# Antipsychotic use in Dementia care

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# What changed in 2012?

# NY times- May 9, 2011

- "Antipsychotic Drugs Called Hazardous for the Elderly" - referencing the OIG audit conducted to evaluate antipsychotic use in dementia
- More than half of the antipsychotics paid for by the federal Medicare program in the first half of 2007 were "erroneous," the audit found, costing the program $116 million for those six months.

# The government view

- "Government, taxpayers, nursing home residents as well as their families and caregivers should be outraged and seek solutions"

Daniel R. Levinson, Inspector General
Department of Health and Human Services

- *A member of Congress requested that OIG evaluate the extent to which elderly nursing home residents receive atypical antipsychotic drugs and the associated cost to Medicare. Specifically, this member expressed concern with atypical antipsychotic drugs prescribed to elderly nursing home residents for off-label conditions (i.e., conditions other than schizophrenia and/or bipolar disorder) and/or in the presence of the condition specified in the Food and Drug Administration's (FDA) boxed warning (i.e., dementia).*

- *Medicare requires that drugs be prescribed for "medically accepted indications" for reimbursement. Further, CMS sets standards to ensure that nursing home residents' drug therapy regimens are free from unnecessary drugs.*

# OIG Audit

- 05-04-2011
- http://oig.hhs.gov/oei/reports/oei-07-08-00150.asp
  - Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents
- For the period January 1 through June 30, 2007, we determined using medical record review that 51 percent of Medicare claims for atypical antipsychotic drugs were erroneous, amounting to $116 million

# MEDICARE ATYPICAL ANTIPSYCHOTIC DRUG CLAIMS FOR ELDERLY NURSING HOME RESIDENTS

## OIG audit - May 4, 2011

**OBJECTIVES :** To determine the extent to which, from January 1 through June 30, 2007:

1. Nursing home residents aged 65 and older had Medicare claims for atypical antipsychotic drugs.
2. Medicare claims for atypical antipsychotic drugs for nursing home residents aged 65 and older were associated with off-label conditions and/or the condition specified in the Food and Drug Administration's (FDA) boxed warning.
3. Claimed atypical antipsychotic drugs for nursing home residents aged 65 and older complied with Medicare reimbursement criteria.
4. Claimed atypical antipsychotic drugs were administered in accordance with Centers for Medicare & Medicaid Services (CMS) standards regarding unnecessary drug use in nursing homes.

http://oig.hhs.gov/oei/reports/oei-07-08-00150.asp

# MEDICARE ATYPICAL ANTIPSYCHOTIC DRUG CLAIMS FOR ELDERLY NURSING HOME RESIDENTS

## OIG audit - May 4, 2011

- Medicare claims data from Part B and Part D and the Minimum Data Set to identify Medicare claims and payments for atypical antipsychotic drugs for elderly (i.e., aged 65 and older) nursing home residents
- January 1 through June 30, 2007
- Using medical record documentation, medical reviewers completed a medical record review instrument to determine the extent to which these drugs were provided to residents diagnosed with conditions that were off-label and/or specified in the boxed warning and whether Medicare erroneously paid for these drugs.
- Based on medical reviewers' responses, also determined whether drugs associated with these claims were provided in compliance with CMS standards for drug therapy in nursing homes.

http://oig.hhs.gov/oei/reports/oei-07-08-00150.asp

# MEDICARE ATYPICAL ANTIPSYCHOTIC DRUG CLAIMS FOR ELDERLY NURSING HOME RESIDENTS

## OIG audit - May 4, 2011

- 14% of elderly nursing home residents had Medicare claims for atypical antipsychotic drugs.
- 83% percent of Medicare claims for atypical antipsychotic drugs for elderly nursing home residents were associated with off-label conditions
- 88% were associated with the condition specified in the FDA boxed warning
- 51% percent of Medicare atypical antipsychotic drug claims for elderly nursing home residents were erroneous, amounting to $116 million
- 22% percent of the atypical antipsychotic drugs claimed were not administered in accordance with CMS standards regarding unnecessary drug use in nursing homes.

# OIG recommendations CMS

- (1) facilitate access to information necessary to ensure accurate coverage and reimbursement determinations,

- (2) assess whether survey and certification processes offer adequate safeguards against unnecessary antipsychotic drug use in nursing homes,

- (3) explore alternative methods beyond survey and certification processes to promote compliance with Federal standards regarding unnecessary drug use in nursing homes, and

- (4) take appropriate action regarding the claims associated with erroneous payments identified in our sample.

