Performance in Practice:
Physician Practice Assessment Tool for the Care of Adults With Schizophrenia

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Abstract: To facilitate continued clinical competence among physicians, the American Board of Medical Specialties (ABMS) and the American Board of Psychiatry and Neurology (ABPN) are implementing multifaceted *Maintenance of Certification* (MOC), which includes requirements for practice assessment in order to enhance the quality of patient care (1). Beginning in 2013, for those applying for 2014 MOC examinations, the practice assessment component will require physicians to compare their care for five or more patients with ". . . published best practices, practice guidelines or peer-based standards of care and develop a plan to improve the effectiveness and efficiency of his/her clinical activities" (1). To this end, the *Performance in Practice (PIP) Physician Practice Assessment Tool for the Care of Adults with Schizophrenia* presented here provides evidence-based quality indicators to enhance the care of patients with schizophrenia and gives psychiatrists experience with practice assessment in preparation for the new MOC requirements.

The American Board of Medical Specialties (ABMS) and the American Board of Psychiatry and Neurology (ABPN) are implementing multifaceted *Maintenance of Certification* requirements to enhance the quality of patient care and assess the competence of physicians over time (1). Beginning in 2013, for those applying for 2014 MOC examinations, a practice assessment component of maintenance of certification will require physicians to compare their care for five or more patients with ". . . published best practices, practice guidelines or peer-based standards of care and develop a plan to improve the effectiveness and efficiency of his/her clinical activities." (1)

Patients with schizophrenia commonly present to specialty mental health settings and comprise approximately 10% of all patients treated by practicing psychiatrists in the United States (2). Although the lifetime prevalence of schizophrenia is estimated to be 1.0% (3), schizophrenia is associated with a very high global burden of disease and disability (4, 5). Early mortality is more common among individuals with schizophrenia, with a lifetime rate of suicide of nearly 5% (6) as well as early death due to general medical conditions (7–10). Disparities in the receipt

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Dr Dixon has no competing interests but reports the following (family member) *Consultant/Advisor:* Eli Lilly, Takeda, Hoffman-LaRoche, Bristol Myers Squibb, Abbott, Genentech, Endo Pharmaceuticals. *DSMB:* Otkuka. *Research Funding:* Pfizer, Novartis, Janssen, Pamlab, GlaxoSmith Kline

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Drs. Duffy, West, Fochtmann, Kreyenbuhl, Moscicki, Plovnick, and Mr. Kunkle report no competing interests.

Funding: This project was funded by the American Psychiatric Association.

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of general medical care act in concert with an increased likelihood of risk factors such as metabolic syndrome and smoking to accelerate mortality in those with schizophrenia (9, 10). Individuals with schizophrenia are more likely to be unmarried, jobless, homeless, and incarcerated (2, 11–14). They are also more likely to be the targets of violence (15) but may also become aggressive to others, particularly in association with substance use problems, psychosis or depressive symptoms, comorbid antisocial personality or childhood conduct problems, neurological impairment, history of violence or victimization (9, 16–20). Consequently, optimizing the care of individuals with schizophrenia is essential to reducing the considerable economic and human costs of this disorder.

Despite an extensive and robust research base on the treatment of individuals with schizophrenia, national data indicate that many individuals with the illness currently do not receive evidence-based treatments. Physician adherence to the evidence base for pharmacologic treatments is generally high, with over 90% of persons with schizophrenia in treatment receiving antipsychotic medications (2), but patients may have difficulty accessing medications, contributing to the risk of relapse and suicidal behaviors (21). Even among those receiving pharmacologic treatments, appropriate and timely monitoring for side-effects and treatment effects are less than optimal (22). A much lower proportion of persons with schizophrenia receive other recommended pharmacologic treatments or evidence-based psychosocial treatments. For example, national data indicate that fewer than half (39.7%) of all individuals with schizophrenia who were treated by psychiatrists received any evidence-based psychosocial treatment, including illness education, social skills training, vocational rehabilitation, case management, cognitive behavioral or other psychotherapeutic interventions recommended by the American Psychiatric Association (APA) and the Patient Outcomes Research Team (PORT) practice guidelines (2). These findings are particularly troubling, as psychosocial and psychopharmacologic interventions have been shown to help provide individuals with schizophrenia significant relief and improved opportunities to lead more fulfilling lives (23).

