Schizophrenia

OBJECTIVE

The objective of this Clinical Practice Guideline (CPG) is to provide evidence-based practice recommendations for the treatment of schizophrenia. The CPG discusses the four domains of symptoms, development of the Behavioral Health Care Plan, when to seek medical attention, and behavioral health implications. Objectives and measureable health outcomes with respect to Care Management are included. In addition, the CPG outlines the organizations that WellCare aligns with regarding schizophrenia and Measureable Health Outcomes.

OVERVIEW

Schizophrenia is a brain disorder is thought to be the expression of a group of genetically distinct conditions. The hallmark symptom is psychosis (e.g., experiencing auditory hallucinations [voices] and delusions [fixed false beliefs]). Additional symptoms may be divided into the following 4 domains:

- **Positive symptoms.** Psychotic symptoms, such as hallucinations, which are usually auditory; delusions; and disorganized speech and behavior.
- **Negative symptoms.** Decrease in emotional range, poverty of speech, and loss of interests and drive; the person with schizophrenia has tremendous inertia.
- **Cognitive symptoms.** Neurocognitive deficits (e.g., deficits in working memory and attention and in executive functions, such as the ability to organize and abstract); members also find it difficult to understand nuances and subtleties of interpersonal cues and relationships.
- **Mood symptoms.** Member may seem cheerful or sad in a way that is difficult to understand; may be depressed.

Impaired cognition or a disturbance in information processing is a less vivid symptom that interferes with day-to-day life. People with schizophrenia have lower rates of employment, marriage, and independent living compared with other people. Schizophrenia is a clinical diagnosis. It must be differentiated from other psychiatric and medical illnesses, as well as from disorders such as heavy metal toxicity, adverse effects of drugs, and vitamin deficiencies. Treatment of schizophrenia requires an integration of medical, psychological, and psychosocial inputs. The bulk of care occurs in an outpatient setting and is best carried out by a multidisciplinary team. Psychosocial rehabilitation is an essential part of treatment. Antipsychotic medications (or neuroleptic medications or major tranquilizers) may diminish the positive symptoms of schizophrenia and prevent relapses however they are also associated with a number of adverse effects.[1]

The onset of schizophrenia usually occurs between the late teens and the mid-30s. For males, the peak age of onset for the first psychotic episode is in the early to middle 20s; for females, it is in the late 20s. The first 5-10 years of the illness can be stormy, but this initial period is usually followed by decades of relative stability (though a return to baseline is unusual). Positive symptoms are more likely to remit than are cognitive and negative symptoms. The prevalence of schizophrenia is about the same in men and women. The onset of schizophrenia is later in women than in men, and the clinical manifestations are less severe. This may be because of the anti-dopaminergic influence of estrogen. Although some variation by race or ethnicity has been reported, no racial differences in the prevalence of schizophrenia have been positively identified. The lifetime prevalence of schizophrenia has generally been estimated to be approximately 1% worldwide; other research found a lifetime risk of 4.0 per 1000 population.[1]

Hierarchy of Support

GUIDELINE HIERARCHY

CPGs are updated annually or as necessary due to updates made to guidelines or recommendations by the National Institute for Health and Care Excellence (NICE) and the American Psychiatric Association (APA). When there are differing opinions noted by national organizations, WellCare will default to the member's benefit structure as deemed by state contracts and Medicaid / Medicare regulations. If there is no specific language pertaining to the topic of Schizophrenia, WellCare will default (in order) to the following:

- National Committee for Quality Assurance (NCQA);
- United States Preventive Services Task Force (USPSTF), National Quality Strategy (NQS), Agency for Healthcare Research and Quality (AHRQ);
- Specialty associations, colleges, societies, etc. (e.g., American Academy of Family Physicians, American Congress of Obstetricians and Gynecologists, American Cancer Society, etc.).

Links to websites within the CPGs are provided for the convenience of Providers. Listings do not imply endorsement by WellCare of the information contained on these websites. NOTE: All links are current and accessible at the time of MPC approval.

WellCare aligns with the NICE and the APA on the topic of schizophrenia; guideline highlights are noted below.

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE (NICE)

WellCare adheres to the 2014 published guideline on *Psychosis and Schizophrenia in Adults.* The guideline makes recommendations on managing psychosis and schizophrenia with aims to improve care through early recognition and treatment, and by focusing on long-term recovery. NICE also recommends checking for coexisting health problems and providing support for family members and providers. The full guideline is available at https://www.nice.org.uk/Guidance/cg178.

AMERICAN PSYCHIATRIC ASSOCIATION (APA)

WellCare adheres to the 2004 practice guideline from the American Psychiatric Association[3]. The *Guideline Watch* published in 2009 highlighted key research studies. The guideline can found at http://psychiatryonline.org/guidelines.

