

Reducing Antipsychotics Appropriately

CMS Antipsychotic Initiative

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Dementia?

Health - Reuters

'Beer Goggles' Are Rose Tinted

LONDON (Reuters) - Want to be more attractive? -- then make sure those around you are having a drink.

Scientists have found even modest amounts of alcohol will make the opposite sex appear better-looking.

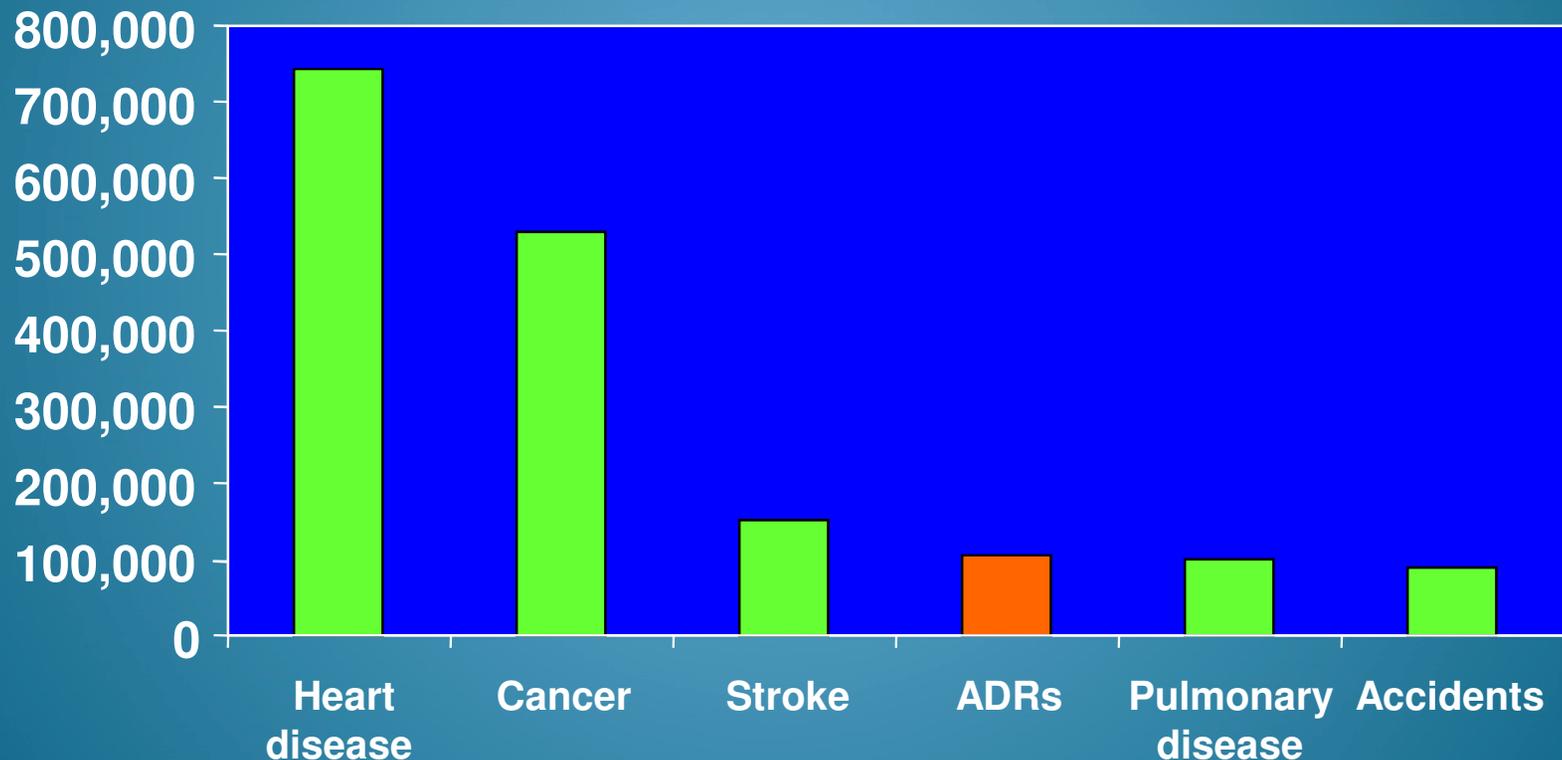
"We have carried out experiments which show that what is known in the trade as the 'beer-goggle effect' does actually exist," Barry Jones, professor of psychology at Glasgow University, told Reuters on Monday.

