WELCOME

GINA GAMBARO

Director, Marketing &

Business Development

Asking a question is easy!

- About the topic being presented —
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  - Questions will be answered at the program's end, or offline if time runs out
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Housekeeping notes

- This webinar is being recorded for on-demand access later, after the series' conclusion
- To earn CE, you must attend the entire session
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Forum 50 YEARS+ EXTENDED CARE SERVICES

2022 MONTHLY WEBINAR SERIES

Appropriate Use of Psychotropic Drugs in Long-Term & Residential Care

Introduction

JEANNETTE BRUCKS ASH
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Director of Consulting & Clinical Services

Forum Extended Care Services

Learning objectives

1. Learn which medications and situations should be flagged for concern
2. Understand how to refine your policies and procedures to reflect best practices and ensure regulatory compliance
3. Identify what your pharmacy partner can do to help improve outcomes and reduce risk

The pandemic & what it caused

- Federal data showed a 1.5% increase in antipsychotic medication use* from Jan 2019 through Jun 2021
  - Census declined in most cases, so this number could be higher
- The current nursing home initiative includes a proposal to refocus on problematic diagnoses & reduce the use of inappropriate antipsychotic medications

*HHS analysis of prescription data January 2019 through June 2021.

What needs to be done

- Upon admission, every medication must have the ***appropriate*** diagnosis listed
- During a facility stay, residents must be monitored for behaviors that warrant the continuing use of these medications
  - This includes watching for medication adverse effects
- When a resident is on an antipsychotic, AIMS/DISCUS tests must be performed upon admission & regularly during the stay

Assisted living considerations

- AHCA/NCAL focus on reducing unnecessary antipsychotic use, promoting nonpharmacological interventions to improve quality of life

INAPPROPRIATE Prescribing in ALF (2021 *JAMDA* Study)*	
Antipsychotics	15%
Antianxiety meds	21%

- Joint Commission launched new standards May 2021, with 5 standardized performance measures that must be documented & reported, including:
  - Off-label use of antipsychotic medications
  - Falls

* https://www.mcknightsseniorliving.com/home/news/15-percent-of-off-label-antipsychotic-use-in-assisted-living-may-be-inappropriate-but-nursing-home-reduction-efforts-have-effect-study/