# OIG inspector general testimony in congress

- http://aging.senate.gov/events/hr240dl.pd

# CMS Response

- Use of the new quality measure to track and eventually report on Medicare compare
- Utilize Survey and Certification to “inspect the defects”
- Engage the QIO’s to improve the process and Dementia care
- Address Part D drug coverage

# Boston Globe
# 4/29/2012

- **“A rampant prescription, a hidden peril”**

Federal data obtained by the Globe show many nursing homes make heavy use of antipsychotic drugs to pacify residents

# CMS view

- *Any Antipsychotic use in any Dementia patient is "inappropriate". CMS may says it's a misunderstanding but nothing in writing is available to disprove that.*
- *Exceptions (turret's, Huntington disease, Schizophrenia)*
- *please note that Bipolar disease and depression is not included in the government approved diagnoses*

# **CMS Measure**:

## Prevalence of Antipsychotic Medication Use

- Patients with Schizophrenia, Huntington's Disease, Tourette's Syndrome are excluded
- Denominator is all patients in the facility not excluded by the above diagnoses
- Numerator is all patients taking at least one antipsychotic medication

# First step by CMS

- *Reduce antipsychotics use by 15% by end of this year*
- *next step???*

# Professional organizations position on this issue

- *officially, all professional organizations are in support*
- *no defense of "off label" use by physician organizations*
- *No defense of "appropriate use" in a at least some dementia patients, by nursing home, and nursing organizations*
- *no one wants to appear to be defending the "inappropriate" use of antipsychotics in the elderly*

Lets pretend the government is not dictating how to treat dementia patients

# Are we overusing antipsychotics in dementia patients?

# YES!!!

- *One in five, One in four, or One in three (depending n the facility) of all our nursing home patients are on antipsychotics*
- *Do they all need it???*

# Medically appropriate “off label” use of antipsychotics

- *other than schizophrenia, bipolar disorder, depression, huntington, and of course the all so common disease in nursing homes “turrets”*

# Psychotic symptoms in dementia patients

- *Delusions or hallucinations*
- *Only if they are disturbing the resident themselves*
- *Quality of life issues and ethical issues when such disturbing feelings in dementia patients are not treated due to regulations*

# Clinically Avoidable cases

- *confusion related behavior*
  - *Exit seeking (there is no medicine to make a dementia resident feel at home)*
  - *Staying up all night (why not have activities and meals at night for some residents)*
  - *Resisting care by people they don't recognize*
  - *Resisting care they don't feel they need (how would you like to be told that you need a shower now)*

# Whom to treat?
# the other easy cases...

- *The residents you are about to send to the ER for crisis behavior*

- *Acute delirium with psychosis (psychotic symptoms again). The behavior must be disturbing to the resident, not just the family or staff*

# Special cases with special considerations

# Parkinson's patients with Alzheimer's dementia with psychosis

- *Parkinson's meds can cause psychosis*
- *Antipsychotics, can cause EPS and worsen Parkinson's*
- *We should consider lowering the Parkinson's meds dose or frequency, especially at night, if there are delusions or hallucinations. instead of adding antipsychotics, especially in cases were there is already significant loss of function and are wheelchair bound*

# More on Parkinson's cases

- *In choosing an antipsychotic for a Parkinson's patient with behaviors neurologists and psychiatrists often chose seroquel because it is supposed to cause less EPS.*

- *CAUTION:*

  - *seroquel also cause drop in BP due to alfa blocking effect (like trazadone). shy-dragger syndrome (parkinson's with orthostasis) cases are a clear contraindication.*

  - *Also, it is more sedating than other antipsychotics*

# Lewy body dementia

- *Basics of Lewy body dementia is that we have a rapidly progressive dementia with Parkinsonism, and vivid visual hallucinations, that are often disturbing to the patient*

# The path to Misdiagnosing Lewy body dementia

- *Dementia with hallucinations*
- *Treated with antipsychotics*
- *Now has EPS secondary to the antipsychotics (Man made Parkinsonism; not pre-existing)*
- *Misdiagnosed as lewy body dementia for having the triad of Parkinsonism and dementia with hallucinations.*

