Reducing Antipsychotic Use in Nursing Homes: A Team Approach
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To Receive CME Credit

1. Go to: https://www.surveymonkey.com/s/antipsychotic
2. Complete and submit completed questionnaire by: Friday, May 9, 2014
3. If you have questions please contact Nick Butler at butlern@health.missouri.edu
REDUCING ANTI PSYCHOTIC USE IN NURSING HOMES: A TEAM APPROACH

Charles Crecelius MD PhD FACP CMD
Why Discuss Behavioral Symptom Management and Medications?

• Behavioral and psychological symptoms of dementia (BPSD) are common in demented persons
  • Hallucinations, delusions, depression, euphoria, agitation, aggression, abnormal vocalization, wandering, apathy, hyperactivity, sexual disinhibition, sleep disturbances
• Can be difficult to distinguish from other diseases
• Lack of consistency in approach and treatment
• A “soft science” – data lacking, as much an acquired skill
• Managing behavioral symptoms is very time-consuming
• Relative value of medication debated
• Requires a team approach for success

BPSD Frequency in AD

- Depression 43.9%
- Apathy 43.1%
- Anxiety 41.6%
- Irritability 36.9%
- Eating Disorder 36.1%
- Agitation 31.2%
- Sleep disturbance 23.6%
- Delusions 22.6%
- Restlessness 22.1%
- Hallucinations 21.1%
- Disinhibition 17.4%
- Euphoria 3.9%

## Neuropsychiatric Symptoms of Dementias

<table>
<thead>
<tr>
<th>NPI Item</th>
<th>AD</th>
<th>PD</th>
<th>DDLB</th>
<th>VaD</th>
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<tbody>
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<td>Disinhibition</td>
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<td>Irritability</td>
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<tr>
<td>Sleep</td>
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</table>

- 0-14% ● 15-29% ●● 30-44% ●●● 45-59% ●●●● ≥ 60%

Why The Concern for Antipsychotic Use?

• Antipsychotic drugs are associated with increased CV, falls, dysphagia and other neurologic risk
• Value of antipsychotics in treatment of BSPD unclear
• CMS data showed 39.4% of nursing home residents nationwide who had cognitive impairment and behavioral problems but no diagnosis of psychosis or related conditions received antipsychotic drugs
• June 2012 OIG report claims only 1% of antipsychotic care plans met all care plan development criteria
• Atypical antipsychotic drugs cost > $13 billion in 2007
  • nearly 5% of all U.S. drug expenditures
Initiatives to Reduce Antipsychotic Use

• The CMS National Partnership to Improve Dementia Care in Nursing Homes has a goal to reduce antipsychotic use.
• CMS added two new measures that report a nursing home’s use of antipsychotic medications in spring 2013.
• CMS has new surveyor guidance on specific and detailed review of antipsychotic / psychototropic medication use.
• Missouri despite improvements is still #6 in highest use of antipsychotics across all 50 states.
Antipsychotic Usage by State 3rd Quarter 2013

<table>
<thead>
<tr>
<th>State</th>
<th>% Residents on Antipsychotics</th>
<th>% Reduction Two Years</th>
<th>State Rank</th>
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<tbody>
<tr>
<td>Missouri</td>
<td>23.95</td>
<td>-9.17</td>
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<tr>
<td>Best</td>
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<td>Hawaii</td>
<td>12.08</td>
<td>-2.94</td>
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<td>Louisiana</td>
<td>26.54</td>
<td>-10.52</td>
<td>50</td>
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<td>Most Improved</td>
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<tr>
<td>Georgia</td>
<td>21.38</td>
<td>-25.37</td>
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</table>
Premise of Use of Antipsychotics in Dementia

The use of antipsychotic drugs for BPSD is not contraindicated, however

• Risk/benefit ratio carefully analyzed / documented
• Antipsychotic drugs should be used only when
  – Symptom relief would be beneficial to resident
  – Alternative therapies have failed
  – Identifiable risk of harm to the patient if no Rx
  – The distress caused by the symptoms is significant
• Informed consent is important
• Ongoing assessment and documentation of the need for continued antipsychotic use is necessary

**Benefits:** In elderly patients, benefits included:
- BPSD: small but statistically significant benefits for aripiprazole, olanzapine, and risperidone.
- Generalized anxiety disorder: quetiapine, some benefits
- OCD: risperidone some benefits, but ADE were common.

