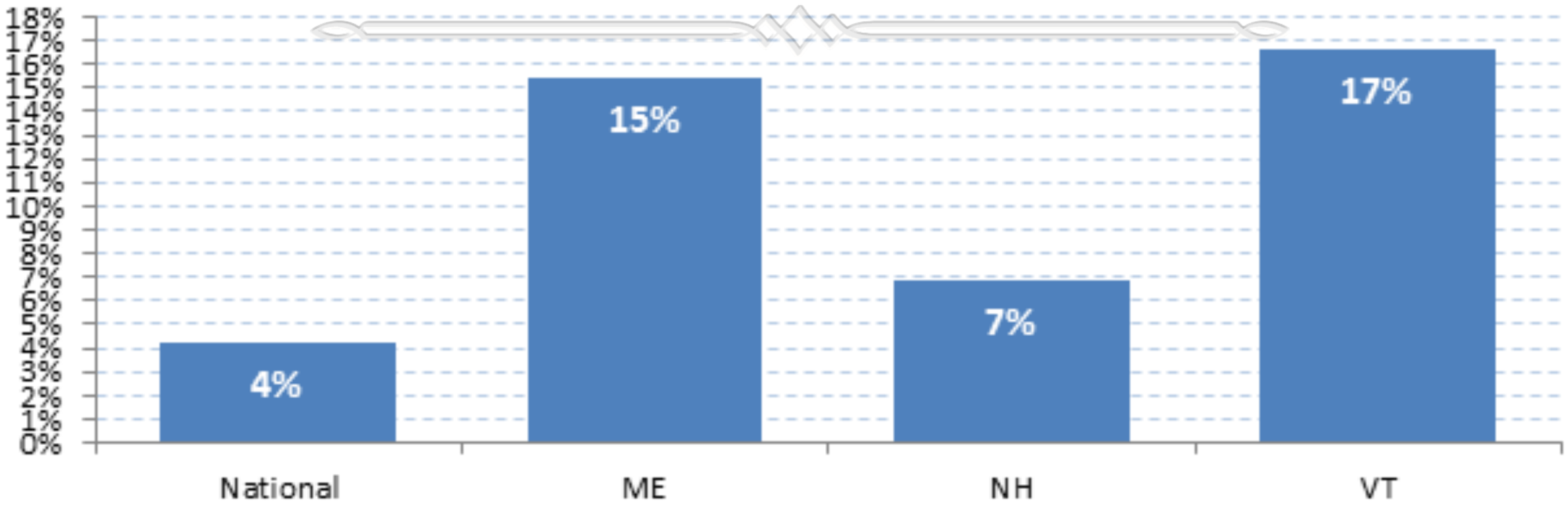
A Pilot Study in Antipsychotic Reduction In Nursing Homes 9/2012-9/2013

