Reducing the Use of Psychoactive Medications

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- Michael has more than 20 years of experience in pharmacy. Michael began his career as a Retail Pharmacist before transitioning 11 years ago to Clinical Pharmacy. In the clinical setting, Michael is a preceptor for 3rd and 4th year Pharmacy students and works with them in the long-term care setting. Michael is currently the Regional Director of Clinical and Consultant Services for Guardian Pharmacy Orlando where he works daily to ensure each resident receives the best clinical services Guardian can provide. He is also a managing partner in Envision Health Consulting, which works to advance education for long-term care providers. He works daily to expand the role of pharmacists and is especially interested in the Pharmacist's role in the Transitional Care setting.

Prof. Alan Obringer, RPh, CPh, CGP

- Professor Alan Obringer, RPh, CPh, CGP., is a licensed pharmacist and pharmacist consultant in Orlando, Florida and holds a faculty position with the University of Florida, College of Pharmacy as an Assistant Clinical Pharmacist, since 2002. Alan is currently the President and owner of Guardian Pharmacy of Orlando. He is also a managing partner in Envision Health Consulting, Alan holds a certification in Geriatric Pharmacy and is a strong advocate for the profession of pharmacy in long-term care.

Objectives

- Review clinical evidence demonstrating the need for change
- Differentiate between appropriate and inappropriate indications for use
- Demonstrate how correct use improves patient care and results for facilities
- Identify alternative treatment options
- Explain CMS rules/regulations regarding antipsychotic use in this patient population
- Describe statistics on antipsychotic use in Florida
- Discuss the impact of COVID-19 on antipsychotic use

Antipsychotics

"Typical" or First Generation		"Atypical" or Second Generation	
Phenothiazines	**Butyrophenone**	Asenapine (Saphris)	Olanzapine (Zyprexa)
Chlorpromazine (Thorazine)	Haloperidol (Haldol)	Aripiprazole (Abilify)	Paliperidone (Invega)
Fluphenazine (Prolixin)	**Others**	Clozapine (Clozaril)	Quetiapine (Seroquel)
Mesoridazine (Serentil)	Loxapine (Loxitane)	Iloperidone (Fanapt)	Risperidone (RIsperdal)
Perphenazine (Trilafon)	Molindone (Moban)	Lurasidone (Latuda)	Ziprasidone (Geodon)
Thioridazine (Mellaril)	Thiothixene (Navane)		
Trifluoperazine (Stelazine)			

Indications for Use

Appropriate Indications		Inappropriate Indications	
Schizophrenia	Brief Psychosis	Restlessness	Mild anxiety
Schizo-Affective Disorder	Mood Disorders	Insomnia	Fidgeting
Schizophreniform	Psychosis NOS	Sadness not related to depression	Uncooperativeness
Atypical Psychosis	Huntington's Disorder	Impaired Memory	Nervousness
Delusional Disorder	Tourette's Disorder	Inattention to surroundings	
Medical Illnesses or Delirium with associated symptoms	Hiccups (not due to medications)		
Dementing Illnesses with associated symptoms	Nausea and Vomiting associated with cancer/ chemo		

Black Box Warning

- April 2005: FDA mandated BBW on all labels
  - Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death
    - Cardiovascular
      - Heart failure
      - Sudden death
    - Infection
      - Pneumonia

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. RISPERDAL® (risperidone) is not approved for the treatment of patients with dementia-related psychosis. *[See Warnings and Precautions (5.1)]*