**Adverse Drug Events:** In elderly patients, ADE included:
- increased risk of death (number needed to harm \([\text{NNH}]=87\))
- stroke (risperidone, \(\text{NNH}=53\))
- extrapyramidal symptoms (olanzapine \(\text{NNH}=10\), risperidone \(\text{NNH}=20\))
- urinary symptoms \(\text{NNH}=\text{from 16 to 36}\).
LTC Needs to Promote Good Behavioral Management

Philosophy of caring
- Policies and procedures
- Communication skills
- Staff attitudes, relationships
- Staff support, education; adequate staffing
- Structure, activities, supplies
- Home-like atmosphere
- Family support and education
- Counseling and consultation services

Roles of the LTC Team Members

• **CNA**
  - Report new symptoms; know care plan; help monitor response to interventions; have competency in conservative management of behaviors

• **LPN / RN**
  - Respond / investigate CNA reports resident symptoms; help develop & adjust care plan; monitor interventions & responses; dialogue with practitioner; help assure GDR done; facility liaison to family

• **Housekeeping / Ancillary Staff**
  - Report new symptoms; have basic competency in conservative behavior management
Roles of the LTC Team Members

- **Social Work**
  - Care plan development; social history; resident advocacy; psychosocial support resident and family; promote conservative behavior management

- **Administrator**
  - Nurture best practice environment; provide needed resources; policy development; dialogue with all

- **Director of Nursing**
  - Education; policy development; assist in care plan development as needed; supervise QAPI related projects; review GDR
Roles of the LTC Team Members

- **Practitioner**
  - Respond / investigate CNA & nurse reported symptoms; help develop care plan; responsible prescribing and re-evaluation; communication with team

- **Pharmacist**
  - Education, monitor use, Gradual Dose Reduction

- **Consultant Psychiatrist**
  - Advise, provide diagnosis, promote appropriate use conservative and pharmacologic measures, re-evaluate

- **Medical Director**
  - Promote best practices; assist in policy development & QAPI issues; monitor practitioner performance / GDR
Why do we fall short of ideal?

• Lack of clear diagnosis
• Lack of identification of triggers
• Lack of communication
• Lack of documentation
• Lack of involvement of the team
• Ease of use of medication
• Inadequate evaluation
• Over-use of “psycho-behavioral metaphor” in prescribing
• Time constraints
• Lack of GDR / Reevaluation
Basic Management of Behavior in Dementia

• Identify and limit behavioral triggers
  – Underlying causes and medications
  – Environmental modifications

• Nonpharmacologic interventions
  – Address the underlying behavioral deficits

• Anti-AD therapy: cholinesterase inhibitors and memantine
  – Treat existing behavioral symptoms
  – Prevent emergence of new symptoms

• Psychoactive therapy for acute behavioral issues
  – Identify the behaviors that respond to therapy

Managing DEMENTIA Related Behaviors

- Define target symptoms and severity
- Environmental factors addressed
- Medical illness revisited
- Establish psychiatric diagnosis
- Nonpharmacological management
- Targeted pharmacotherapy (if needed)
- Initiate low and go slow
- Assess outcomes and re-evaluate

Causes of “Problem” Behaviors

“Often there are very real human needs that lay behind disturbed behaviors.”

Dawn Brooker, PhD
Bradford Dementia Group
2004

A True Root Cause Analysis Must Be Done
Premise of Non-Pharmacologic Management in Dementia Behaviors

Majority of behavioral symptoms result from cognitive and functional impairments of dementia

– Unmet psychosocial needs
  » Sensory deprivation, boredom, loneliness
– Loss of learned behavior and consequences
– Progressively lowered stress threshold
  » Loss of coping abilities, greater vulnerability to the environment

Nonpharmacologic interventions address the underlying deterioration former level of intellectual function

Behaviors Are Often a Simple Response to Understandable Stimuli

Persons with Dementia May:
• Interpret personal care as assault
• Be expressing frustration with care staff giving too much or not enough help
• Express frustration with their disabilities
• Respond to people they feel are threatening
• Express anger at restraints
• Become upset at excess noise
• Have a low threshold for stress when fatigued

“Person Centered Dementia Care: An Introductory Course.”
Anthea Innis, University of Bradford 2000
Behavior May Be a Reflection of Life History Within the Context of World History

- **Hoard**ing = Deprivation experienced during the Great Depression, Internment Camps, War Rationing
- **Fear of Showers** = Holocaust Survivor
- **Activity Refusal** = Clearly defined gender rules and roles (1950’s)
- **Fear of People Different from Self** = Segregation, Isolation experienced living in rural areas
Reconsider Behavior Causes

