Reducing the Use of Antipsychotics in Long Term Care Communities

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Objectives
- Recognize the clinical evidence for the need to change
- Differentiate between appropriate and inappropriate indications for use
- Demonstrate how correct use improves patient care and results for facilities
- Identify alternative treatment options
- Explain CMS rules/regulations regarding antipsychotic use in this patient population
- Describe statistics on antipsychotic use in Florida

Antipsychotics

<table>
<thead>
<tr>
<th>&quot;Typical&quot; or First Generation</th>
<th>&quot;Atypical&quot; or Second Generation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phenothiazines</td>
<td>Asenapine (Saphris)</td>
</tr>
<tr>
<td>Chlorpromazine (Thorazine)</td>
<td>Olanzapine (Zyprexa)</td>
</tr>
<tr>
<td>Fluphenazine (Prolixin)</td>
<td>Clozapine (Clozaril)</td>
</tr>
<tr>
<td>Meprobamate (Miltown)</td>
<td>Quetiapine (Seroquel)</td>
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<tr>
<td>Perphenazine (Stelazine)</td>
<td>Ziprasidone (Geodon)</td>
</tr>
<tr>
<td>Thioridazine (Mellaril)</td>
<td>Thiothixene (Navane)</td>
</tr>
<tr>
<td>Trifluoperazine (Stelazine)</td>
<td>Others</td>
</tr>
</tbody>
</table>

"Typical" or First Generation
- Phenothiazines
  - Chlorpromazine (Thorazine)
  - Fluphenazine (Prolixin)
  - Meprobamate (Miltown)
  - Perphenazine (Stelazine)
  - Thioridazine (Mellaril)
  - Trifluoperazine (Stelazine)

"Atypical" or Second Generation
- Asenapine (Saphris)
- Olanzapine (Zyprexa)
- Clozapine (Clozaril)
- Quetiapine (Seroquel)
- Ziprasidone (Geodon)
Indications for Use

<table>
<thead>
<tr>
<th>Appropriate Indications</th>
<th>Inappropriate Indications</th>
</tr>
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<tbody>
<tr>
<td>Schizophrenia</td>
<td>Restlessness</td>
</tr>
<tr>
<td>Schizophreniform disorder</td>
<td>Insomnia</td>
</tr>
<tr>
<td>Schizo-affective disorder</td>
<td>Mood disorders</td>
</tr>
<tr>
<td>Schizophrenic psychosis</td>
<td>Fidgeting</td>
</tr>
<tr>
<td>Atypical psychosis</td>
<td>Insomnia</td>
</tr>
<tr>
<td>Delusional disorder</td>
<td>Nervousness</td>
</tr>
<tr>
<td>Delirium or delirium with associated symptoms</td>
<td>Nausea and vomiting associated with cancer/chemo</td>
</tr>
</tbody>
</table>

Black Box Warning

- April 2005: FDA mandated BBW on all labels
- Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death
  - Cardiovascular
  - Heart failure
  - Sudden death
  - Infection
  - Pneumonia

Beers Criteria

- PIM: For chronic or intermittent use in patients with dementia
- Avoid products unless
  - All non-pharmacological options have failed
  - AND patient is threatening themselves or others
- Avoid products if patient has history of falls, fractures, or chronic constipation
CMS: Goals

- Enhance use of non-pharmacological approaches and person-centered dementia care practices
  - Reduce antipsychotic medications by 25%
  - Reduce antipsychotic medications by 30%

1. Health Inspections
2. Staffing
3. Quality measures

Five-Star Rating: Quality Measures

- February 2015: 2 quality measures relating to antipsychotic use were added
  - Long-Stay Residents: Percent of residents who received an antipsychotic medication
  - Short-Stay Residents: Percent of residents who newly received an antipsychotic medication
How to get there?