Non-pharmaceutical Approaches

PEGGY WEDER
RN, BSN, MBA

Regional Nurse Coordinator – South

Forum Extended Care Services

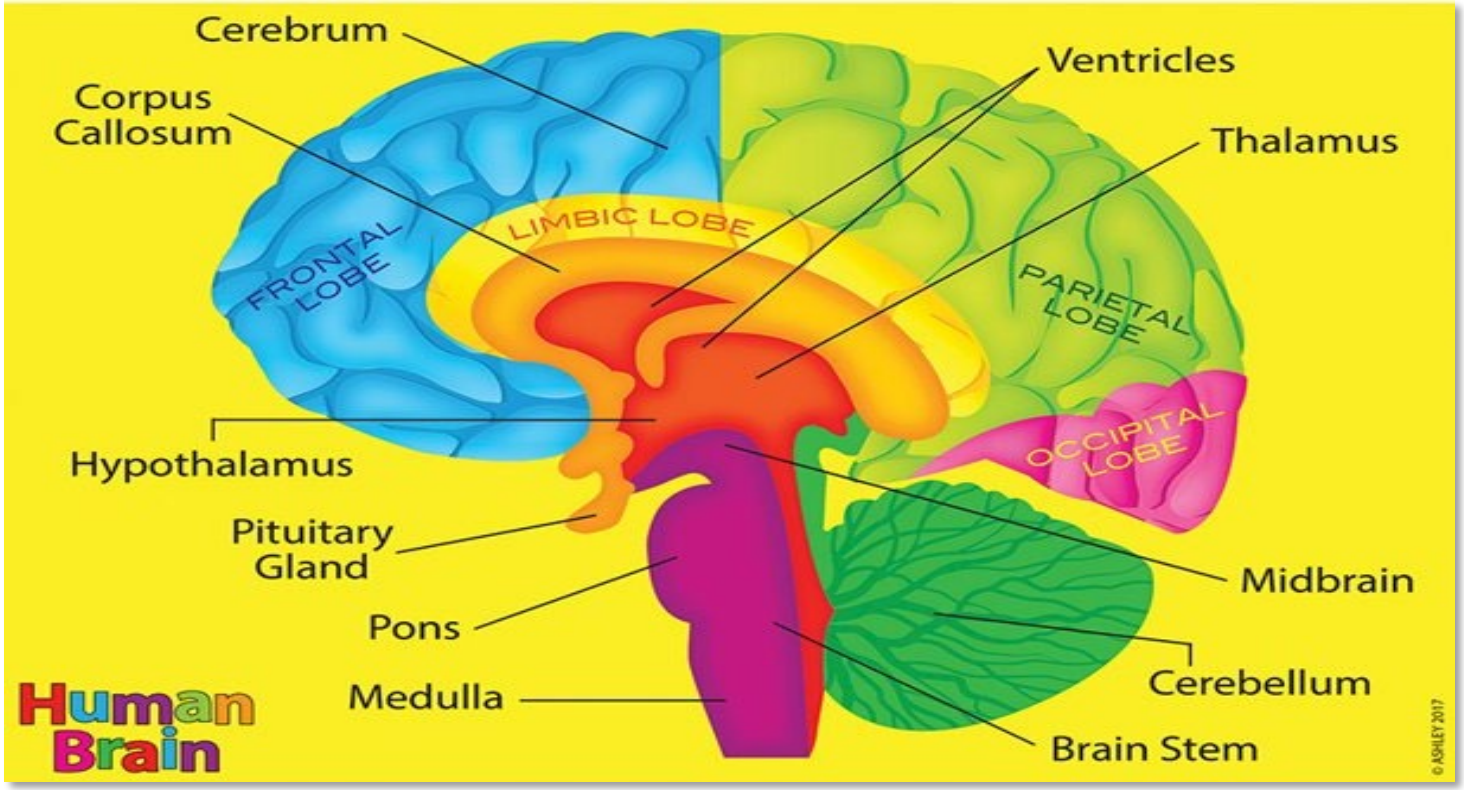




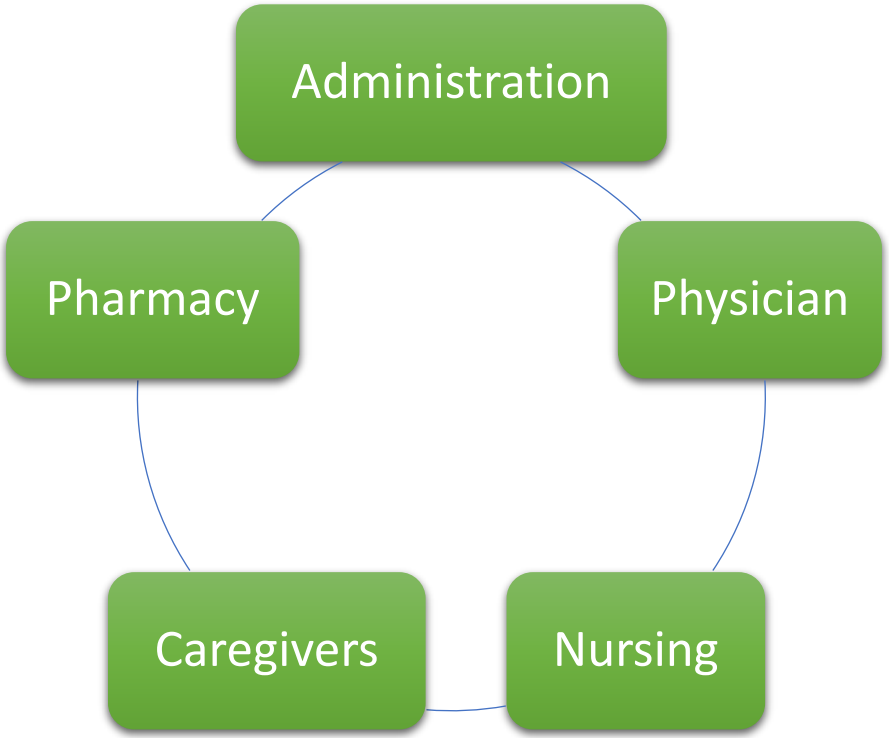


Recognize these behaviors?

