaluation)

- System-level barriers:
  - Lack of mechanisms, structural resources, staff to ensure that SE monitoring is done
  - Perceived limitations of clinical reminder for metabolic monitoring
- Provider-level barriers:
  - Lack of awareness of VA guidelines
  - Low perceived need for quality improvement
  - Inertia – resistance to change
- Patient-level barriers:
  - Appointment attendance

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# ASSIST Study Results

- Team QI site
  - Increased weight monitoring from 70% to 93% at six months
  - Increased glucose monitoring from 53% to 80%
  - Increased lipid monitoring from 29% to 67%
- Opinion Leader site
  - Increased weight monitoring from 80% to 88%
  - Increased glucose monitoring from 48% to 63%
  - Increased lipid monitoring from 30% to 57%

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# External Facilitation in *ASSIST*

- **Facilitator**
  - **Guided formation of QI team**
  - **Assisted team in development of local implementation plan**
  - **Maintained regular contact with local QI team**
    - **Email/telephone communication**
    - **Participate in monthly ASSIST Team meetings**
  - **Monitored implementation of project tools/strategies; performance on AP side effect monitoring and dosing**
  - **Identified and problem-solved barriers to implementation**
  - **Assisted in adapting tools/strategies as needed or suggested by local QI team to meet project goals**

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# External Facilitation 'Products' (Team QI Facility)

- Collaborative research-clinical partnership
- Placement of recommendations for antipsychotic side effect monitoring on medication order screens
- Enhanced monthly performance reports, tailored to clinician preferences and specifications
- Development of weekly reporting system identifying patients in need of metabolic side effect monitoring
  - Provider name, patient identifier, AP fill date, medication name, info on monitoring parameters
  - Now fully automated

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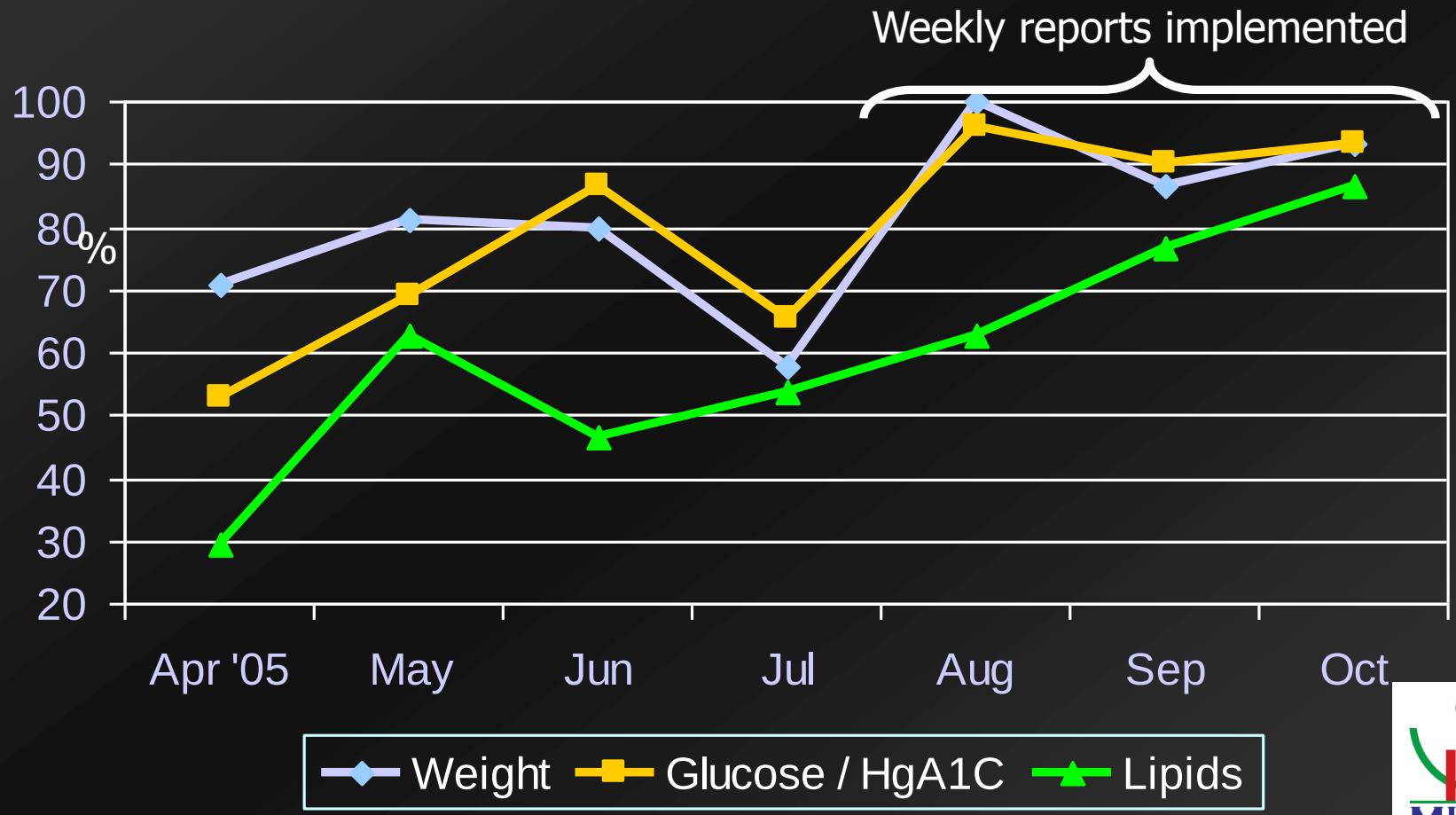
# Metabolic Monitoring at Team QI Facility