The study of 120 male and female students found drinking up to four units of alcohol--about two pints of beer or four glasses of wine--increased the perceived attractiveness of members of the opposite sex by about 25 percent.



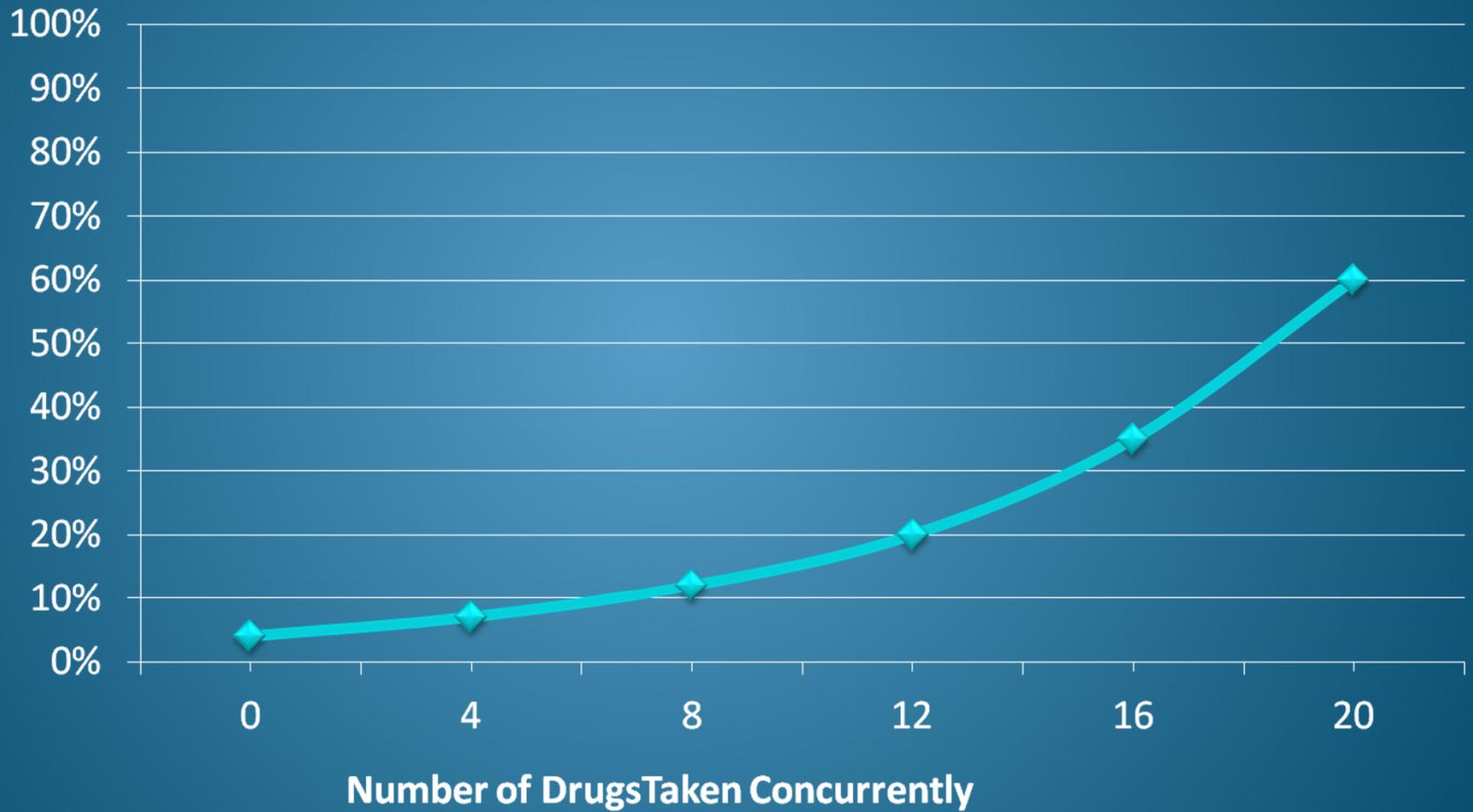
- **America's Seniors average 14.4 new prescriptions a year versus 2.3 for the rest of the public.**
- **About 20% receive contraindicated medications**
- **1.9 million seniors hospitalized annually for Adverse Drug Reactions (*17% of all admissions*)**
- **106,000 fatal adverse drug reactions per year. If ranked that would place adverse reactions to medications as the fourth leading cause of death in the United States.**

