LeadingAge™ New York

Assembly Committee on Health
Antipsychotic Medication Usage in Nursing Homes
Testimony

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Room 1923
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Introduction

Thank you for the opportunity to testify on the usage of antipsychotic medications in nursing homes in New York. My name is Michelle Synakowski and I am a policy analyst and long term care consultant with LeadingAge New York. I have been a registered nurse working in geriatric medicine for over 30 years. I am a certified nurse executive and Master Teacher with the American Association of Nurse Assessment Coordinators. I served as a director of nursing services for three years, and have been a licensed nursing home administrator for 16 years. I work closely with the members of our organization to promote quality service delivery and person-centered care in the long-term and post-acute care environment for the elders of our society.

Founded in 1961, LeadingAge New York is the only statewide organization representing the entire continuum of not-for-profit, mission-driven and public continuing care, including home and community-based services, adult day health care, nursing homes, senior housing, continuing care retirement communities, adult care facilities, assisted living programs and Managed Long Term Care (MLTC) plans. LeadingAge New York's approximately 500 members serve an estimated 500,000 New Yorkers of all ages annually.

The use of antipsychotic medications in the nursing home has become increasingly controversial, and an area of focus by regulators, providers, and consumer groups over the past few years. The Centers for Medicare and Medicaid Services (CMS) have initiated quality measures and interpretative guidance aimed at addressing antipsychotic use, along with a new dementia-focused survey process aimed at addressing usage among the dementia population. Providers have been focusing on person-centered care models that promote non-pharmacological interventions, and minimize use of medications for easing symptomology and behaviors commonly associated with dementia.

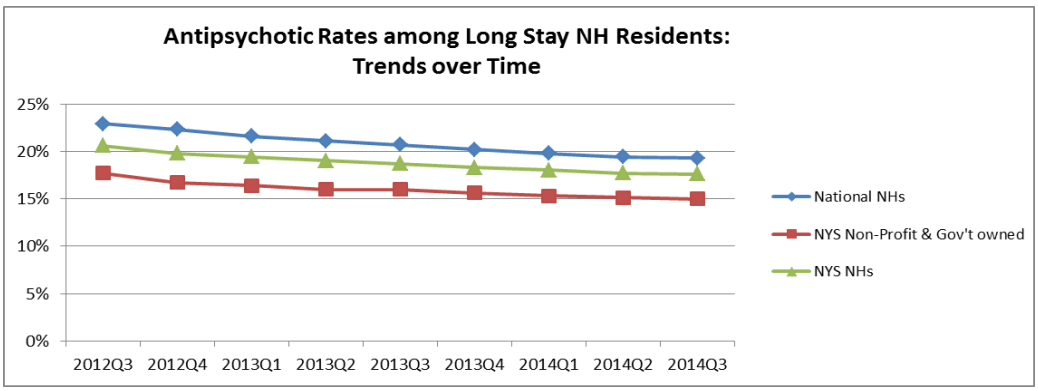
With this background in mind, I plan to focus on the following key points in my testimony:

- The decline in antipsychotic medication use;
- Efforts by LeadingAge NY member facilities to reduce usage and initiate non-pharmacological therapies;
- Appropriate usage of antipsychotic medications to alleviate severe distress commonly associated with dementia; and
- The potential to misinterpret data and other findings on antipsychotic use in nursing homes.

Antipsychotic Usage in Nursing Homes

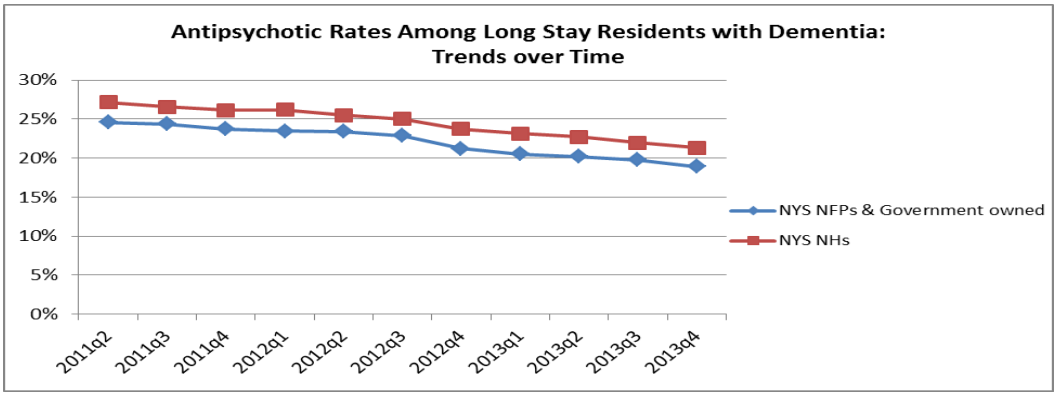
Overall, the use of antipsychotic medications in nursing homes nationwide has declined 19.7 percent over the past three years. This rate of decrease was derived from CMS *Nursing Home Compare* publically reported data, which shows the percentage of residents taking antipsychotic medications in the fourth quarter of 2011 at 23.9 percent, declining to 19.2 percent by the third quarter of 2014.

