Improving Behavioral Health and Reducing Inappropriate Use of Antipsychotics: Making it Happen, Step–by–Step

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Disclosure

› This presentation will include discussion of off–label uses of medications.
Objectives

1. Describe the efficacy and risks associated with antipsychotic medication use among older adults with dementia.
2. Identify common challenges associated with gradual dose reduction of antipsychotics in the long term care setting.
3. Discuss a quality improvement process that can be utilized by the interdisciplinary team to reduce the inappropriate use of antipsychotics among older adults with dementia

Antipsychotic Medications are frequently prescribed to older adults with dementia

- Community dwelling (1.7%-5.1%)
- Nursing home residents (16%-40%)
  - CMS National 23.9% to 18.0% (2012- Quarter 2 of 2015)
  - CMS New York 21.4% to 16.0% (2012-Quarter 2 of 2015)
    - Conventional (1.75%) atypical (31.63%)
      - Beck et al., 2005; Briesacher et al., 2005; Gruber-Baldini et al., 2007; Kamble et al., 2009)
- Acute care
  - 34% (Elie et al 2009)
  - 10% on ACE units (Flaherty & Little, 2011)
FDA approved uses for antipsychotics

- Bipolar disorder***not an exclusion from the denominator
- Schizophrenia
- Adjunct to antidepressants for major depressive disorder (aripiprazole)
- Tourette’s syndrome (conventional antipsychotics only)
- Huntington’s Disease

Some off-label use of antipsychotics

- Psychotic symptoms associated with dementia
  - Delusions in AD patients 9-63% (median 36%)
  - Hallucinations in AD patients 4-41% (median 18%) (Jeste & Finkle, 2000)
- Agitated behavioral symptoms associated with dementia (Fick & Mion, 2008)
- Delirium (Hakim, Othman & Naoum, 2012)
Off Label Prescribing

- Prescribing medication for an off-label indication and with a black box warning is a common practice and does not necessarily reflect inappropriate prescribing
- 20% of all medications are prescribed off-label

Behavioral and Psychological Symptoms of Dementia

- Up to 90% of nursing home residents with dementia may have behavioral symptoms
- There is no medication that is currently approved for use in BPSD
- Non-pharmacological approaches are generally preferred as initial therapy
Efficacy of Antipsychotics in Older Adults

- Some efficacy (small effect sizes 0.12-0.20) among those with psychotic symptoms and significant physical aggression in short term use only (Maglion, et al., 2011) though risks may outweigh benefits (Schneider et al., 2005; 2006)
- Little evidence of efficacy with restlessness, verbal outbursts, resistance to care
Efficacy of Antipsychotics in Older Adults

- May have increased risk of relapse for those with severe neuropsychiatric symptoms (2x compared to placebo)
  - Devanand et al 2012 NEJM
- Cochrane review: most can be tapered off successfully (7 out of 9 studies)
  - Declercq et al 2013

Efficacy of Antipsychotics in Older Adults

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- Little evidence of efficacy with agitation, verbal outbursts, resistance to care
Conclusions

- Many older adults with dementia can be withdrawn from antipsychotics without negative effects on NPS.
- Uncertain whether antipsychotic withdrawal improves cognition or functional status.
- Proceed with greater caution in older adults with agitation, or psychosis who had responded well to antipsychotics and those who had more severe NPS at baseline.

THE BAD and the UGLY
Risks associated with Antipsychotics

- Falls and Fracture
- Sedation, Delirium
- Extrapyramidal symptoms (Parkinsonism, Dyskinesias)
- Anticholinergic side effects (orthostasis, constipation, blurry vision, etc)
- Hyperglycemia
- Hyperlipidemia

Risks associated with Antipsychotics

- Pneumonia
- Cardiovascular risks
  - QT prolongation, ventricular tachycardia (especially when given IV)
- Death
  (Bronskill et al., 2004; FDA, 2005; Galik & Resnick, 2012; Gray et al., 2002; Gurwitz et al., 2005; Lanctot et al., 2000; Muzk et al., 2012; Schneider et al., 2005; 2006; Takkouche et al., 2007)
Black Box Warning