Adverse Drug Reactions: Fourth Leading Cause of Death



Lazarou et al. *JAMA* 1998;279:1200–1205

Adverse Drug Reactions



Themes

- **Dementia/Behaviors are communicative**
 - **PAIN**
 - **DISTURBED SLEEP (Noise, Wake Protocols)**
- **“Disturbed versus Disturbing”**
- **Defining Harm – not the “stretched” version**
- **We do not know if the initial dose of a psychoactive is the right dose (high or low)**
- **Psychoactive medications are clumsy (30%)**
- **Create problems as often as solve them (ADEs)**

Reduction Strategies:

- **Eliminate PRN Antipsychotics**
- **Eliminate Antipsychotics used for “other” indications**
 - **“Quetiapine 12.5mg HS for sleep”**
- **Ensure Antipsychotics are not used for acute delirium secondary to another condition**
 - **UTI or other infections**
- **Focus medication reviews on other meds that might amplify or exacerbate “psychotic” symptoms (Ranitidine, Oxybutynin, Anti-cholinergic load, genetics)**

New Regulations

When an antipsychotic medication is being initiated or used to treat an emergency situation (i.e., acute onset or exacerbation of symptoms or immediate threat to health or safety of resident or others) related to one or more of the aforementioned conditions/diagnoses, the use must meet the above criteria and all of the following additional requirements:

1. The acute treatment period is limited to seven days or less;
AND
2. A clinician in conjunction with the interdisciplinary team must evaluate and document the situation within 7 days to identify and address any contributing and underlying causes of the acute condition and verify the continuing need for an antipsychotic medication.
3. 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.

GDR Regulations

Considerations Specific to Antipsychotics. The regulation addressing the use of antipsychotic medications identifies the process of tapering as a “gradual dose reduction (GDR)” and requires a GDR, unless clinically contraindicated.

Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated.

GDR Regulations

Considerations Specific to Sedative/Hypnotics. For as long as a resident remains on a sedative/hypnotic that is used routinely and beyond the manufacturer's recommendations for duration of use, the facility should attempt to taper the medication quarterly unless clinically contraindicated.

Admit Regulations

Medication Regimen Reviews for Stays under 30 days and Changes in Condition

The facility is expected to have a proactive, systematic and effective approach to monitoring, reporting, and acting upon the effects, risks, and adverse consequences of medications. The pharmacist may need to conduct the medication regimen review more frequently (for example weekly), depending on the resident's condition and the risks for adverse consequences related to current medications. The requirement for the medication regimen review applies to all residents, including residents receiving respite care, residents at the end of life or who have elected the hospice benefit, residents with an anticipated stay of less than 30 days, or residents who have experienced a change in condition. Complex residents generally benefit from a pharmacist's review during the transition from hospital to skilled nursing facility.

This review may prevent errors due to drug-drug interactions, omissions, duplication of therapy or miscommunication during the transition from one team of care providers to another.

Survey Routine

- Request a list of the names of residents who have a diagnosis of dementia and who are receiving, have received, or presently have PRN orders for antipsychotic medications over the past 30 days.
- If the facility population includes residents with dementia, ask the administrator or director of nursing to describe how the facility provides individualized care and services for residents with dementia and to provide policies related to the use of antipsychotic medications in residents with dementia.

