1. American Psychiatric Association: Practice Guideline for the Treatment of Patients with Schizophrenia – Third Edition

Rationale for choosing this one:

- Schizophrenia is associated with significant health, social, occupational, and economic burdens as a result of its early onset and its severe and often persistent symptoms. (APA 2013)
- Schizophrenia is also associated with increased mortality, with a shortened life span and standardized mortality ratios that are reported to be twofold to fourfold those in the general population (Hayes et al. 2017; Heilä et al. 2005; Hjorthøj et al. 2017; Laursen et al. 2014; Lee et al. 2018; Oakley et al. 2018; Olfson et al. 2015; Tanskanen et al. 2018; Walker et al. 2015).
- About 4%– 10% of persons with schizophrenia die by suicide, with rates that are highest among males in the early course of the disorder (Drake et al. 1985; Heilä et al. 2005; Hor and Taylor 2010; Inskip et al. 1998; Laursen et al. 2014; Nordentoft et al. 2011; Palmer et al. 2005; Popovic et al. 2014; Saha et al. 2007; Tanskanen et al. 2018).

Scope: 18+ Years Old

- Both Clinical Practice Guidelines #1 and #2 are for members over 18 years old. Therefore, questions for #1 and #2 should be asked for each member record included in these audits for members over 18 years old.

Setting: Outpatient or Inpatient Level of Care

- Continue to use your local methodologies to identify records and volumes of records for Clinical Practice measurement in 2022 and ensure that enough records are reviewed. The HEDIS® measure SAA may be assessed for adherence to this clinical practice guideline and treatment record review may not be necessary (please review internal TRR SOP).

Evidence Found: Intake Assessments including Screening Tools and Ongoing Assessments, if applicable

- When requesting records, you will be reviewing this evidence found. We have limited the review to this evidence which aligns with the resource and should aid in both provider buy-in to send materials and time/resource allocation for the region.

Questions	Answer Options	Notes	Reference
1. Was the initial assessment comprehensive (including presenting reason, goals/preferences of individual, review of psychiatric symptoms, **assessment of substance use**, assessment of physical health, assessment of psychosocial and cultural factors, a mental status exam including cognitive assessment and risk of suicide and aggressive behaviors)?	Yes No N/A	*Score no if all items were not assessed* **Are there symptoms in a period when not using or withdrawing from substances?* ** N/A would be only be chosen when the record reviewed did not meet the scope (age and/or setting) for this question.*	P7, P21, P22 Statement 1: Assessment of Possible Schizophrenia
2. Did the practitioner use quantitative measures as part of the initial assessment?	Yes No N/A	*APA is not prescriptive on which tool the clinician must use, some examples are the PANSS-6, PANSS-30, Brief Psychiatric Rating Scale (BPRS), SOFAS, WHOQOL* *If individual is unable to complete quantitative assessment due to cognitive impairment, literacy level or other reason the clinician should attempt to obtain information from collateral sources.* *In the absence of a formal quantitative assessment is there a baseline level of functioning compared to current level of functioning?*	P18 P19 P20 Statement 2: Use of Quantitative Measures

Questions	Answer Options	Notes	Reference
		** N/A would be only be chosen when the record reviewed did not meet the scope (age and/or setting) for this question.*	
3. Is there a documented, comprehensive, person-centered treatment plan that includes evidence-based non-pharmacological and pharmacological treatments?	Yes No N/A	*APA recommends (1C) that patients with schizophrenia have a documented, comprehensive, and person-centered treatment plan that includes evidence-based non-pharmacological and pharmacological treatments.* ** N/A would be only be chosen when the record reviewed did not meet the scope (age and/or setting) for this question.*	P23 Statement 3: Evidence-base treatment planning
4. Medication Assessment: 1) If there is a history of non-adherence to prescribed antipsychotic medication is there documentation that an LAI (long acting injectable) was offered? If not prescribed is there a clear rationale for why it was not indicated? 2) If there is a history of non-responsiveness to 1st and 2nd generation antipsychotic medication was clozapine offered? If not offered is there a clear rationale for why it is not indicated?	Yes No N/A	**NA chosen if no history of non-adherence to antipsychotic medication or no history of non-responsiveness to 1st and 2nd generation antipsychotic medications*	

2. American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults, Third Edition

Rationale for choosing this one: Assessment is vital to diagnosis and treatment.

