Content from April 24, 2019 SWG Clinical Staff Meeting - amended with a focus on Antipsychotic Drug (APD) usage for BPSD (Behavior & Psychological Symptoms associated with Dementia) and considerations for proper usage of other psychotropic drugs

I. In 2011Q4, 23.9 percent of long-stay nursing home residents were receiving an antipsychotic medication; since then, there has been a decrease of 38.9 percent to a national prevalence of 14.6 percent in 2018Q3. While there is encouragement by the progress to date.

a. There was mixed reaction to the news from CMS. Dr. Jerry Gurwitz, chief of geriatric medicine at the University of Massachusetts Medical School, is quoted as describing the decrease as "one of the most dramatic changes I've seen in my career." Gurwitz suggests that some nursing homes might be finding other medications that sedate their patients into passivity without drawing the same level of scrutiny as antipsychotics.

Advocacy groups like the Washington-based Center for Medicare Advocacy and AARP Foundation Litigation say even the lower rate of antipsychotic usage is excessive, given federal warnings that elderly people with dementia face a higher risk of death when treated with such drugs.

"Given the dire consequences, it should be zero," said attorney Kelly Bagby of the AARP foundation, which has engaged in several court cases challenging nursing home medication practices. Bagby contends that the drugs are frequently used for their sedative effect, not because they have any benefit to the recipients.

b. In December 2017, through the work of the National Partnership, approximately 1,500 nursing homes were identified as late adopters, meaning facilities that had not improved their antipsychotic medication utilization rates for long-stay nursing home residents since 2011Q4 and had high rates of usage. Among facilities with high rates of usage (late adopters), CMS has set a goal for a decrease of antipsychotic medication use by 15 percent for long-stay residents by the end of 2019.

i. The late adopter identification is based upon 2017Q1 Minimum Data Set data which showed: These nursing homes continued to have a high rate of antipsychotic medication use (2017Q1 top quartile for the long-stay antipsychotic medication quality measure, greater than 20.29 percent); • Their percentage of antipsychotic medication usage changed very little or increased between 2011Q4 to 2017Q1 (an increase or decrease of less than 6.47 percent); • These nursing facilities were not in the top decile of schizophrenia prevalence in 2017Q1 (18.29 percent); and • Their rate of antipsychotic medication usage remained above the 2017Q1 national average of 15.7 percent.

- Michigan – 44 facilities identified as Late Adopters/Ohio – 106 facilities
- Michigan 3rd Qtr 2018 AP usage for Lstay R's 13.2%, #14/Ohio 14.6%, #26

ii. CMS intends to continue to expand its efforts by pursuing a two-pronged approach. The first approach will involve enhanced oversight and enforcement actions, while the second approach will focus on outreach with corporations that own or operate significant numbers of late adopter facilities.

II. Leader of federal congressional committee that oversees MC, Richard Neal, is pushing for putting NH's use of APDs even further under the microscope.
   a. data shows progress has slowed, reversed in instances
   b. concerned about studies showing falsification of diagnoses to accommodate the use of APDs, the increased off-label use of other psychotropic drugs and often given without consent – such use without consent and appropriate clinical indications are "inconsistent with human rights norms" … "we have a moral obligation to protect NH residents from the inappropriate use of (APDs)" (in an avg. week, NHs in the US administer APDs to over 179,000 people who do not have dxs for which the drugs are approved)

III. Some leaders within the long-term care community deflect responsibility from themselves and rather, point the finger at the physicians and other clinicians who write the orders for the drugs.

- e.g., current situation involving several SWG facilities under common ownership; multiple reasons for high usage of APDs and ones that do not involve our service, but it seems that we're largely being held responsible for the extant trends anyway.

CARE POCESS

A. Recognition of a potential problem
B. Identification of a valid problem
C. Assessment of the problem, targeting the root cause and diagnosis
D. Development and implementation of an intervention/care plan
E. Monitoring of effect and outcome, in determination of whether any adjustments or changes in the intervention/care plan are necessary

A. Recognition and Identification of a problem

- **for dementia and BPSD, determine - is the behavior an actual symptom of illness or "abnormality" vs "normal" expression of distress associated with one or more underlying unmet needs, a reaction to psychosocial stress, physical discomfort or pain ("normal" does not require the use of an APD)**

