

Enhancing Quality and Utilization in Psychosis (EQUIP)

INTERVENTION MANUAL

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INTRODUCTION TO EQUIP

Schizophrenia is a debilitating, costly mental disorder, presenting significant challenges to patients and their families as well as to the healthcare organizations responsible for their care. Occurring in 1% of the U.S. population, schizophrenia accounts for 10% of permanently disabled people and 2.5% of all healthcare expenditures. Schizophrenia was largely untreatable until the 1950s, when antipsychotic medications such as chlorpromazine and haloperidol were developed and widely distributed. These medications represented dramatic breakthroughs but, while effective for some patients, caused frequent side-effects. A new medication, clozapine, improves symptoms in many patients who previously failed to respond to treatment; several additional medications have also been released (risperidone, olanzapine, quetiapine, ziprasidone) that, when appropriately used, cause fewer side-effects and improve quality of life for a large proportion of patients. Other beneficial advances include a psychosocial intervention approach, Assertive Community Treatment, that allows severely ill people to live successfully in community settings; interventions for families and caregivers to allow them to cope better with the illness while substantially improving outcomes in patients; and a vocational rehabilitation technology (Individual Placement and Support) that allows a substantial proportion of patients to return to competitive employment. Despite the availability and effectiveness of these strategies, the vast majority of people with schizophrenia who need these treatments do not receive them. Roughly half of people with schizophrenia receive no care at all in a given year. Those that receive some services often do not receive appropriate care: one-third or more receive medication management that is clearly inappropriate, while Assertive Community Treatment is only available to a small minority of patients. Not surprisingly, outcomes under usual care are much worse than those for patients receiving state-of-the-art treatment protocols, with higher rates of relapse and substance abuse and higher risk for homelessness, hospitalization, incarceration, or premature death.

The EQUIP project was funded by the Department of Veterans Affairs Health Services Research and

Development Service (VA HSR&D) to develop, implement and evaluate a collaborative care model for schizophrenia. EQUIP has been implemented at the Greater Los Angeles Healthcare System and the Long Beach Healthcare System in close collaboration with the VA Desert Pacific Mental Illness Research, Education and Clinical Center (MIRECC).

The EQUIP collaborative care model is designed to improve treatment through assertive management of care, involvement and education of caregivers, and feedback of clinical information to clinicians. The model extends proven illness self-management approaches to family members and other caregivers, since these individuals are a critical component of successful treatment for schizophrenia. It creates a collaborative environment within which psychiatrists are responsible for guideline-concordant prescribing, and case managers are responsible for ensuring access to needed treatment services. By implementing a collaborative care model, the project targets key problems in care identified in previous studies of treatment quality in schizophrenia (failure to coordinate and monitor care for individual patients, lack of attention to illness self-management skills, and a minimal availability of clinical information).

As part of the model, EQUIP employs a locally-developed computer system that interfaces with the VA's Computerized Patient Record System (CPRS). The system, "MINT" (Medical Informatics Network Tool), was developed by staff of the Desert Pacific MIRECC. It supports clinicians by improving the availability of clinical data and communication between members of the treatment team, and by providing feedback regarding the extent to which care is consistent with guidelines. The system has a browser-based component for project and data management, reports, and messaging between members of the clinical team. Clinicians use this interface to enter their assessment of a patient's symptoms, side-effects, and other problems in living. MINT also includes applications that reside on the clinician's PC. These applications provide feedback of clinical information and guideline information to psychiatrists, and facilitate messaging between psychiatrists and other members of the treatment team.

Overview of this Manual

This manual describes the two primary components of the EQUIP intervention in which the Care Coordinator has responsibility:

1	Use MINT to gather and manage patient data, which includes conducting Brief Assessments of patients
2	Monitor patient progress, assessing and working with intervention families, and ensuring all intervention patients receive a high level of care from their providers

MINT (Medical Information Network Tool) Overview

The informatics tool, MINT, provides real-time information to psychiatrists about their patients. An internet-based web system facilitates data entry and management, report generation, and care management. Additionally, compiled programs reside on the clinicians' PC and interact with CPRS. When a psychiatrist accesses the record of a patient, an interactive pop-up window is displayed. The window displays the patient's current and recent status including key symptoms and side-effects, compliance with treatment, stressors, medical needs and psychosocial functioning. The window also provides one-click access to treatment guidelines and allows communication between members of the treatment team and the research team.

