Antipsychotic Use in Nursing Homes

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The Problem of Dementia

- In 2000, 5 million adults with dementia
- In 2050, 13 million adults with dementia
- Costs in 2010, $172 Billion
- 70% of adults with dementia die in nursing homes
- 42% of nursing home residents have dementia
- Special Care Units may provide better care?
- Variability in care prevails despite some standards – e.g. the underlying prescribing culture of a nursing home may determine if and what type of antipsychotic is prescribed
Between Scylla and Charybdis

- Greek mythology proverb meaning “having to choose between two evils”
- Antipsychotics are bad, benzodiazepines are no better and perhaps also antidepressants
- How do you weigh the impact on the unit of aggressive and disruptive behavior over the risk to the individual?
- Most difficult dementia patients end up in the nursing home
Use of antipsychotics to treat dementia and behavioral problems is NOT FDA approved
Why are antipsychotics BAD?

- BLACK BOX WARNING: increases mortality likely from cardiovascular death and within 30 days
- Increases risk for gait instability and falls
- Metabolic syndrome (diabetes, weight gain)
- Anticholinergic properties (constipation, urinary retention, etc)
- Dopaminergic properties (parkinsonism)
- Tardive dyskinesia and neuroleptic malignant syndrome
Why are antipsychotics BAD?

- CATIE-AD trial – risperdal and olanzapine found to have modest improvements in inappropriate behavior but high discontinuation rate due to side effects
- Meta-analysis of 16 placebo-controlled trials showed increase death among those on antipsychotics (3.5% vs 2.3%)
- Benzodiazepines have shown similar rate of increased mortality
- Atypicals (second generation) may be better than typical (e.g. Haloperidol) antipsychotics
Potential Benefit of Antipsychotic Medications in Advanced Dementia

- Reduce anxiety and behavioral problems in some limited residents with advanced dementia
- Improve quality of life for some residents with advanced dementia with behavioral problems
- Calmer and safer environment in dementia units
- However, no robust evidence to support this use in the medical literature
- There is much controversy!
Other Issues with Antipsychotics

- 17% had daily doses exceeding recommended levels
- 18% had both inappropriate indications and high dosing (Breisach, 2005)
- Likelihood of a person with dementia getting antipsychotic was directly correlated with a NH antipsychotic prescribing rate, even after adjusting for confounder (Chen, 2010)
- So facility and physician variation EXISTS
- State to state variation EXISTS as well (Hawaii 13% to MA 28% using Q3 2012 data)
FIGURE 3. Kaplan-Meier plot of crude association between users of different antipsychotics and risk of death.
Risk for Men > Women  JAGS 2013

<table>
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<th>Sex</th>
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<th>No. of persons</th>
<th>Event rate</th>
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<td>High</td>
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Increasing risk for a serious event
Areas for Improvement in Dementia Care → The Low Lying Fruit

- Residents with advanced dementia who are no longer able to produce violent or aggressive behaviors
- Use of antipsychotics for *disruptive* behaviors (crying, yelling) and *not* aggressive or dangerous behaviors
- Use of antipsychotics for anxiety or depression without proper trial of SSRI or mood stabilizers or non-pharmacological strategies
The Low Lying Fruit Continued

- Continued use of antipsychotics started for reversible episodes of delirium or psychotic depression
- Continued use of antipsychotics started prior to nursing home admission
- Infrequently used *PRN* antipsychotics can probably be discontinued
- Use for psychotic symptoms that are not problematic to the patient (e.g. non-violent hallucinations)
Potential Unintended Consequences of Focusing on the Rate of Antipsychotic Use

- If the medication has been successful in an individual patient and attempts at reduction have failed, stopping the medication may produce more harm than good.
- NH may start to refuse residents who are already on antipsychotics.
- More frequent ED referrals for agitation or behavior problems rather than addressing the issue internally.
How to address this problem

- KNOW YOUR DATA: Review all residents on antipsychotic medications for alternatives (pharmacological AND non-pharmacological)

- Do NOT replace antipsychotics with benzodiazepines or other potentially equally harmful medications (e.g. trazodone)

- Do NOT suddenly stop antipsychotics in residents who have been on the medication for a long time, consider a slow weaning trial (sudden withdrawal or rapid weaning can cause withdrawal psychosis)
How to address this problem

- Learn proper strategies for holistic, individualized care of the resident with dementia e.g. HATCH model
- Guideline-based multifactorial interventions have been proven to work
- Work with your team including your pharmacists, physicians and consultants
Resources

1. