BEHAVIORAL HEALTH

By Nicole Coniglio, MSN, APRN, PMHNP/ACNP

Key Insights Into Schizophrenia Misdiagnosis and the Use of Antipsychotics

In September 2021, the *New York Times* published an article entitled "Phony Diagnoses Hide High Rates of Drugging at Nursing Homes" (https://nyti.ms/3miySfH), which focused on the overdiagnosis of schizophrenia presumably to justify the prescribing of antipsychotics to residents with dementia. Understandably, this article has led to a significant number of discussions among nursing home operators, medical professionals, and families concerned with the misdiagnosing and subsequent "drugging" of residents. Although there are examples of medical professionals misdiagnosing patients and wrongly prescribing medications, clinicians agree this is not only poor clinical practice but also a breach of medical ethics.

Generally it is uncommon for individuals to be diagnosed with schizophrenia after the age of 40, and the National Alliance on Mental Illness estimates the prevalence of schizophrenia in the population to be between 0.25% and 0.64%. Although nursing home residents tend to have a higher rate of mental illness, these averages suggest overdiagnosis is indeed occurring.

Regulatory Impact

One significant factor that may be contributing to this overdiagnosis can be found in the guidelines and regulations promulgated by the Centers for Medicare & Medicaid Services. These guidelines include a Five-Star Quality Rating System and a separate rating for each of the following three sources of information: Health Inspections, Staffing, and Quality Measures (QMs). QMs can be negatively affected by the use of certain medications, including antipsychotics, even with proper justification and documentation. If QMs are negatively affected, the Overall Five-Star Quality Rating is lowered, which impacts the number of referrals that the nursing home receives from hospitals and residents' families.

In responding to the concern about overdiagnosis of schizophrenia in nursing homes, Jacquelynn Hoffman, MSN, PMHNP-BC, a psychiatric mental health nurse practitioner and clinical trainer at Psych360, reflected that "this is a common theme and question. ... Communities, especially long-term care facilities, are preoccupied with tags or antipsychotic numbers over patient care."

Lea Watson, MD, MPH, a board-certified adult and geriatric psychiatrist and co-chair of AMDA – The Society for Post-Acute and Long-Term Care Medicine's Behavioral & Mental Health Advisory Council, said, "The select focus on antipsychotics, as opposed to all psychotropics, has put administrators in a bind." She notes that nursing homes are "bound to keep the use [of psychotropics] in their building below a certain percent or [the nursing homes] risk reducing their star rating. So a well-meaning director of nursing may ask a medical director to change a diagnosis to schizophrenia instead of dementia with behaviors, possibly as a means to keep her job. This is not a tenable situation."

Dr. Watson added, "A large substitution effect [is] going on, where other dangerous drugs are being used without regulation. These drugs include antiepileptic medications, benzodiazepines, muscle relaxants, and gabapentanoids. We have essentially traded one problem for another."

Richard Juman, PsyD, psychologist and director of Behavioral Health Policy and Regulations for TeamHealth and co-chair of the Society's Behavioral & Mental Health Advisory Council, noted that "there are some residents with dementia who absolutely benefit (especially short term) from antipsychotics" and that clinicians should work with facilities to provide the best outcome for all residents. However, he noted that

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nursing home staff want to use "antipsychotics to manage dementia" but also want to "avoid penalties and sanctions by mislabeling residents with a diagnosis that makes sense for the medication, but not for the patient."

Misdiagnosing patients is a question of medical ethics. "Clinicians that misdiagnose residents as schizophrenic ... are putting their licenses at risk," Dr. Juman said. "Purposefully skirting a regulation in order to prescribe a drug is not only harmful but fraudulent. It also leads to fraudulent billing for services related to a diagnosis that was not rendered."

Appropriate Prescribing Practices

Ms. Hoffman detailed four key areas that impact her decision on whether to prescribe an antipsychotic without the CMS-approved diagnosis. She looks at the impact of symptoms on daily life, rules out other drugs without effect, assesses physical harm to the patient's self or others, and rules out underlying medical conditions. She stressed the importance proper documentation and ensuring that staff are charting "mood and behaviors to support psychotropic use." She stated that it is good practice to use "the lowest effective dose" while "monitoring for side effects, quality of life, and physical mobility" and re-evaluating the need for medication as needed.

Regulatory and Educational Reform

Dr. Kaylee Mehlman, PharmD, a member of the American Society of Consultant Pharmacists and owner of Geramed Senior Care Consulting, stated that while the *New York Times* article "has highlighted some of the very negative, abusive uses of antipsychotic agents, it also highlights shortcomings of the current regulation." She noted that the three approved diagnoses for antipsychotic use per the CMS regulations are schizophrenia, Tourette's syndrome, and Huntington's disease. There are also antipsychotics approved by the U.S. Food and Drug Administration for conditions such as bipolar disorder and treatment-resistant depression, but the current regulations "do not allow for appropriate use of antipsychotics for conditions like bipolar disorder without penalty in both ratings and reimbursement from CMS" although such conditions are "enduring and progressive and require continued treatment in our elderly population."

The *New York Times* article has uncovered a real issue with the current regulatory process. Among this interdisciplinary group of medical professionals was a consensus that significant reform is needed. They advocated for an entire psychopharmacology regulatory review and allowance for the use of FDA-approved antipsychotics with proper diagnosis when antipsychotics are deemed appropriate and when the benefits clearly outweigh the risks. Also, they identified the need for training requirements for staff, and all of them encouraged the use of nonpharmacological interventions, particularly because these have been proven to be more effective at treating the behaviors associated with dementia than psychotropics.

Dr. Watson also suggested a solution "would be to link all prescriptions back to the specific prescriber and make them accountable for the orders, as opposed to laying the blame at the facility level only." Of course, as Dr. Watson also pointed out, many facilities are doing the right things: "We have spent an inordinate amount of time and energy educating frontline staff about nonpharmacologic interventions with much success."

All these professionals pointed out that a more patient-centered approach to care and treatment without regulatory burden is necessary. As Dr. Mehlman said, this includes studying the benefits versus the risks of medication and specifically considering quality of life and comfort for the patient.

In sum, education and training on appropriate diagnoses and antipsychotic medication is needed at all long-term care facilities and across the interdisciplinary team. The Society's position is that diagnoses should follow the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), collateral information should be obtained, and other potential diagnoses should always be ruled out. Diagnosis should never be justified only to meet prescribing regulations. Advocacy should continue through organizations such as Project Pause, which pushes for reform, and by an emphasis on collaborative approaches to treatment across the interdisciplinary team.

Ms. Coniglio is the president, CMO, and a founding member of Psych360 (http://Psych360.org) and a member of the Behavioral & Mental Health Advisory Council of AMDA – The Society for Post-Acute and Long-Term Care Medicine.

Sepsis

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allows for a "more thoughtful approach" to decision-making and management of suspected or early sepsis, Dr. Gaur told *Caring*.

The guidance also recognizes the long-term morbidity and mortality of sepsis and calls for a handoff process of key information during transitions of care, early GOC discussions, and an assessment of physical, cognitive, and emotional symptoms after hospital discharge. Additionally, it addresses equity, recommending that patients be screened before discharge for economic and social support.

"For all this to appear in the Surviving Sepsis Campaign, as geriatricians it's very heartening to see," Dr. Gaur said.

More "Thoughtful" Management, Important Downstream Issues

Prior guidelines recommended the initiation of broad-spectrum intravenous antimicrobials as soon as possible after recognition or within 1 hour for both septic shock and sepsis without shock. The 2021 guidelines present a more stratified framework for approaching antibiotics; they recommend immediate administration in cases of "possible septic shock or a high likelihood for sepsis" but advise rapid assessment of infectious versus noninfectious causes of acute illness in cases of "possible sepsis without shock."

"For adults with possible sepsis without shock, we suggest a time-limited course of rapid investigation and if concern for infection persists, the administration of antimicrobials within 3 hours from the time when sepsis was first recognized," the new guidelines say. "For adults with a low likelihood of infection and without shock, we suggest deferring antimicrobials while continuing to closely monitor the patient."

The guidelines also recommend basing antibiotic selection on whether patients are at high risk of methicillin-resistant *Staphylococcus aureus* (MRSA), multidrug-resistant organisms, or fungal infections. The new guidance "gives space to investigate while monitoring," Dr. Gaur said. "We've gone from being asked to do it all ... to now assess the likelihood of these infections and treat accordingly."

The guidance is "still saying time is of the essence, but they're allowing for the thoughtfulness that we hope and expect with our good antimicrobial stewardship programs," she said.

In a section on long-term outcomes and GOC, the SSC recommends addressing GOC within 72 hours for patients with sepsis or septic shock and integrating the principles of palliative care into the treatment plan if appropriate. "They're recognizing the high-risk nature of critical illness and the fact that outcomes are poor ... and that, in addition to treating the condition, we need to be able to also treat the patient," Dr. Gaur said.

The new recommendation to assess survivors of sepsis or septic shock for physical, cognitive, and emotional symptoms after hospital discharge "is a nod to trauma-informed care and has bearing on what we [see and do] in long-term care," she said. "We have to be able to screen for and understand the complications ... and how to manage them appropriately."

Another pertinent item is the suggestion that survivors who have received mechanical ventilation for more than 48 hours or had an intensive care unit stay of more than 72 hours be referred to a posthospital rehabilitation program. This sometimes will be a nursing home, Dr. Gaur said. "We need to be prepared," she said, "to provide comprehensive care for these patients."

Screening for Sepsis

Screening for sepsis remains a challenge, particularly for long-term care facilities.

The updated SSC guidelines take a twist and recommend against using the quick Sequential Organ Failure Assessment (qSOFA) compared with the Systemic Inflammatory Response Syndrome (SIRS) criteria, the Modified Early Warning System (MEWS), or the National Early Warning Score (NEWS) as a single-screening tool for sepsis or septic shock. (The latter two are used commonly in the United Kingdom.) The qSOFA, a tool employed in some long-term care facilities, is less sensitive than the SIRS criteria.

More important for nursing facilities, said Bernardo J. Reyes, MD, CMD, AGSF, of the Charles E. Schmidt College of Medicine at Florida Atlantic University, will be the development of new ways to screen for sepsis using changes in vital signs and other measures rather than set published values. "We need to create scoring systems that work for older people in nursing homes," he said.

The concept of "vital parameters" was first discussed in a 2019 paper by Dr. Reyes and colleagues (*J Am Geriatr Soc* 2019;67:2234–2239), and it is currently under discussion by a group from the Florida Medical Directors Association (FMDA) Quality Advocacy Coalition. The group aims to develop goals and guidance on sepsis identification and early management.

"With [electronic medical records], we have access to an enormous amount of data that we didn't have before," Dr. Reyes told *Caring*. "And current technology allows us to do machine learning [so we can know] what is abnormal for specific individuals."

A growing number of facilities have the capability to treat patients with suspected sepsis in-house, he said, noting that point-of-care technology has changed the equation along with on-site nursing and in-house intravenous fluids and antibiotics.

Dr. Levy, coauthor of the first-responders editorial in *JAMDA*, agreed. "Many facilities have upped their clinical ability," she said; but even facilities with limited resources can still "get the ball rolling" with frequent monitoring and other aspects of early management. "It's not all or none," she said.

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