Evidence Based Practice

MEASUREMENT OF COMPLIANCE

WellCare is committed to adhering to the measures and standards published by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). Please reference WellCare's Clinical Policy Guiding Document titled *Measures of Compliance.*

NOTE: To access Clinical Policy Guiding Documents visit www.wellcare.com – select the Provider tab, then "Tools" and "Clinical Guidelines".

Care Management

The goals for Care Management is are to support the member's ability to self-manage his or her disease/disorder, minimize risks of Schizophrenia, and remove barriers preventing the member from achieving those goals.

Members will be educated about primary symptoms and will follow the Behavioral Health Care Plan and contact Behavioral Health Professional to report increased symptoms of:[4]
- Hallucinations (auditory, visual and tactile)
- Delusions and/or delusional themes may vary across cultural contexts.
- Disorganized speech (Frequent derailment of incoherence)
- Disorganized or catatonic behavior (disturbances in motor (muscular movement) **behavior** that may have either a psychological or a physiological basis. The best-known of these symptoms is immobility, which is a rigid positioning of the body held for a considerable length of time).
- Negative symptoms (diminished emotional expression or avolition (severe lack of initiative or motivation))

Member should seek immediate psychiatric and/or medical care for:
- Suicidal ideation/behavior
- Homicidal ideation/behavior
- Any life threatening situations
- Medication problems or severe side effects

Members on Antipsychotic Medication should be screened for:
- Diabetes (HbA1c test annually)
- Cardiovascular disease (LDL-C test annually)
- Ongoing monitoring of Diabetes for People with Diabetes and Schizophrenia

MEASURABLE HEALTH OUTCOMES

Targeted Case Management outcomes (**Extended Program Goals**) result from successful self-management (see Case Management Objectives).

- **SYMPTOMS:** Decreased Member behavioral health symptoms. Compare Member response to assessment question (SF12), provider input and/or member narrative related to symptom changes pre- and post-engagement at 6-12 months.
- **ADHERENCE:** Improved Member adherence to medication and attendance of behavioral health and medical appointments. Compare pharmacy and office visit claims data pre-and post- engagement to validate adherence to timely refill of the prescribed medication(s) and provider visit(s). In absence of pharmacy and office visit claims data, the Member narrative and/or professional reporting of adherence to medication and attendance of behavioral health related appointments may be used.
- **ENGAGEMENT:** Improved Member social engagement with others through meaningful roles and relationships in his/her social life, educational and occupational settings. Compare member narrative pre- and post-engagement at 6-12 months.
- **UTILIZATION:** Decreased Member psychiatric episodes leading to emergency room visits and/or psychiatric hospitalization. Compare utilization data pre- and post- engagement at 6-12 months. In absence of these data sources, Provider and/or Member narrative may be used.

CASE MANAGEMENT GOALS

Case Goals should target specific care gaps and/or adherence issues, and measure the member's progress towards self-management and adherence which lead to the targeted health outcomes above Example:

- **SYMPTOMS:** Reduction of behavioral health symptoms by 10% using valid, reliable rating scales (e.g.
- **SYMPTOMS:** Member describes a routine that includes checking and logging behavioral health symptoms per treatment recommendation over the last 30 days and shares data with treatment providers.
- **SYMPTOMS:** Member describes coping skills and support system over the last 30 days that demonstrates improved adherence to guideline and/or treatment recommendations.
- **ADHERENCE:** Attendance of >75% of behavioral health and medical appointments during a 90-day period
- **ADHERENCE:** Member's prescription refills demonstrate at least an 80% adherence rate (verified by claims or member/provider narrative) over last 30 days.
- **ADHERENCE:** Monitoring of medication adherence (member self-report).
- **ENGAGEMENT:** Increased frequency of social engagement by **≥25%** over previous period as measured by number of social interactions (self-report)
  UTILIZATION: Documentation of use the of Therapist visit, Case Management intervention, Crisis Line call, Primary Care Physician call or visit, or Urgent Care visit *prior* to emergency department visit or BH Inpatient Admission **≥75%** of the time

CASE MANAGEMENT OBJECTIVES

Case Management objectives should focus on improving Member self-management skills and mental health through:
- Implement Care Plan
- Contact/outreach Member according to identified Acuity Level and Stratification Level:
  - Acuity Level 1/Stratification Level 1 – Monthly monitoring. Minimum member contact once monthly

