C·B·H

a division of DBHIDS

CLINICAL PRACTICE GUIDELINES

Pharmacologic Treatment of Schizophrenia

Updated May 1, 2025

Community Behavioral Health

MAIN OFFICES 215.413.3100 | MEMBER SERVICES 888.545.2600 | PROVIDER RELATIONS 215.413.7660 | CBHPHILLY.ORG

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1. BACKGROUND

Schizophrenia is considered one of the most severe and detrimental mental health conditions, especially if untreated. Symptoms of schizophrenia tend to result in social isolation, stigma, and unemployment. One in a hundred people will develop schizophrenia and distribution is seen moderately more in men than women. The age of onset is typically in early adulthood, in the late teens and early twenties[1].

Symptoms of schizophrenia can be categorized as positive (e.g., hallucinations and delusions), negative (e.g. lack of motivation, flat affect), or cognitive impairments. Certain symptoms of schizophrenia can resemble other diagnoses such as schizoaffective disorder, depressive disorder with psychotic features, and bipolar disorder with psychotic features. Patients who are diagnosed with schizophrenia may also have dual diagnoses of anxiety, depression, panic, or obsessive-compulsive disorders. Due to the nature of schizophrenia, many patients lack awareness of their illness and have high rates of medication nonadherence, symptom relapse, poor psychosocial function, poor hygiene, and overall negative health outcomes. Patients may also develop comorbid substance use disorders secondary to schizophrenia[2]. Patients with schizophrenia are more likely to die earlier than the general population due to physical conditions, co-occurring psychiatric disorders, and other unnatural causes such as accidents or traumatic injuries.

The cause of schizophrenia is not clear. There are general hypotheses that correlate the disease with genetic and environmental factors. However, there are many care options available for patients who have schizophrenia. Options include medication, psychoeducation, family interventions, cognitive behavioral therapy, and psychosocial rehabilitation. One or multiple of these can be integrated into a patient's specific care plan.

2. PURPOSE

Community Behavioral Health (CBH) is committed to working with our provider partners to continuously improve the quality of behavioral health care for our shared population. Whenever possible, this is best accomplished by the implementation of evidence-based practices, as well as those informed by nationally recognized treatment guidelines, while respecting the need for individualized treatment and recovery planning. These guidelines will be maintained and updated collaboratively with providers and system stakeholders to reflect evolving evidence-based practices or changes in national guidelines.

The following are medication prescribing standards, adapted for the CBH Network from national treatment guidelines. They are intended to guide providers in aligning their practices with the best available scientific evidence to help members with schizophrenia access state-of-the-art care.

To assess quality of care, CBH will be collecting several standardized metrics. These metrics come either from the **Healthcare Effectiveness Data and Information Set** (HEDIS) set of measures, used by most major

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[1] *Jauhar S, Johnstone M, McKenna PJ. Schizophrenia. The Lancet (2022 Feb 4);399(10323) doi: 10.1016/S0140-6736(21)01730-X.*

[2] *Lähteenvuo M, Batalla A, Luykx JJ, Mittendorfer-Rutz E, Tanskanen A, Tiihonen J, Taipale H. Morbidity and mortality in schizophrenia with comorbid substance use disorders. Acta Psychiatrica Scand. 2021 Jul;144(1):42-49. doi: 10.1111/acps.13291.*

healthcare organizations for quality improvement, or are measures of clear clinical priority in our network. While CBH will be collecting specific data related only to guidelines that have been issued to the network thus far, the use of empirical guidelines and practice parameters is encouraged in all prescribing.

CBH expects providers to follow these guidelines in addition to all other relevant CBH, state, and federal regulations and standards, including the **CBH Provider Manual** and the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) **Practice Guidelines for Resiliency and Recovery-Oriented Treatment**.**Practice Guidelines for Resiliency and Recovery-Oriented Treatment**.

Note further that the following are guidelines for the pharmacologic treatment of schizophrenia. CBH and DBHIDS encourage a biopsychosocial and recovery-based approach to treatment; in each case, these guidelines for medication treatment should be but one part of a robust, multidisciplinary treatment approach that involves high-quality psychosocial treatment, collaboration with physical health providers, and inclusion of families and other supports.