**% OF ALL DEMENTIA DIAGNOSES RESIDENTS AND PRESENCE
OF ANTI-PSYCHOTIC**

Background to Initiative on AP

- A 2011 report from the Department of Health and Human Services Office of the Inspector General (OIG) found that 14% of all nursing home residents with Medicare had claims for antipsychotics, and 88% of the atypical antipsychotics prescribed off-label were for dementia.
- Unnecessary antipsychotic drug use is a significant challenge in ensuring appropriate dementia care, the agency said in a press release, noting that in 2010, more than 17% of nursing home patients had daily doses of antipsychotics exceeding recommended levels.
- "A CMS nursing home resident report found that almost 40% of nursing home patients with signs of dementia were receiving antipsychotic drugs at some point in 2010, even though there was no diagnosis of psychosis," said CMS Chief Medical Officer and Director of Clinical Standards and Quality Patrick Conway, MD, in the release.

Metrics

- Listed by nursing facility on the website:
www.medicare.gov/nursinghomecompare
- Two measures:
 - Short Term (new start antipsychotics in people in facility <100 days) – 2.4% Ohio, 2.4% National
 - Long Term (residents on an antipsychotic) – 21.7% Ohio and 19.5% National

**CMS is aiming for another 15% reduction by
12/31/2015**

Control

- Ultimately in the nursing home setting, the unit floor nurses are the quarterbacks.
 - Most knowledgeable of residents
 - Best able to document change in status
 - Witness to behaviors
- Most influential to therapy choice
 - Not agent or agents but use of medications in general
 - “They need a (med)”
 - Most at risk for asking for inappropriate medications



Need to become and maintain themselves as a specialist in behavior management.

Diagnosis

- CMS Defines an appropriate diagnosis for use of an antipsychotic as:
 - Schizo-affective disorder
 - *Schizophreniform disorder*
 - *Delusional disorder*
 - *Mood disorders (e.g. bipolar disorder, severe depression refractory to other therapies and/or with psychotic features)*
 - *Psychosis in the absence of dementia*
 - *Medical illnesses with psychotic symptoms and/or treatment related psychosis or mania (e.g., high-dose steroids)*
 - *Tourette's Disorder*
 - *Huntington disease*
 - *Hiccups (not induced by other medications)*
 - *Nausea and vomiting associated with cancer or chemotherapy*
- Symptoms (agitation, hallucinations, behaviors) are not sufficient
- *PRN antipsychotics should not be used.* And in the rare case that they are used, they must have substantial documentation indicating the threat of “harm”

Diagnosis

- “Catch all” diagnosis’ will be scrutinized closely
 - Organic Mental Syndrome
 - Psychosis
 - Dementia with Psychosis
 - Dementia with Behaviors
- Best Practice: Identify the psychotic component upon admission.
 - Can catch meds ordered d/t non psych-conditions or delirium (UTIs/Infection)
 - Identify high doses

Common Presentations of “Agitation”

- Repetitive requests
- Wandering
- Yelling and screaming
- Inappropriate sexual behavior
- Resisting care
- Verbal and physical aggression
- Delusions, hallucinations
- Sleep problems