Functions of brain & behavior



Intradisciplinary team approach to managing & treating behavioral symptoms



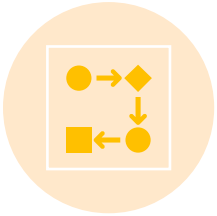
Non-pharmacological approach

Think of behavior as a form of communication

Try to identify what is causing the behavior change

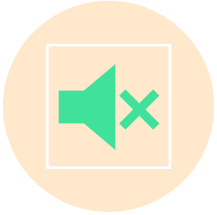
Consider whether the behavior is risky and hazardous, versus annoying and frustrating

Non-pharmacological approach



Try to create a daily routine that is structured & predictable

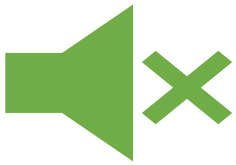
Foster an attitude of acceptance



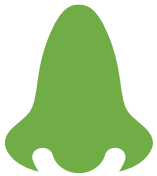
Try to be calm & patient

Talk to other caregivers—what has worked before?

When behavioral situations occur



Give the resident space & time to calm down



Take a deep breath; try to stay calm

Reduce background noise

Listen & offer reassurance

If behavior continues…

Provide a comforting distraction

Find moments of connection (music, storytelling, humor, touch)

Don’t be afraid to change assignments or Caregiver

Assessing Cause(s) of Behaviors in Dementia

SOHAM DEWASHRAYEE
PharmD, RPh

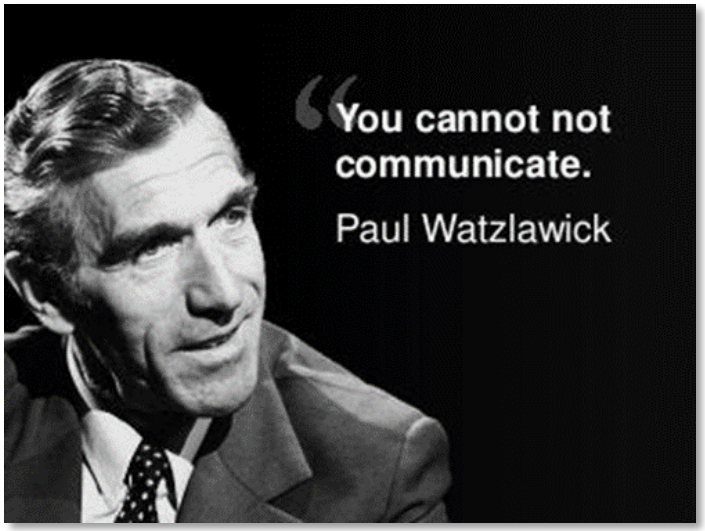
Consultant Pharmacist

Forum Extended Care Services

Every behavior is a version of a communication attempt

I cannot say it, but I might be...

A wise man once said...