CBH has updated its guidelines for the treatment of schizophrenia to reflect the **published evidence-based practice parameters of the American Psychiatric Association issued in 2020**. CBH encourages its network providers to remain current with the state of evidence-based practice parameters and to incorporate these into the clinical care offered. These guidelines reflect the best scientific evidence available to guide treatment delivery and should be considered the standard of care in the CBH Network.

3. PRACTICE GUIDELINES [3]

3.1. Screening and Referral

One of the first priorities of treatment is to assess safety and make appropriate referrals for any urgent or emergent medical or psychiatric problems. This includes assessment of imminent danger to self or others, acute medical emergency or substance intoxication or withdrawal that needs acute medical care. In cases of emergency, assessors should directly facilitate and ensure transfer to appropriate emergency medical or psychiatric services, such as emergency room and crisis response center.

3.2. Safety/Risk Assessment

At intake, and throughout the course of treatment, members should be assessed for potential risk of harm to self or others. CBH recommends use of an evidence based structured tool to assess suicide risk. Risk assessments should include consideration of factors such as history of past attempts or violence, ideations, self-harm, current status, stressors, medication adherence, family supports, social determinants of health, etc. For members with heightened risk, provider should ensure appropriate measures are taken to reduce risks, including safety planning, and link member to any needed services. The risk assessments and steps taken to address risk should be documented in the medical record.

[3] *Summarized and adapted from the **APA Practice Guidelines***

3.3. Harm Reduction

For members with schizophrenia and comorbid substance use disorder, harm reduction strategies should be considered to mitigate risks associated with substance use that could worsen outcomes. Co-occurring substance use disorder with schizophrenia is associated with high rates of hospitalization and mortality. One suggested model to approach co-occurring substance use disorders is employing a comprehensive integrated treatment model, where the same team treats both conditions. If this model is not feasible, there should be close collaboration with all treating physicians/teams.

3.4. Assessment

Every individual should have as thorough an initial evaluation as their clinical status allows, including complete psychiatric and general medical histories and physical and mental status examinations. Interviews with family members or other persons knowledgeable about the individual should be conducted routinely (unless the individual refuses to grant permission) especially since some members with psychosis are unable to provide a reliable history at the first interview. The initial psychiatric evaluation should include the following:

- History of present illness
- Psychiatric history, including hospitalizations, prior psychiatric diagnoses, and treatments and trauma history
- Medication history with focus on prior medication trials, results, efficacy, side effects
- Current medications, including prescribed and over-the-counter agents and supplements
- History of substance use and treatment for substance use disorders
- Medical history
    - with focus on ensuring adequate medical workup was performed for members with new onset psychosis
- Family History
- Personal, social, and occupational history (e.g., response to life transitions, major life events)
- Examination, including mental status examination
- Assessment of risk of harm to self and others, including both suicidal and homicidal ideations

Family inclusion in the intake process, to the extent possible, is a vital part of care adherent to DBHIDS recovery principles. Specific goals for care should be discussed with the member, along with the member's friends, family, and/or family of choice, if applicable.

Measurement of body weight and vital signs (e.g., heart rate, blood pressure, temperature) is also required and will serve as a baseline measurement to ensure continued monitoring for metabolic syndrome occurs in accordance with the requirements set forth in the **CBH Policy on the Screening for and Treatment of the Components of Metabolic Syndrome Appendix**. For specific monitoring frequencies, please reference the **Lab Monitoring Recommendations Appendix**. An electrocardiogram (EKG) should be obtained prior to initiating a medication with a risk of prolonged QTc, or in individuals with cardiac risk factors.

Ongoing evaluation of substance use should be documented to ensure the negative effects of substance use are not limiting recovery. This evaluation should involve an assessment of tobacco use and if positive, a recommendation for smoking cessation. Tobacco interacts with some antipsychotic medications, potentially lowering serum levels of the drug leading to subtherapeutic levels[4]. This should be considered when any changes to smoking frequency or quantity occur, including switching to vaping or electronic products.