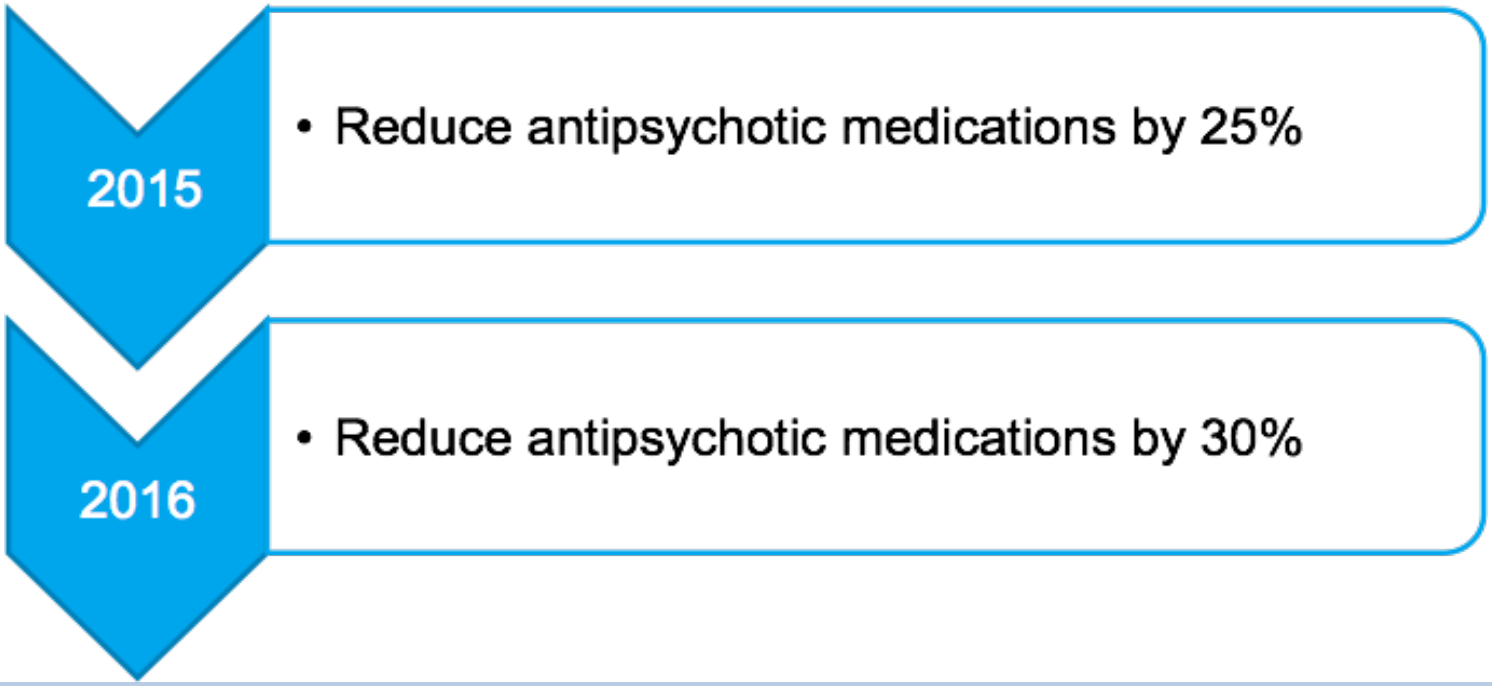
Beers Criteria

AGS BEERS CRITERIA
FOR POTENTIALLY INAPPROPRIATE
MEDICATION USE IN OLDER ADULTS
FROM THE AMERICAN GERIATRICS SOCIETY

- PIM: For chronic or intermittent use in patients with dementia
- Avoid products unless
  - All non-pharmacological options have failed
  - AND patient is threatening themselves or others
- Avoid products if patient has history of falls, fractures, or chronic constipation

CMS: Goals

- Enhance use of non-pharmacological approaches and person-centered dementia care practices



