



## Improving Dementia Care – Reducing Unnecessary Antipsychotic Medications

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### Session Objectives

1. Describe an overview of the CMS initiative to improve behavioral health and reduce antipsychotic medications
2. Discover non-pharmacologic approaches to manage dementia-related behaviors
3. Obtain resources to ensure appropriate use of medications for dementia care in skilled nursing, assisted living and other settings

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### Why this Initiative? Why Now?



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## Antipsychotics



- Antipsychotic drugs (AP)
  - 8 antipsychotic drugs approved in the US
    - Only FDA approved for use in schizophrenia & bipolar disease
    - “Off label use”
    - “Black Box warning” FDA
  - Typical (TAP) – the most common example is haloperadol (Haldol). Side effects were common....
  - Then came the atypical (AAP) antipsychotics...

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## Most Common *atypical* antipsychotics

**Medication**                      **Most Common Brand Names**

<a href="#">Aripiprazole</a>	Abilify
<a href="#">Clozapine</a>	Clozaril
<a href="#">Olanzapine</a>	Zyprexa
<a href="#">Quetiapine</a>	Seroquel
<a href="#">Risperidone</a>	Risperdal
<a href="#">Ziprasidone</a>	Geodon or Zeldox

Expensive, yet thought to be safer. Were heavily marketed as the solution for “challenging behaviors”

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## FDA Black Box Warning

**WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS**

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of seventeen placebo-controlled trials (median duration of 10 weeks) largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality. The extent to which the findings of increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patients is not clear.

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## OIG Report

- Office of the Inspector General May 2011 Report (Jan-June 2007 data): *Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents*
  - Senator Charles Grassley initiated
    - Using AP's on demented elders is elder abuse
  - 14% of elderly NH residents had claims for atypical antipsychotics
  - 83% of Medicare claims for AAP for elderly NH residents were off-label use
  - 22% of AAP were not administered according to CMS standards regarding unnecessary drug use in NH's

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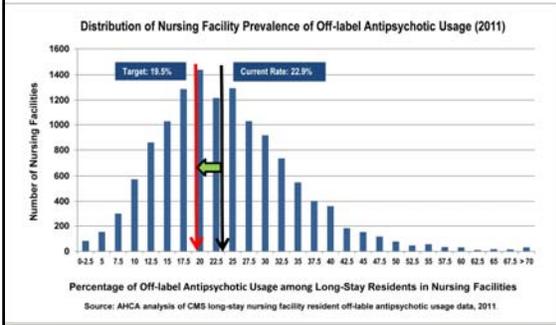
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## Off-Label Use of Antipsychotic Meds, 2011




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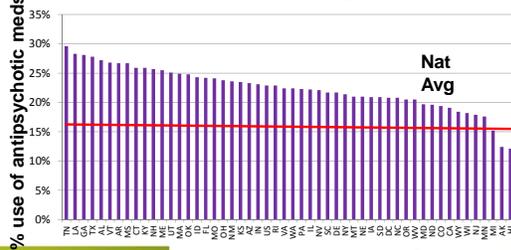
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## Off-Label Use of Antipsychotics 2011

### State-State Average



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## CMS Initiative

- Centers for Medicare & Medicaid Services (CMS):  
New initiative to improve behavioral health & reduce unnecessary antipsychotic use
  - Kick-off national video stream March 29, 2012 with two panels
    - Clinical panel
    - CMS officials panel
  - Goal: reduce antipsychotic use by 15% by the end of 2012
  - Began April 1, 2012

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## CMS Initiative

- National Action Plan
  - Raising awareness
  - Non-pharmacological interventions first
  - Regulatory oversight
  - Training
  - Research
  - Targeting patient-centered care, particularly those with dementia
  - PUBLIC REPORTING

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## While the CMS Initiative Applies to NHs, the Principles Apply Across Settings



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## CMS Measurement Specs for Antipsychotics



- Two measures; long-stay and short stay
- Exclusions include schizophrenia, Huntington's Dx, Tourette's syndrome (not bipolar or MDD - also FDA approved indications)
- **Short stay measure** = no. of residents started on an antipsychotic within first 100 days from admission / no. of residents in the facility 100 days or less during the reporting period (those admitted on drug not included)
- **Long stay measure** = no. of residents in the facility for more than 100 days with antipsychotic drug use / total number of resident in the facility for more than 100 days

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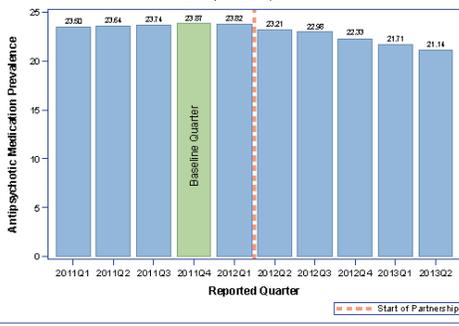
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Quarterly Prevalence of Antipsychotic Use for Long-Stay Nursing Home Residents, 2011Q1 to 2013Q2




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## Where is Wisconsin?