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# Effective QI Components

- Computer routine to identify patients due for monitoring
- Designating a provider or clinic to ensure that monitoring occurred
  - Team site – designated team member to review weekly reports and contact providers
  - Opinion Leader site – established clinic to perform baseline monitoring
- Leadership support
- VISN performance measures for SE monitoring

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# Limitations

- Case study results may not generalize to other VA sites
- One site randomized to Team QI had initial site visit but never began implementation phase of study

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# EQUIP

- EQUIP (Enhancing QUality of care In Psychosis)
  - HSR&D QUERI implementation research
  - Alexander Young, MD & Amy Cohen, PhD (Co-PIs)
- Evidence-Based Quality Improvement
  - implement effective care in specialty mental health
- 8 medical centers assigned to intervention or control
  - VISNs 3, 16, 17, 22
- Teams at intervention sites work to make locally driven clinical changes

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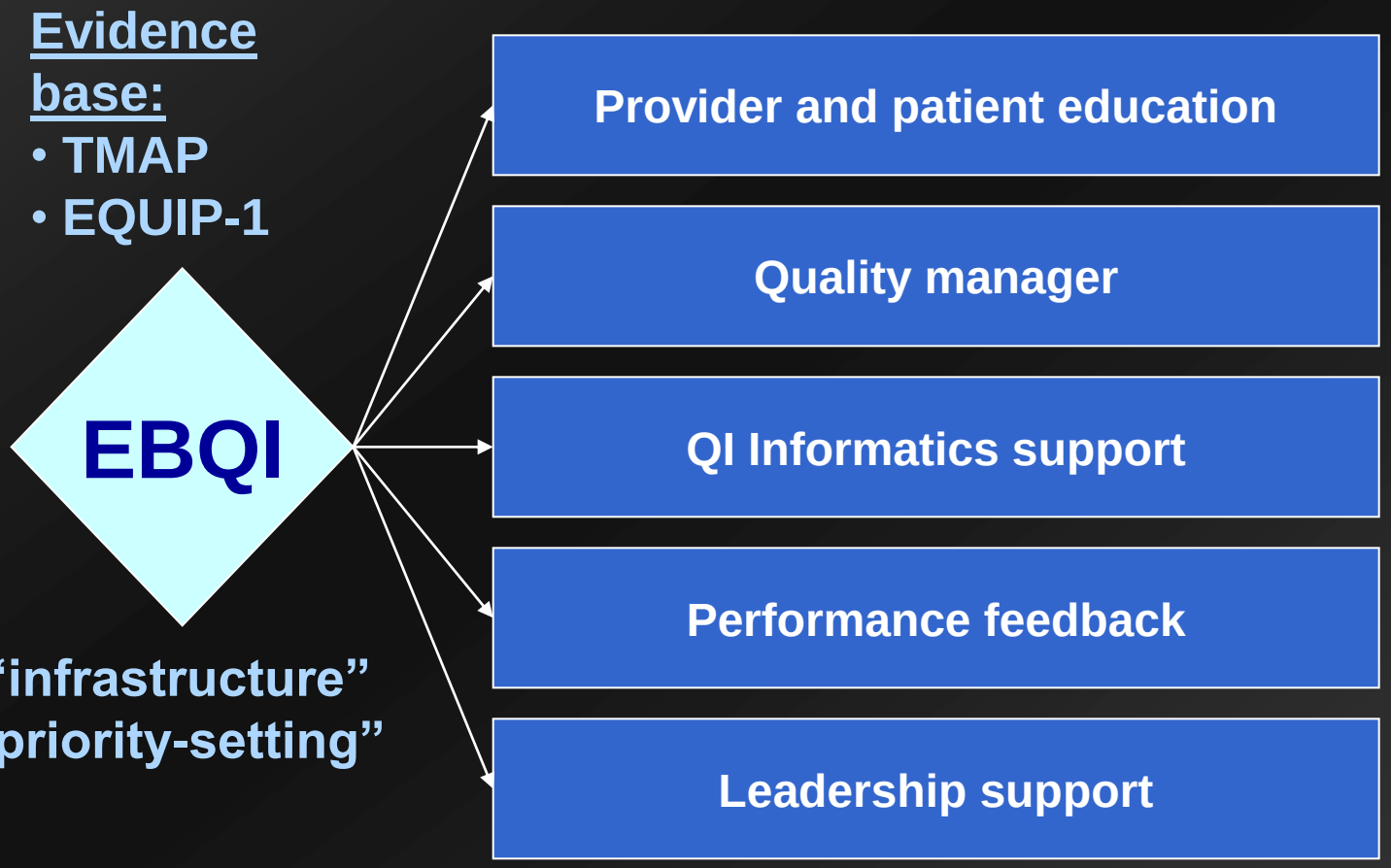
# EQUIP: EBQI Design