CMS: Five-Star Rating

1. Health Inspections
2. Staffing
3. Quality measures

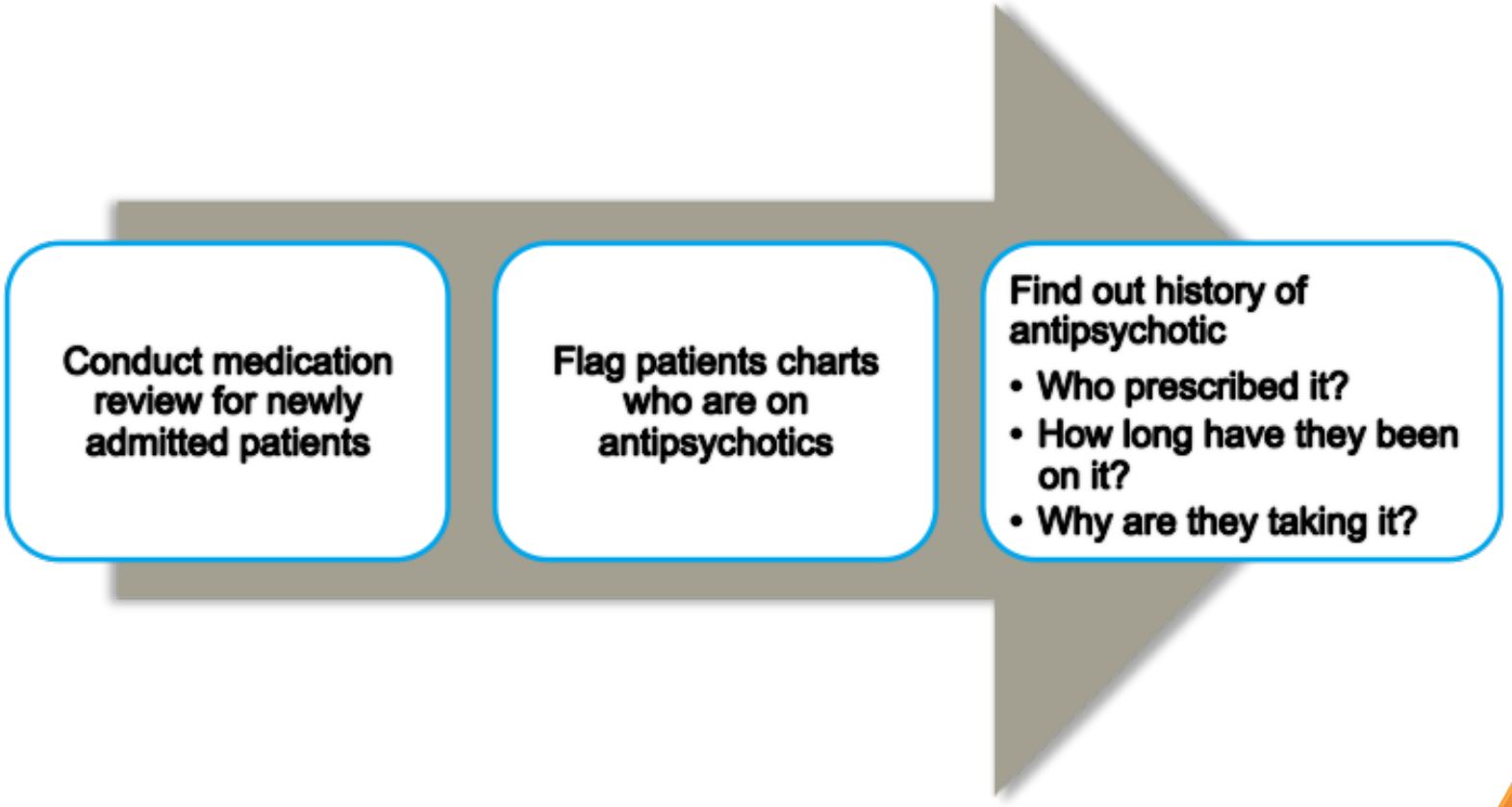
Five-Star Rating: Quality Measures

- February 2015: 2 quality measures relating to antipsychotic use were added
  - Long-Stay Residents: Percent of residents who received an antipsychotic medication
  - Short-Stay Residents: Percent of residents who newly received an antipsychotic medication

How to get there?