- **Agitation** – Response to misinterpretation of environmental factors including other people
- **Rummaging** – Looking for something meaningful or comforting
- **Wandering** – Leaving an area that creates discomfort, expending excess energy
- **Elopement** – Leaving an area that causes discomfort, exhibiting lifelong patterns of work or time schedule.
- **Refusing Personal Care** – Perceived violation of person, misinterpretation of environment as dangerous or threatening
- **Repetitive Crying Out** – Unresolved discomfort
General Non-Pharmacologic Measures

- Create a predictable, person centered routine
- Ensure familiarity (same staff, own possessions)
- Use simple language, explain actions
- Simplify tasks
- Distract and redirect
- Ensure a safe environment
- Orient (clocks, calendars, etc)
- Moderate lighting in day and night
- Reduce excessive stimulation
- Group and individual activates

More Examples of Interventions

• Detailed social history - a picture of who the resident is and their likes and dislikes. Refer back as needed

• “Memory book” of photos of special people, special events, & special times. Use during visits, pre-problems

• Tap into resident interests

• If family / caregiver engages in a communication/behavior that upsets the person, counsel and provide suggestions for alternative interactions

• Use music, walking activity, social interaction to address aggression, anxiety, depression

• Frequent communication with caregivers
Individualized Interventions For Specific Behaviors

- Physical pain or discomfort?  Medical treatment; nursing intervention; change environment
- Looking for home?  Make place feel more home-like
- Need for social contact?/Restless?  Social interaction (real or simulated); Identify meaningful activities
- Disturbing others?  Separate people who may trigger negative responses in each other
- Hallucinations?  Vision/hearing; use familiar things
- Need more control?  Offer choices
- Refusing help with ADL?  Perform ADL at a different time or by a different method

Nonpharmacologic Interventions for Behavior Clusters in Dementia

- **Apathy** - Activity therapy
- **Agitation / Aggression** - Cognitive/behavior therapy, Therapeutic touch, Music therapy. Multisensory stimulation, Simulated presence
- **Depression** – Cognitive therapy, Cognitive stimulation, Behavioral intervention. Therapeutic activity, Music therapy
- **Psychosis** - Changing medication, Correcting visual and hearing impairment, Improving lighting conditions, Modifying patient environment
- **Wandering** - Management of surroundings, Covering Doors, Visually changing environment
- **Sleep** - Bright-light therapy, Music therapy, Behavior therapy

Pain Can Be An Unrecognized Cause of Agitation

- Nursing home residents with pain were treated with a stepwise protocol for pain management:
- Patients in the treatment group improved:
  - Agitation was reduced (CMAI 17% decrease)
  - Aggression was reduced (NPI 9% decrease)
  - Pain ratings decreased (MOBID 39% decrease)

All effects markedly dissipated within 2 to 4 weeks off medication

Husebo et al. BMJ. 2011;343:d4065.
A Fresh Look at Medication Management in Dementia

- Current and correct emphasis is on behavioral management over medication management.
- Cognitive enhancers may modify behavior – possibly improving cognition, social & coping skills.
- All other medication use is off-label and empiric.
- Must take risk & benefit into consideration and document.
- Must re-evaluate at regular intervals.
- “Psycho-behavioral metaphor” is best applicable when there is occult psychiatric disease.
- Pharmacologic treatment of BPSD is warranted when behavior treatments fails and patient benefits from Rx.
New Surveyor Guidance
F329 Unnecessary Drugs     F309 Quality of Life

• Released May 24, 2013, dovetails with CMS Initiative to Reduce Antipsychotics
• Addresses “common practice to use various types of psychopharmacological medications in nursing homes to try to address behaviors without first determining whether there is a medical, physical, functional, psychological, emotional, psychiatric, social or environmental cause of the behaviors”
• Demands close attention to root cause analysis
Practitioners and Antipsychotic Use in F329

Practitioner given more responsibility

• Looks for person centered approach
• Requires non-pharmacologic behavior management use with or without use of pharmacologic agents that are care planned and demonstrated to be used
• Looks for shifts to other agents in an attempt to reduce antipsychotics
• Looks for clear documentation of diagnosis supporting the use of antipsychotics
• Looks for regular re-evaluation / GDR
Practitioner Care Process for BPSD

• Recognition and Assessment
• Cause Identification and Diagnosis
• Thorough Evaluation of New or Worsening Behaviors
• Individualized Approaches and Treatment
• Development of Care Plan
• Critical Thinking Related to Antipsychotic Drug Use
• Engagement of Resident / RP in Decision Making
• Monitoring, Follow-up and Oversight
Possible Diagnosis for Antipsychotic Use
Current Surveyor Guidance: F329

- Schizophrenia
- Schizo-affective disorder
- Schizophreniform disorder
- Delusional disorder
- Mood disorders (e.g., bipolar disorder, severe depression w/ psychotic features)
- Psychosis in the absence of dementia
- Medical illnesses with psychotic symptoms (e.g., neoplastic disease, delirium, high dose steroids)
- Tourette’s Disorder or Huntington disease
- Hiccups; Nausea & vomiting from cancer or chemo
Must Have a Firm Diagnosis for Use !!