First, rule out pain…

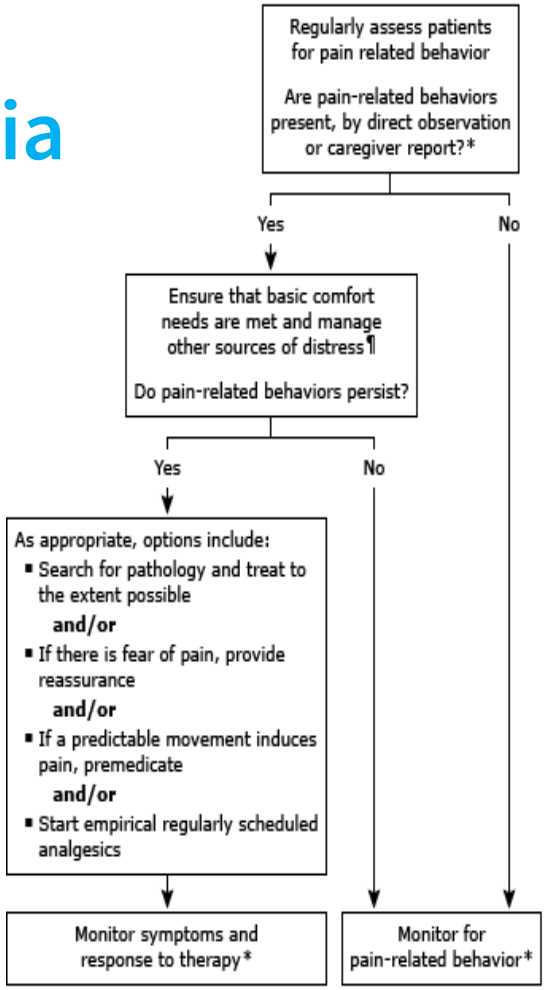
Caregiver reports & clinical observational scales may give clues through:

- Facial expressions
- Verbalizations/vocalizations
- Body movements
- Changes in interpersonal communications
- Changes in activity patterns/routines
- Mental status changes

Approach to pain management in advanced dementia

Should be pragmatic

1. Consider a therapeutic trial of scheduled analgesics
2. Use a stepped-care strategy to analgesic prescribing
3. "Start Low and Go Slow," but use enough
4. Careful monitoring for risk vs benefit analysis of pain treatment vs persistent pain



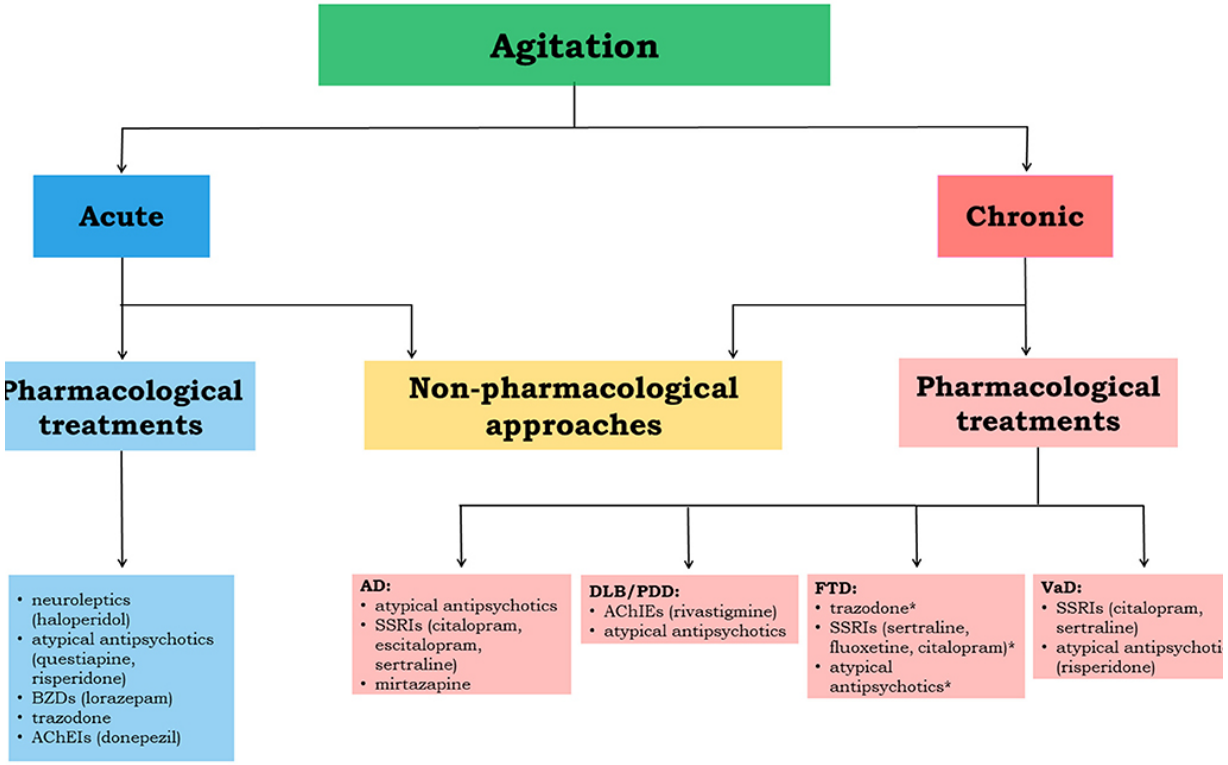
Pain-related behaviors may be diverse, including:

- Grimacing
- Guarding
- Combativeness or disruptive behavior
- Groaning with movement
- Resisting care
- Agitation, irritability, or fidgeting
- Rigidity
- Rapid blinking
- Sleep disturbance
- Diminished appetite
- Reclusiveness

A number of tools for pain assessment in patients with dementia are available (eg, Pain Assessment in Advanced Dementia [PAINAD], Mobilization-Observation-Behaviour-Intensity-Dementia-2 [MOBID-2])

And then rule out everything else…

- Medication side effects
- Delirium
- Depression
- Sleep disorders
- Delusions
- Misperception



Antidepressants & Antipsychotics

KRISTEN NIEDBALSKI
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Antidepressants

Selective Serotonin Reuptake Inhibitors (SSRI)

- Sertraline (Zoloft), Escitalopram (Lexapro), etc

Serotonin and Norepinephrine Reuptake Inhibitors (SNRI)

- Duloxetine (Cymbalta), Venlafaxine (Effexor), etc

Tricyclic Antidepressants (TCA)

- Amitriptyline (Elavil), Doxepin (Silenor), etc

Monoamine Oxidase Inhibitors (MAOI)

- Selegiline, Tranylcypromine, etc

Mixed Action agents

- Mirtazapine (Remeron), Bupropion (Wellbutrin), Trazodone (Desyrel), etc

Antidepressant use

Approved

- Major Depressive Disorder
- Obsessive-Compulsive Disorder
- Panic Disorder
- Post-Traumatic Stress Disorder
- Generalized Anxiety Disorder
- Bulimia Nervosa
- Premenstrual Dysphoric Disorder
- Bipolar I Disorder (acute depressive)
- Vasomotor Symptoms (menopausal)
- Others

Other

- SNRI
  - Neuropathic Pain
  - Musculoskeletal Pain
- Mirtazapine
  - Insomnia
  - Gain Weight
- Bupropion
  - Smoking Cessation

Antipsychotics

1st Generation (Typical)

- Chlorpromazine, Prochlorperazine, Thioridazine, Haloperidol, Fluphenazine, etc

2nd Generation (Atypical)

- Aripiprazole (Abilify), Clozapine (Clozaril), Olanzapine (Zyprexa), Quetiapine (Seroquel), Risperidone (Risperdal), etc

Antipsychotic use

Approved

- Schizophrenia
- Huntington's
- Major Depressive Disorder-Recurrent (adjunct)
- Bipolar I
- Bipolar Depression
- Delusional Disorder
- Tourette's Syndrome
- Psychosis

Unapproved

- Agitation
- **Dementia Without Behaviors**
- Insomnia

Antipsychotic adverse effects/ warnings

Sedation & cognition

Extrapyramidal symptoms (EPS)

Anticholinergic

Cardiovascular

Weight gain, diabetes, lipids

Prolactin

Black box warning (dementia-related psychosis)

Considerations

- **Gradual Dose Reductions (GDRs)**
- **14-day PRN quantities**
- Person-centered, individualized comprehensive treatment plan
  - Non-pharmacological interventions
    - ✓ **Behavioral interventions**
  - Pharmacological interventions
  - **Monitoring** for behaviors & adverse effects
- Training for staff

Appropriate Use of Anxiolytics & Sedatives/Hypnotics

MICHAEL GAWRONSKI
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Anxiolytics

Benzodiazepines — **Short-acting**

- Alprazolam (Xanax)
- Lorazepam (Ativan)
- Oxazepam (Serax)

Benzodiazepines — **Long-acting**

- Chlordiazepoxide (Librium)
- Clonazepam (Klonopin)
- Clorazepate (Tranxene)
- Diazepam (Valium)

Buspirone (Buspar)

As a whole, longer-acting benzodiazepines are not recommended for use in the elderly unless absolutely necessary.