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## Quarterly Prevalence of Antipsychotic Use for Long-stay residents, WI

Q1 2011	Q1 2013	Rank in Q1 2013 (lower = better)	Percent Change
19.04	17.41	11th	-8.60%

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## How to Access Your Nursing Home Data

- Visit the Nursing Home Compare (NHC) website [www.medicare.gov/nursinghomecompare](http://www.medicare.gov/nursinghomecompare)
- Find your nursing home using the search bars
- Navigate to the quality measures tab Compare the facility's QM scores to state and national averages  
You can also graph the values on NHC  
Note: QM values on *Nursing Home Compare* are a three quarter average, and lag by 3 months

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## The Great Dementia Myth

*“People with dementia display dementia-related behavior and other than giving them medication there is nothing we can do about it”*

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## Why adults with dementia receive antipsychotic medication?

- resists care/assistance
- Refuses medication
- Irritable or aggressive with others
- Paces
- Calls out/Yells
- Exit seeking
- BECAUSE WE'RE NOT SURE WHAT ELSE TO DO WHEN DEMENTIA-RELATED BEHAVIOR HAPPENS!

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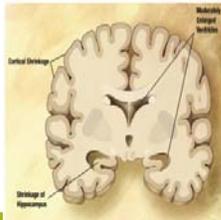
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## How dementia impacts human behavior-Moderate Dementia



- Difficulty with short and long-term memory. Struggles to learn new things
- Difficulties with understanding and being understood
- Knows comfort and discomfort
- Can't self regulate emotions
- Often easily upset or frustrated
- Can become fearful
- May misinterpret the actions of others

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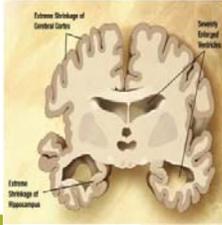
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## How dementia impacts human behavior-Advanced Dementia



- Limited/no short and long-term memory-often lives in the moment
- Can't learn new information or pick up new routines
- Unable to carry on meaningful conversation
- May appear withdrawn and can have difficulty interacting or responding to surroundings

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## Stopping Dementia-related Behavior Before it Happens

- Comfortable people don't resist care or medication, they don't pace or seek the exit, they don't call out for help or wail, they don't become irritable and aggressive with others
- To stop dementia-related behavior we must make the person's comfort our top priority
- The adult with dementia is the expert on what is most comfortable for them

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## Elements of Comfort-focused Behavior Management Plan

- Recognize, assess and treat physical pain
- Examine ways to minimize fear and reduce self protective actions
- Focus on what is important to the adult with dementia
- Schedule tasks according to what the adult with dementia considers most comfortable
- Promotes sleep whenever the adult with dementia is tired

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## Resists care/service road map (Beatitudes Campus, Arizona)

Dementia-specific behavior	What is the person communicating?	Possible remedies
Resists care/service	Physical pain	Pain medication, reposition , bed rest, assist with ambulation, or to the toilet
	Fearful/self protective	Adopt his/her routine slow down, approach softly, console, back off when upset, Don't reason or confront

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## Refuses medication road map (Beatitudes Campus, Arizona)

Dementia-specific behavior	What is the person communicating?	Possible remedies
Refuses to take medication	Tastes bad or has trouble with consistency of the medication	Give with soft, sweet foods, consider offering liquid medication if available, review the need for the medication if refusals persist
	Fearful of the experience (what are you putting in my mouth)	Slow down, soft approach, don't confront or reason
	Doesn't think they need it or believe they are being poisoned	Have another staff member try, re approach later, don't reason or confront

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## "Calls Out" Road map (Beatitudes Campus, Arizona)

Dementia-specific behavior	What is the person communicating?	Possible remedies
Calls out repeatedly	Physical pain	Pain medication, repositioning , bed rest, ambulation
	Hungry/thirsty or needs the restroom	Give food and fluid-preferably soft & sweet Escort to toilet
	Bored/needs to move	Engage in meaningful event, take on short walk or help them stand for a few moments

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In short – what we label as “behavior” in dementia is really a method of communication by the person affected. Our job is to figure that out and respond appropriately



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### Approach to Problematic Behavior: “ABC” Framework

- “A-B-C” concept
  - A: What are the antecedents to the behavior?
  - B: What is the behavior?
  - C: what are the consequences of the behavior?
- Two Case Studies – a tale of Esther and Walter



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### “Don’t leave me alone”



- Esther is in her room – she seems “agitated”, the room is dark and she is alone – she starts to bang on the bed rail and eventually yells
- An aide comes in to calm her down – but that works for only a couple of minutes
- Staff finally bring her out to the nurses station where she seems more happy
- When she goes back to her room – she starts her vocalizations again – eventually striking out when the aide comes in to “calm her down”
- If this continues for several days – what does Esther “learn”?
- What are the ABC’s to this situation?