# Lewy body dementia treatment

- *DisturbingVisual hallucinations=need for treatment with antipsychotics?*
- *Clinical analogy: Rt side MI is suspected when we see a precipitous drop in BP when given nitro; Lewy body dementia should be suspected when there is a precipitous physical collapse (worsening Parkinsonism) after one or a few doses of antipsychotics.*
- *Exelon at low dose (better tolerated) is the primary treatment of choice for the hallucinations*

# Use of choline esterase inhibitors in dementia with behaviors

- *drugs like aricept and exelon and razadyne are shown in some studies, especially aricept, to help with behaviors.*
- *In a dementia patient with behaviors it's worth a trial*
- *Aricept 5 mg vs 10 mg, and insidious weight loss due to loss of appetite. Pharmacy will always recommend an increase to 10 but we shouldn't always go up to 10*

# Namenda use in dementia with behaviors

- *Namenda is indicated for treatment of behaviors in the more ADVANCED stages of Dementia, not in mild dementia*

- *It doesn't slow disease progression so it shouldn't be used in mild dementia cases which is an increasing trend.*

- *If a trial fails to treat the behaviors it should be stopped as one of the documented side effects can be psychosis.*

# When one uses antipsychotics... a few cautions…

- Quetiapine (Seroquel) lasts 8 hours, is sedating, and has an alfa-blocking effect (watch BP)
- Rispiradone (Risperdal) lasts 12-24 hours (more than QD may require prior authorization)
- Olanzapine (Zyprexa) lasts for 24-36 hours, usually more sedating than Risperdal and causes more weight gain
- Aripiprizole (Abilify) last up to 72 hours, is stimulating (not sedating) in most cases therefore better given in AM.
- Ziprasidone (Geodon) is dosed twice a day and can have cardiac side effects and is usually not on formularies

# Side effects

- *Early death (may r may not be a concern giving advanced age and palliative focus)*
- *CVA*
- *Diabetes*
- *EPS*
- *Falls*
- *Weight gain*
- *Neuroleptic malignant syndrome*
- *etc.*

# Eliminating Polypharmacy as a factor for behavior

- *Benadryl and Atarax*
- *Amitriptyline (don't stop, taper)*
- *Benzodiazepines (Valium, Ativan, etc., taper is preferred)*
- *hypnotics and antidepressants (some better than others)*
- *Anticholinergics (such as Ditropan, Detrol, etc.)*
- *Narcotics, Also consider pain itself as a cause for behavior*

# More Special Cases

# Serotonin Syndrome

- *Serotonin syndrome secondary to drug interaction between Ultram and antidepressants*
- *It is really delirium with a specific cause and has all the usual symptoms of delirium.*
- *Common in SNF Ortho admissions where Ultram is used as pain killer to avoid narcotics (to avoid delirium!)*
- *It should be avoided in patients already taking an Antidepressant*

# PBA

- *Emotional incontinence*
- *"Repetitive yelling or verbalizations with no clear purpose" etc.*
- *NUDEXTA (*Detromethorphan and Quinidine) can be tried to reduce such behavior

# Behavior other than psychosis and confusion related behaviors

- *Cranky man syndrome (not a recognized diagnosis), common in vascular dementia, irritability, ready to pounce, sometime aggression towards staff and other residents.*

- *A good example of proper use of mood stabilizers like depakote*

- *The goal is not to reach therapeutic levels so pharmacy requests for level checks can be declined once it is established that the depakote level is not toxic*

# Akathesia

- *Medicare's closest diagnostic code for this recognized clinical entity is* **333.99** *"***Other extrapyramidal diseases and abnormal movement disorders"**

- **Drug induced Akathesia:** G25.71

- *Patients are always on the go. Have to be fed as they walk or during short intervals of pause.*

- *They lose weight much faster than other dementia patients unless their feeding plans are adjusted to their particular need (i.e frequent snacks with finger food)*

# Akathesia

- *It should be considered as a common side effect of antipsychotics.*
- *Pre-existing Akathesia can become worse with use of antipsychotics*
- *The only treatable aspect is allowing the patient a time for rest so they don't end up too exhausted and fall.*
- *Perfect example for proper use of hypnotic or benzos to induce sleep.*
- *Merry walkers can be useful*