Prior to a patient's visit with their psychiatrist, nurse clinicians trained in assessment instruments assess the patient's current status and enter the information into the web system. When the psychiatrist next sees the patient they are presented with this information via the pop-up window and can make use of it during their clinical encounter, compare current status with the previous visit status, agree or disagree with the assessments, and communicate with other members of the clinical team.

The text in this section will describe how to:

- Enroll new patients using MINT
- Enter patient consent information into EQUIP web database and CPRS
- Enter patient's consent to contact a family member into EQUIP web database and CPRS
- Login to the EQUIP website
- Add new DataForms for an enrolled patient
- Proofread and Edit DataForms for an enrolled patient
- Use the DataForm to conduct the Brief Assessment for a patient
- Provide information about the EQUIP pop-up screen

USING EQUIP WEB DATABASE AND MINT

Procedure for Enrolling New Patients and Other Mental Health Clinicians (Case Managers, Psychiatrists) and Care Coordinators using MINT

(1) How to enter a new patient into the EQUIP web database

- (a) Run MINT-Enroller by clicking on Windows Start menu → Programs → MINT → Mint-Enroller
- (b) Start CPRS and log in
- (c) Open the chart of the patient to be enrolled
- (d) Go to the task bar at the bottom of the screen and click on “MINT Enroller” to switch to the Enroller application
- (e) Two boxes appear: one on the left has information about the patient from the MINT database (empty if the patient has not yet been enrolled); one on the right has information about the patient from CPRS. If the patient is not already in the database, a button will appear saying “Enroll Patient”. Push the button. A message will appear saying that the patient has been added to the database.
- (f) Repeat steps 1-c through 1-e above for all patients to be enrolled

For all patients that are enrolled, a note must be placed in CPRS about their consent. Choose “research enrollment note” and use the template provided in CPRS. If there is no template at your site use the following template to write the note:

Protocol #: EQUIP Study
Promise #: [enter promise number for your site]

Patient #: [enter patient ID number]

Visit #: Patient Screening and Enrollment

Date of Visit: [enter date of visit]

Date of consent signed: [enter date of consent].

Location of study specific documentation (source document): Pt. Research chart, Room [enter room number]

Consent process was completed & the Pt. Signed the informed consent & given copy. Original consent filed in chart (see below).

For further information, contact [enter name of relevant staff].

Location of consent within chart: Original consent filed in Volume #[enter volume #]

Then the note must be signed.

(2) Enter all remaining patient information in the EQUIP web database

- (a) Start Internet Explorer
- (b) Use Favorites to open the EQUIP web page, or enter <http://10.180.1.76/equip> into Explorer
- (c) Log into the web page
- (d) Select “Participant Info”
- (e) Click on the name of the patient
- (f) Enter Patient ID (which is their EQUIP Project ID), Enrollment Date (which is the Baseline interview date), select site and principal provider. Enter gender, ethnicity, and height in inches. Enter the patient’s phone number and address. Also enter any other contact info including any useful information about how to get in touch with the patient.
- (g) If the patient has not yet been asked for the team to speak with his family/caregiver, indicate that by selecting “Patient not asked”. If the patient does not have a caregiver, click “No Caregiver.” If the patient refused consent for the team to speak to his family/caregiver, click “No.”

NOTE: A “Caregiver” is anyone in the patient’s life who provides them with emotional support and with whom the patient has regular contact (via phone or visits).

If the patient has given consent for the team to speak with his family/caregiver, click “Yes”, and enter contact information in the “Caregiver Contact Info” box. This can include caregiver names, phone numbers, when to call, or any other useful

information. Please note that if the patient has given consent for the team to contact his family/caregiver, you need to also enter a note in CPRS. Use the following template to write the note:

Consent to Contact Family/Caregiver

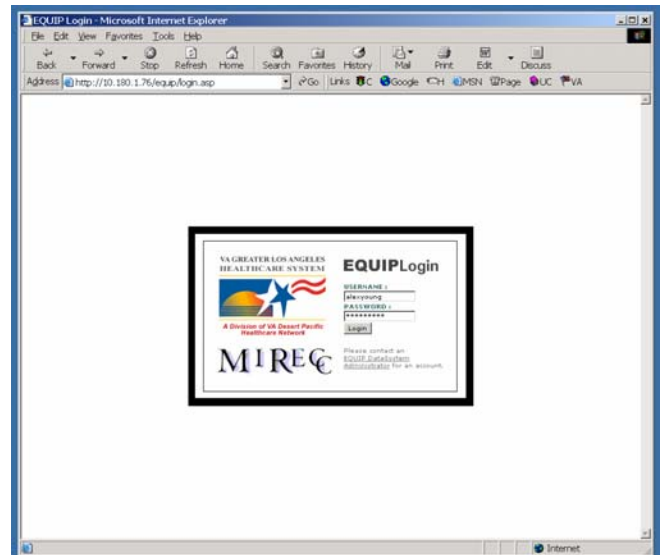
Edit note by choosing which person they have allowed us to contact.