Another potential gap in the care of individuals with schizophrenia relates to the identification of co-occurring psychiatric symptoms and/or disorders. Clinical heterogeneity and psychiatric comorbidities are common (24–26). High rates of co-occurring mood, anxiety, substance use and personality disorders have been found among patients suffering from schizophrenia (26–28). About half of patients with schizophrenia may have co-occurring depression; point prevalence for depressive symptoms is 50% and one-month prevalence is 30%–35% (27, 28). Estimates for life-time prevalence of co-occurring anxiety disorder range from 15 to 29% (27). Symptoms of depression and anxiety are considered integral to schizophrenia (27), and have impact on the course and outcomes of the illness (27, 29). Moreover, nearly one-half of patients with schizophrenia have a co-occurring substance use disorder (27), not including nicotine abuse/dependence, which in and of itself has a prevalence that exceeds 50% among patients with schizophrenia (25, 27, 28, 30–32). In general, co-occurring psychiatric disorders and symptoms can worsen the course of illness, and are associated with poorer outcomes (10, 27, 33–36); thus thorough assessment, identification and management of co-occurring conditions is a significant aspect of care for schizophrenia.

Given the high levels of morbidity, mortality and social burden of disease and suffering associated with schizophrenia, the *Performance in Practice (PIP) Physician Practice Assessment Tool for the Care of Adults with Schizophrenia* presented in Appendix 1, was developed to help meet the new ABMS and ABPN MOC requirements and to assist psychiatrists in optimizing care to patients. This PIP tool is also intended to: 1) Provide a simple retrospective chart review tool for physicians to examine the care provided to adult patients with schizophrenia to determine whether the clinician's current assessment and treatment practices are consistent with the latest evidence-based recommendations; and 2) Offer key evidence-based recommendations and valuable clinical resources related to screening, assessment, treatment interventions, and possible ways to improve clinical practice.

The first step in developing this PIP tool involved identifying clinically significant evidence-based assessment and treatment recommendations from the following sources: the American Psychiatric Association's (APA's) *Practice Guideline for the Treatment of Patients with Schizophrenia* (9); the APA's "Guideline Watch: Practice Guideline for the Treatment of Patients with Schizophrenia" (37); and the Schizophrenia Patient Outcomes Research Team (PORT) (38, 39). The evidence-based guidelines were developed through systematic medical literature reviews and critical evaluation of the scientific research by experts in the assessment and treatment of schizophrenia. The Guideline Watch (37) is a more recent review of the literature that provides an update for the published APA guideline (9). The PIP tool presented here is based on a synthesis of information from these sources and provides evidence-based measures that relate to the assessment and treatment of schizophrenia.

The PIP tool presented in Appendix 1 includes three sections related to: 1) patient assessment; 2)

general treatment approaches; and 3) treatments that are indicated for specific patient subgroups. Each section highlights aspects of care that have significant public health implications, or for which gaps in guideline adherence are common, for example, use of long-acting injectable antipsychotics for individuals with antipsychotic adherence difficulties, or use of cognitive behavior therapy for individuals with residual symptoms despite adequate pharmacotherapy. The core assessment and treatment recommendations highlighted in sections 1 and 2 of Appendix 1 generally can be managed by individual psychiatrists and applied as a part of their routine practice, rather than relying on other health care system resources. The last column of the tool provides guideline-supported recommendations and clinical resources to assist in practice improvement efforts.

This PIP clinical tool has been designed to be relevant across different clinical settings; is straightforward to complete; and is usable in a pen-and-paper format to aid adoption. In addition to its value as a self-assessment tool, this form could be also used for retrospective peer-review initiatives. Although the ABPN Maintenance of Certification program requires review of at least 5 patients as part of each PIP unit, it is important to note that larger samples will provide more accurate estimates of quality of care within a practice.

After using the PIP tool to assess the pattern of care provided to patients, the physician should determine whether specific aspects of care need to be improved. Through such practice assessment, the physician may determine that deviations from the quality indicators are clinically appropriate and justified, or he or she may choose to acquire new knowledge and modify his or her practice to improve quality. For example, if patients with schizophrenia in the physician's current psychiatric caseload are not routinely screened for tobacco or alcohol use, then an area for improvement could involve implementation of systematic screening for alcohol and tobacco use, which are especially common among patients with schizophrenia.

It is important to note that while this tool is intended to highlight current evidence-based assessment and treatment recommendations for patients with schizophrenia, justifiable variations from recommended care may occur. Assessment and treatment recommendations provided in the practice guidelines are generally intended to be relevant to the majority of individuals (40, 41). However, patients vary widely in their preferences for treatment, clinical presentation, history of treatment and prior response, presence of comorbid physical and psychiatric conditions, and other factors that may influence clinical decision making. Because patients with schizophrenia often have high levels of complex symptomatology and co-occurring psychiatric and other general medical comorbidities, divergence from evidence-based recommendations may occur. Deviations from guidelines may also arise because of treatment nonresponse to adequate trials of antipsychotics, a relatively common occurrence in clinical practice due to the limited efficacy of the antipsychotics that are currently available (42, 43). In addition, practice guidelines and quality indicators are often derived from findings of efficacy and effectiveness trials in which stringent enrollment criteria are used; thus individuals in clinical trials often differ in important ways from those seen in routine clinical practice (44).

