New Guidelines Help With Schizophrenia Diagnosis

Christine Kilgore

Instances of schizophrenia being newly diagnosed in long-term care residents with dementia who had been receiving antipsychotic medications — seemingly to have such antipsychotic usage exempted from a Nursing Home Compare quality measure — led AMDA – the Society for Post-Acute and Long-Term Care Medicine and nine other organizations to issue a joint summary statement reinforcing the importance of appropriate diagnostic practices for the condition.

"Diagnosing late-life schizophrenia in a resident who has an underlying diagnosis of dementia is particularly challenging" and "should be made only after other causes of the symptoms have been excluded through a careful review of the patient's medical and psychiatric history, an assessment of past and current medication therapy, and a physical examination," the statement says.

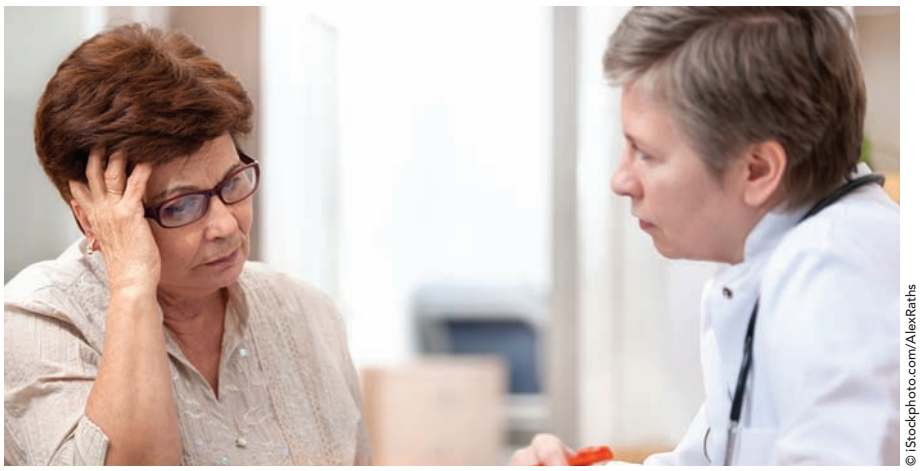
Susan Levy, MD, CMD, the Society's immediate past-president, said the Society and the statement's cosigners "don't want to see anyone in the nursing home or elsewhere labeled with the diagnosis of schizophrenia unless they really have the diagnosis."

"It's important to acknowledge that patients with dementia may require treatment with psychotropic medications if their behavioral symptoms endanger them or others and have not responded to nonpharmacological treatments."

"And certainly," she said, "no one should be misdiagnosing patients in order to meet certain quality measures."

The Centers for Medicare & Medicaid Services became aware of an uptick of new schizophrenia diagnoses in certain facilities — with particular "clusters in timing" — and then found through onsite reviews that appropriate diagnostic assessments were often not conducted and that residents were given the diagnosis after the use of antipsychotic medications, according to a CMS spokesperson.

David Gifford, MD, MPH, senior vice president of quality and regulatory affairs at the American Health Care Association (AHCA), coordinated the consensus statement. "It was important as professional associations to band together to issue a statement, and to nip it in the bud before it became a significant problem," he said.



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Late-life diagnoses of schizophrenia are rare, and a rise in new diagnoses in nursing homes may be related to the CMS quality measure on antipsychotic medication.

There were "anecdotal reports of some physician groups and pharmacy groups that were offering their services to SNFs [skilled nursing facilities] to relabel [individuals with dementia] on antipsychotics as having schizophrenia," Dr. Gifford told *Caring*, emphasizing that such practices are not widespread.

The percentage of residents who receive an antipsychotic medication is one of the Minimum Data Set (MDS)–based quality measures for long-stay residents that are posted on Nursing Home Compare and are included in the calculation of a facility's rating under the Five-Star Quality Rating System. The measure is also used to track progress in the CMS Partnership to Improve Dementia Care in Nursing Homes, begun in 2012.

The measure excludes residents with schizophrenia, Tourette's syndrome, and Huntington's disease.

Making the Diagnosis

According to the joint statement, the diagnosis of new-onset schizophrenia in a post-acute and long-term care setting "should be made by a qualified health professional with mental health training using DSM-5 criteria."

