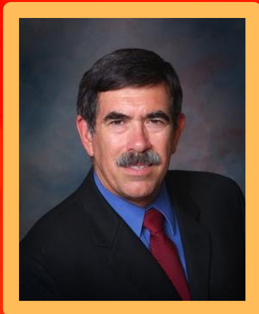
INAPPROPRIATE ANTIPSYCHOTIC REDUCTION:

A REGULATORY PRIORITY



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Learning Objectives

At the conclusion of this session, the learner will…

- …report confidence in defining inappropriate antipsychotic use and the documentation needed to justify appropriate use
- …express awareness of tactics to reduce use inappropriate antipsychotic use in LTC
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- …be able to explain the barriers to compliance to the Public and Legislators that is created by inadequate resourcing of LTC and by lack of evidence basis for non pharmacologic alternatives chosen without individualized care planning and delivery

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No conflict of interest in this presentation.

Presentation taken from:

Smith DA, Guest K. Is Education All That's Needed to Reduce Inappropriate Drugs in Long Term Care? J Am Dir Assoc 16(2015)9-11.

www.amda.com

JAMDA

The Journal of Post-Acute and Long-Term Care Medicine

An Abbreviated History of Antipsychotic Reduction in LTC

- OBRA ’87
  - 30% to 50% reduction
  - Hands off approach to antidepressants
- Since 1999, gradual increase in AP use in LTC
  - 15% to 27% of NH Residents on AP/APP
- “Collapsing” of AP Guidelines into F329-Unnecessary Drugs
  - application of GDR expectations to antidepressants
- FDA Boxed Warnings for AAP’s re: CV events/deaths
  - cause & effect not established by meta- analysis
  - no apparent reduction in use
- AE program and Partnership in Dementia Care by CMS coupled with surveyor training to heighten scrutiny

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Indications for Antipsychotics: Center for Clinical Standards and Quality / Survey & Certification Group

Indications for Use:

An antipsychotic medication should *generally* be used for the following conditions/diagnoses as documented in the record and as meets the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Training Revision (DSM-IV TR or subsequent editions

Conditions Other than Dementia

- schizophrenia
- schizo-affective disorder
- delusional disorder
- mood disorders
  - bipolar ds., severe depression refractory to other therapies and/or with psychotic features
- **psychosis in the absence of dementia**
- medical illness with psychotic symptoms
  - neoplastic ds., delirium, Rx related psychosis or mania
- Tourette's Disorder
- Huntington's disease
- hiccups (not induced by other meds)
- nausea & vomiting associated with cancer or chemotherapy

(Ref: S&C:13-35-NH May 24, 2013)

Study of ten hour educational curriculum to Prescribers that improved performance concerning inappropriate medications, but-

*closed staff model

*Hawthorne Effect

*not generalizable to other countries

e.g. USA with open staff model

(Garcia-Gollarte F, et al. J Am Med Dir Assoc 2014:15.)

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Mixed Messages from CMS & DADS!

- Expectations to avoid “inappropriate antipsychotics” & “chemical restraints”
- Severe regulatory risk for SNFs if Res/Res events
- Quality measures implying poor care if high scores e.g.
  - » QM 2.2 Prevalence of behavior symptoms affecting others
  - » QM 2.3 Prevalence of Sx’s of Depression without antidepressant Rx
  - » QM 10.1-10.3 Imply better care if less use of psychotropics
- Mandatory inquiries by Consultant Pharmacist

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Systematic Underfunding of the LTC Industry

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Per Diem: Resource Utilization Groups (RUGS)

Special Rehabilitation (14)

Physical Function (10)

Clinically Complex (6)

Impaired Cognition (4)

Behavior Problems (4)

Extensive Services (3)

Special Care (3)

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Unrecognized or Under-recognized Aspects of BPSD are:

1. Providing objective symptom monitoring, evaluation & re-evaluation
2. Time to collaborate with Physician/NPP, all members of IDT & family
3. Inadequate numbers and training of direct care staff for needed supervision and interventions (one on one, line of sight, basic milieu surveillance)
4. Cost of individualized activities
5. Cost of regulatory and legal risks