For a more thorough presentation of specific clinical and psychosocial issues relating to the acute, stabilization and stable phases of treatment for schizophrenia, physicians and others interested in strengthening the quality of care provided to their patients with schizophrenia are strongly encouraged to more carefully review the primary sources from which these indicators were developed:

- PORT 2009 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2800150/pdf/sbp130.pdf;
- APA Guideline Watch 2009 http://psychiatryonline.org/data/Books/prac/Schizophrenia_Guideline%20Watch.pdf;
- APA Practice Guideline; APA Practice Guideline 2004 http://psychiatryonline.org/data/Books/prac/Schizophrenia2e_Inactivated_04-16-09.pdf.

The APA guideline in particular presents a treatment approach emphasizing that, as a chronic illness affecting all aspects of a person's life, treatment planning for patients with schizophrenia should have three goals: 1) reduce or eliminate symptoms, 2) maximize quality of life and adaptive functioning, and 3) promote and maintain recovery from the debilitating effects of illness to the maximum extent possible. The source guidelines highlight critical issues related to these treatment goals which are not fully reflected in the quality indicators presented here, including the importance of establishing a therapeutic alliance in order to identify barriers to the patient's ability to participate in treatment and engage the patient's family members and other significant support persons.

The PIP tool in Appendix 1 provides clinicians with an opportunity for practice assessment in preparation for the new 2014 ABPN Maintenance of Certification program requirements. Because the evidence-based quality indicators presented here are considered core components in the care of patients with schizophrenia, use of this tool can serve as a

foundation in developing a systematic approach to practice improvement for the assessment and treatment of patients with schizophrenia. Use of the PIP tool will likely highlight potential treatment services gaps, which may include, for example, lack of availability of cognitive behavioral therapy, Assertive Community Treatment, substance abuse treatment services, or Supported Employment programs. It is hoped that this tool, together with the evidence-based guidelines underlying these clinical recommendations, may be useful in advocating for increased availability of critically needed core services to help improve the lives and functioning of individuals with schizophrenia. With Health Care Reform (i.e., the 2010 Patient Protection and Affordable Care Act) bringing promising new services delivery models and systems such as Accountable Care Organizations and Health Homes, it is an opportune time for clinicians and advocates to draw attention to the importance of availability of the full array of evidence-based services and treatments for care of patients with schizophrenia as well as other psychiatric disorders.

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NOTES

Appendix 1: Performance in Practice Physician Practice Assessment Tool for the Care of Patients with a Diagnosis of Schizophrenia (p. 1 of 8)

Instructions: Choose five adult patients from your current psychiatric caseload meeting diagnostic criteria for schizophrenia. Review their charts to determine if patients have received assessment and treatment that was consistent with key evidence-based recommendations shown in the left-hand column of the following table. If YES, check the appropriate box; if NO or UNKNOWN, leave the box unchecked. Please note: the right hand column provides supporting evidence, resources and clinical issues that can be considered in relation to a specified recommendation.

Scoring: In the TOTAL column, tally the total number of checkmarks in each row. For any row for which the total is less than 5, examine whether clinical or other circumstances explain why practice was not consistent with recommended care. Consider whether changes in your practice or use of any of the suggested clinical tools could strengthen the provision of evidence-based care.

Diagnostic Criteria for Schizophrenia (DSM-IV) (45):

A. ***Characteristic Symptoms*** **-** Two or more of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated): Delusions; Hallucinations; Disorganized Speech; Grossly Disorganized or Catatonic Behavior; Negative Symptoms.

B. ***Social/Occupational Dysfunction*** – For a significant portion of time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, self-care, or academic/occupational achievements are markedly below the level achieved prior to the onset.

C. ***Duration*** **-** Continuous signs of the disturbance persist for at least 6 months (include at least one month [or less if successfully treated] of characteristic symptoms meeting criterion A); may include periods of prodromal or residual symptoms.

D. ***Schizoaffective and Mood Disorder Exclusion***

E. ***Substance/General Medical Condition Exclusion***

F. ***Relationship to a Pervasive Developmental Disorder*** **–** If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the diagnosis of schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