As shown in the figure below, LeadingAge NY members have consistently demonstrated lower rates of antipsychotic use among long-stay nursing home residents as compared to national and state levels, with this lower rate continuing as overall rates fell.



Data Source: LeadingAge New York Quality Metrics Report using CMS Nursing Home Compare data downloaded from https://data.medicare.gov/data/nursing-home-compare

Antipsychotic medication use among people with dementia is of particular concern and an area of focus. LeadingAge NY reviewed Minimum Data Set Version 3.0 (MDS 3.0) resident assessment data over a three-year period (i.e., 2011 to 2013) for those residents diagnosed with dementia. As shown in the figure below, we found a similar trend of declining usage in New York State, and an even greater decline in rates of antipsychotic use among LeadingAge NY member facilities. Specifically, not-for-profit and governmental facilities showed a decline in antipsychotic usage for dementia residents from 24.6 percent in 2011 to 18.9 percent in 2013 for a decrease of 23.2 percent, while the corresponding overall New York State rate of decrease was 21.4 percent.



Data Source: MDS 3.0 provided by NYS DOH

As evidenced by these analyses, LeadingAge NY member nursing homes began their efforts to reduce the usage of antipsychotic medications in the long term care environment before CMS began its initiative aimed at decreasing usage of these medications. Many of our members utilize LeadingAge NY's EQUIP for Quality data analytics products to track antipsychotic medication use rates, identify various characteristics of those residents for whom such medications have been prescribed, and target specific clinical and other interventions. LeadingAge New York's member facilities remain fully committed to providing high-quality, person-centered care and utilizing data available from national and state quality measures to assist in the evaluation of the services they provide.

Dementia Care and Behavioral Management

Dementia is a leading cause of institutionalization in the elderly.[1] According to one study, 46 percent of caregivers cite dementia-related behaviors as a reason for nursing home placement.[2] Psychosis and agitation associated with dementia cause considerable distress to patients and families and may hasten institutionalization for some individuals. Often, nursing home residents who have dementia exhibit significant behaviors that are potentially harmful to the resident, as well as to other residents and staff of the facility. Persons with dementia often experience hallucinations and delusions that cause them significant anxiety. As a result of this fear and anxiety, these individuals have been known to exhibit prolonged episodes of tearfulness, calling out for help, wandering to search for family members to help them, and physical or verbal aggression. When these symptoms are persistent, they can take a significant toll on the resident resulting in sleep deprivation, loss of appetite, loss of interest in pleasurable activities, and withdrawal.

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[1] Melanie Luppa, Tobias Luck, Siegfried Weyerer, Hans-Helmut König, Elmar Brähler, Steffi G. Riedel-Heller, "Prediction of institutionalization in the elderly. A systematic review," *Age and Ageing,* 39:31-38, 2010.

[2] Buhr GT, Kuchibhatla M, Clipp EC. "Caregivers' reasons for nursing home placement: clues for improving discussions with families prior to the transition," *Gerontologist,* 46(1):52-61, Feb. 2006.

Medications are sometimes the only intervention that will alleviate these symptoms for some residents. So, although providers and medical practitioners are diligent in their efforts to utilize non-pharmacological interventions, there are times that the medications are deemed to be the most therapeutic option for the resident, outweighing potential adverse effects.

CMS, the agency that provides regulatory guidance for nursing facilities, has acknowledged in the *State Operations Manual (SOM)* that in certain cases residents "*…may benefit from the use of medications"* particularly when the resident has a "*…persistent, frightening delusion causing the resident to be inconsolable most of the day or night despite staff and family approaches to address this fear*." In the SOM, CMS has further stated that *"…if other potential causes of the behavior are ruled out, the team may determine that a trial of low dose antipsychotic medication is warranted."*[3]

The key is for the interdisciplinary team of professionals, including the physician, to fully evaluate the behaviors and seek to identify potential causes and interventions that may be successful in minimizing the incidence and duration of the behavior. When myriad attempts to do so have been made, all being unsuccessful, and there is persistent delusional behavior, sometimes there is no effective non-pharmacological intervention available. In these cases, the team may determine the benefit to the overall health and well-being of the resident would outweigh the potential risk of adverse effects of medication due to the overall impact on the health and quality of life of the individual caused by the unrelenting anxiety and discontent the resident is experiencing without the medication.