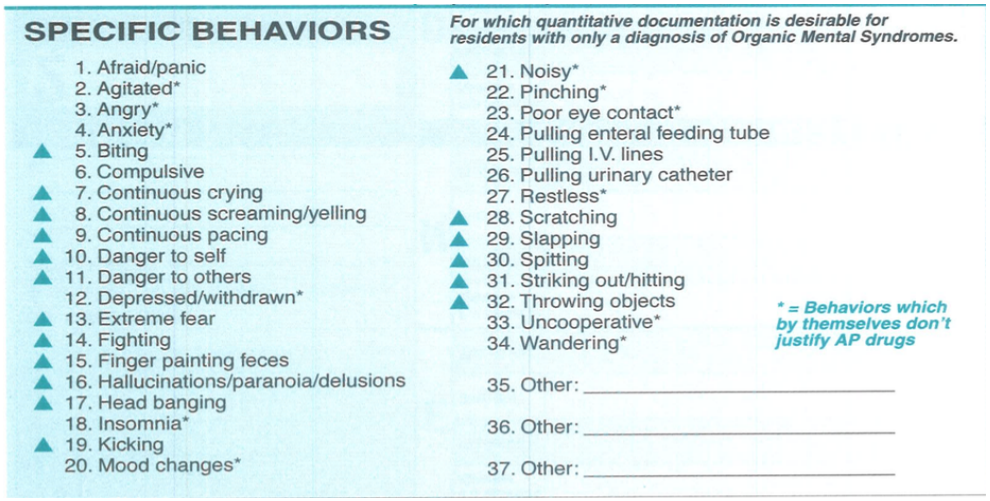
- Screen and identify patients
- Have correct indication for use
- With correct criteria for use
- Treating with lowest effective dose
- Monitoring for effectiveness

Screen and identify patients



Accurate Description of Behavior

- Identify any underlying causes for patient behavior
  - Pain
  - Over-sedation
  - Depression
- Talk with the patient and family about reasons for behavior
  - Could be a simple solution
    - Food is always cold
    - TV is always on Matlock



SPECIFIC BEHAVIORS

For which quantitative documentation is desirable for residents with only a diagnosis of Organic Mental Syndromes.

1. Afraid/panic
2. Agitated*
3. Angry*
4. Anxiety*
5. ▲ Biting
6. Compulsive
7. ▲ Continuous crying
8. ▲ Continuous screaming/yelling
9. ▲ Continuous pacing
10. ▲ Danger to self
11. ▲ Danger to others
12. Depressed/withdrawn*
13. ▲ Extreme fear
14. ▲ Fighting
15. ▲ Finger painting feces
16. ▲ Hallucinations/paranoia/delusions
17. ▲ Head banging
18. Insomnia*
19. ▲ Kicking
20. Mood changes*
21. ▲ Noisy*
22. Pinching*
23. Poor eye contact*
24. Pulling enteral feeding tube
25. Pulling I.V. lines
26. Pulling urinary catheter
27. Restless*
28. ▲ Scratching
29. ▲ Slapping
30. ▲ Spitting
31. ▲ Striking out/hitting
32. ▲ Throwing objects
33. Uncooperative*
34. Wandering*

** = Behaviors which by themselves don't justify AP drugs*

35. Other: _____
36. Other: _____
37. Other: _____

Correct Criteria For Use

- Diagnosis alone does NOT warrant use
- Clinical condition must also meet at least one of the following:
  - Symptoms present a danger to the resident or others
  - Symptoms are identified as being due to mania or psychosis
  - Symptoms are significant enough that the resident is experiencing one or more of the following:
    - Inconsolable or persistent distress
    - Significant decline in function
    - Substantial difficulty receieving needed care

Challenges

- Use of evidence-based medicine
  - Use of antipsychotics without appropriate clinical justification
- Interdisciplinary team approach
- One-size fits all model
- Adverse drug effects
  - Monitoring
- Screening methods and other resources