Screen and identify patients

- Have correct indication for use
- With correct criteria for use
- Treating with lowest effective dose
- Monitoring for effectiveness

Accurate Description of Behavior

- Identify any underlying causes for patient behavior
  - Pain
  - Unsedation
  - Depression
- Talk with the patient and family about reasons for behavior
  - Could be a simple solution
   - Food is always cold
   - TV is always on Matlock
Correct Criteria For Use

- Diagnosis alone does NOT warrant use
- Clinical condition must also meet at least one of the following:
  - Symptoms present a danger to the resident or others
  - Symptoms are identified as being due to mania or psychosis
  - Symptoms are significant enough that the resident is experiencing one or more of the following:
    - Inconsolable or persistent distress
    - Significant decline in function
    - Substantial difficulty receiving needed care

Challenges

Use of evidence-based medicine
- Use of antipsychotics without appropriate clinical justification
Interdisciplinary team approach
- One-size fits all model
Adverse drug effects
- Monitoring
- Screening methods and other resources

Monitoring of Antipsychotics

- Evaluate ongoing effectiveness
  - Re-evaluate targeted behavioral symptoms at least quarterly
    - After initiation or after increasing dose
  - Documentation
- Identify potential adverse consequences

<table>
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<tr>
<th>Category</th>
<th>Examples</th>
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<tr>
<td>General</td>
<td>Anticholinergic effects, falls, excessive sedation</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Cardiac arrhythmias, orthostatic hypotension</td>
</tr>
<tr>
<td>Metabolic</td>
<td>↑ total cholesterol and triglycerides, poor glycemic control, weight gain</td>
</tr>
<tr>
<td>Neurologic</td>
<td>Akathisia, NMS, neuroleptic malignant syndrome, Parkinson's, cerebrovascular events (stroke, TIA)</td>
</tr>
</tbody>
</table>
Behavior Monitoring & Intervention

● Monthly Flow Record

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Lab Monitoring

● Lipids/LFTs
  - Unknown or unstable → every 6 months
  - Stable → yearly
● Hemoglobin A1c (or blood sugar monitoring)
  - Unknown or unstable → every 3 months
  - Stable → every 6 months
● EKG (Patients on Geodon only)
  - Yearly
● WBC/ANC (Patients on Clozaril only)
  - Every week for first 6 months
  - Every two weeks for the next 6 months
  - Every 4 weeks thereafter

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Antipsychotic Use and Fall Risk

Among older adults, falls are the leading cause of deaths due to injury

More than 60 percent of people who die from falls are 75 and older

In 2011, 2.4 million fall related injuries among older adults were treated in the emergency department
Antipsychotic Use and Fall Risk

Use of more than one antipsychotic
Dosing discrepancies
Increased sensitivity to medications leading to ADEs
Abrupt discontinuation

Prevention strategies:
- Gradual dose reduction
- Use of shortest treatment duration possible

Dosing of Antipsychotics

- To improve target symptoms being monitored
  - Treatment should be at the **lowest possible dose** for the **shortest period of time**

- Doses for acute indications may differ from long-term treatment
  - Ex: Delirium or acute psychosis

Gradual Dose Reductions

- GDR is required for antipsychotics
  - Must be attempted within first year of admission
  - Must be attempted in 2 separate quarters
    - With at least 1 month in between
  - After first year, must attempt annually

- MDS data should be updated at:
  - Admission
  - Day 90, 60, 90
  - Quarterly
  - Annually
  - With any significant change in condition
Gradual Dose Reduction

- Documentation Requirement
  - If contraindications to GDRs
    - For those residents receiving an antipsychotic drug to treat behavioral symptoms related to dementia
    - For those residents receiving an antipsychotic drug to treat psychiatric disorders other than behavior symptoms related to dementia

Antipsychotic Use in Florida: 2012

- Year: 2012
- Facilities: 600
- Residents: 73,956
- Antipsychotic Use (%): 24.8%

Antipsychotic Use in Florida: 2016

- Year: 2016
- Facilities: 600
- Residents: 79,587
- Antipsychotic Use (%): 21.6%
Summary

● Have your pharmacists and physicians work together to evaluate medication use.
  ○ Remembering that diagnosis alone is not justification for use, there must be tangible clinical evidence.
● Ensure medication is optimal treatment for diagnosis
  ○ Depressed → antidepressant
  ○ Pain → analgesics
  ○ Anxiety → anxiolytic
● Only use antipsychotic medications for short periods of time (2 to 3 days) with frequent breaks to reassess patient need.

Questions?

References

5. Unik BY, Kaskie BP, Carnahan RM. Improving antipsychotic prescribing practices in nursing facilities: The role of surveyor methods and surveying agencies in upholding the Nursing Home Reform Act. Res Social Adm Pharm. 2015.