3.5. Cultural and Social Determinants of Health

Schizophrenia falls within the top 15 leading causes of disability worldwide. Members with schizophrenia often have other physical health conditions and/or co-occurring mental or behavioral health conditions. Financial costs that are associated with schizophrenia tend to be higher than those with other conditions. This makes it difficult for members to receive care, especially given that the nature of the disease may prevent members from employment. Costs associated with schizophrenia can be categorized as direct and indirect. According to the **World Health Organization**, indirect costs include loss of productivity, criminal justice involvement, and social services, amongst others.

3.6. Diagnosis

Diagnosis of schizophrenia should be made in accordance with **DSM-5-TR** criteria. The DSM-5-TR criteria for schizophrenia states that two or more active-phase symptoms must be present for a period of at least one month. Of the active-phase symptoms, one must be delusions, hallucinations, or disorganized speech. The member must also show a decreased level of functioning in daily activities related to work, relationships, or self-care. Continuous signs must be evident for at least 6 months, with one month of active-phase symptoms. Lastly, a comprehensive differential diagnosis is needed to rule out other conditions in which a member may present with similar symptoms[5].

The American Psychiatric Association (APA) Practice Guidelines for the Treatment of Patients with Schizophrenia, Third Edition recommend that an initial psychiatric evaluation includes history of pertinent illness, psychiatric history, substance use history, medical history, family history, personal and social history, and examination including mental status examination. The guidelines mention that upon initial presentation, neurosyphilis, Huntington's disease, Wilson's disease and anti N-methyl-D-aspartate (NMDA) receptor

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[4] *Kennedy WK, Jann MW, Kutscher EC. Clinically Significant Drug Interactions with Atypical Antipsychotics. CNS Drugs (2013);27:1021-1048.*

[5] ***Substance Abuse and Mental Health Services Administration. Impact of the DSM-IV to DSM-5 Changes on the National Survey on Drug Use and Health***

encephalitis are conditions that can mimic schizophrenia symptoms. A thorough history allows clinicians to better understand how to treat schizophrenia, along with any co-occurring mental conditions.

3.7. Laboratory Testing

Initial medical evaluation should include a Complete Blood Count (CBC); measurements of blood electrolytes, glucose, cholesterol, and triglycerides; tests of liver, renal, and thyroid function; a syphilis test, along with other STIs, with consent; and, when indicated and permissible, determination of HIV status and a test for Hepatitis C. Routine evaluation of substance use with a urine drug screen (UDS) screen should also be part of the medical evaluation. A pregnancy test is recommended for individuals with childbearing potential. In individuals for whom the clinical picture is unclear or where there are abnormal findings from a routine examination, more detailed studies (e.g., Magnetic Resonance Imaging (MRI) scan or Computed Tomography (CT) scan) should be considered. Members' files should include documentation of all components of evaluation completed; providers should obtain documentation of evaluation completed by outside providers when applicable.

3.8. Treatment

The goals of treatment for schizophrenia include targeting symptoms, preventing relapse, and improving the overall functioning of the member in society. While pharmacotherapy is an effective mainstay of disease management, residual symptoms may persist. Therefore, the combination of nonpharmacological interventions, such as psychotherapy, should also be incorporated in care. Additionally, treatment plans should include a determination of the most optimal setting of care, such as partial hospital, intensive outpatient, psychosocial rehabilitation, clubhouse models, coordinated specialty care, etc.

Pharmacologic treatment with an FDA-approved antipsychotic medication should be initiated promptly upon diagnosis of schizophrenia due to the association between acute psychotic exacerbations and emotional distress, disruption to the individual's life, and substantial risk of dangerous behaviors to self, others, or property. Considerations should be made for instances where medication may interfere with diagnostic assessment. Except in cases of emergency, a full-informed consent process must take place.