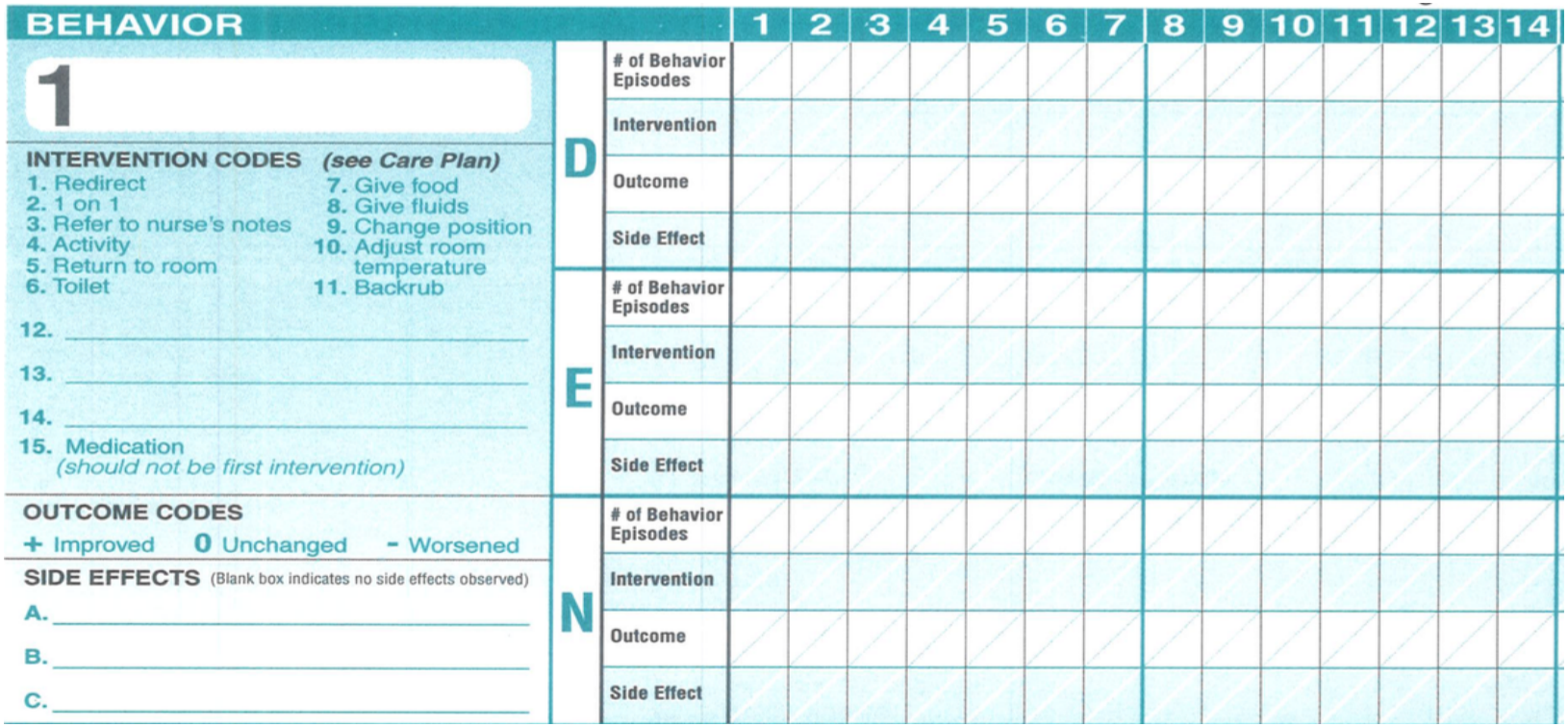
Monitoring of Antipsychotics

- Evaluate ongoing effectiveness
  - Re-evaluate targeted behavioral symptoms at least quarterly
    - After initiation or after increasing dose
  - Documentation
- Identify potential adverse consequences

General	Anticholinergic effects, falls, excessive sedation
Cardiovascular	Cardiac arrhythmias, orthostatic hypotension
Metabolic	↑ total cholesterol and triglycerides, poor glycemic control, weight gain
Neurologic	Akathisia, AIM, neuroleptic malignant syndrome, Parkinson's, cerebrovascular events (stroke, TIA)