• Only diagnosis excluded from consideration: Schizophrenia, Tourette’s syndrome, and Huntington’s disease
• Bipolar affective disorder and refractory depression not excluded from quality measure but FDA approved, need thorough documentation of use – benefit / risk
• All others need underlying diagnosis and specific target symptoms (e.g. yelling at meals) that
  • are refractory to simple management
  • can be quantitated and monitored
Criteria for Off-Label Use

- The behavioral symptoms present a danger to the resident or others

AND one or both of the following:

- The symptoms are identified as being due to mania or psychosis (such as: auditory, visual, or other hallucinations; delusions, paranoia or grandiosity)

- Behavioral interventions have been attempted and included in the plan of care, except in an emergency.
General Principles for Antipsychotic Use for BPSD

• Only appropriate in a minority of circumstances
• Only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes have been identified and addressed
• Lowest possible dosage for the shortest period of time
• Subject to gradual dose reduction and re-review
• Not for individual symptoms e.g. wandering, nervousness, insomnia
Emergent Use of Antipsychotics

Acute onset or exacerbation of symptoms or immediate threat to health or safety of resident or others

- The acute treatment period is limited ≤ seven days

AND

- A clinician & IDT must evaluate / document the situation within 7 days to identify / address any underlying causes of the acute condition, and verify continued need for an antipsychotic medication.

- If the behaviors persist beyond the emergency situation, pertinent non-pharmacological interventions must be attempted (unless clinically contraindicated) and documented following the resolution of the acute psychiatric event.
Criteria for Enduring Use

All four required

• Not due to a medical condition or problem expected to improve / resolve as condition or Rx is addressed
• Not due to environmental stressors alone that can be addressed to improve the symptoms or maintain safety
• Not due to psychological stressors alone, anxiety or fear from cognition-related misunderstandings expected to improve as the situation is addressed
• Persistent despite non-pharmacologic measures and which affects resident quality of life
New Admissions & Antipsychotics

Facility is responsible for
• Obtaining physician’s orders for the resident’s immediate care.
• Preadmission screening for mentally ill and intellectually disabled individuals. PASRR screening should include appropriate clinical indications for use of antipsychotic.

For residents admitted on an antipsychotic (and not requiring PASRR), facility / physician must
• re-evaluate antipsychotic use at admission and/or within two weeks of admission (MDS assessment) and
• consider reduction or discontinuation
Effectiveness, Potential ADE

- Must reevaluate antipsychotic – Efficacy, ADE, potential to reduce / discontinue
  - After initiation or increasing dose
  - At least quarterly
- Must adequately monitor, identify and act on ADE
  - If benefits of drug therapy exceed risk must document and have patient / representative involved in decision to continue
Why Do We Need to Do All This??
F 329 Immediate Jeopardy Example

- An 89 year old male was re-admitted to the nursing home from the hospital. Admitting diagnoses included pneumonia, CHF, and dementia with moderate cognitive decline and delirium with psychotic features. The history from the hospital indicated the resident was treated with antibiotics, fluid replacement, and was placed on an antipsychotic due to the sudden development, one day after admission, of delirium with psychotic features. The resident had a change in cognition, disorientation and was less alert for prolonged periods and had attempted to remove the IV fluids and crawl out of bed. After the resident’s infection stabilized, he was discharged back to the nursing home.
• Four months after NH readmission, the antipsychotic medication was still ordered. Staff was monitoring for the identified target behavior but the resident had none documented for over 3 months. The facility failed to evaluate and/or consider GDR, and no alternative approaches had been tried. The consultant pharmacist had recommended GDR but the physician had continued the medication.

• The resident had orthostatic hypotension and a high fall risk. He missed group activities as he was sleeping off and on throughout the day in his recliner. The resident went from ambulatory with one staff at admission to no longer ambulating. The resident developed stage III pressure ulcers on his hips and coccyx. He was losing weight due to decreased food and fluid intake.