- I discussed with the patient the potential involvement of their caregivers in the treatment process. The patient gave informed consent for the mental health treatment team to talk with their [mother/brother/sister/child] about their care. The patient understands that they can rescind this consent at any time in the future.
- (h) For patient status: All patients are “active”. “Inactive” status is reserved for patients who withdraw from the study.
 - (i) Repeat steps 2-d through 2-g for all patients enrolled.

For further information: contact alexander.young@med.va.gov or amy.cohen@med.va.gov

EQUIP Login Screen

To gain entrance to the system, go to the following URL: <http://10.180.1.76/equip> and enter your username and password at the first screen shown to the right: **EQUIP Login Screen**.

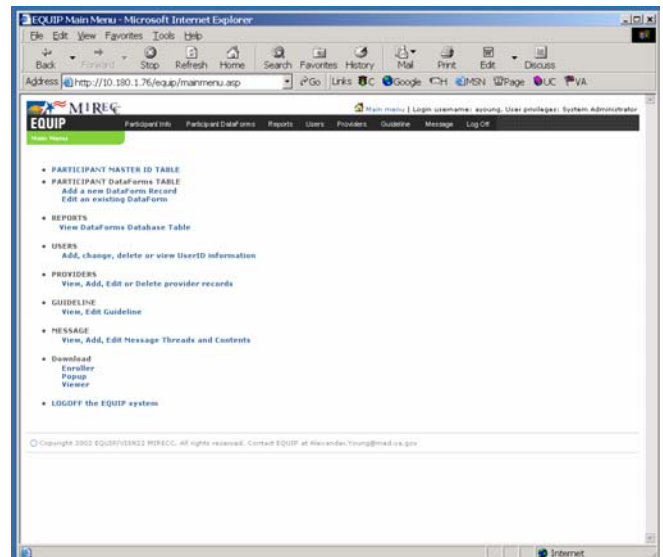


You can change your password once you enter the site by going to the main menu (written in blue next to the little house at the middle top of most of the web screens—see right screen).

 [Main menu](#) |



On the **Main Menu screen**, the fourth bullet down is “Users”. Clicking on this link will take you to a screen that lists all the users of the EQUIP system. From there you can change your password.



Add DataForm Data

After you enter the username and password, you will be brought to this screen: **Add DataFrom Data**. It lists all the active patients. To add a DataForm, click on the blue ID number for the patient in which you are interested.

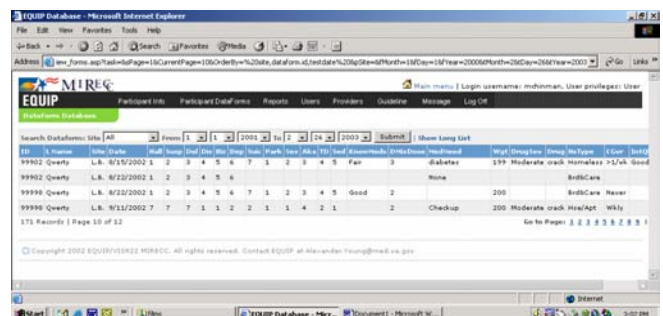
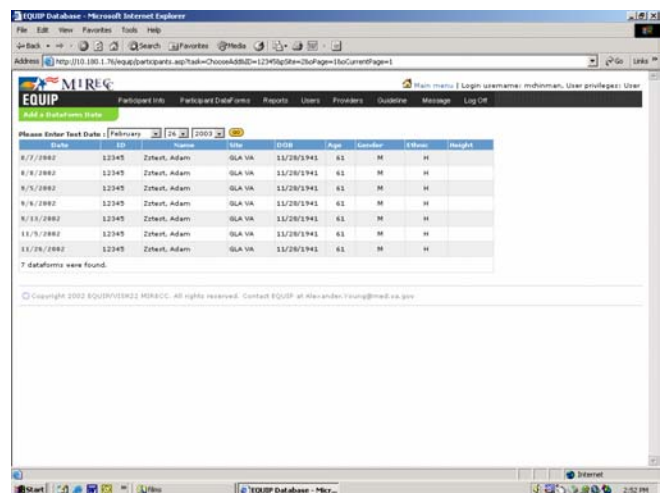
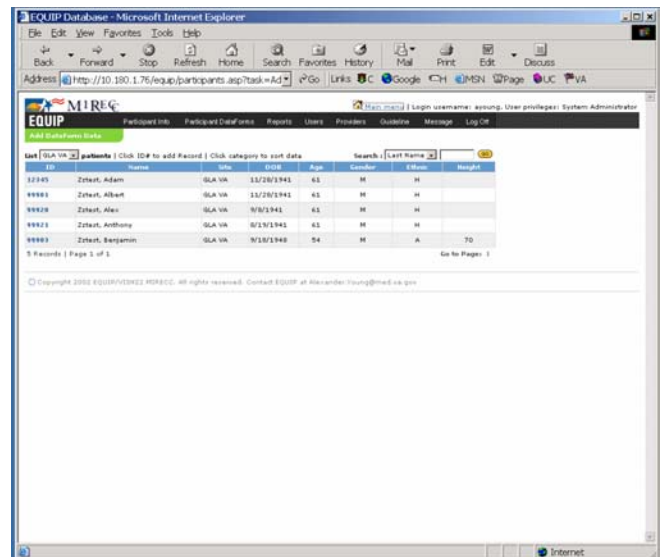
Add a DataForm Date