While antipsychotic medications are considered first line agents for the treatment of schizophrenia, they have an adverse effect profile that requires risk versus benefit considerations when selecting an individual medication. Movement-related adverse effects such as bradykinesia, akathisia, tremor, dystonia, parkinsonism, tardive dyskinesia, and rigidity may occur. Metabolic-related adverse effects such as elevated blood pressure, weight gain, increased hemoglobin A1C, and dyslipidemia also require close monitoring, including screening for metabolic syndrome. Several medications also have an increased risk of cardiac QTc prolongation. Although movement-related adverse effects are more commonly associated with first generation antipsychotics and metabolic-related adverse effects with second generation antipsychotics, all antipsychotic medications carry some risk of each. Additionally, members should be evaluated on their risk for suicide and aggressive behaviors, including homicide, at each visit.

Additionally, the selection of an antipsychotic medication should be guided by the member's previous experience with antipsychotics, including the degree of symptom response, side effects, and preferred route of medication administration. Of note, individuals experiencing a first episode psychosis (FEP) or who are medication-naive are more susceptible to side effects and will often respond to doses that are in the lower

half of the antipsychotic medication's typical therapeutic dose range. While many members prefer oral medication, the experience of recurrent relapses related to nonadherence, member preference, convenience, or other lifestyle factors should prompt a discussion of long-acting injectable antipsychotic medication through patient-centered shared decision making.

In cases of treatment resistance (defined as symptoms that fail to respond to two adequate trials of traditional antipsychotic medications[6]), serious consideration to an appropriately monitored trial of clozapine should be given. The FDA recently announced the termination of the **clozapine Risk Evaluation and Mitigation Strategy (REMS) program** requirements. It should be noted that at this time, while reporting lab values is no longer required, the FDA still recommend monitoring labs at the frequencies described in the prescribing information.

Adjunctive medications are also commonly prescribed for comorbid conditions. Benzodiazepines may be used to treat catatonia as well as to manage both anxiety and agitation acutely until the antipsychotic has had time to be therapeutically effective. Antidepressants can be considered for treating comorbid major depression or obsessive-compulsive disorder. Mood stabilizers and beta-blockers may be considered for reducing the severity of recurrent hostility and aggression. However, these medications are not recommended as primary treatments for schizophrenia, or even as routinely prescribed "adjuncts" absent clear indications. Careful attention must be paid to potential drug interactions, especially those related to metabolism by cytochrome P450 enzymes. Polypharmacy without clear rationale should be particularly avoided in the FEP population. Anticholinergic medications should be considered for treatment-emergent movement side effects (e.g., dystonia or pseudo-parkinsonism) if dose modification or medication change is not advisable. For moderate to severe tardive dyskinesia, consider therapy with a reversible inhibitor of the vesicular mono-amine transporter 2 (VMAT2).

3.9. Monitoring of Treatment

The most common contributors to symptom relapse are antipsychotic medication nonadherence, substance use, and stressful life events, although relapses may occur due to the natural course of the illness, despite continuing treatment. If nonadherence is suspected, reasons for it should be evaluated and considered in the treatment plan.

Providers should consider adherence scales such as the Drug Attitude Inventory (DAI-10 and DAI30), the Personal Evaluations of Transitions in Treatment (PETiT), **Medication Adherence Rating Scale** (MARS), or Clinician Rating Scale (CRS).[7]

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[6] *Kane JM, Honigfeld G, Singer J. Clozapine for the treatment resistant schizophrenic: a double-blind comparison versus chlorpromazine/benztropine. Arch Gen Psychiatry. 1988;45:789–96.*

[7] *Medication Adherence Rating Scale (MARS) Calculator. Available from: http://pub.basecase.com/EvGWaXTPrR/*

Strategies to improve adherence that are deemed most rigorously backed by research from the Expert Consensus Guidelines on Adherence include:[8]

- Symptom and side effect monitoring
- Social work targeting logistical problems (e.g., assistance with community resource navigation)
- Medication monitoring/environmental supports

Additional strategies include but are not limited to:

- Consideration of long-acting injectable antipsychotics
- Cognitive Behavioral Therapy (CBT)
- Devoting more time in the therapeutic encounter to specifically address adherence
- Shared decision-making approaches
- Motivational Interviewing (MI)
- Simplifying the regimen to decrease number of medications and dose frequency

A comprehensive treatment/recovery plan that emphasizes avoiding hospitalization, treatment interruptions, medical illness, substance use, and other barriers to recovery must be developed and individualized to reflect individual recovery goals, consistent with the APA guidelines. Additionally, the member should be provided a list of resources for psychiatric rehabilitation programs within the community. Ongoing collateral contact with important people in the member's life should occur (with member's consent).