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# EBQI Process

- Design choices by VISN leadership based on evidence
  - pick sites, select 2 care targets, engage local medical center leadership
- Implementation by Medical Center leadership
  - supported administratively and technically by researcher team acting as technical experts
  - assemble local QI teams with facilitation and evaluation by researchers
  - review progress & guide reorganization

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# Results

- 791 veterans with schizophrenia enrolled
  - mean BMI=30 & 78% overweight
- Limited clinician knowledge regarding treatment options
- Intervention
  - all clinicians informed of treatment options
  - group leaders trained in 16-session intervention
  - all patients screened & educated using kiosk
- Provision of evidence based care to patients
  - intervention sites: increased from 15% to 32%
  - control sites: no change

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# Take-Home Messages – Successful Implementation/QI efforts Involve:

- Leadership buy-in and active support
- Urgency for change
- Social influence strategies – e.g., opinion leaders
- Involvement of stakeholders
  - Interdisciplinary team approach
  - Local adaptation and implementation planning
- Integration with existing efforts
- Hard work
- Tools that make hard work more efficient
- Facilitation - internal or external

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# QUESTIONS?

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MENTAL HEALTH QUERI
Quality Enhancement Research Initiative

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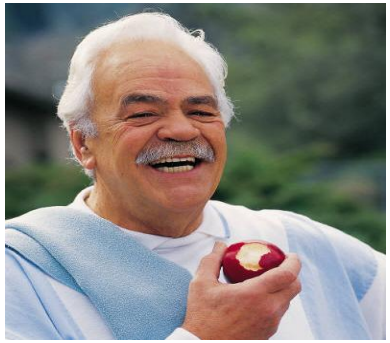


MOVE!®
WEIGHT MANAGEMENT PROGRAM FOR VETERANS

# VHA Weight Management in Review


**Lynn Novorska, RD, LDN**
MOVE! Dietitian Program Coordinator

National Center for Health Promotion and Disease Prevention (NCP),
VHA Office of Patient Care Services