I. Assessment of Patients Meeting Diagnostic Criteria for Schizophrenia	Patient #1	#2	#3	#4	#5	TOTAL Number of patients with check mark in each row	Supporting Evidence, Resources, and Clinical Issues for Consideration
1. Were the patient's goals for treatment identified as part of the assessment?	☐	☐	☐	☐	☐	__/5	• It is important to obtain information from the patient about his/her goals in terms of promoting shared decision making and arriving at a treatment plan that will address the patient's goals/concerns, foster a more collaborative therapeutic relationship, and promote adherence (46). Such discussion should consider desires and concerns about treatment, per se, as well as goals and concerns relating to factors such as quality of life, relationships, and schooling or employment.
2. Was the patient screened for current or past tobacco use?	☐	☐	☐	☐	☐	__/5	• Rates of tobacco use are high among individuals with schizophrenia and contribute to morbidity and mortality. Thus, it is important to inquire about patients' current and past use of tobacco and document their tobacco use status. Screening to identify tobacco use is a crucial step in educating patients and providing treatment and follow-up aimed at cessation. Should you wish to use a systematic approach to identify tobacco use and dependence, the 5 A's model for screening and treating tobacco use and dependence can be found at the U.S. Department of Health and Human Services Public Health Service Clinical Practice Guideline (47). Additionally, the Fagerstrom Test for Nicotine Dependence (FTND), a validated rating scale, can screen for the presence of nicotine dependence and also inform treatment planning by providing an estimate of severity (48, 49).

Appendix 1: Performance in Practice Physician Practice Assessment Tool for the Care of Patients with a Diagnosis of Schizophrenia (p. 2 of 8)

I.	Assessment of Patients Meeting Diagnostic Criteria for Schizophrenia	Patient #1	#2	#3	#4	#5	TOTAL Number of patients with check mark in each row	Supporting Evidence, Resources, and Clinical Issues for Consideration
3.	Was the patient screened for use of alcohol and other substances?	☐	☐	☐	☐	☐	__/5	• Screening for alcohol and other substance use is important as substance use can confound the assessment of psychotic symptoms and can affect the course of schizophrenia (46). The presence of a co-occurring substance use disorder will need to be addressed in the treatment plan. • Available, validated, guideline recommended screening tools for alcohol use problems include the NIAAA single screening question about number of heavy drinking days in the past year, the 4-item CAGE, and the 3- or 10-item AUDIT: http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm (50–52). • Assessment and screening for SUD may include self-report corroborated by other sources such as family, friends, case-managers, and treatment personnel and, as indicated, urine and blood toxicology and other tests such as liver function tests (46).
4.	Was the patient assessed for risk of suicide and other self-harming behaviors?	☐	☐	☐	☐	☐	__/5	• It is important to consider suicide risk at all stages of illness and to perform an initial suicide risk assessment and follow-up assessments as part of each patient's psychiatric evaluation (46). • Assessment of the risk for suicidal behaviors typically includes asking the patient and (when possible) the patient's family about current or prior thoughts, plans or intentions to harm or kill oneself, or prior suicidal behaviors (46, 53). • Patients with schizophrenia share the same risks for suicide fatalities and behaviors as in the general population, including male sex, family history of depression, comorbid depression or depressive symptoms, comorbid substance use disorder, increased agitation, worthlessness, hopelessness, and significant recent loss event (54, 55). • Risks unique to schizophrenia have also been identified, and include younger age at diagnosis (6), diagnosis after academic attainment (54), fear of mental disintegration (54), poorer adherence to treatment (54), and disruptions in medication regimens (21).

Appendix 1: Performance in Practice Physician Practice Assessment Tool for the Care of Patients with a Diagnosis of Schizophrenia (p. 3 of 8)

I. Assessment of Patients Meeting Diagnostic Criteria for Schizophrenia	Patient #1	#2	#3	#4	#5	TOTAL Number of patients with check mark in each row	Supporting Evidence, Resources, and Clinical Issues for Consideration
							• Awareness of disorder before treatment initiation may be associated with elevated suicide risk, but is mediated by symptoms of depression and hopelessness. Changes in disease awareness related to treatment are associated with a lower suicide risk (55). Timely and appropriate treatment is a central component of suicide prevention (56), especially for highly vulnerable patients such as those with schizophrenia. Clinical approaches may include use of medications demonstrated to decrease the probability of suicide (55, 57); consistent medication regimens (21); active treatment of symptoms of depression and hopelessness (54, 6), and vigilance regarding recent loss events (54).
5. Was the patient assessed for risk of dangerous or aggressive behaviors including interpersonal aggression and harm to others?	☐	☐	☐	☐	☐	__/5	• Assessment of the risk for aggressive behaviors typically includes asking the patient and, when possible, the patient's family about current or prior thoughts, plans or intentions of aggression toward others. • The primary risk factor for aggression in schizophrenia is comorbid substance use/abuse (16). Other correlates and risk factors may include male sex, being poor, unskilled, uneducated, or unmarried; and having a history of prior arrests or a prior history of violence. The risk of aggressive behavior also increases with comorbid antisocial personality and neurological impairment. Serious violence has also been associated with psychotic and depressive symptoms, childhood conduct problems, and victimization (16–20).
6. Was the patient assessed for mood symptoms including mania or depression?	☐	☐	☐	☐	☐	__/5	• The presence of significant mood or anxiety symptoms may signal an increased risk of suicidal behaviors, and may suggest a need to modify the diagnosis or treatment plan (27). Akathisia, which is a common side effect of antipsychotic medications, may be associated with dysphoria or be mistaken for the restlessness associated with anxiety.
7. Was the patient assessed for anxiety symptoms?	☐	☐	☐	☐	☐	__/5	