Once stabilized on medication, ongoing evaluations should assess maintenance of progress towards recovery goals, effective treatment of increased symptoms or relapses, and monitoring of adverse treatment effects. The optimal antipsychotic medication dose may not always result in complete symptom remission but should balance the member's goals of stability and wellbeing, while avoiding side effects that interfere with functioning. Relapses are often precipitated by psychosocial stressors. Ongoing evaluations must be comprehensive in this regard (i.e., not limited to "medication management").

It is an expectation of CBH providers that monitoring for the adverse metabolic effects of antipsychotic medications should occur according to the policy in the **CBH Policy on the Screening for and Treatment of the Components of Metabolic Syndrome Appendix** and guided by the table in the **Lab Monitoring Recommendations Appendix**. Ongoing evaluations for extrapyramidal side effects (EPS) should be documented regularly using a standardized instrument, such as the Abnormal Involuntary Movement Scale

[8] *Velligan, D. I., Weiden, P. J., Sajatovic, M., Scott, J., Carpenter, D., Ross, R., & Docherty, J. P. (2010). Strategies for addressing adherence problems in individuals with serious and persistent mental illness: recommendations from the expert consensus guidelines. Journal of Psychiatric Practice®, 16(5), 306-324.*

(AIMS)[9]. More information on how to administer the AIMS assessment is available on the **American Association of Psychiatric Pharmacists website**. Monitoring for EPS should occur at each visit using a screen tool, such as AIMS, to be utilized no less than every 12 months. The risk of EPS, including tardive dyskinesia, should form part of any informed consent discussion related to antipsychotic medications, even those considered "atypical." Monitoring for other adverse effects, such as hyperprolactinemia should be completed according to the prescribing information for each individual agent (see **Lab Monitoring Recommendations Appendix**).

3.10. Coordination of Care/Linkages

Given the burden of physical health challenges faced by persons with schizophrenia and the physical health effects of many medication treatments, collaboration with physical health providers, and documentation of such collaboration, is imperative. This should include all laboratory results.

Through the state-initiated Integrated Care Plan (ICP) Program, BH-MCOs and PH-MCOs collaborate to create an ICP (a care coordination tool) which includes the member's physical health information, as mentioned above, combined with behavioral health information and the member's goals. This document is then shared with the member, the member's PCP and behavioral health provider to facilitate integrated care and to mitigate the challenges of BH – PH collaboration. The ICP is meant to be used as a care coordination tool to benefit persons with a Serious Persistent Mental Illness, including schizophrenia, via information sharing about medications, physical and behavioral health diagnoses, and gaps in care (including recommended laboratory tests) relayed to the person's entire care team to address any physical health challenges the person is facing or at risk of developing. More information about the ICP Program can be found on the **CBH Integrated Care Plan for Providers** webpage.

3.11. Aftercare Planning/Discharge

Whether prescribed in oral or long-acting injectable form, the member's ability to obtain the medication through their pharmacy benefit provider must be considered: many members may begin a medication in the hospital, only to find that the medication is not routinely covered upon discharge. Efforts must be made to eliminate the occurrence of such predictable interruptions in treatment. The **Provider Resources Appendix** has the LAI and Discharge Medication Planning resources to identify best practices when transitioning a member from an inpatient setting to outpatient, with medication related transitions of care.