- Analysis of 17 placebo controlled trials
- Modal duration 10 weeks
- Risk of death in the drug treated patients between 1.6-1.7 times that seen in placebo
- Rate of death 4.5% in drug treated patients compared to 2.6% in the placebo group
- Cardiovascular events or infection (pneumonia)
  Schneider et al., (2005) JAMA

Risks of Antipsychotic Use with Dementia Patients

- Clinical Antipsychotic Trials of Intervention and Effectiveness-Alzheimer’s Disease (CATIE-AD)
  - No significant differences found among the atypical antipsychotics (risperidone, olanzapine, quetiapine)
  - 26-32% in Rx group improved compared to 21% in control
  - Adverse events may offset advantages in the efficacy of antipsychotic use for treatment of agitation, aggression (15-24% d/c med in Rx group, 5% in control) (Schneider et al., 2005, 2006)
Risks of Antipsychotic Use with Dementia Patients

- Conventional antipsychotics seem to carry a similar, if not greater risk of death and perhaps a greater risk of adverse events when compared to the atypicals (Gill et al., 2005; Herman et al 2004; Wang et al., 2005)

Factors Associated with Antipsychotic Medication Use in Long Term Care

- Male gender
- Low levels of RN staffing
- Dementia
**CMS Initiative**

- National Initiative to Improve Behavioral Health and Reduce Antipsychotic Use among Nursing Home Residents with Dementia
  - Quality indicator, Ftag 329 will result in penalties
  - Documentation to support use, non-pharm interventions, risk benefit discussion, monitoring for side effects, gradual dose reduction
  - Resources: [https://www.nhqualitycampaign.org/dementiaCare.aspx](https://www.nhqualitycampaign.org/dementiaCare.aspx)

**Common Challenges Associated with Gradual Dose Reduction of Antipsychotics**

- Silo Approach
- Misunderstanding of CMS regulation
- Unfamiliar with assessment tools to monitor antipsychotic use
- Gradual dose reduction is done without emphasis on non-pharmacological approaches
Misunderstanding of CMS Regulation

- “I have to change the diagnosis to one that is approved as an exclusionary diagnosis.”
- “If we just start using Depakote or Lorazepam instead, it will be OK.”
- “My facility is fine because we have a geriatric psychiatrist as a consultant.”
- “We don’t get any credit for lowering the dose.”
F-Tag 329: Unnecessary Drugs

- Residents should have drug regimens that are free of unnecessary drugs defined as
  - There is an excessive dose including duplicate therapy
  - There is an excessive duration of being on the drug
  - There is inadequate monitoring of the drug
  - There is inadequate indication for the use of the drug
  - There are adverse consequences

F Tag 329 Specific to Antipsychotics

- The facility must ensure that residents are not given these drugs unless the drug therapy is necessary, and recorded in the clinical record
- In an effort to decrease the use of antipsychotics residents must receive gradual dose reduction and alternate therapies, unless they are contraindicated
Assessment Tools

- Professional Resources
  - [https://www.nhqualitycampaign.org/professionalDementia.aspx](https://www.nhqualitycampaign.org/professionalDementia.aspx)
    - Patient at Risk form for Antipsychotic Medication Reduction
    - Psychopharmacologic Interdisciplinary Medication Review
    - Multidisciplinary antipsychotic use in dementia assessment

Gradual dose reduction is done without teaching non-pharm approaches
Origins and Risk Factors of Behavior Problems

- Psychiatric Disorders
- Cognitive Status
- Physical/Medical Disorders
- Environment
- Caregiver Approach

What is the Resident Trying To Communicate?