Jabbar Fazeli, MD

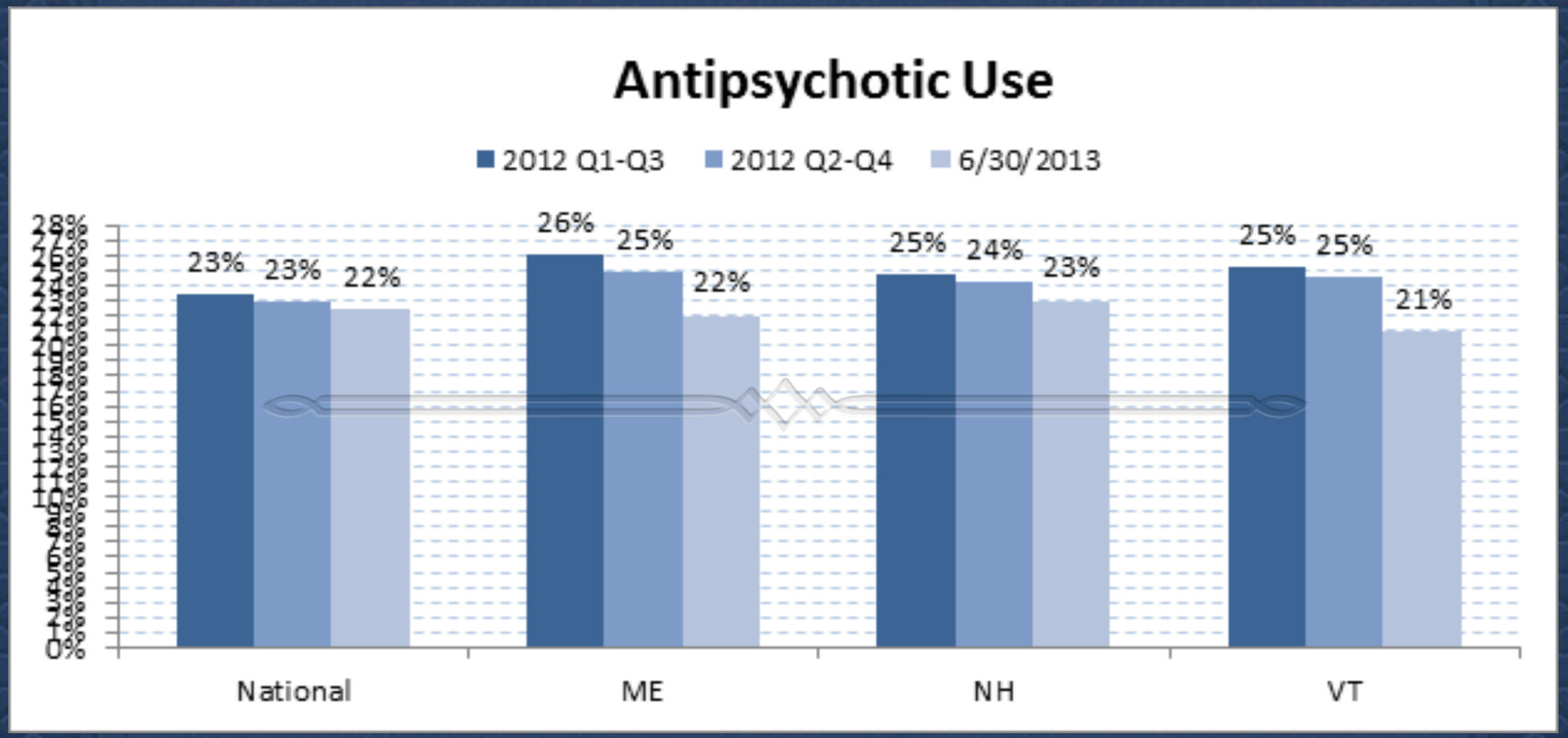
www.Mainegeriatrics.com

How Are We Doing Nationally and in Maine?