4. MONITORING

CBH encourages providers to maintain robust internal quality management programs to ensure treatment of CBH members adheres to these and other applicable guidelines. In addition to "as needed" reviews of records

[9] *Guy W. ECDEU Assessment Manual for Psychopharmacology: Revised (DHEW publication number ADM 76-338). Rockville, MD, US Department of Health, Education and Welfare, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration, NIMH Psychopharmacology Research Branch, Division of Extramural Research Programs, 1976: 534–7*

when quality issues arise, CBH will be tracking various performance metrics, including the following National Committee for Quality Assurance (NCQA) HEDIS measures:

1. SAA: Adherence to Antipsychotic Medications for Individuals with Schizophrenia
2. SSD: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
3. SMD: Diabetes Monitoring for People with Diabetes and Schizophrenia: Assesses adults 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.
4. SMC: Cardiovascular Monitoring for People with Cardiovascular Disease and Serious Mental Illness

HEDIS Tip Sheets can be found on the **Clinical Practice Guidelines page** of the CBH website.

In addition, providers must maintain documentation of all evaluations and interventions described in these guidelines, whether delivered by the provider or an outside practitioner. CBH will continue to monitor treatment provided to ensure that care is consistent.

5. APPENDICES

5.1. References

- Jauhar S, Johnstone M, McKenna PJ. Schizophrenia. The Lancet (2022 Feb 4);399(10323). doi: 10.1016/S0140-6736(21)01730-X.
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- Velligan, D. I., Weiden, P. J., Sajatovic, M., Scott, J., Carpenter, D., Ross, R., & Docherty, J. P. (2010). Strategies for addressing adherence problems in individuals with serious and persistent mental illness: recommendations from the expert consensus guidelines. Journal of Psychiatric Practice®, 16(5), 306-324. doi: 10.1097/01.pra.0000388626.98662.a0.
- Guy W. ECDEU Assessment Manual for Psychopharmacology: Revised (DHEW publication number ADM 76-338). Rockville, MD, US Department of Health, Education and Welfare, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration, NIMH Psychopharmacology Research Branch, Division of Extramural Research Programs, 1976: 534–7
- APA Guidelines: Keepers GA, Fochtmann LJ, Anzia JM, Benjamin S, Lyness JM, Mojtabai R, Servis M, Walaszek A, Buckley P, Lenzenweger MF, Young AS, Degenhardt A, Hong SH; (Systematic Review). **The American Psychiatric Association Practice Guideline for the Treatment of Patients with Schizophrenia**. Am J Psychiatry. 2020 Sep 1;177(9):868-872. doi: 10.1176/appi.ajp.2020.177901.
- World Health Organization. **Schizophrenia Fact Sheet** [Internet]. Geneva (CH): World Health Organization; [published 2022 Jan 10].

5.2. Special Population: Members of Childbearing Potential

Members who are pregnant or breastfeeding should consult with their provider regarding the plan of care that optimizes outcomes for both the member and the infant. Prior to conception, during pregnancy, or while breastfeeding, it is. important for the member to collaborate with providers to identify the risk versus benefit of untreated illness and the potential for negative fetal or neonatal effects. During pregnancy, symptoms should be managed using the lowest effective dose; however, abrupt discontinuation or subtherapeutic dosing of medications should be avoided in order to prevent symptom recurrence and relapse. Long-term effects of breastfeeding while taking antipsychotic medications are not well established. Members who want to continue breastfeeding while being treated with psychotropic medications should review the care plan with their provider utilizing shared decision making. Furthermore, because many pregnancies are unplanned, or may go unrecognized until after the period of highest risk for teratogenicity in early pregnancy, providers should be prepared to discuss these risks and benefits with all members of childbearing potential, even when pregnancy is not being considered. Providers should provide education, resources, and referrals for reproductive health care, including pregnancy testing and options for contraception if desired by the member.

The following are recommended resources for more information related to schizophrenia during pregnancy:

- **PubMed Drug and Lactation Database (LactMed)**
- **CDC's Treating for Two**
- **WomensMentalHealth.org**
- **NCRPTraining.org**

Member-facing resources:

- **MothertoBaby.org**
- **PostPartum.net**

5.3. Provider Resources

- **CBH Pharmacy Education and Resources for Providers page** relevant resources:
  - Long-Acting Injectable Antipsychotics (LAIs) Fact Sheet
  - Discharge Medication Planning Tip Sheet for Acute Inpatient Psychiatric Providers, Clinical Care Managers, and Case Managers
  - HEDIS and ICP Tip Sheets:
    - SSD: Diabetes Screening for People with Serious Mental Illness Who Are Using Antipsychotic Medications
    - SMD: Diabetes Monitoring for People with Schizophrenia and Diabetes