NCP

# Organization

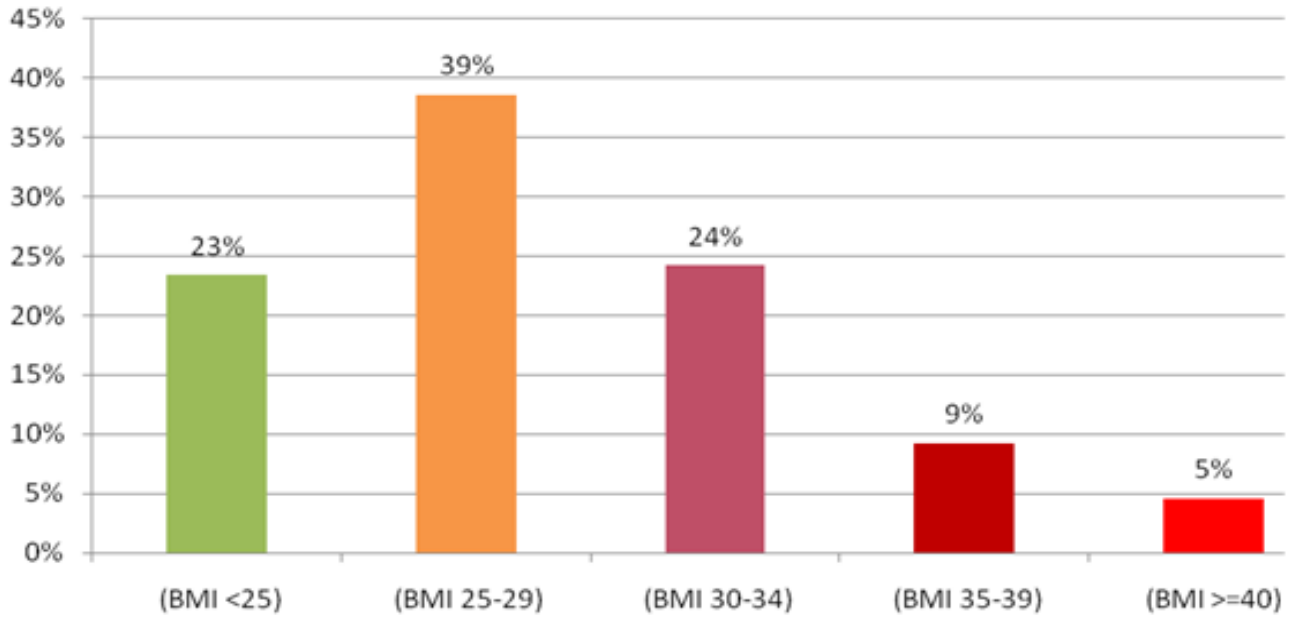
**Office of Patient Care Services –**

- VHA National Center for Health Promotion and Disease Prevention (NCP), Durham, NC
  - Linda Kinsinger, MD, MPH
    Chief Consultant for Preventive Medicine
  - Products:
    - Prevention Policy
    - Clinical Prevention Tools
    - Oversight

# MOVE! Weight Management

- **NCP MOVE! Weight Management Team:**
  - Ken Jones – Clinical Health Psychologist
  - Lynn Novorska – Registered Dietitian
  - Sophia Hurley – Physical Therapist
  - Tony Rogers – Web Master
  - Susi Lewis – Registered Nurse
  - Dr. Kinsinger – Medical Consultation/Oversight
- Our Products:
  - Weight management policy
  - Clinical tools for weight management
  - Oversight of weight management care

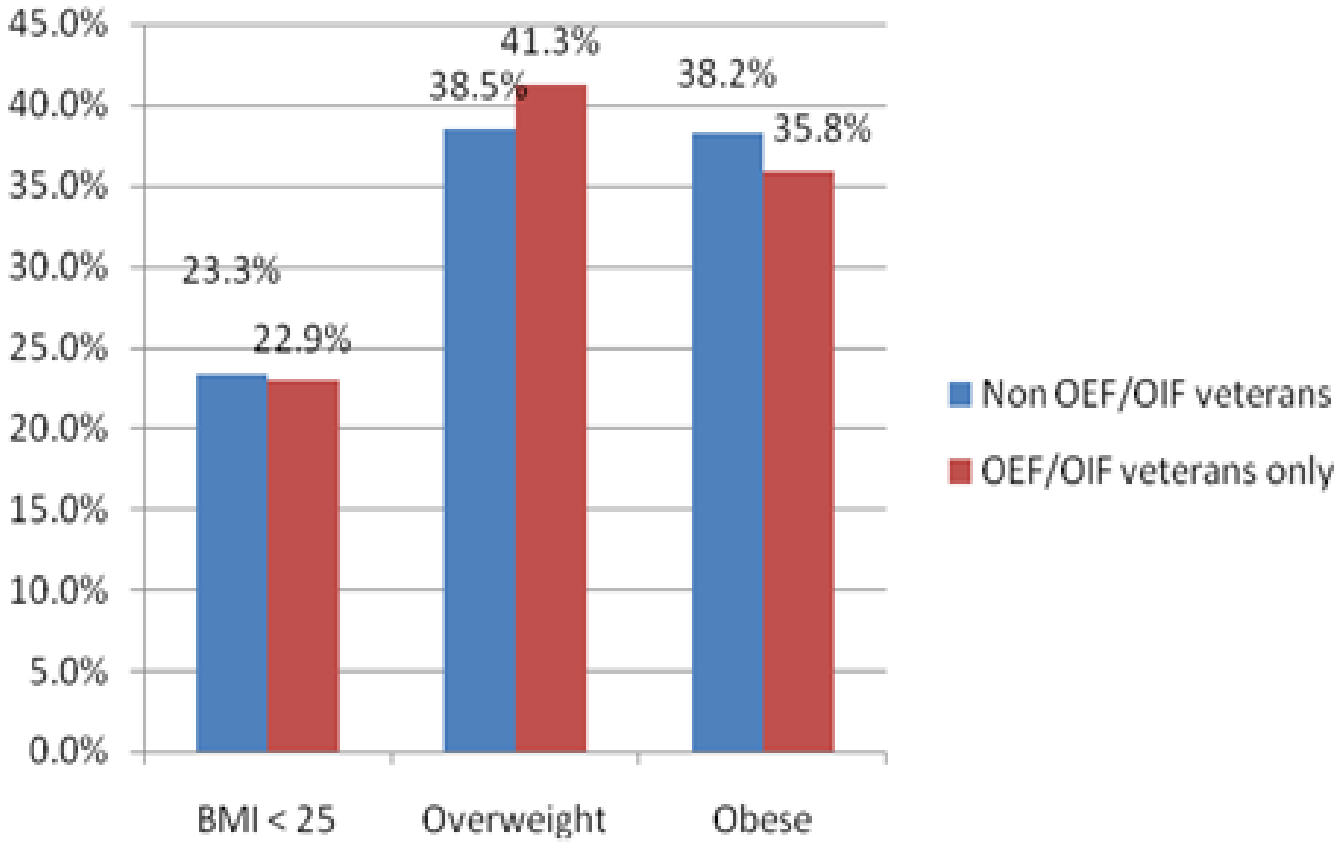
# Prevalence of Overweight/Obesity among Veterans in VHA