Relative Reduction in Antipsychotic Use
Dec 2011-June 2013



We Are Still Above 20% In Most Places



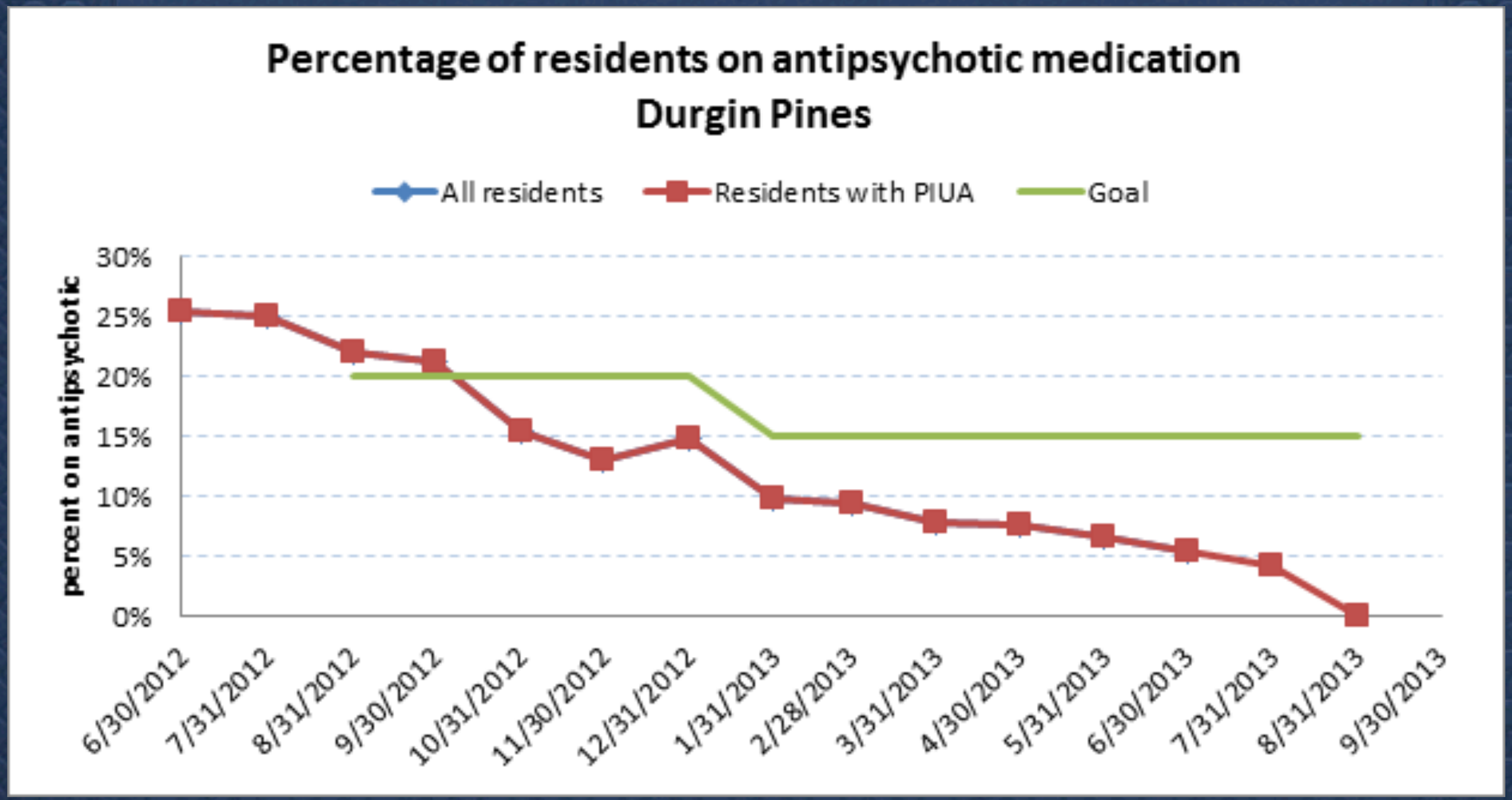
Pilot study

- *3 Nursing home facilities*
- *Same medical team*
- *2/3 facilities had psych service, one didn't*
- *Interventions outlined in this lecture were initiated in August-September of 2012 with the goal of a total 15% or higher dose reduction in use of antipsychotics by Dec 2012 with no higher than 5% increase in benzo use.*
- *The reduction of antipsychotics without an increase in ER visits or hospitalizations*

DATA collection

- *Snap shot look at end of the month, 2 months before intervention and for 12 months (so far) post intervention.*
- *All patients were counted even those arriving on antipsychotics from the hospital*
- *Total number of patients on Antipsychotics were tracked and within that all dementia cases without diagnosis of Schizophrenia, Huntington, and Tourette's were also tracked*
- *Other FDA approved indication such as bipolar disorder and depression were not considered as exemptions*

Durgin Pines Data Since CMS Initiative



Two Other Facilities In The Study

Facility A: Started with 17.1% *and is now* 9.38%

Facility B: Started with 21.2 % *and is now* 11.53%

Same medical providers

Addition of Psych service availability

NO QIO Envelopment in Training or Reviews

Principles

- *Clinical determination of need for antipsychotics in dementia patients with behaviors*
- *Overall use of antipsychotics in dementia patients is higher than it should be.*
- *Patient need the determining factor not ZERO tolerance approach to use of antipsychotics*
- *multidisciplinary approach*