Behavior Monitoring & Intervention

- Monthly Flow Record



BEHAVIOR			1	2	3	4	5	6	7	8	9	10	11	12	13	14
1	D	# of Behavior Episodes														
		Intervention														
		Outcome														
		Side Effect														
	E	# of Behavior Episodes														
		Intervention														
		Outcome														
		Side Effect														
	N	# of Behavior Episodes														
		Intervention														
		Outcome														
		Side Effect														

INTERVENTION CODES *(see Care Plan)*

1. Redirect
2. 1 on 1
3. Refer to nurse's notes
4. Activity
5. Return to room
6. Toilet
7. Give food
8. Give fluids
9. Change position
10. Adjust room temperature
11. Backrub
12. _____
13. _____
14. _____
15. Medication *(should not be first intervention)*

OUTCOME CODES

\+ Improved 0 Unchanged - Worsened

SIDE EFFECTS (Blank box indicates no side effects observed)

A. _____

B. _____

C. _____

Lab Monitoring

- Lipids/LFTs
  - Unknown or unstable → every 6 months
  - Stable → yearly
- Hemoglobin A1c (or blood sugar monitoring)
  - Unknown or unstable → every 3 months
  - Stable → every 6 months
- EKG (Patients on Geodon only)
  - Yearly
- WBC/ANC (Patients on Clozaril only)
  - Every week for first 6 months
  - Every two weeks for the next 6 months
  - Every 4 weeks thereafter

Antipsychotic Use and Fall Risk

- Among older adults, falls are the leading cause of deaths due to injury
- More than 60 percent of people who die from falls are 75 and older
- In 2011, 2.4 million fall related injuries among older adults were treated in the emergency department

Antipsychotic Use and Fall Risk

- Use of more than one antipsychotic
  - Dosing discrepancies
- Increased sensitivity to medications leading to ADEs
- Abrupt discontinuation
  - Prevention strategies:
    - Gradual dose reduction
    - Use of shortest treatment duration possible

Dosing of Antipsychotics

- To improve target symptoms being monitored
  - Treatment should be at the **lowest possible dose** for the **shortest period of time**

- Doses for acute indications may differ from long-term treatment
  - Ex: Delirium or acute psychosis

Gradual Dose Reductions

- GDR is required for antipsychotics
  - Must be attempted within first year of admission
  - Must be attempted in 2 separate quarters
    - With at least 1 month in between
  - After first year, must attempt annually

- MDS data should be updated at:
  - Admission
  - Day 30, 60, 90
  - Quarterly
  - Annually
  - With any significant change in condition

Gradual Dose Reduction

- Documentation Requirement
  - If contraindications to GDRs
    - For those residents receiving an antipsychotic drug to treat behavioral symptoms related to dementia
    - For those residents receiving an antipsychotic drug to treat psychiatric disorders other than behavior symptoms related to dementia