Appendix 1: Performance in Practice Physician Practice Assessment Tool for the Care of Patients with a Diagnosis of Schizophrenia (p. 4 of 8)

I. Assessment of Patients Meeting Diagnostic Criteria for Schizophrenia	Patient #1	#2	#3	#4	#5	TOTAL Number of patients with check mark in each row	Supporting Evidence, Resources, and Clinical Issues for Consideration
8. Was the patient assessed for any baseline abnormalities in general neurological and medical status?	☐	☐	☐	☐	☐	__/5	• Before initiating pharmacotherapy, patients should receive a comprehensive assessment of neurological and general medical status (37, 46). Attention to neurological signs such as motor rigidity or abnormal involuntary movements, and metabolic parameters such as body mass index (BMI), blood glucose, and lipid levels are particularly important to determine given the frequent occurrence of extrapyramidal and metabolic side effects with antipsychotic therapy (37, 46). • Occurrence of side effects may be influenced by the patient's history, pre-existing conditions, and use of other medications in addition to antipsychotic agents.

II. Treatment of Patients Meeting Diagnostic Criteria for Schizophrenia	Patient #1	#2	#3	#4	#5	TOTAL Number of patients with check mark in each row	Supporting Evidence, Resources, and Clinical Issues for Consideration
9. Was patient education on the course and outcome of the illness provided?	☐	☐	☐	☐	☐	__/5	• Patient education about illness and treatment is an on-going process. This includes discussion of strategies for problem solving, relapse prevention, and symptom and medication management. Patients should be provided with education about the illness and its treatment at the time of illness episodes as well as during routine periodic updates.
10. Was the patient offered the opportunity to involve family in treatment and have his or her family receive education and support?	☐	☐	☐	☐	☐	__/5	• The patient's consent to involve his or her family should be sought. Such consent does not have to be comprehensive. Hesitant patients can be invited to limit the types of information shared or what is discussed. Also, consent can be limited to family members chosen by the patients. • Optimal family interventions include illness education, crisis intervention, emotional support, and training in how to cope with illness symptoms and related problems. However, even more limited forms of support and education can be helpful in both assisting the patient's recovery or improve family well-being, as well as during routine periodic updates.

Appendix 1: Performance in Practice Physician Practice Assessment Tool for the Care of Patients with a Diagnosis of Schizophrenia (p. 5 of 8)

II. Treatment of Patients Meeting Diagnostic Criteria for Schizophrenia	Patient #1	#2	#3	#4	#5	TOTAL Number of patients with check mark in each row	Supporting Evidence, Resources, and Clinical Issues for Consideration
11. Was treatment with an antipsychotic medication provided?	☐	☐	☐	☐	☐	__/5	• Selection of an antipsychotic agent should be guided by the patient's past medication history, current symptoms and co-occurring conditions, other concurrent treatments, and preferences (37–39, 46). • For persons with schizophrenia experiencing their first acute positive symptom episode (38), antipsychotic medications other than clozapine and olanzapine are recommended as first-line treatment. • For patients with treatment-responsive, multi-episode schizophrenia who are experiencing an acute exacerbation of their illness, antipsychotic medications other than clozapine should be used as a first-line treatment for reducing positive psychotic symptoms (38).Patients with treatment-responsive, multi-episode schizophrenia who experience acute and sustained symptom relief with an antipsychotic medication should be offered continued antipsychotic treatment in order to maintain symptom relief and reduce the risk of relapse or worsening of positive symptoms (38, 46). • Clozapine should be offered to individuals with schizophrenia who have treatment-resistant symptoms, demonstrate intolerance to side effects, or experience chronic and persistent suicidal behaviors or behaviors that do not respond to other treatments (38, 39, 46).
12. Was the patient monitored for adverse neurologic effects during treatment with an antipsychotic medication?	☐	☐	☐	☐	☐	__/5	• When individuals are receiving treatment with an antipsychotic medication, it is important to be alert for the development of adverse effects. These include, but are not limited to, adverse neurological effects such as extrapyramidal side effects and tardive dyskinesia, and development of weight gain, diabetes mellitus, hyperlipidemia, and metabolic syndrome. In addition to routine clinical observation, more systematic monitoring is also recommended.
13. Was the patient monitored for metabolic syndrome during treatment with an antipsychotic medication?	☐	☐	☐	☐	☐	__/5	
14. Was the patient monitored for changes in body mass index (BMI) during treatment with an antipsychotic medication?	☐	☐	☐	☐	☐	__/5	