Use can result in excessive sedation, increased risk of falls, and hang-over effect.

Anxiolytic use

<table>
<tr><th colspan="2">Indications & Diagnoses</th><th>Additional Clinical Situations</th></tr>
<tr><td>Generalized anxiety disorder (GAD)</td><td rowspan="3">Delirium, dementia & other cognitive disorders with associated behaviors that:
Are quantitatively & objectively documented
Are persistent
Are not due to preventable or correctable reasons
Constitute clinically significant distress or dysfunction to the resident or represent danger to the resident or others</td><td rowspan="3">Benzodiazepine withdrawal (long-acting agent used to withdraw resident from a short-acting benzodiazepine</td></tr>
<tr><td>Panic disorder</td></tr>
<tr><td>Symptomatic anxiety that occurs in residents with another diagnosed psychiatric disorder</td></tr>
<tr><td>Sleep disorders</td><td rowspan="3">Evidence exists that other possible reasons for the distress have been considered & use results in maintenance or improvement in mental, physical, or psychosocial well-being (as reflected on MDS or other assessment tools)</td><td rowspan="2">Neuromuscular syndromes (cerebral palsy, tardive dyskinesia, restless leg syndrome or seizure disorders)</td></tr>
<tr><td>Acute alcohol withdrawal</td></tr>
<tr><td>Significant anxiety in response to a situational trigger</td><td>Symptom relief at end of life</td></tr>
</table>

Anxiolytic side effects

Increased Risk of	Other Possible Reactions			
Confusion	Dizziness	Insomnia	Respiratory depression	Euphoria
	Drowsiness	Withdrawal syndrome with delirium/hallucinations	Weight loss	
Sedation	Hypotension	Headache	Weight gain	Ataxia
Falls	Depression	Physiological dependence	Tremor	Restlessness
	Nightmares	Syncope	Fatigue	

General rules & considerations for anxiolytics

- Minimize use of long-acting benzodiazepines:
  - Increased risk of falls & accumulation, leading to over-sedation, cognitive impairment & confusion
- Attempt to minimize duration of use of short-acting benzodiazepines
- SSRIs may be better than chronic benzodiazepines for elderly residents with anxiety
  - Many SSRI antidepressants also carry an indication for Generalized Anxiety Disorder (GAD)

Drugs not appropriate for anxiety:

- Triazolam (Halcion)
- Diphenhydramine
- Hydroxyzine*

*Use of Hydroxyzine for pruritis or other dematologic conditions requires consent & periodic dose reductions due to its anxiolytic effect.

Sedatives/hypnotics

Medication	Drug Class	Considerations
Temazepam (Restoril)	Benzodiazepine (short-acting)	Considered best/safest among benzodiazepine hypnotics
Estazolam (ProSom)	Benzodiazepine (intermediate-acting)	Considered safer than Quazepam, Flurazepam & Triazolam
Quazepam (Doral)		Inappropriate for elderly based on significant side-effect profile
Flurazepam (Dalmane)		
Triazolam (Halcion)		
Zolpidem (Ambien®)	Non-benzodiazepine hypnotic	Indicated for short-term treatment of insomnia
Zaleplon (Sonata)		
Eszopiclone (Lunesta)		
Ramelteon (Rozerem)	Melatonin receptor agonist	Not classified as a controlled substance
Chloral hydrate		Inappropriate for elderly based on side-effect profile
Suvorexant (Belsomra)	Orexin receptor antagonist	• Similar side effects as the benzo and non-benzo sleep meds ("sleep driving“ & daytime impairment) • Can cause transient leg weakness or sleep paralysis during sleep-wake transitions (rare)
Trazodone	Sedating antidepressant	
Diphenhydramine	Sedating antihistamine	• Inappropriate in elderly based on side-effect profile • Not a med of choice for insomnia, especially in the elderly
Hydroxyzine	Sedating antihistamine	Not a med of choice for insomnia, especially in the elderly

Gradual Dose Reduction of Antipsychotic Medications

ROBIN FINE
BS, RPh

Consultant Pharmacist

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Why gradual dose reduction (GDR)?