• When interviewed, staff stated the resident’s decline was related to his dementia. They had not considered reducing the medication and failed to recognize that the medication was used for delirium in the hospital.
Gradual Dose Reduction
A Key to Best Practices Prescribing

- Mandated by federal regulation
  F329 Unnecessary Medications

- Antipsychotics / non-anxiolytic/sedatives
  - 1st year – 2 separate quarters, at least 1 month between
  - Annually thereafter
  - Unless clinically contraindicated

- Potential Immediate Jeopardy
  - Failure to monitor or dose reduce for antipsychotic in presence of side effect
  - Failure to do non-contraindicated GDR with resulting tardive dyskinesia while on prolonged antipsychotics
Practitioner Plan for Reducing Use

- Firm Diagnosis
- Make sure target symptoms are clearly defined
- Triggers and causes investigated
- Assist in non-pharmacologic plans
- Measureable objectives
- Use of IDT monitoring
- Timeline for use
- Plans for GDR
Set Objectives for Antipsychotic Use

• Effect on Target Symptoms
  • Reduction of depression symptoms (appetite, sleep, activities, self care)
  • Percent reduction in specific symptoms (e.g. 50%)
  • Quality of life improvement (e.g. goes to activity)
• How efficacy will be measured (flow sheet)
• Length of treatment
  • Acute vs. chronic need
• Estimated time to GDR
Getting Firm with GDR

- Strict facility policy of reviewing all antipsychotics
- Include team recommendations with MMR / GDR
  - Suggest joint effort pharmacy, medical director, APRN
- Careful review of response to GDR requests
  - Must include clear and reasonable reason(s) for not doing GDR
- Medical director / team review refusals to perform GDR
- ? Family awareness of refusal?
Keep GDR Simple

• Pharmacy GDR requests need to be straightforward and direct
  • Note time person has been on RX
  • Give a simple suggestion for reduction
    Risperdone currently 0.5 mg g noon and 1 mg q HS
    Suggest taper to:
    0.25 mg q noon, and 0.75 mg q HS
    (or __ mg q noon, __ mg q HS)
    Will review in two weeks with further taper as possible
• Pharmacy needs to follow up on requests and taper results
Keeping GDR Simple

- Practitioner lack of response requires attention of pharmacist, DON and medical director
  - Comparative performance among practitioner can be helpful
- GDR principles the domain of the attending physician – ultimately cannot defer just to the psychiatrist or family
  - Reluctant Psychiatrist – taper and have psychiatrist follow-up.
  - Reluctant Family – Explain concept of taper, ultimately not their right to have prescribe medication
- Psychiatrist and attending both responsible for documenting inability to taper
GDR and Pharmacological Treatment of BPSD

- Symptoms should only be treated if they continue to be troubling, burdensome, a source of distress or danger for the patient
- Provide the most accurate diagnosis available
- There is a paucity of well-controlled clinical research in this area, so reconsider often
- Start low, go slow AND taper slow, but taper !!
- Non-pharmacologic treatment should continue
- Benefit and risk needs regular re-evaluation and documentation
- Family should be informed
Consider Forming a BPSD team

- DON, Pharmacist, floor nurse, CNA, SW, activity therapy, APRN, Medical Director, Psychiatrist Practitioner, Therapy as indicated
- Family / RP liberally
- Consider administrator
- Reviews all persons with behavior issues
- New onset / escalating behavior ASAP
- Admissions within a week
- Chronic use quarterly
- Reviews / tracks GDR
BPSD Team

- Use standardized templates
- Targeted letters to practitioners
  - Residents without GDR, proper documentation
  - Reminders to support non-pharmacological interventions first when appropriate
- Work with pharmacy to produce physician-specific comparative use reports
- Personal outreach to physicians who refuse to consider antipsychotic alternatives
- Oversees training and QAPI interventions

Alice Bonner, Former Head CMS Survey & Certification, personal communication
Use State & National Resources

- Changing Antipsychotic Thinking (CAT)
- Primaris  http://www.primaris.org/cat_tips
- MOLANE
  - Missouri chapter of Advancing Excellence campaign
  - dfinley@primaris.org (Deborah Finley)
- Advancing Excellence Campaign
  - http://www.nhqualitycampaign.org/star_index.aspx?controls=dementiaCare
Behavioral Disorders in Dementia: A Checklist

• Assess patient thoroughly
• Treat medical/psychiatric disorders
• Involve the whole team
• Do a root cause analysis
• Begin with nonpharmacologic approaches
• Use non-antipsychotics first / treat occult disease first
• If medication needed, start low and go slow
• Continue nonpharmacologic approaches if Rx used
• Involve patient & family
• Reassess at regular intervals – take GDR seriously !!