Exploring Barriers to Implementing Monitoring Guidelines When Prescribing Second Generation Antipsychotics

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Introduction

Psychiatric patients seek treatment to decrease the severity of their symptoms, improve overall daily function and health outcomes. In addition to being mentally vulnerable, these patients are often also physically vulnerable. In recent study, individuals who seek treatment at mental health clinics were stated to be: already overweight (27%), have elevated triglycerides (51%), and meet criteria for metabolic syndrome (52%) (Correll et al., 2011). Many of these patients are then prescribed second generation antipsychotics (SGAs) which include significant metabolic risks.

Although monitoring guidelines for the deleterious side effects of SGAs have been published since 2004, and it is widely recognized that SGAs are associated with significant metabolic symptoms, rates of screening have remained relatively low since the publication of monitoring guidelines. The translation and integration of research into practice has not been seamless. Morrato et al. (2010) report consistently low rates of screening by providers, with rates of 26.9% for baseline monitoring and 26.2% for periodic monitoring guidelines. Amiel et al. (2008) report consistently low rates of screening by providers, with rates of 26.9% for baseline monitoring and 26.2% for periodic monitoring guidelines. The translation and integration of research into practice has not been seamless. Morrato et al. (2010) report consistently low rates of screening by providers, with rates of 26.9% for baseline monitoring and 26.2% for periodic monitoring guidelines. Amiel et al. (2008) report consistently low rates of screening by providers, with rates of 26.9% for baseline monitoring and 26.2% for periodic monitoring guidelines.

This study aimed to investigate barriers to medical provider monitoring of side effects when prescribing SGAs. Providers were surveyed regarding knowledge of the guidelines, compliance, and ease vs. difficulty of monitoring due to patient, systems and insurance issues. Qualitative, semi-structured interviews identified and explored barriers to monitoring of side effects when patients are taking SGAs. A qualitative methodology was used to allow further exploration of perceived barriers and provide detail related to healthcare providers’ views and experiences.

Methods

An electronic survey was distributed via email distribution using purposive sampling. Purposive samples were utilized to identify stakeholders involved in prescribing and monitoring SGAs to patients. After obtaining stakeholder buy-in and approval, email invitations with a link to the SurveyMonkey.com survey were sent to the American Psychiatric Nurses Association Member Bridge, Tennessee Nurses Association listserv for nurse practitioners, medical providers at Frontier Health and medical providers working within the ETSU nurse-managed clinics. Questions queried provider demographics including: Age, Race, Ethnicity, Gender, Professional Designation, Specialty, Practice Setting, How often provider prescribes SGAs, Comfort level with prescribing SGAs, and years practicing. Survey questions assessed provider knowledge base of the requirements outlined in the monitoring guidelines, compliance (monitoring or not monitoring at specified time points in treatment), agreement with the recommended guidelines, and ease vs. difficulty of monitoring due to patient, systems and/or insurance issues.

Participants were asked at the end of the survey to provide their email if interested in participating in a follow-up interview. Sample size for interviews was determined by data saturation as indicated when interviews arrived at no new emerging themes. Invitations to complete interviews will be sent out to the same practitioners via email. Sample size will be determined by data saturation as indicated when interviews arrive at no new emerging themes from conversations. This was estimated to be a minimum of 8 and maximum of 40 interviews. Participants consented to be audio-recorded. Interviews were conducted by the same researcher and were approximately 30 minutes in duration. Interviews were completed by Skype and recorded if long-distance or in-person if located within 15 miles of ETSU campus. If completed online, electronic informed consent was obtained. If a face-to-face interview was completed, a paper copy of the informed consent was obtained.

Quantitative Data

Participants were asked at the end of the survey to provide their email if interested in participating in a follow-up interview. Sample size for interviews was determined by data saturation as indicated when interviews arrived at no new emerging themes. Invitations to complete interviews will be sent out to the same practitioners via email. Sample size will be determined by data saturation as indicated when interviews arrive at no new emerging themes from conversations. This was estimated to be a minimum of 8 and maximum of 40 interviews. Participants consented to be audio-recorded. Interviews were conducted by the same researcher and were approximately 30 minutes in duration. Interviews were completed by Skype and recorded if long-distance or in-person if located within 15 miles of ETSU campus. If completed online, electronic informed consent was obtained. If a face-to-face interview was completed, a paper copy of the informed consent was obtained.

Survey questions assessed provider knowledge base of the requirements outlined in the monitoring guidelines, compliance (monitoring or not monitoring at specified time points in treatment), agreement with the recommended guidelines, and ease vs. difficulty of monitoring due to patient, systems and/or insurance issues.

Quantitative Results

Results inform future areas in practice for improvement:

- Education and continued review of monitoring guidelines with providers
- Open inter-professional dialogue/discussion for improved quality of care
- Systems change to increase monitoring (scheduling, staffing)
- Expand inter-professional monitoring to improve care and quality of life

Qualitative Results

Interview Themes:
- Insufficient Collaborative Care
- Lack of Knowledge

Limited Patient Encounter Time

Patient Non-adherence to Completing Labs

"I absolutely see a need for improvement in collaboration. If we could communicate better, I feel we could monitor and treat patients better."

"I would say non-adherence is a major barrier to metabolic monitoring because a lot of the patients are very sick, they don’t show up for appts, they don’t get their labs done when you give them orders, they don’t have insurance so cost is a problem too."

Implications for Practice

- Results inform future areas in practice for improvement:
  - Education and continued review of monitoring guidelines with providers
  - Open inter-professional dialogue/discussion for improved quality of care
  - Systems change to increase monitoring (scheduling, staffing)
  - Increase psychiatric services available in medical home model

References

Wether et al. (2011). Impact of a Metabolic Screening Bundle on Rates of Screening for Metabolic Syndrome in a Psychiatric Resident Outpatient Clinic. American Academy of Psychiatry. 92(3), 118-121.