The physician, often in concert with a psychological professional, determines the indication for usage and class of medication that would be best suited to the resident's individual symptoms. The options for treating these conditions are sometimes very limited, leaving practitioners very few alternatives. Medications are provided to treat medical symptoms, as ordered by a medical professional. The intent for providers that have a mission to provide quality care to the elderly is not to *chemically restrain* the individual. The ordering physicians are simply attempting to treat the distressing symptoms the resident is presenting with, based on their best professional judgment.

The regulatory expectations of nursing homes require that all residents have an environment that allows them to meet their highest practicable level of functioning and well-being – physically, mentally, and emotionally. When inconsolable residents display their distress through repeated behavioral outbursts, or threaten their own physical safety or the safety of other residents, they are not able to attain that high level of well-being. As more information about the use of antipsychotic medications has become available, and there has been an increased focus on the potentially negative or harmful effects of these medications, nursing

[3] State Operations Manual, Appendix PP-- Guidance to Surveyors for Long Term Care Facilities, CMS Manual System, Pub. 100-07 State Operations Provider Certification, Transmittal 127, revised November 26, 2014, p. 175.

homes and other providers have sought to minimize their use and identify alternative interventions to improve the well-being of their residents.

As previously documented, there has been a significant decline in the use of antipsychotic medications in nursing homes over the last few years and the trend is continuing. This can be attributable to quality improvement organizations, such as *Advancing Excellence*, and provider associations partnering to provide insight and information about alternatives to usage of antipsychotic medications. Providers have taken advantage of educational programming, such as the *Hand in Hand* training offered by CMS, to improve their skills for root cause analysis of the unique or individualized causes of resident behavior that can lead to more effective interventions that address the actual cause of the behavior. New York State recently mandated dementia training for all staff in nursing homes. Many advocacy organizations and post-acute care educational providers have offered educational programming as well. The continued need for, and effectiveness of, education and awareness of risks and alternatives cannot be overstated. Families, caregivers, facility staff, and physicians all benefit from increased awareness and sharing of best practices.

Our members are continually implementing and sharing strategies for non-pharmacological interventions for behavior management. Several of our member facilities have initiated innovative non-pharmacological methods that have proven effective, and have resulted in antipsychotic medication use rates of below 10 percent, while the state and national averages are nearly double that level. These innovative methods include, but are not limited to:

- Music therapy;
- aromatherapy;
- massage therapy;
- Reiki;
- Snoezelen rooms (i.e., spaces with light, sound, scents, and music to promote relaxation and well-being); and
- Hand-in-hand (i.e., a high-quality, staff training program that emphasizes person-centered care for residents with dementia).

Nursing homes work to identify root causes and find creative solutions to address dementia-related behaviors. Often this involves the care team being able to access historical information about the resident's life, including occupational and familial data, to get into the resident's frame of mind and interpret the data available. Residents with dementia oftentimes see themselves as living at a time many years in the past, and have a frame of reference of a past experience that was significant. Unfortunately, these significant prior events, which we all experience in our lives, may be negative or stressful events that contribute to anxiety or fear.

This anxiety, often caused by delusions or hallucinations, is not always captured in the list of approved diagnoses for exclusion in quality measures, and risk adjustment for off-label use of antipsychotic medications, along with other diagnoses such as bipolar disorder or manic depressive disorders. Due to this, the risk-adjusted measures may overstate potentially inappropriate use of the medications, as discussed in the next section.

Quality Metrics and Data Evaluation

The Long Term Care Community Coalition (LTCCC), an advocacy group for older adults and people with disabilities, has asserted there is evidence of alarming above-average antipsychotic medication usage rates in some regions of the State and in many nursing homes, after adjusting the data to exclude residents with diagnoses for which the drug would be medically appropriate.

Statistical evaluation of antipsychotic medication usage is a multi-faceted process and should not be undertaken independently of other significant contextual information. Other factors that should be considered in conjunction with the cited usage rates include:

- additional conditions for which antipsychotic medication use is appropriate;
- the relatively high percentage of residents with dementia in nursing homes (i.e., approximately 60 percent on average);
- evaluation of the limited number of diagnoses currently deemed medically-appropriate for purposes of CMS quality measures;
- clinical presentation of residents with behavioral manifestations related to the progression of dementia;
- usage of such medications prior to nursing home admission;
- ongoing gradual dosage reductions by practitioners; and
- the efficacy and/or adverse effects of the medication on the resident.