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## “I’ve had ENOUGH!”



- Walter has always been a “quiet man”. Worried he is withdrawn the staff bring him to a day room that has a piano, a bird, a TV and other loud activities
- Walter begins to get restless – and when an aide walks by, he strikes out at her
- Walter is then put in his room for “time out” and he seems much calmer
- The next day the same thing happens
- How long before Walter figures out the best way to get out of the noisy setting is to hit someone?
- What are the ABC’s to this situation?

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## “Unnecessary Drugs”

### 1. General.

Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

- (i) In excessive dose (including duplicate therapy); or
- (ii) For excessive duration; or
- (iii) Without adequate monitoring; or
- (iv) Without adequate indications for its use; or
- (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
- (vi) Any combinations of the reasons above.

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## “Unnecessary Drugs”

### 2. Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that:

- (i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and
- (ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

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## “Medication Regimen Review”

- “Medication Regimen Review” (MRR) is a **thorough evaluation of the medication regimen of a resident**, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication. The review includes preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities, and collaborating with other members of the interdisciplinary team.

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## Putting Change into Practical Terms

1. Consider a check-list before starting an antipsychotic
  - What is the indication? Is it an appropriate indication? Is it caused by something else that needs to be addressed?
  - Is there a non-medication approach? Has such been tried? Is there a reason why it should not be tried first?
  - If the medication is started – is it working? Are there adverse affects? (have you documented both effect and adverse reactions?) Has the individual’s function improved?
  - What is the shortest time and the lowest dose the person can be on the drug? Can you stop after 2 weeks? 1 month?
  - Have you had a discussion with the family and/or legal representative of the resident about the drug, the reasons for its use, the risks and benefits?

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## Putting Change into Practical Terms

2. Do you have a process to review each new start of an antipsychotic drug with the IDT? Within 7 days?
3. Does your medical director work with the consulting pharmacist to review residents who have been on antipsychotics for longer than 3 months
4. Do you track *incidence* (number of new orders over a given time period) and *prevalence* (number residents who are on antipsychotics over a given time period)?
5. Do you share this data with your IDT? Medical Director? Attending physicians?

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### Putting Change into Practical Terms

6. What is your process for addressing individuals who are admitted to the nursing home on an antipsychotic?
- Why was the medication started and when?
  - Has it been effective?
  - Can the family or others identify what tends to get the resident upset or frightened?
  - Can the family or others share what activities tend to give the individual pleasure or calm them down?
  - Have you incorporated this into the care plan?
  - Is it time to reduce or discontinue the antipsychotic?

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### Not just a Nursing Home Opportunity

- While the CMS initiative is focused on NHs, the principles of improving person-centered care and reducing the use of antipsychotics applies to ALL settings.
- Many of the check lists discussed today can be modified for assisted living communities – who often face just as great of a challenge in caring for people with dementia.

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### Resources to Reduce Use of Antipsychotics and Improve Dementia Care

- Advancing Excellence Website
  - [www.nhqualitycampaign.org](http://www.nhqualitycampaign.org)
- Resource Center with materials from a variety of organizations (QIO, Provider, Consumer)
- Links to CMS Webinar
- Background materials
- Performance Improvement Resources and Tool Kits (assessment forms, policies and procedures)
- Consumer-friendly materials

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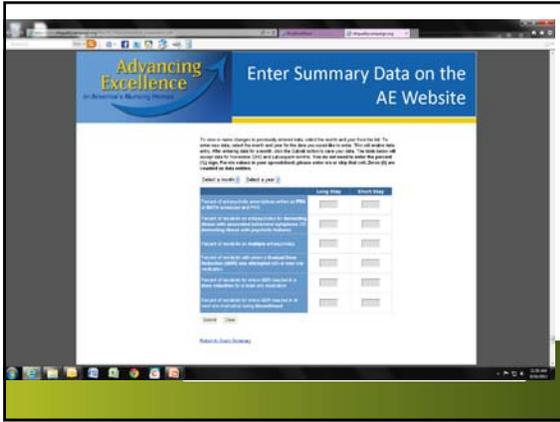
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## A New Framework

**Remember when we believed that restraints were necessary for safety and that it was impossible to have a “restraint free” goal?**

That same kind of thinking will get us to Improved dementia care!



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