Appendix 1: Performance in Practice Physician Practice Assessment Tool for the Care of Patients with a Diagnosis of Schizophrenia (p. 6 of 8)

II. Treatment of Patients Meeting Diagnostic Criteria for Schizophrenia	Patient #1	#2	#3	#4	#5	TOTAL Number of patients with check mark in each row	Supporting Evidence, Resources, and Clinical Issues for Consideration
							• Decisions about the frequency of such monitoring will depend on the clinical circumstances of the individual patient and will be influenced by the antipsychotic that is prescribed as well as by the patient's history, pre-existing conditions, and use of other medications in addition to antipsychotic agents. • There are no evidence-based data on the recommended monitoring frequency, also consensus recommendations for monitoring differ (46, 58, 59). However a reasonable approach might include baseline measurements followed by subsequent monitoring at the intervals noted: ➢ weight (with calculation of BMI), approximately monthly for 3 months and then every 3 months ➢ blood pressure at 3 months, and then annually ➢ fasting glucose or measurement of hemoglobin A1C at 3 months, then annually ➢ fasting lipid levels at 3 months, then at least every 5 years ➢ waist circumference, annually ➢ assessment for abnormal involuntary movements every 3 to 12 months, depending on the individual's risk for developing tardive dyskinesia • Appendix 2 provides a summary of various guidelines/consensus statements regarding proposed monitoring schedules for various side-effects associated with the treatment of schizophrenia • Links to ADA/APA/AACE/NAASO Consensus document (59) on Metabolic Monitoring and the latest diabetic screening recommendations can be found at: http://www.ncbi.nlm.nih.gov/pubmed/14747245 http://care.diabetesjournals.org/content/35/Supplement_1/S11.full#T2

Appendix 1: Performance in Practice Physician Practice Assessment Tool for the Care of Patients with a Diagnosis of Schizophrenia (p. 7 of 8)

III. Treatments Indicated for Select Patient Subgroups

A number of evidence-based interventions have been shown to benefit specific subgroups of patients and are important to consider when developing treatment plans. Have any of the interventions listed below been provided or offered to address patient-specific needs?

- **If the index intervention was PROVIDED or OFFERED to the select patient, please check the appropriate box; if NO or UNKNOWN, leave the box unchecked.**
- **If the index intervention currently is not available or accessible, or if the patient does not qualify to receive the indicated intervention, please circle NA (not applicable).**

Scoring: In the TOTAL column, tally the total number of checkmarks AND circled NAs in each row. For any row for which the total is less than 5, examine whether clinical or other circumstances explain why practice was not consistent with recommended care, or whether the indicated treatment currently is not available and therefore not applicable for the index patient. Consider whether changes in your practice could strengthen the provision of evidence-based care.

	Patient					TOTAL Number of patients with check marks OR circled NAs in each row	
	#1	#2	#3	#4	#5		
15. Clozapine, for individuals with treatment-resistant symptoms	☐ NA	☐ NA	☐ NA	☐ NA	☐ NA	__/5	• Clozapine should be offered (38, 39, 46) to individuals with schizophrenia who have treatment-resistant symptoms. Treatment resistance, defined by the persistence of clinically significant positive symptoms after two adequate antipsychotic treatment trials, is a relatively common occurrence and warrants additional intervention.
16. Cognitive behavior therapy (CBT), for individuals with residual symptoms despite adequate pharmacotherapy	☐ NA	☐ NA	☐ NA	☐ NA	☐ NA	__/5	• CBT has been shown to reduce both positive and negative symptoms, and to improve social functioning and overall outcome in patients who are experiencing residual symptoms (37, 39, 46).
17. A long-acting, injectable antipsychotic, for individuals with adherence difficulties	☐ NA	☐ NA	☐ NA	☐ NA	☐ NA	__/5	• A long-acting, injectable formulation of an antipsychotic medication should be offered for the maintenance treatment of schizophrenia for persons who have a: a) history of frequent relapse on oral medication; b) history of problems with adherence on oral medication; or c) preference for the long-acting, injectable depot regimen (38, 39, 46).
18. Assertive Community Treatment, for individuals who have high rates of hospitalization, difficulty remaining in traditional services, or recent homelessness	☐ NA	☐ NA	☐ NA	☐ NA	☐ NA	__/5	• Assertive Community Treatment may be beneficial for individuals with recent homelessness, difficulty remaining in traditional services, or high rates of hospitalization, often in the context of poor adherence. The key elements of ACT include a multidisciplinary team (including a psychiatrist), a shared caseload among team members, direct service provision by team members, a high frequency of patient contact, low patient-to-staff ratios, and outreach to patients in the community.