Both CMS and the New York State Department of Health (NYSDOH) have developed quality measures (QMs) to assist facilities and the public in tracking the level of usage of antipsychotic medications in nursing homes. However, these QMs have some inherent limitations due to the way in which they are calculated. For example, the current CMS antipsychotic QM for long-stay residents excludes those residents with schizophrenia, Tourette's, and Huntington's disease, all conditions for which antipsychotic treatment is approved. However, bi-polar disorder, also an approved condition, is not excluded from the CMS QM definition which may result in an overstatement of off-label antipsychotic use in some facilities with higher numbers of residents diagnosed with this condition. The QM also does not allow for other conditions with psychotic features for which medication use would be appropriate. Some residents with dementia are diagnosed with psychotic conditions related to physiological changes in the brain manifesting with hallucinations and delusions, which are similar to those seen in schizophrenia.

LeadingAge NY has participated extensively in the NYSDOH workgroup assisting in the development of measures used in the NYS Nursing Home Quality Initiative (i.e., the Quality Pool). We advocated for NYSDOH to continue to incorporate an antipsychotic QM in the Quality Initiative scoring for 2013 and beyond, and, after careful consideration and review, the Department also decided to include bi-polar disorder as an approved diagnosis for exclusion. We have also argued that it may be beneficial at some point to include a sub-measure which only looks at dementia residents who received an antipsychotic medication, since this is the population most directly being targeted for reduction.

Another limitation of the current methodology for calculating antipsychotic usage rates in long stay nursing home residents is the inability to indicate on the MDS 3.0 assessment form whether a resident is on a gradual dose reduction program. Therefore, facilities could be decreasing the dosage or frequency of antipsychotic medication usage, and these efforts will not be measured by the current metrics in place. In fact, CMS has indicated that an increased number of facilities are implementing formal gradual dose reduction programs, but their efforts are not reflected in the QM rates.

Facilities undergo an annual onsite evaluation of their practices by NYSDOH surveyors who evaluate facility policies and procedures relative to antipsychotic medication usage and behavioral management strategies. This comprehensive evaluation examines aspects of the issue that are not apparent in the statistics. QM trends reported on *Nursing Home Compare* do not define actual problem areas, but rather are representative of trends to be investigated for further explanation. For example, a facility that has a high pressure ulcer QM rate on *Nursing Home Compare* may specialize in wound therapy, thereby attracting more wound patients, and resulting in higher prevalence of pressure wounds. This would not be an indication that the facility is providing deficient care.

Likewise, the many nursing homes that have high percentages of residents with dementia and associated behavioral manifestations should not be evaluated simply on the level of antipsychotic medication use without full investigation into what is driving that level or trends in the level over time. Facilities often collect detailed data to assist them in tracking trends associated with prescribing, reductions, and behavioral management strategies through their own quality assurance systems and tools like EQUIP for Quality. Surveyors perform quality of care evaluations of individual residents during the onsite regulatory visit where all facts can be examined to determine if the facility exhausted all efforts before initiating a medication; whether a resident was admitted with a medication and it was subsequently decreased over time; and what effect the medication had on the resident's health and quality of life as well as on the health and quality of life of other individuals in the facility.

The interpretive guidelines for surveyors prompt them to determine whether facility staff monitors the effectiveness and potential adverse consequences of the medication. The

evaluation seeks to determine if the resident experienced a decline in function, an increased or worsening behavior, or less than anticipated level of improvement in response to interventions. In addition, the surveyor evaluates whether the medication was clinically indicated; informed consent of the resident's representative was obtained; the lowest possible dosage to achieve the desired therapeutic effects was used; and gradual dose reductions or other behavioral interventions were planned.

Conclusion

LeadingAge NY and its membership remain dedicated to ensuring that the care provided to the elders of our society is individualized, person-centered, and of the highest quality within the guidelines set forth by CMS and the NYSDOH.

Providers are making sustained efforts to identify innovative programmatic solutions, provide education and training to their employees, participate in quality care initiatives, track and interpret data, and conduct resident and family satisfaction surveys to promote quality care delivery through reductions in antipsychotic medication usage and improvements in other indicators of quality.

Late last week, CMS announced a new approach in the way it will calculate the scores for the *Nursing Home Compare*, 5-Star Quality nursing home rating system. Among the changes is the inclusion of antipsychotic medication use in the calculation of 5-Star ratings. LeadingAge NY and its national affiliate, LeadingAge, support the addition of the antipsychotic measures in the scoring system. We believe this revision – together with the inclusion of a similar measure in the NYS Quality Initiative – will underscore the importance of continued attention to this issue.

As always, LeadingAge NY is available to provide additional information and support to the Health Committee and Legislature as a whole. Thank you again for the opportunity to testify.