Summary: 77% of Veteran patients are overweight or obese

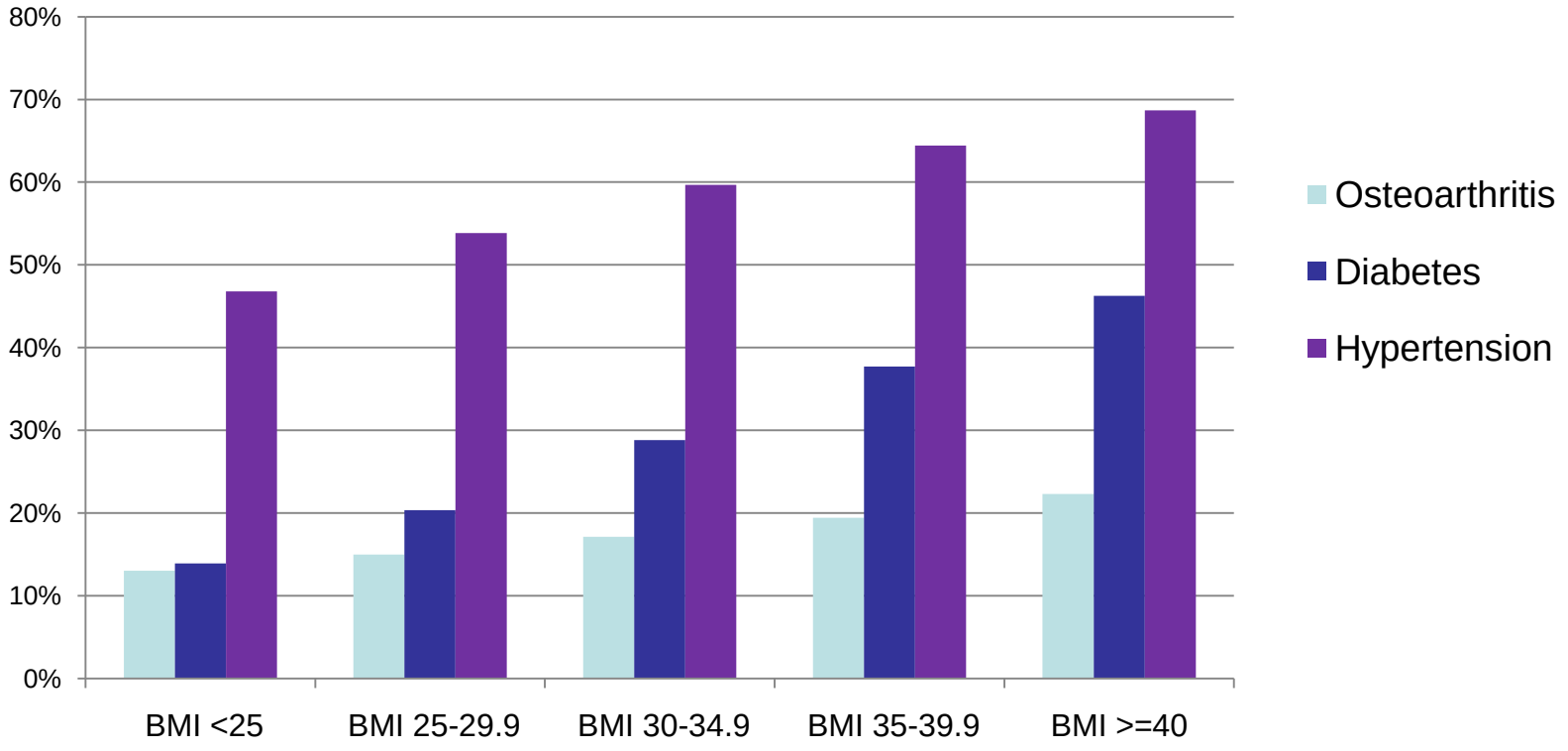
Based on FY 2008 Corporate Data Warehouse - Vital Signs Data (VSSC) for 4,367,962 with height and weight on the file of approx. 5.5 million patients