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BPSD Treatment

Pharmacologic Rx BPSD

- Costly to Medicaid/Medicare
- Minimal teaming required
- Minimal staffing time
- Little need for consistent staffing
- Minimal collaboration of family

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BPSD Treatment

Pharmacologic Rx BPSD

- Tile or RUGs level validates minimal resource utilization
- Telephone/fax contact to prescriber
- “efficacy” thru chemical restraint
- Appearance of protecting others
- Minimal regulatory risk & liability

BPSD Treatment

Non-pharmacologic Rx BPSD

- Costly to NF
- Maximal teaming required
- Maximal staffing time Required & need for consistent staffing
- Maximal collaboration of family

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BPSD Treatment

Non-pharmacologic Rx BPSD

- Tile or RUGs level inadequate
  for NF to profit from care
- Maximal involvement of provider in IDT
- Partial or incomplete improvement, not cure is typical
- Maximal regulatory risk & liability

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VA Study: Non-Pharm Rx

- Looked for evidence basis of efficacy of non-pharm interventions
- Only a few showed very minimal evidence for efficacy
- Probably non-pharm interventions must be highly individualized to be modestly effective and few are "cures"

(O'Neil M, et al. VA-ESP Project #05-225. Washington DC: Dept. of Veterans Affairs:2011.)

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Texas was the worst state
for inappropriate antipsychotics
but…

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…I found a significant correlation between Medicaid reimbursement per elderly recipient and State ranking for antipsychotic use!!

(The Henry J. Kaiser Family Foundation. Available at: http://kff.org/medicaid/state-indicator/medicaid-payments-per-enrollee/. Accessed Sept. 29, 2014.)

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Table 1. Five Lowest and Highest States by Prevalence of Antipsychotic Use in Long Stay Residents of Nursing Facilities* Compared to State Ranking of Greater to Lesser Medicaid Payments per Elderly Enrollee**

Ranking by Low AP Use*	State	Rank by Medicaid Paymnt/Elderly Enrollee**
1	Hawaii	18
2	Alaska	3
4	Michigan	17
5	District of Columbia	5
47	Tennessee	47
48	Illinois	36
49	Mississippi	40
50	Louisiana	45
51	Texas	42

* Q4 2013 Ref: CMS National Partnership to Improve Dementia Care in Nursing Homes; Q4 2011-Q1 2014. April1,2014
**http://.org/Medicaid/state-indicator/Medicaid-payments-per-enrollee/

That said…

Ways to decrease inappropriate AP use in your Facility

- Identify and encourage Prescribers to DC all PRN antipsychotics! It's chemical restraint!
- Get rid of all Seroquel orders for sleep!! It's wrong!

Continued…

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Ways to decrease inappropriate AP use in your Facility (cont.)

- Identify and scrutinize all APs for appropriateness on transfer from ERs, hospitals, other SNFs or ALFs
- Identify and scrutinize all new AP orders in house (and all old orders once)
- Look for documentation of true psychosis to justify use, not just “ agitation” or “behaviors”, etc.

Continued…

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Ways to decrease inappropriate AP use in your Facility (cont.)

- Identify all Residents who truly have Schizophrenia, Tourette's, Huntington's, or delirium and highlight that diagnosis as the reason for AP
- Do GDR to DC at 6 month intervals on Residents with AP's for dementia with psychosis. Resume AP if objective evidence of relapse and document. Document if GDR fails x2
- Care plan to do AIMS regularly and to monitor for ADRs with review of benefit/burden if ADR

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Paucity of Governance in LTC in USA

- Few SNFs credential
- Few with Bylaws/Rules & Regs
- Medical Director role but varying “engagement”

- Coming soon: Managed Care and ACOs

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Getting Prescribers to Comply

- Identify Champions & Offenders
- Medical Director & Consultant Pharmacy collaboration
  - » Show attempts to modify Prescribers behavior in QA minutes, effective or not
- Send Prescribers the usage data of all Prescribers; de-identified except for them
  - » MD's hate to be outliers
- Talk to families as last resort
- Decline admissions by severe offenders- last, last resort

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Q&A