Tapering

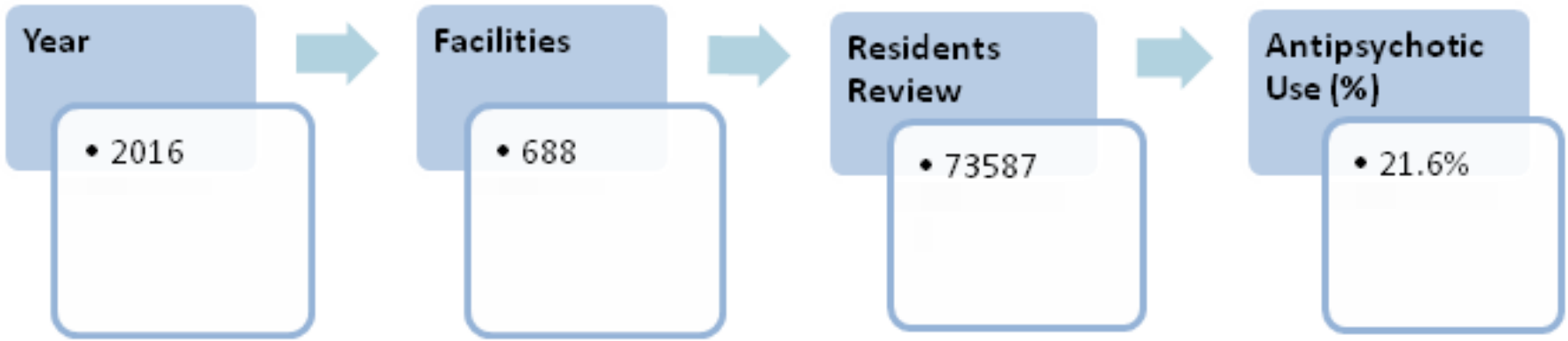
Generic	Brand	t1/2	Time between dose adjustments	Estimated time to discontinuation
Clozapine	Clozaril	Parent: 8-12 hrs	2 weeks	4 weeks
Lurasidone	Latuda	Parent: 15 days	2 weeks	4 weeks
Quetiapine	Seroquel	Parent: IR: 6 hrs ER: 7 hrs	2 weeks	4 weeks
Ziprasidone	Geodon	Parent: 7 hrs	2 weeks	4 weeks
Paliperidone	Invega	Parent: 23 hrs Renal impaitment: 24-51 hrs	2 weeks *3-4 weeks in renal impairment	4 weeks (6-8 weeks in renal impairment)

Tapering

Generic	Brand	t1/2	Time between dose adjustments	Estimated time to discontinuation
Risperidone	Risperdal	Parent: 3-20 hrs Active metabolite: 21-30 hrs	2-3 weeks	4-6 weeks
Olanzapine	Zyprexa	Parent: 21-54 hrs	2-4 weeks	4-8 weeks
Iloperidone	Fanapt	Parent: 15-19 days P88: 18-24 days P95: 17-21 days	3 weeks	6 weeks
Asenapine	Saphris	Parent: 24 hrs	3 weeks	6 weeks
Aripiprazole	Abilify	Parent: 75 hrs Active Metabolite: 94 hrs	2 months	4 months

Antipsychotic Use in Florida: 2012

Antipsychotic Use in Florida: 2016



Antipsychotic Use in Florida: 2020

12.2%

Long Stay Residents

50% reduction since the program started

Q2 2020 CMS Data

Increased Antipsychotic Prescribing in Patients with Dementia During COVID-19 Pandemic

- Data obtained from English National Health Service and published by Lancet Neurology
- Proportion of patients who have been prescribed antipsychotics between 2018 and 2019 remained constant, between 9.28% and 9.47%
  - In March of 2020, percentage increased to 9.69% (95% CI 9.60–9.77)
  - In April of 2020, percentage increased to 9.99% (95% CI 9.90–10.08)
  - In July of 2020, percentage 9.74% (95% CI 9.65–9.83)
- Rates were higher than they were in 2019

Increased Psychotropic Medications in Nursing Home Residents during COVID-19 Pandemic

- Data obtained from Ontario nursing home residents
- Nursing home residents had an increase in antipsychotic (1.6%) and antidepressants (1.6%) prescriptions from Jan – Sep 2020
- These results align with the previous data obtained from the United Kingdom

Concerns with Increased Antipsychotic Use in Elderly and COVID-19

- In addition to the known fall risk and increased risk of death associated with antipsychotic use in the elderly, some studies are suggesting atypical antipsychotic use can increase the risk of COVID-19 infection
- Two different studies showed that risperidone and clozapine can alter a patient's immune response, which increases the risk of being infected with COVID-19
- Patients treated with atypical antipsychotics in long term care facilities should be closely monitored during this pandemic

Summary

- Have your pharmacists and physicians work together to evaluate medication use.
  - Remembering that diagnosis alone is not justification for use, there must be tangible clinical evidence.
- Ensure medication is optimal treatment for diagnosis
  - Depressed → antidepressant
  - Pain → analgesics
  - Anxiety → anxiolytic
- Only use antipsychotic medications for short periods of time (2 to 3 days) with frequent breaks to reassess patient need.

Questions?

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