# Prevalence of Overweight/Obesity among OEF/OIF Veterans




Source: 2008 VSSC data

# Common Diseases by BMI




Source:
2008 VSSC
data

# A Bit of MOVE! History

- 2001 **Primary Care Meeting/Survey**
- 2002 **Initial staffing, development of tools**
- 2003 **Pilot began**
- 2004 **National Program Manager & team formed**
- 2005 **Early implementation**
  - VISNs 2, 8, 23 and individual medical centers
- 2006 **National Implementation**
  - HealthierUS Veterans Initiative
  - CPG
  - Resources
- 2008
  - Copayment eliminated by modification of CFR
  - Developed and initiated FY-2009 – Weight Screening Performance Measure
- 2009
  - First two national meetings with MOVE! Coordinators
- 2010
  - TeleMOVE! Launched
  - Training update – conversion to LMS
  - HealthierUS Veterans Initiative transformed

# Resources

- 2006
  - Websites
    - www.move.va.gov - Patients
    - vaww.move.med.va.gov – VA Staff
  - MOVE! Handbook 1101.1 signed by USH in March 2006
  - On-line training – 1st release
  - Toolkits and supplements
  - Starter Packs, Clinical Reference Guide & Quick Start Manuals
  - Pedometers available in Prosthetics
  - VSSC Utilization Data Cube
  - VA/DoD CPG
- 2008
  - Co-payment Exempt, June 2008
  - Performance Measure for Screening (FY ’09)
- 2009
  - MOVE! Intensive Guidance
- 2010
  - TeleMOVE! – Launch of CCHT Weight Management DMP
  - MOVE! Online Training
  - Revised References

# Goals of MOVE!

- Address obesity using best available medical evidence
- Screen every Veteran and assess risk of excess weight
- For those at risk, offer a weight loss program that can achieve a 5-10% weight reduction
- Base of program is supported self management
- Integrate treatment with Primary Care
- Maintain a program that will evolve through evaluation, identification of best practices, and new evidence

# MOVE! Screening and Treatment

- Screening/Assessment
  - Annual PC Screening - offering MOVE! to “at risk patients” – patient wanting to work on weight complete MOVE!23 Patient Questionnaire
- Supporting Self Management
  - Individual (telephone) – Initially called Level 1
  - Group Sessions – Initially called Level 2
  - Specialty Consultation – Initially called Level 2

More Intensive Weight Management Care
(<u>not required</u> to be available at every facility)

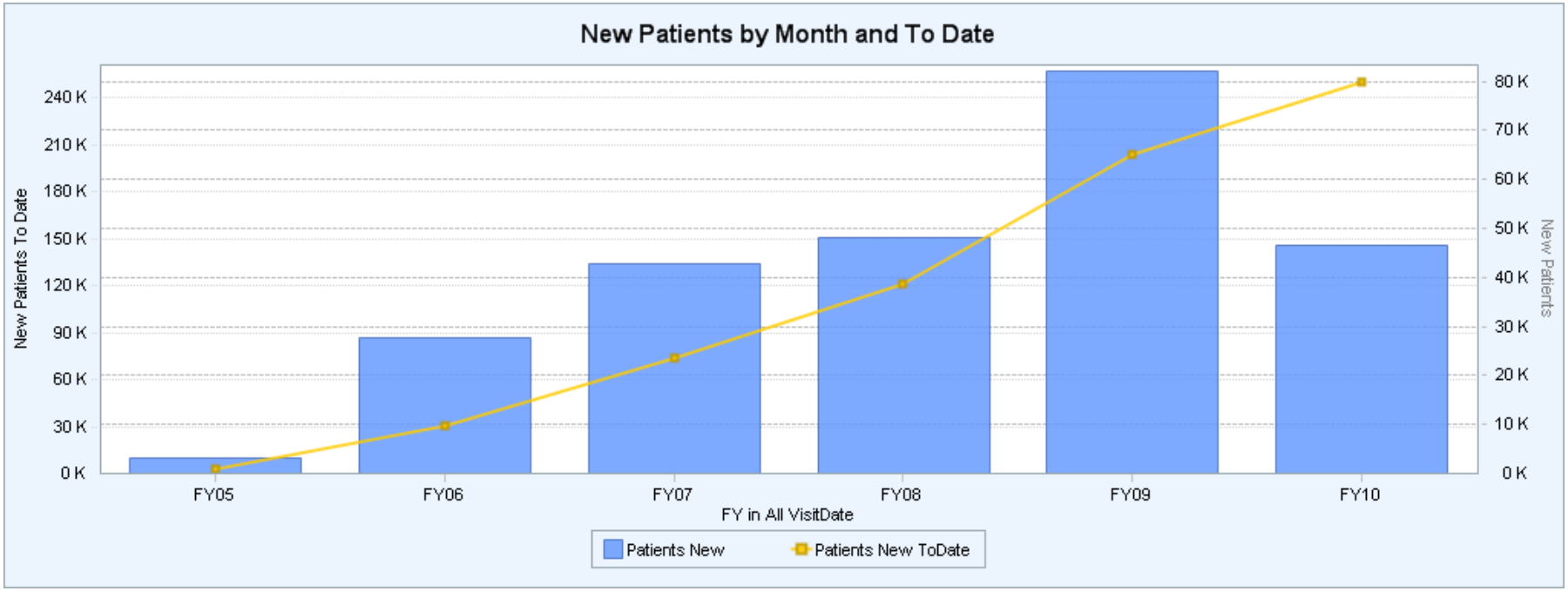
- Weight Loss Medications (Level 3) - Available
- MOVE! Intensive (Level 4) – Some Facilities
- Bariatric Surgery (Level 5) – Some Facilities