Dr. Levy said this does not necessarily mean that a psychiatrist must make the diagnosis, but it does require that "if you're making the diagnosis, you should know that your education, training, and competency enable you [to do so]."

It is "possible that over time, as a patient is in a facility, the diagnostic criteria will fit, and indeed a patient [for whom medical records and history are absent or lacking] may be diagnosed with schizophrenia," Dr. Levy said. "Frequently, we find out that these patients had prior psychiatric hospitalizations in mid-life … and it becomes apparent that they've probably had this diagnosis their entire lives."

However, late-onset schizophrenia is rare, she and Dr. Gifford emphasized. "The diagnosis requires you not only to meet a set of symptoms, but to exclude other causes for the symptoms," including dementia, Dr. Gifford said.

The higher-than-expected rates of new schizophrenia diagnoses in some facilities appear to be an unintended consequence of the quality measure on antipsychotic medication, said Dr. Gifford and Dr. Levy. According to the CMS spokesperson, the agency "understands that [the schizophrenia diagnoses] may be a result of these facilities being assessed on a measure [of antipsychotic use]" and the fact that schizophrenia is not included in the measure.

What began as an effort to reduce the use of antipsychotic medications in patients with dementia and to emphasize nonpharmacologic alternatives has evolved into a climate with a laser-like focus on drug utilization rates, according to Dr. Levy and Dr. Gifford.

The climate is seeped with "absolutist" rhetoric and a "purist" approach that assumes any use of antipsychotics is bad, Dr. Gifford said. "We [have] swung the pendulum too far," he said. "It's clear that antipsychotics are commonly overused, and that they can be harmful when they're overused. But there also are clearly some indications for patients [with dementia] to benefit from these medications, and we need to be better at tailoring that."

The joint statement conveys this message, stating that it's "important to acknowledge that patients with dementia may require treatment with psychotropic medications if their behavioral symptoms endanger them or others and have not responded to nonpharmacological treatments."

Bipolar Affective Disorder

The CMS quality measure on antipsychotic drug use is causing consternation in the long-term care community as it relates to bipolar affective disorder (historically referred to as manic-depressive illness) as well. Although schizophrenia is excluded from the measure, bipolar affective disorder is not excluded, despite repeated efforts by the Society, AHCA, and other organizations to have it exempted, and even though antipsychotic medication is an FDA-approved mainstay of its treatment.

According to Sabine von Preyss-Friedman, MD, CMD, the medical director for several skilled nursing facilities in the Seattle area and chief medical officer for Avalon Health Care, the lack of exclusion of bipolar affective disorder in the quality measure is not aligned with standards of treatment and — in another unintended consequence of the measure and its use in the marketplace — is "interfering with the proper care of bipolar patients."

Anecdotally, it appears that facilities in her state and in surrounding areas have become increasingly reluctant to admit residents with bipolar affective disorder for fear of increasing their antipsychotic medication numbers reflected in the quality measure, Dr. von Preyss-Friedman said during a broader interview with *Caring* about the Five-Star rating system.

Photo by Craig Huey Photography

Sabine von Preyss-Friedman

The objections to excluding bipolar affective disorder from the quality measure were driven at least in part by concerns that patients with dementia would be inappropriately labeled with the diagnosis to justify medication use, Dr. Levy said. Officials "didn't want to see an epidemic of bipolar disease," she said.

By now, said Dr. Gifford, the failure to exclude affective bipolar disorder has "created a complete distraction from having meaningful discussions about how to reduce the use of antipsychotics" in patients with dementia. Combined with the recent concerns about schizophrenia diagnoses and an excessive focus on measure parameters and drug utilization rates, this situation demonstrates "that by not addressing these fundamental needs and questions about the measure, [we're] creating an incentive for bad behavior."

In addition to the Society and AHCA, the joint summary statement on diagnosing schizophrenia in skilled nursing facilities was supported by the following organizations: the American Association for Geriatric Psychiatry, the American Association of Nurse Practitioners, the American Geriatrics Society, the American Psychiatric Association, the American Society of Consultant Pharmacists, the Gerontological Advanced Practice Nurses Association, Leading Age, and the Society of Hospital Medicine.

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