B. Assessment & Development/Implementation of an Initial Treatment Plan

- Existing Drug Regimen, must target questions of whether drug(s) has an appropriate clinical indication and diagnosis and remains necessary
- If necessary and no acute/urgent issues present, can defer decision-making until further observation is made; document thinking and when the matter will be re-assessed; **for APD used for BPSD in newly admitted residents, must trial GDR ASAP, unless there is a documented h/o recently failed GDR along with other current clinical contraindications**
- Be mindful of non-pharmacological treatment options for first line intervention; have these been trialed; consider acuity and severity of symptoms and whether condition is a response to psychosocial stress vs biological basis. If due to psychosocial stress, may be no indication for drug intervention, and rather, trial of psychotherapy by psychologist or clinical social worker from our team.
- **If presenting problem is BPSD, and psychosocial stress, social-environmental triggers, or unmet needs are likely causing or contributing significantly to its occurrence, there is NO Indication for use of an APD.**
- Be mindful of problem of POLYPHARMACY; 3 drug rule (no scientific research supports the use of more than 3 psychotropic drugs for an individual patient); problem of over- and inappropriate utilization of BENZODIAZEPINES and hypnotic drugs for insomnia. BZD USE AMONG LONG-STAY RESIDENTS IN SOME OF OUR FACILITIES IS EXTREMELY HIGH, 30 – 40% AND EVEN HIGHER, AS HIGH AS 59% IN ONE FACILITY. APPLY BZD REDUCTION PROGRAM.
- Know the risks and benefits of any and all drugs being considered for use and when choosing to RX be sure that you've made reference to these considerations in your documentation along with reference to any applicable Black Box Warning
- Psychotropic medications are used only when the medication(s) is appropriate to treat a resident's specific, diagnosed and documented condition, i.e., has FDA approval
- **APDs FOR BPSD ONLY USED WHEN SPECIFIC CRITERIA SATISFIED – IN ACCORDANCE WITH SWG'S ALGORITHM (ATTACHED)**
- The use of psychotropic drugs such as antidepressants, in Adj. Disorder with anxious or depressed mood is not properly supported and should be avoided, while the usefulness of psychotherapies is more solidly supported by clinical evidence; DO NOT USE TRAZODONE FOR "INSOMNIA;" **AVOID USE OF HALDOL (HIGHLY NEUROTOXIC), TAPER AND DC WHEN PART OF EXISTING REGIMEN UNLESS CONTRAINDICATED.**
- **RX'ers must reliably refer to psychologists and CSW's from SWG for non-pharmacological interventions for BPSD – BEHAVIOR MANAGEMENT PROGRAMMING**
- Patient's Rights – Informed consent with Risk/Benefit Information for initial tx plan; significant changes in tx plan including intended action of GDR; **RELIABLY USE APD INFORMED CONSENT FORM AND R/B ANALYSIS FORM FOR ALL PSYCHOTROPIC DRUGS**

C. Monitoring and Follow-up Care

- Frequency of visits - consistent with clinical practice guidelines/standards of practice; Consideration of severity/risks of condition being treated and risks of interventions
- **Psychotropic Meds must be monitored at least Quarterly, with documentation of continued "necessity" or otherwise action to change current regimen (regulatory guidance)**
- Acute/recent changes in clinical status; progress/improvement, decline/worsening, staying the same/lack of response to intervention; re-administer objective assessment tools; RELIABLY DOCUMENT YOUR IMPRESSIONS OF PROGRESS FROM VISIT TO VISIT
- For efficacy of psychotropic drugs and adverse consequences; drug that is not working is unnecessary and must be dc'd; with adverse consequences either dc'd, adjusted, changed or DETERMINATION MADE THAT BENEFITS OF CONTINUING MED. STILL EXCEED RISKS; DOCUMENT YOUR IMPRESSIONS, SUPPORTS MEDICAL NECESSITY OF YOUR VISIT!
- **Consider the potential contribution of the medication regimen itself to an unanticipated decline or newly emerging or worsening symptom**
- Necessary adjustments in plan of care; provision of Informed Consent as necessary; inclusion of patient even when 3rd party legally appointed
- Make changes in any initial non-specific ICD-10 DX to specific ones as further observations and data are obtained
- Consult with clinical team members as necessary on issues of differential dx, treatment options
- **AIMS -** Completed at initial Pt. encounter, before start of APD, when measuring initial response, when making any significant changes, when DC'ing APD **or reliably on a Quarterly basis as tx continues.**
- **GDRs –** Mandated schedule…; **quarterly** for drugs used to treat insomnia; exclusion of cognitive stabilizers; **MUST be done during 1st year vs CONSIDER when APD being used to tx BPSD; initial trial of GDR when used for BPSD, 2-3 months after stabilization or sooner; if failed, then repeat effort after the next 2-3 month interval of stabilization or otherwise specify in documentation clinical contraindications for not doing so and that the last attempt at GDR failed (required)**
- **GDR's, tapering, and DC of APD used for BPSD must be approached consistently and "aggressively;" if there is no documented history of a recent failure of a GDR after a reasonable period of stabilization (generally considered 2 – 4 months), must trial a GDR**
- For all psychotropics taper gradually, slowly if necessary so as to minimize or prevent withdrawal symptoms or illness effects; but as effort succeeds, **be sure to continue the GDR process to completion or full DC unless sound rationale for not doing so.**
- **Family's (decision-maker's) refusal of recommended GDR is not, in and of itself, necessarily sufficient to not proceed with the trial in accordance with federal guidelines; if this occurs, must bring it to attention of IDT or DSS of facility.**
- Tracking Dates of the last AIMS, GDRs, start of APD (relies on entries in Pt Recall/WRS); reliably use Administrative/Add-on codes formatted in WRS.