Appendix 1: Performance in Practice Physician Practice Assessment Tool for the Care of Patients with a Diagnosis of Schizophrenia (p. 8 of 8)

	Patient					TOTAL Number of patients with check marks OR circled NAs in each row	
	#1	#2	#3	#4	#5		
19. Treatment for co-occurring substance use disorders, for individuals with schizophrenia who also have a substance use disorder	☐ NA	☐ NA	☐ NA	☐ NA	☐ NA	__/5	• For individuals who have a co-occurring substance use disorder as well as schizophrenia, each disorder will need to be addressed as a part of the treatment plan. Concurrent treatment of schizophrenia and substance use disorder is recommended (46), preferably using a comprehensive integrated treatment model in which the same clinicians or team of clinicians provide treatment for both schizophrenia and substance use disorder (46).
20. Skills Training for individuals with functional impairments	☐ NA	☐ NA	☐ NA	☐ NA	☐ NA	__/5	• Skills training facilitates improvement in broad functional outcomes by addressing impairment in social skills or activities of daily living (37, 46).
21. Supported Employment, for individuals who have the goal of employment	☐ NA	☐ NA	☐ NA	☐ NA	☐ NA	__/5	• For patients who identify employment as a goal, supported employment should be recommended, when appropriate. The key elements of supported employment include individualized job development, rapid placement emphasizing competitive employment, ongoing job support, and integration of vocational and mental health services (37, 46).

Appendix 2: Summary of Guidelines/Consensus Statements Regarding Monitoring Schedules

Side effect	APA Schizophrenia PG	APA/ADA Consensus	Expert Consensus
Tardive dyskinesia	3-6 months for 1st gen agent 6-12 months for 2nd gen agent (variation depends on TD risk)	No comment	4 month for 1st gen agent 6 months for 2nd gen agent 9 months for Clozapine
Lipids	Baseline and q5 years	Baseline, at 3 months and q5 years	No comment
BMI	Baseline, Each visit x 6 mo, then q3mo	Monthly x 3 mo, then q3 mo	No comment
Glucose (Fasting blood sugar or HbA1C)	Baseline, at 4 months, then annually	Baseline, at 3 months then annually	No comment
Blood pressure	As clinically indicated	Baseline, at 3 months then annually	No comment
Waist circumference	No comment	Baseline and annually	No comment

Summary of various guidelines/consensus statements regarding proposed monitoring schedules for various side-effects associated with treatment of schizophrenia. A reasonable approach might include baseline measurements when initiating psychopharmacologic treatment, followed by subsequent monitoring at the intervals noted.

Directions for completing the PERFORMANCE IN PRACTICE (PIP) CLINICAL MODULE (MOC Part 4)

Physician Practice Assessment Tool for the Care of Patients with a Diagnosis of Schizophrenia

The PIP module, *Physician Practice Assessment Tool for the Care of Patients with a Diagnosis of Schizophrenia* can be used to fulfill a Maintenance of Certification (MOC) Part 4 Performance in Practice (PIP) requirement. The module is approved for MOC Part 4 by the American Board of Psychiatry and Neurology (ABPN). **Forms for chart review data collected in Stages A and C, as well as the improvement plan documentation STAGE B, are included in this issue of Focus. The data are for your use. You do not submit the data to the ABPN. To earn credit, submit an evaluation (see p. 171) to APA as you complete each of the three stages (A, B, C) of a module. You must complete Stages A, B, and C of a PIP module within 24 months, to qualify for a completed MOC Part 4 activity. The PIP module provides clinicians with an opportunity for practice assessment. The evidence-based quality indicators presented in this module are core components of the care of patients with a diagnosis of schizophrenia.

Instructions to Use a Module to Fulfill ABPN MOC Part IV Requirement and Earn CME credit.
STAGE A Chart Review

Through chart review, the physician uses the Practice Assessment Tool to assess whether their current assessment and treatment is consistent with evidence-based recommendations.

Program Evaluation Stage A – complete the evaluation for Stage A and submit it to American Psychiatric Association (APA).
CME Credit for Stage A – 5 AMA PRA category 1 credits™

STAGE B Improvement Plan and Suggested Interventions
After comparing your recorded patient data to quality measures in Stage A you should initiate and document a plan for improvement. You may decide to access additional resources as part of your improvement plan.

For a more thorough presentation of specific clinical and psychosocial issues relating to the acute, stabilization and stable phases of treatment for schizophrenia, physicians and others interested in strengthening the quality of care provided to their patients with schizophrenia are strongly encouraged to more carefully review the primary sources from which these indicators were developed:

- PORT 2009 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2800150/pdf/sbp130.pdf
- APA Guideline Watch 2009 http://psychiatryonline.org/guidelines.aspx
- APA Practice Guideline; APA Practice Guideline 2004. http://psychiatryonline.org/guidelines.aspx

Other suggested activities and resources that may be used as part of your improvement plan include:

1. Use of specific recommendations and clinical resources outlined in Stage A of the module.
2. FOCUS Journal of Lifelong Learning in Psychiatry: Schizophrenia; review original papers and influential publications on schizophrenia published in this issue such as: 2009 Schizophrenia PORT Psychopharmacological Treatment Recommendations and Summary Statements
3. CME Course - APA Practice Guideline for the Treatment of Patients with Schizophrenia www.apaeducation.org

Improvement Plan Documentation
Record your improvement plan in the space below or on a separate sheet for your own use. Your improvement plan is not submitted to ABPN.