- *Note:* These questions are currently in the PRRT, so that data may be utilized. Additionally, these questions align closely with Clinical Practice questions used for the MBHP legal entity. The reference questions for the PRRT and MBHP are documented in the Notes section below.

Scope: 18+ Years Old

- Both Resource #1 and #2 are for members over 18 years old. Therefore, questions for #1 and #2 should be asked for each member record included in these audits for members over 18 years old.

Setting: Outpatient or Inpatient Level of Care

- Continue to use your local methodologies to identify records and volumes of records for Clinical Practice measurement in 2019 and ensure that enough records are reviewed.
- Please choose records from Outpatient or Inpatient Levels of Care. While the volume can remain the same, please be prepared to stratify the data if both levels of care are chosen.
- This resource notes that the recommendations can apply to both outpatient and inpatient settings per the definition of initial psychiatric evaluation on p 149.

Evidence Found: Intake Assessments

- When requesting records, you will be reviewing this evidence found. We have limited the review to this evidence which aligns with the resource and should aid in both provider buy-in to send materials and time/resource allocation for the region.

Questions	Answer Options	Notes	Reference
1. Is there documentation of a substance use assessment?	Yes No N/A	*Substance use may include tobacco, alcohol, or other substances (e.g. marijuana, cocaine, heroin, hallucinogens) and any misuse of prescribed or over-the-counter (OTC) medications or supplements assessed.* ** N/A would be only be chosen when the record reviewed did not meet the scope (age and/or setting) for this question.* MBHP: Exact same language	P5, P15f, P138
2. Is there documentation of a cultural and/or	Yes No N/A	*Culture is defined as "Systems of knowledge, concepts, rules, and practices that are learned and transmitted across generations. Culture includes language, religion and spirituality, family structures,*	P6, P27-30, P141-142

Questions	Answer Options	Notes	Reference
linguistic assessment?		*life-cycle stages, ceremonial rituals, and customs, as well as moral and legal systems (American Psychiatric Association 2013c)" (P 148).* ** N/A would be only be chosen when the record reviewed did not meet the scope (age and/or setting) for this question.* MBHP: Is there documentation of an assessment of cultural factors in the context of the key clinical issues?	
3. Is there documentation of a medical assessment?	Yes No N/A	*See Assessment definition below.* ** N/A would be only be chosen when the record reviewed did not meet the scope (age and/or setting) for this question.* MBHP: Exact same language	P5, P 30-35, P142-143

3. American Academy of Pediatrics **Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/ Hyperactivity Disorder in Children and Adolescents**

Rationale for choosing this one:

- Attention Deficit Hyperactivity Disorder (ADHD) is one of the most common child and adolescent diagnoses of Beacon's members, as evidenced by Beacon's population assessment. Proper diagnosis is crucial to ensure that members receive the proper treatment. Incorporating members family and school into

Scope: Members age 4-18 Years Old with a diagnoses of Attention Deficit Hyperactivity Disorder (ADHD) (DSM 314.00, 314.0X and ICD 10 F90.X) (including Other and Unspecified)

- Per Page 5, "There is insufficient evidence to recommend diagnosis or treatment for children younger than 4 years (other than parent training in behavior management [PTBM] which does not require a diagnosis to be applied); in instances in

which ADHD-like symptoms in children younger than 4 years bring substantial impairment, Primary Care Clinicians (PCC) can consider making a referral for PTBM."

Setting: Outpatient

Evidence Found: Intake Assessments including Screening Tools, Ongoing Assessments, Treatment Planning and Goals