Intervention Components

- *Providers*
- *Administration*
- *Nursing*
- *CNAs*

"No Magic Drug" Concept

- *When treatment is successful it is due to a Successful "Treatment Plan" not just the particular drug utilized as part of the plan*
- *Soon the team can see that once all non-pharmaceutical components are in place consistently then the drugs become redundant*

Avoiding Pitfalls

- *Treating based on general descriptions such as being danger to self or others is an erroneous emerging concept. No target symptom to help judge the dose or duration of treatment.*

- *Technically a person deemed "out of control" or "A danger to self or others" can be given any off label medicine as there is no FDA approved drug for this "condition"*

- *Avoiding an increase in the use Benzos and hypnotics (less than 5% increase was the goal)*

Providers Concepts

- *Antipsychotics are overused for treatment of untreatable confusion related symptoms (exit seeking, restlessness, Akathesia, resistance to care, etc.)*
- *The use of antipsychotics should be reserved for specific psychotic symptoms (delusions or hallucinations), especially if disturbing to patients and affect their quality of lives.*
- *(Increasing use of Haldol, why is it happening?)*
- *NO FDA indication, but* ***not all off label use is inappropriate***
- *Use of Anti-psychotics is POTENTIALLY inappropriate*

Limiting Orders for Antipsychotics Upon Admission

- *PRN antipsychotics on hospital transfer summaries can often be DC-ed if no recent psychotic symptoms (ask the admitting nurse if he or she knows when and why the PRN antipsychotics was used)*
- *PRN antipsychotics, if continued, should at least have a stop order (7-14 days to allow for transition time)*

Dealing With Scheduled Antipsychotics Orders Upon Admission

- *In case of delirium with psychotic symptoms it is reasonable to continue the medication for the severe cases without a stop date and revisit once patient stabilizes. Acute Delirium Can last up to two months, Subacute delirium even longer.*

- *For non severe cases or cases without psychotic symptoms an early DC or taper to DC within days to weeks should be the goal upon admission*

Substitute Antipsychotics With More Appropriate Drugs Whenever Possible

- *If hypnosis is the goal then hypnotics should be used. Avoid Daytime trazadone as it reverses sleep cycle and makes nighttime behavior worse. Most daytime Trazadone should be given in the afternoon.*
- *If behavior is likely to be secondary to pain i.e. Ortho cases then a scheduled Pain killers especially at time of max activities and HS as insomnia and night time behaviors can be pain related*
- *Narcotics also cause delirium but uncontrolled pain and related delirium is a worse evil*
- *Never substitute Antipsychotics with Benzos unless true anxiety is present*

Utilization Of Substitute Drugs For Some Dementia Behaviors

- *Anticholinergics*
- *NMDA antagonists for severe dementia with behavioral disturbance or loss of basic functions. not indicated for early dementia*
- *Nuedexta (dextromethorphan/Quinidine) for PBA*

Post Admission Dose Reduction Principles

- *Beware of automatic dose reduction requests by pharmacy for recent admits if patients have long standing Schizophrenia or recent psych hospitalization related to dementia with psychosis.*
- *Delirium cases take up to two months to stabilize so slow med reduction maybe needed*
- *Dementia with subacute or chronic psychosis will needs weeks to months to reassess, NOT days to weeks*

On Call Provider Protocol

- *Limit ordering antipsychotics if no clear psychotic symptoms (resist the pressure to say yes)*
- *If you must, Give "one time" orders OR orders with "stop dates"*
- *Requesting follow up (patient to be put on the problem list to ensure follow up and further med adjustments). Nursing should consider such add ons even when not ordered.*

Routine Dose Reduction Principles

- *Every recert visit is an opportunity for dose reduction*
- *Prior failures of dose reductions are not an absolute contra-indication especially a few months out.*
- *Stability is a prerequisite for dose reduction. Behaviorally unstable patients should not undergo routine med reduction unless provider feels that the medications are part of the problem.*