# MOV5 Weight Screening: Supporting Indicator (FY '08) Performance Measure (FY '09 & 10)

| | FY '08 | FY 2009 | FY 2010 (thru 2nd Qtr.) |
|---|---|---|---|
| National | 65%<br>No Goal | 90%<br>Target = 65% | 94%<br>Target = 90% |

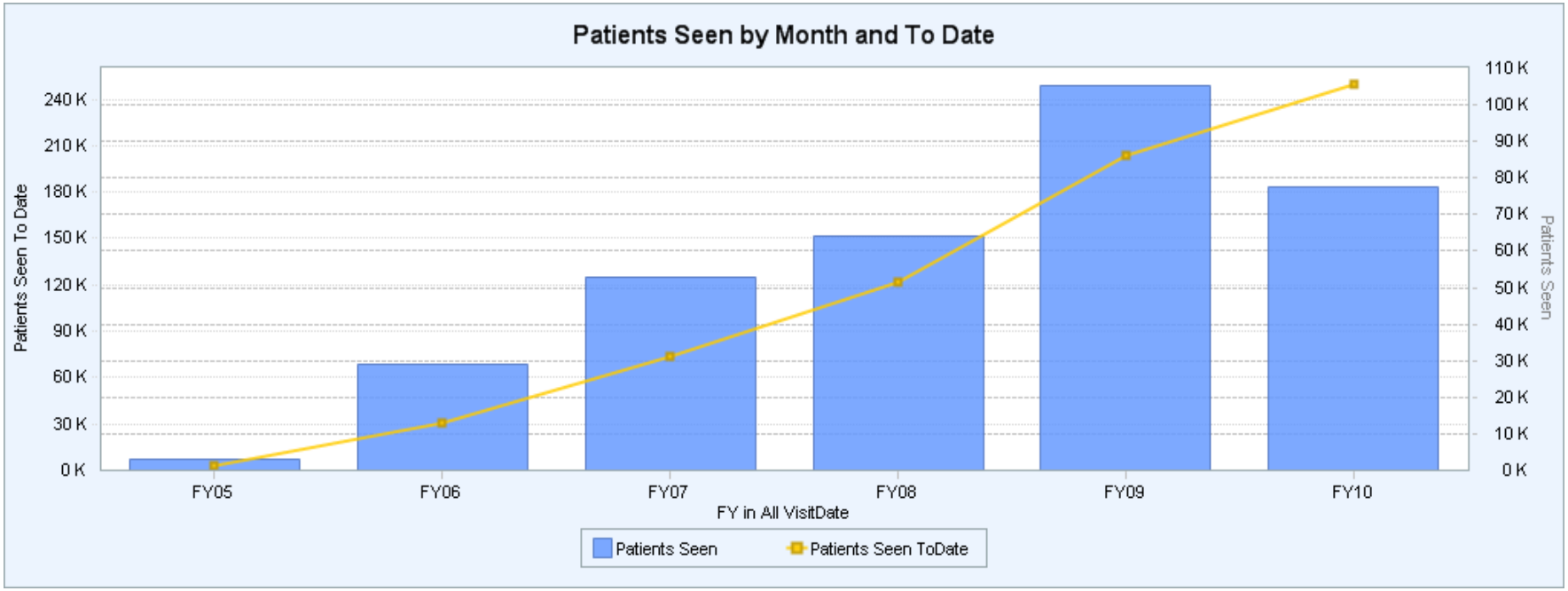
http://vaww.pdw.med.va.gov/MeasureMaster/MMIndex.asp?qtr=20102