Questions	Answer Options	Notes	Reference
1. Is there documentation that the member meets the DSM-5 criteria, including documentation of symptoms and impairment in more than 1 major setting (i.e., social, academic, or occupational)?	Yes No N/A	See APA DSM-5 (2013; p 59-61) ADHD criteria *(for internal user guide, it is included below the question grid)* ** N/A would be only be chosen when the record reviewed did not meet the scope (age and/or setting) for this question.*	Page 5 & 6 (Level B): **To make a diagnosis of ADHD, the PCC should determine that DSM-5 criteria have been met, including documentation of symptoms and impairment in more than 1 major setting (i.e., social, academic, or occupational)**, with information obtained primarily from reports from parents or guardians, teachers, other school personnel, and mental health clinicians who are involved in the child or adolescent's care. The PCC should also rule out any alternative cause.
2. Is there documentation that the member meets the DSM-5 criteria based on information obtained primarily from reports from parents or guardians, teachers, or other school personnel and mental health clinicians who are involved in the child or adolescent's care? (Evidence should include evidenced based tools i.e. Connors, Iowa Connors, Vanderbilt for child, parents, school personnel)	Yes No N/A	** N/A would be only be chosen when the record reviewed did not meet the scope (age and/or setting) for this question.*	Page 5 & 6 (Level B): **To make a diagnosis of ADHD, the PCC should determine that DSM-5 criteria have been met,** including documentation of symptoms and impairment in more than 1 major setting (i.e., social, academic, or occupational), **with information obtained primarily from reports from parents or guardians, teachers, other school personnel, and mental health clinicians who are involved in the child or adolescent's care.** The PCC should also rule out any alternative cause. *Recommend that school personnel is more than one staff

Questions	Answer Options	Notes	Reference
3. Is there documentation that when assessing a member's diagnosis, differential diagnoses or alternative causes were ruled out?	Yes No N/A	APA DSM 5 (2013; p 59) The following is included in the Diagnostic Criteria as a note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. APA DSM 5 (2013, p 63-65) Examples of differential diagnoses including oppositional defiant disorder, intermittent explosive disorder, other neurodevelopmental disorders, specific learning disorders, intellectual disability (intellectual developmental disorder), autism spectrum disorder, reactive attachment disorder, anxiety disorders, depressive disorders, bipolar disorder, disruptive mood dysregulation disorder, substance use disorders, personality disorders, psychotic disorders, medication-induced symptoms of ADHD, and neurocognitive disorders. ** N/A would be only be chosen when the record reviewed did not meet the scope (age and/or setting) for this question.*	Page 5 & 6 (Level B): **To make a diagnosis of ADHD, the PCC should determine that DSM-5 criteria have been met,** including documentation of symptoms and impairment in more than 1 major setting (i.e., social, academic, or occupational), with information obtained primarily from reports from parents or guardians, teachers, other school personnel, and mental health clinicians who are involved in the child or adolescent's care. **The PCC should also rule out any alternative cause.**
4. For members 4-18 years old, is there documentation that the provider included behavioral treatments for	Yes No N/A	** N/A would be only be chosen when the record reviewed did not meet the scope (age and/or setting) for this question.*	Page 6 (Level A): Age 4-6: Recommendation for evidence based parent training in behavior management (PTBM) and/or behavioral classroom interventions.

Questions	Answer Options	Notes	Reference
family and/or school settings?			Age 6-12: Recommendation for training and behavioral treatments for ADHD with family and school. Age 12-18: Recommendations for training and behavioral treatments for ADHD with the family and school.

APA DSM-5 (2013; p 59-61) ADHD criteria:

A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) and/or (2):
   1. Inattention: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities: Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.
      a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).
      b. Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).
      c. Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).
      d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked).
      e. Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy disorganized work; has poor time management; fails to meet deadlines).
      f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reporting, completing forms, reviewing lengthy papers)
      g. Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
      h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).
      i. Is forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).
   2. Hyperactivity and impulsivity: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with the developmental level and that negatively impacts directly on social and academic/ oppositional activities. Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.
      a. Often fidgets with or taps hands or feet, or squirms in seat.
      b. Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office, or other workplace, or in other situations that require remaining in place).
      c. Often runs about or climbs where it is inappropriate. (Note: In adolescents or adults, may be limited to feeling restless.)
      d. Often unable to play or do leisure activities quietly.
      e. Is often "on the go," acting as if "driven by a motor" (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).
      f. Often talks excessively.
      g. Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation).
      h. Often has difficulty waiting his or her turn (e.g., while waiting in line).
      i. Often interrupts or intrudes on others (e.g., butts into conversations, games or activities; may start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).

B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.
C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).
D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.
E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g. mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication, or withdrawal.