- o Acuity Level 2/Stratification Level 2 – 5 or more interventions in 4 weeks. Minimum member contact every 3 to 4 weeks.
  - o Acuity Level 3/Stratification Level 3 – 5 or more interventions in 2 weeks. Minimum member contact every 2 to 3 weeks.
  - o Acuity Level 4/Stratification Level 4 – 5 or more interventions in 1 week. Minimum member contact every 2 weeks.
- Provide psychoeducational material and related information
- Educate Member on signs and symptoms of behavioral health decompensation
- Provide community resources
- Provide professional resources including: psychiatry, counseling, and other behavioral health resources
- Provide medical resources necessary to maintain positive physical health
- Conduct Periodic Assessment of Suicidal Ideation and Homicidal Ideation
- Screen for substance abuse treatment needs
- Encourage and monitor maintenance of social contact and interaction within social groups and social supports
- Encourage and monitor medication adherenceEncourage and monitor attendance of scheduled appointments

OTHER CONSIDERATIONS

Diabetes Risk. Those members treated with antipsychotic medications are at higher risk of diabetes. Fasting plasma glucose is the screening recommended by the American Diabetes Association for this population. Fasting plasma glucose, lipid levels, BMI and blood pressure should be assessed baseline (before starting antipsychotic medication) and 3 months after initiation of antipsychotic medications. At a minimum thereafter, these members should be screened annually, more frequently if a member's risk factors increase or there are medication dosage changes.[5]

MEMBER EDUCATIONAL RESOURCES

WellCare contracts with Krames/StayWell for Member educational materials utilized by Case Managers. Items are available to review with Members to address knowledge gaps. Case Managers verbally educate Members on the topics below related to asthma.

- Treating Schizophrenia
- Understanding Schizoaffective Disorder
- Understanding Schizophrenia
- Understanding Selective Mutism

These materials are in the approval process and will be available for member educational mailing in the future. Providers may wish to research the titles above related to schizophrenia that Case Managers utilize with Members.

PHARMACOLOGY

The FDA has added a warning to the labeling of the antipsychotic ziprasidone and its generic versions on the risk of DRESS (drug reaction with eosinophilia and systemic syndromes), a rare but potentially fatal skin reaction. Ziprasidone is used to treat schizophrenia and bipolar I disorder. The warning, for the capsule, oral suspension, and injection formulations, is based on reports of six patients who developed signs and symptoms of DRESS 11 to 30 days after initiation of ziprasidone treatment.[3]

Antipsychotic medications diminish the positive symptoms of schizophrenia and prevent relapses. There is no clear antipsychotic drug of choice for schizophrenia. Clozapine is the most effective medication but is not recommended as first-line therapy due to a rare but serious complication, agranulocytosis.

Psychosocial treatment is essential. The best-studied psychosocial treatments are social skills training, cognitive-behavioral therapy, cognitive remediation, cognitive enhancement training, and social cognition training. Psychosocial treatments are currently oriented according to the recovery model. According to this model, the goals of treatment for a person with schizophrenia are as follows:[3]

- To have few or stable symptoms
- Not to be hospitalized
- To manage his or her own funds and medications
- To be either working or in school at least half-time

Related WellCare Guidelines

In addition to the information contained in this document, please reference the following CPGs: *Diabetes in Adults:* HS 1009, *Persons with Substance Use Disorders*: HS 1031, and *Substance Use Disorders*: HS 1031.

NOTE: Clinical Policies can be accessed by going to www.wellcare.com – select the Provider tab, then "Tools" and "Clinical Guidelines".

References

1. Frankenburg, FR. Schizophrenia. *MedScape.* http://emedicine.medscape.com/article/288259-overview. Published August 26, 2016. Accessed November 16, 2016.
2. Psychosis and schizophrenia in adults: prevention and management. National Institue for Health and Care Excellence Web site. https://www.nice.org.uk/Guidance/cg178. Published February 2014. Accessed November 15, 2016.
3. Practice guideline for the treatment of patients with schizophrenia (2nd ed.). American Psychiatric Association Web site. http://psychiatryonline.org/guidelines. Published 2004. Accessed November 16, 2016.
4. American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
5. American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, and North American Association for the Study of Obesity. Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes. Diabetes Care 2004 Feb; 27(2): 596-601. http://dx.doi.org/10.2337/diacare.27.2.596.
6. Guideline watch: practice guideline for the treatment of patients with schizophrenia (2nd ed.). American Psychiatric Association Web site. http://psychiatryonline.org/guidelines. Published 2009. Accessed November 16, 2016.

Disclaimer

Medical Policy Committee Approval History

Date	History and Revisions by the Medical Policy Committee
10/10/2017	• Approved by MPC. No changes.
12/8/2016	• Approved by MPC. Enhanced Care Management and Measures of Compliance sections. Revised with CM, DM, QI, UM, BH and the Chief Medical Directors.
8/6/2015, 3/5/2015	• Approved by MPC. Added items from Care Management Training; included Measures of Compliance.
1/9/2014, 12/1/2011	• Approved by MPC. No changes.
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