*Disturbed or Disturbing?
Harmful to self or others?*

Behaviors Unlikely to Respond to Medication

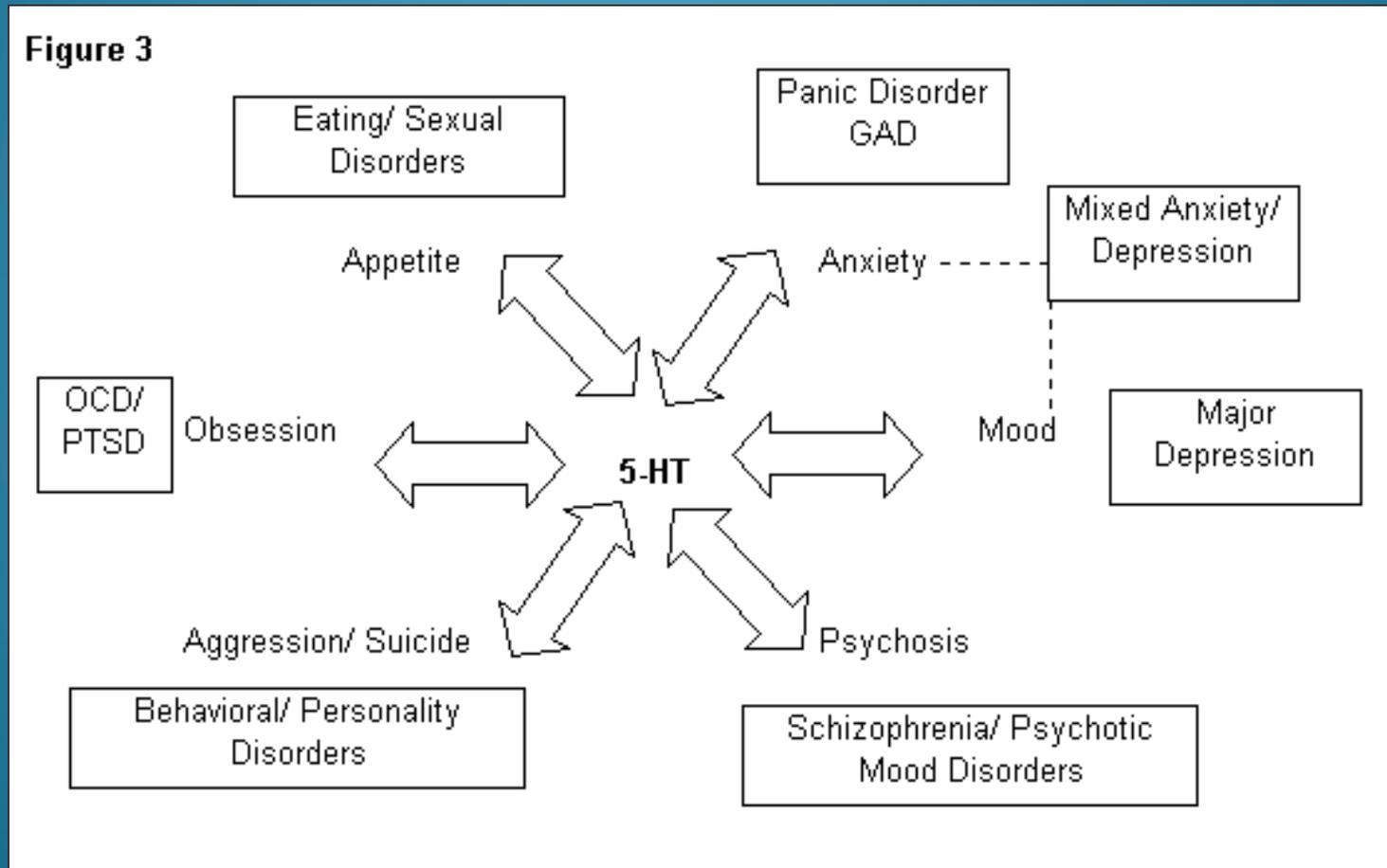
- Wandering, pacing, exit seeking
- Screaming, inappropriate verbalizing, using foul language
- Resistance with toileting
- Inappropriate voiding, defecation, or spitting
- Inappropriate sexual behaviors, public masturbation, disrobing

Shooting in the Dark

- Antipsychotics have a “shotgun” effect and impact multiple sites in the CNS
 - Black Box Warning
- Antidepressants can be stimulating
 - use of Benzos often trail use of SSRIs
- Poor Hypnotic choices
 - Tricyclic Antidepressants
 - Diphenhydramine
- Anxiolytics – Buspar, Benzos
- Keppra (levetiracetam)- agitation
- Anticholinesterase inhibitors (Donepezil, Namenda)

Effects of Serotonin

Figure 3



Non - Pharmacologic Interventions

“Emphasize non-pharmacological alternatives for nursing home residents as alternative to antipsychotics. These include consistent staff assignments, increased exercise or time outdoors, monitoring and managing acute and chronic pain, and planning individualized activities.”