- HPCMI: Comprehensive Diabetes Care for People with Serious Mental Illness (SMI): Hemoglobin A1c (HbA1c) Poor Control (>9/0%)
- SMC: Cardiovascular Monitoring for People with Cardiovascular Disease and Serious Mental Illness
- SAA: Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Provider Lab Tip Sheet

» Tips for Initiating and Engaging Members After Hospital Visits for Mental Health or Substance Use

» Tips for Following Up After Hospital Visits for Mental Health or Substance Use

5.4. Lab Monitoring Recommendations

Parameter	Suggested Frequency
Metabolic syndrome*	Determine if metabolic syndrome criteria are met at four months after initiating a new antipsychotic and at least annually thereafter
Vital signs (pulse, blood pressure, temperature)	As clinically indicated
Body weight, height, and Body Mass Index (BMI)	BMI every visit for six months and at least quarterly after
Diabetes (screening for diabetes risk factors, fasting blood glucose)	Fasting blood glucose or hemoglobin A1C at four months after initiating a new treatment and at least annually after
Hyperlipidemia (lipid panel)	Lipid panel at four months after initiating a new antipsychotic medication and at least annually thereafter

Metabolic syndrome is currently defined as presence of at least three of the following five risk factors: elevated waist circumference, elevated triglycerides, reduced HDL-C, elevated blood pressure, and elevated fasting glucose. More detailed information can be found in **Harmonizing the Metabolic Syndrome: A Joint Interim Statement of the International Diabetes Federation Task Force on Epidemiology and Prevention; National Heart, Lung, and Blood Institute; American Heart Association; World Heart Federation; International .*

5.5. Member Resources

➡ **CBH Pharmacy Education Resource for Members page** has English and Spanish versions of the following relevant resources available:

» Antipsychotic Medication Guide

» Antipsychotic Education for Parents and Caregivers

» Long-Acting Injectable Antipsychotics (LAIs) Guide

- CBH Member Medication Wallet Card

➡ **Integrated Care Tip Sheet Page** has English and Spanish versions of the following relevant resources available:

- Cardiovascular Monitoring for Members with Behavioral Health Conditions
- Diabetes Care for Members with Behavioral Health Conditions
- Diabetes Screening for Members with Behavioral Health Conditions Who Take Medications
- Diabetes Monitoring for Members with Behavioral Health Conditions Who Take Medications
- Taking Medications for Your Behavioral Health Conditions
- Tips for Engaging in Follow-Up Care

5.6. CBH Policy on the Screening for and Treatment of the Components of Metabolic Syndrome

CBH providers who prescribe medications are **required** to have a policy addressing the screening and treatment of Metabolic Syndrome in members prescribed antipsychotic medications.

Individuals with psychotic disorders are at an elevated risk of developing obesity, hyperlipidemia, and diabetes, which is further increased by the use of antipsychotic medications. It is imperative to ensure that all individuals receiving behavioral health treatment services in Philadelphia receive treatment that aligns with best practice standards. Therefore, monitoring for Metabolic Syndrome should be included as part of a comprehensive treatment plan.

The policy must, at a minimum, include or address the following components:

1. Member, family, and/or care giver education
2. Initial and ongoing monitoring includes the following items. The frequency of monitoring should reflect current clinical guidelines and standards. For more information, please see Appendix 5.4.
    - Fasting plasma glucose or hemoglobin A1c
    - Lipid panel
    - Blood pressure
    - Weight/BMI or waist circumference

- » Personal and family history of diabetes, hyperlipidemia, metabolic syndrome, cardiac risk factors, obesity

3. Notification of abnormal results to primary care provider and member/caregivers
    - » Abnormal results require review of psychotropic regimens. Such reviews can trigger alteration of dosage or change of medication
4. Referral for definitive diagnosis
5. Treatment and coordination between the psychiatrist and the source of primary care