# MOVE! Patients to Date Nationally (at least one visit)




- Total = 250,048 Patients
- Averaging about 6,300 new patients per month

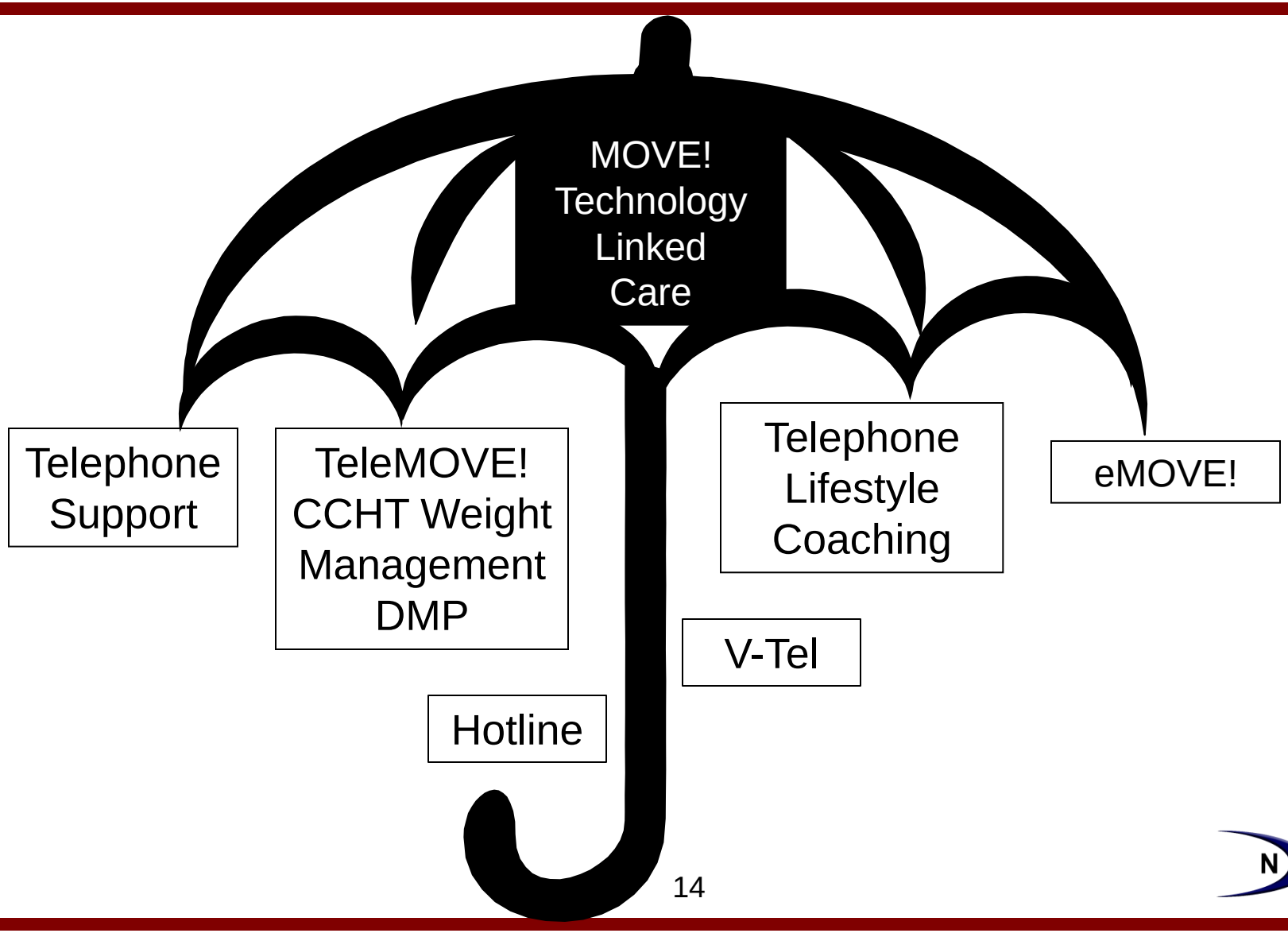
# MOVE! National Data Treatment Encounters




Total Visits = 1,363,297

1,363,297/250,048 = 5.5 contacts per patient

# What's next?


MOVE!
Technology
Linked
Care
Telephone
Support
TeleMOVE!
CCHT Weight
Management
DMP
Hotline
V-Tel
Telephone
Lifestyle
Coaching
eMOVE!

# Questions?

## National Center for Health Promotion and Disease Prevention

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