- Environmental Modifications
 - Photosensitivity
 - Audio sensitive
 - Temperature
 - Personality Conflicts

Non - Pharmacologic Interventions

- Behavioral Interventions
 - one-on-one attention
 - reassurance and verbal efforts to calm
 - allow pacing if elopement not a risk
- Encourage pleasant experiences (ex. Recreation, pets, art, gardening, responsibilities)
- Psychotherapy
- Bereavement Therapy
- Chaplain
- Family members
- Relaxation therapy
- Physical Therapy

Pharmacologic Interventions

- Use of a Psychiatrist or Nurse Practitioner specializing in Psych
 - Not a “get out of jail free card”
- Attempt targeted medications
 - DC when failing
 - **Adjust one agent at a time**
 - Don't overcorrect
 - Eliminate all outside causes (Ranitidine, TSH, Antidepressants, UTI, Delirium, senile dementia)

Behavioral Symptom Categories Associated with Agitation

Category

Possible medications

Aggression or anger

Mild

Divalproex, SSRI,
trazodone, buspirone

Severe

Divalproex,
risperidone

Depressive symptoms

Without psychosis

SSRI

With psychosis

Antidepressant +
atypical
antipsychotic

Behavioral Symptom Categories Associated with Agitation

Category

Possible medications

Anxious symptoms

Buspirone

Insomnia

Trazodone

Episodic Agitation
("Sundowning")

Divalproex, trazodone,
risperidone, levetiracetam

Psychotic symptoms

Risperidone, conventional
antipsychotic

Antipsychotic Side Effects

Anticholinergic

- “Atropine Psychosis”
 - Dry as a Bone
 - Red as a Beet
 - Mad as a hatter (Crazy as a loon)

Extrapyramidal

- Parkinsonian Symptoms
 - Tremor
 - Akathisia
 - Shuffling Gait
 - Masked Face
 - Flat Affect

Dose Reductions

- Two attempts in the first year which typically means at 6 months and 12 months.
- Includes all medications (PPIs, Antidepressants, Antiepileptics)
- PRNs should be used to help lower Routine psychoactives.
 - i.e. If resident isn't using their PRN Lorazepam, lower the routine TID order to BID and monitor use of PRN
- New admits should be reviewed for diagnosis and high doses – GDRs at 6 months

Dose Reduction – others

- All medications are technically regulated for gradual dose reduction – PPIs, Antidepressants, BP meds
- Antidepressants, by nature, are stimulating. Too much can induce anxiety.
- Anti-epileptics used for behavior management are subject to the same GDR regulations as other psychoactive medications
- Hypnotic should rarely be prescribed routinely. Everyone deserves a chance to fall asleep normally. Sleep disturbances are typically environmental or social.

Controlled Synergy

- Because of the relatively individual effects of psychotropics – the prescribing lends itself to trial and error and experience counts.
- This almost artistic skill, allows for low-dose combinations of agents that, although may appear to be a drug interaction risk, actually are purposeful and the individual patient is considered.
- **ADVENT OF PHARMACOGENOMICS**

It is never about a particular drug or a condition, it is about the depth of thought and documentation supporting the therapeutic pathway chosen.

Time to Determine Response to Therapy

<i>Medication / Class</i>	<i>Acute Treatment</i>	<i>Long Term Treatment</i>
Antipsychotic	2 - 8 days	2 - 4 weeks
Benzodiazepine	1 - 6 days	1 - 3 weeks
Trazodone	7 - 10 days	3 - 4 weeks
Buspirone	-	4 - 6 weeks
Divalproex	-	3 - 6 weeks
SSRI	-	4 - 6 weeks
Tricyclic antidepressants	-	4 - 6 weeks

Common Sense

- Communication – at the core, behaviors are a mechanism of communication.

The question becomes is that “disturbed or disturbing”?

- Give medications time to be effective - results with psychoactive medication are not overnight - especially with anti-depressants
- Approach new problems with ONE drug at a time – ONE psych medication dose change at a time - so impact can be easily monitored.

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Common Strategies

- Tracking of psychoactive meds and diagnosis
- Use of a Psychiatrist Service or Geropsych NP
- Behavior Management Meeting – track use of PRNs, discuss GDRs, identify psych and non-psych symptoms, effort to streamline/remove psychoactives
- Consent Forms
 - Potential New State or Federal Reg/Law
 - Identify drug name (not strength)
 - Strength will change and form will need to be updated each time if strength is specific on consent

Questions

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