Program Evaluation Stage B – complete the evaluation for Stage B and submit it to APA.
CME Credit for Stage B – 5 AMA PRA category 1 credits™

STAGE C Repeat Chart Review
Within 24 months following your initial chart review and completion of an improvement plan, and within a reasonable time to enact and be able to see review improvements in your chart (at least 30 days) complete a second chart review using the same module. Reevaluate your performance by comparing results of Stage C with Stage A review. You may use the same or different patient charts. Document Improvement for your records.

Program Evaluation Stage C – complete the evaluation for Stage C and submit it to APA.
CME Credit for Stage C – 10 AMA PRA category 1 credits™ and Completion of Part 4 MOC ABPN Clinical Module Requirements.

**Completion of this PIP module does not fulfill MOC Part 4 Patient and Peer feedback requirements. Forms for MOC Part 4 Peer and Patient Feedback are available on the ABPN website at: http://www.abpn.com/forms

EVALUATION SURVEYS FOR USE WITH PERFORMANCE IN PRACTICE PHYSICIAN PRACTICE ASSESSMENT TOOL

Physician Practice Assessment Tool for the Care of Patients with a Diagnosis of Schizophrenia.

Check the Stage you are Evaluating Stage A ____, B ____, or C ____.

CME credit Begin Date: June 2012 End Date: June 2015.

To earn AMA PRA category 1 credit™ for **Physician Practice Assessment Tool for the Care of Patients with a Diagnosis of Schizophrenia**, and to document participation in an ABPN approved MOC Part 4 activity, physicians should use the assessment tool as indicated. Physicians who complete in sequence, the three stages (A-C) of a Performance in Practice module may be awarded a total of 20 credits. Participants should complete an evaluation survey for each of the three STAGES of a module.

CME credit is earned for each of the three stages in sequence. Stage A = 5 credits, Stage B = 5 credits, Stage C = 10 credits. Stages are completed within a 24 month period.

Objective: After completion of this activity, physicians will have the foundation for performance improvement initiatives aimed at enhancing outcomes for the care of patients with a diagnosis of schizophrenia.

The APA is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide Continuing Medical Education for physicians. APA designates this PI CME activity (completion of Stages A-C) for a maximum of *20 AMA PRA Category 1 Credits*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This Performance in Practice Module: **Physician Practice Assessment Tool for the Care of Patients with a Diagnosis of Schizophrenia**. is approved by the American Board of Psychiatry and Neurology (ABPN) for MOC Part 4.

EVALUATION SURVEY FOR STAGES A or C

		1	2	3	4	5	
1. Overall, I am satisfied with the usefulness of this PIP tool in assessing my practice patterns.	Strongly disagree	0	0	0	0	0	Strongly agree
2. The material was presented without bias.	Strongly disagree	0	0	0	0	0	Strongly agree
3. Completing this PIP tool has helped me to verify that I am providing appropriate care to my patients.	Strongly disagree	0	0	0	0	0	Strongly agree
4. By completing this PIP tool, I have identified at least one way in which I can improve my care of patients.	Strongly disagree	0	0	0	0	0	Strongly agree

EVALUATION SURVEY FOR STAGE B

		1	2	3	4	5	
1. Overall I am satisfied with the usefulness of STAGE B	Strongly disagree	0	0	0	0	0	Strongly agree
2. Based on STAGE A in STAGE B I accessed additional resources and/or increased awareness of key recommendations	Strongly disagree	0	0	0	0	0	Strongly agree
3. In STAGE B I developed an improvement plan that I will apply in practice	Strongly disagree	0	0	0	0	0	Strongly agree
4. This activity promotes competence, performance or improvements in patient care	Strongly disagree	0	0	0	0	0	Strongly agree

Please explain how this PIP tool will improve your practice _____

_____

Use this space for additional comments or suggestions _____

_____

Date_____ APA Member: Yes _____ No _____

Focus subscriber number _____

_____

Last name First name Middle initial Degree

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Mailing address

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City State Zip code Country

Fax number: _____ E-mail address: _____

To earn credit for each completed stage of a Performance in Practice Module, complete an evaluation and send this page to the APA. Retain a copy of this form for your records.

I would like to receive my certificate by: Fax ____ E-mail ____

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