- "I’m depressed."
- "I’m in pain."
- "You’re rushing me."
- "I don’t understand you."
- "It’s too noisy."
Non-pharmacologic Alternatives

- Rule out medical cause (delirium screening, vigilant medical care)
- Address unmet needs
- Routine & consistency (in activities and caregivers)
- Environmental modifications (familiar objects)
- Maximize sensory input (glasses, hearing aides, shades up during the day)

Non-pharmacologic Alternatives

- Involve in functional and physical activities
- Supervision & safety
- Pain control
- Delirium Room (Physical Restraint Free)/Structured activity program
  - Flaherty & Little (2011)
Non-Pharm Resources

- Nursing Home Toolkit
- Advancing Excellence
  - [http://www.nhqualitycampaign.org/star_index.aspx?controls=dementiaCare](http://www.nhqualitycampaign.org/star_index.aspx?controls=dementiaCare)
- Function Focused Care
  - [http://www.functionfocusedcare.org](http://www.functionfocusedcare.org)

A Step Approach to Antipsychotic Reduction and Appropriate Use

1. Assess facility policies, the environment and culture, and your baseline data
2. Staff and family education
3. Interdisciplinary team of champions
4. Start with the low hanging fruit
5. Ongoing motivation and mentoring
Assess facility policies, environment and culture

- Do you have a policy on the assessment and management of behavioral symptoms? Use of antipsychotics?
- Activities
- Physical environment
- Staffing levels to support non-pharm approaches
- What is rewarded and recognized?

Education of Staff and Families

- Most long term care staff and families are unaware of the limits of efficacy of antipsychotics and may also have decreased awareness of the risks associated with their use.
- Tell them your stats
- Need to teach and reward use of non-pharmacological approaches by direct care workers. It is hard work!
Interdisciplinary Team of Champions

- Identifying champions: volunteer, peer recommendation, administrative recommendation
- Truly interdisciplinary
- It is not just about filling out tracking forms
- Partner with your consultants
- Members will have different skills and expertise

For those already taking antipsychotics

- Residents who are prescribed antipsychotic
- Dosage
- Target behavior
- Efficacy?
- Last GDR
- Side effects
- Use one of the assessment tools
- Track your data statistically
Who to reduce first?

- Lack of efficacy
- Negative side effects
- Already on low doses or PRN doses
- Those who do not have a clear history of physically aggressive behavior or psychosis
- Those with no GDR in 6 months

Strategies

- Go slow
- Strategize with your clinician prescribers
- Reassess
- Realize that it won’t always be successful
- Put a non-pharmacological plan in place; involve family
Case 1

- 89 year old woman with Alzheimer’s disease with behavioral symptoms
- On quetiapine 25 mg TID for the past 9 months without a taper
- Target symptom: “agitated” wandering in the evening; bangs walker
- Sleeping during the day
- 2 falls in the past three months

Case 2

- 78 year old woman with vascular dementia
- On Risperdal 0.25 mg BID
- Prescribed for persecutory delusions and hallucinations
- No side effects noted
- Still some suspiciousness
- Psychiatrist attempted GDR 4 months ago with symptom relapse
Before starting an Antipsychotic

1. Thoroughly assess behaviors
2. Attempt alternatives (non-pharm, pharm)
3. Clearly identify target symptom
4. Discussion of risks and benefits
5. Low dose, short term use
6. Monitor for adverse events

Clearly identify target symptom

- Be specific (who, what, where, when, frequency, intensity)
- Avoid non-descript words like “agitation”
- Documentation of behaviors by more than psychiatric provider
- Avoid PRN use
Risk Benefit Discussion

- Patient when appropriate; family/legally authorized representative
- Reasons for prescribing them
  - Behavioral interventions and other pharmacologic options have failed
  - Symptoms are severe and/or distressing with negative impact on quality of life and/or safety
- Outline risk and benefit ratio
  - Risk of harm to the resident or others without treatment

Documentation requirements to initiate antipsychotics

- Diagnosis/indication for use (can be off label, but must make sense)
- Target behavior
- Non-pharmacological or other pharm interventions attempted and ineffective
- Risk benefit discussion with legally authorized representative
On going monitoring

- Effectiveness—change in target symptom
- Evidence of adverse effects or functional decline
- Any previous GDR attempt and response
- Update LAR of any change in dose (up or down)
- GDR should be considered in 3–6 months once symptoms have been effectively treated OR if adverse effects outweigh benefits

Other psychotropic medications to monitor

- Anxiolytics
- Antidepressants....when is a GDR appropriate? Cannot be treated the same as antipsychotics. Risks are different and taper of antidepressants may lead to symptom relapse if done in same time frame as antipsychotics