# Benzodiazepines

- *They are less regulated and were commonly used before antipsychotics were introduced as a treatment option*
- *Big danger of CMS initiatives is that providers might revert to 20th century medicine and start treating all dementia behaviors with benzos. Some CMS advisors are old, and old fashioned, enough to not mind that. Facilities should watch their stats and see if benzos use increase as antipsychotic use decreases.*

# Benzos proper use

- *True panic attacks. You would see dramatic positive result. Easy to mislead staff that benzos are great for dementia patients*

- *Separation anxiety, patients escalate as soon as left alone*

- *There need to be a concomitant use of an SSRI for anxiety disorder as maintenance treatment even in later stages of dementia.*

- *When benzos are for chronic use then long acting benzos are better (exception to the rule) Klonopin instead of Ativan*

# Managing behavior crisis

- *Most patients going to the ER end up receiving IM benzos or IM antipsychotics. It's better for the residents if they received meds on site instead with available ODTs.*

- *Nursing home staff could use orally dissolving Antipsychotics to avid ER referrals.*

- *common concerns with ODTs (learn proper use, PA, avoid Generic ODTs*

- *Need documentation of POA authorization to administer meds without resident consent*

# Simple Interventions to reduce antipsychotic use

- *Avoiding night and weekend med changes, unless its an emergency*
- *all behaviors should be addressed during the day and not at 2 am. Calling the doctor at 2 am is only going to result in a quick decision to treat the immediate symptoms and not address the overall case.*
- *foreseeing a crisis as it develops and addressing it early*

# Addressing the obvious

- *Among dementia patients on antipsychotics, how many are scheduled for evening showers?*
- *How many of those patients receive glucoscans?*
- *How many need BP checks daily per CMS survivors?*
- *How many are pressured to eat or take supplements due to weight loss issues even when they fight that every time.*
- *How many of these patients are woken up at 6 am?*
- *How many are woken up in the middle of the night for turning or toileting?*

# Practical goals

- *Limit the use of antipsychotics to those that you can defend with you documentation and those who failed non-pharmaceutical interventions.*

- *Avoid doing the wrong thing (like using benzos, or stopping meds on those who need them) in order to please CMS.*

- *Keep in mind that dementia patients evolve, so they may not need what they needed 6 months prior =>always consider taper even if they failed before.*

- *Delirium patients shouldn't need antipsychotics more than 2 months out, so they should be DC-ed in most cases.*

# Psychiatry referrals

- Be careful what you ask for…
- The problem is not primarily a underlying psychiatric disorder
- More psychiatry referrals will probably result in more antipsychotic use
- Behavioral issues in nursing homes are primarily a geriatrics issue of underlying medical diseases not a psychiatric issue

# Palliative care

- *At the time of death the use of antipsychotics and benzos should be liberalized with little regard to side effects, just like we do with narcotics. Daily max dose can also be ignored but with proper documentation.*
- *This should be considered a quality of life, and quality of death issue. Any restrictions at time of death should be resisted for residents' sake. The ombudsman should be involved if meds are denied in such cases.*

# Part D coverage issues

- CMS directed Part D plans to retrospectively review drug utilization focusing on
  - Establishing clinical upper thresholds for appropriate dosing consistent with clinical guidelines
  - Creating and monitoring beneficiary–level utilization reports
  - Assign clinical staff to review and determine if interventions are warranted
  - Address by request exceptions
  - (If all uses in dementia patients are not ‘appropriate” then whats the exception for Part-D coverage. Part D could potentially deny all new and renewal scripts for atypical antipsychotics in any dementia patient)

# Part D coverage issues

- *Based on my personal experience with Part D plans, CMS appears to have green lighted medicare part D plans to deny antipsychotics prescribed when associated with a dementia diagnosis. Physicians can have a standard response to PA denials that states, that they are aware that the medication is not FDA approved for dementia, and they consider it medically necessary. Most plans will approve, the ones who deny should hear from the families.*

- *Denials despite doctors recommendation should be of concern to the ombudsman and state surveyors*

# Family issues

- *Some families will resist taking away meds that they think helped their loved ones*
- *Nursing and providers should approach the issue in terms of unnecessary meds and need to minimize meds, instead of focusing on federal and state regulations to taper Antipsychotic meds.*

# Dementia care needs to be flexible and evolve over time

- *Strict government restrictions are unlikely to keep pace with the evolution of dementia science, but what do I know, I'm just the doctor!*