After you click on the blue ID number, you will be brought here, to the **Add a DataForm Date** screen. Above the blue bar there is a space to enter the month, day, and year of the assessment you are about to perform (today's date). Once you are finished entering the brief assessment date, hit "Go". Then you will be taken to the brief assessment screen (see Brief Assessment section for more details on this screen and how to complete it).

After you complete the DataForm for the Brief Assessment, you will need to proofread (i.e., edit) your data for correctness. This must all be done on the same day as you see the patient. You will not be allowed to edit your DataForms the day after you complete the assessment.

Proofreading your Brief Assessment: The DataForm Database

The way to check your assessments is to use the **DataForm Database**. This screen shows the assessment results of many patients all at once. You can access this under "Reports" from the black bar across the top of most screens. A drop down menu will appear. Choose "DataForm Records" and you will be brought to the screen below. From here, you can visually check the assessment for correctness. If you see an error, then you will need to edit the DataForm.

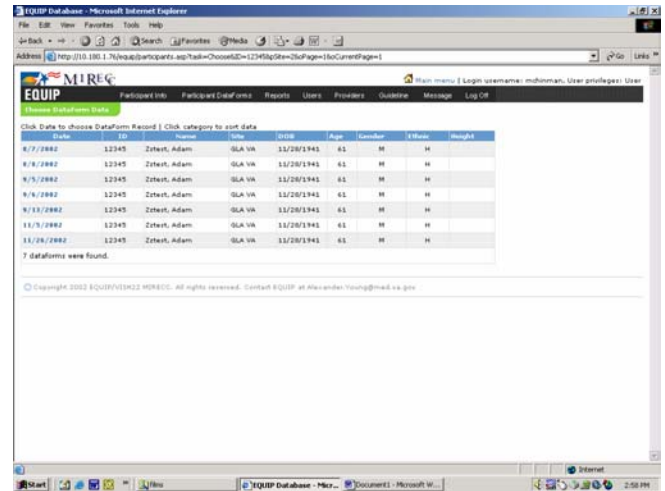


To edit existing DataForms: Choose DataForm Data

To proofread and edit your existing DataForms on the same day, click on “Participant DataForms”. It is listed at the top of most screens in the black bar. A drop down menu will appear. Choose the “Edit/delete DataForm” option. After that, a screen will appear called “Choose DataForm Data” that lists all the active DataForms. Click on the blue date for the one you want to edit. When you do that, the actual DataForm for the Brief Assessment will come up. Then you can edit the information.

When you are done, you have four choices:

- Update – updates the form with the changes
- Update and send message – updates the form with the changes and sends a new message
- Delete – Deletes the whole DataForm
- Cancel – Leaves the DataForm as is



The Pop-up screen

After you enter the information into the DataForm for the Brief Assessment, it will be saved into the secure EQUIP database. Then, when a provider accesses that patient’s medical record in CPRS, the pop-up screen below will automatically appear. As you can see, it summarizes the information from the Brief Assessment and provides any message you may have sent. Any symptoms or side effects that are “moderate” or “severe” are highlighted. Any additional concerns will be highlighted. Click OK to go to the CPRS chart.

To redisplay the Pop-up after looking at a patient's record, go in the "File" menu in CPRS, and click "Refresh Patient Information". The Pop-up will appear again.