Standard of practice

- Provide the lowest possible dose of psychotropic medication needed to provide maximum benefit with the lowest risk of adverse effects

GDR

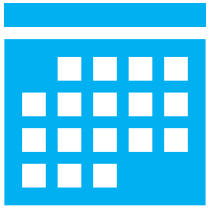
- Stepwise tapering of psychotropic med dose/frequency
- Determine if symptoms, conditions, or risks can be managed and/or if the dose of medication can be discontinued

Which meds should be considered for GDR?

Psychoactive Medication	Special Considerations
Anxiolytics	
Antidepressants	
Antipsychotics	
Hypnotics	
Anticonvulsants	When used for behaviors (Valproic acid, Carbamazepine)
Antihistamines	When used for behaviors (Diphenhydramine, Hydroxyzine)
Prochlorperazine (Compazine)	CMS considers this an antipsychotic

GDR requirements for skilled nursing*

- **Initial attempts** must be made in two separate quarters (at least one month between them)
  - **In the 1st year** in which a resident is admitted on a psychotropic medication
  - **After initiation** of a psychotropic medication
- **After the 1st year**, must be attempted annually



Prescribers must address reasons for not attempting a GDR routinely in progress notes to ensure the facility remains in compliance.

*Unless clinically contraindicated. When antipsychotics are used for medical conditions such as Huntington's Disease or Tourette's Syndrome, dose reductions is not warranted.

GDR requirements for MCDD and ICDD*

- Must be conducted upon:
  - Initiation
  - Dosage increases
  - Discontinuation
- Reductions must be attempted on one or more psychotropics annually

The Human Rights Committee (HRC) regulates psychotropic usage in IL:

- May be comprised of prescribers, nurses, pharmacists, behavioral specialists, and independent community members.
- Meets routinely and when dosage adjustments may need to be made & when emergency situations arise

*MCDD: Medically complex facilities with individuals with developmental disabilities. ICFDD: Intermediate Care Facilities for adults with developmental disabilities.

GDR considerations for assisted living

- No specific Federal or Illinois regulations
- Psychotropics should be **reevaluated periodically** to ensure resident is receiving the lowest dose providing maximum benefit with no adverse effects.

In Closing

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Director of Consulting & Clinical Services

Forum Extended Care Services

Talk to your pharmacy consultants @

- Dealing with psychotropic polypharmacy
- Creating/enforcing a PRN auto-stop policy for antipsychotic meds
- Limiting PRN quantities for psychoactive medications
- Timing, scheduling & special focus for GDRs
- Opportunities when new behaviors/ signs/symptoms emerge
- Monitoring considerations for new orders & dosage changes
- Ensuring effective, ongoing documentation of behaviors
- Effect of PRN & hospice orders on your facility's antipsychotic usage reports
- Ensuring appropriate diagnosis is associated with each psychotropic med
- Training on the regulations your facility must follow to maintain compliance

Q & A

About CE credit

Administrator credit

This program has been approved for one clock hour of continuing education credit by the National Continuing Education Review Services (NCERS) of the National Association of Long-Term Care Administrator Boards (NAB).

Approval #20230518-1-A83018-DL

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This program has been approved for one clock hour of continuing education credit by The Illinois Board of Nursing, an approved sponsor of continuing education by the Illinois Department of Professional Regulation.

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- Certificates should be **emailed in the next 30 days**

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Sep: *Happenings on the Hill – Updates on LTC Initiatives and Legislation*

Oct: *Recruitment, Retention & More in the New Normal*

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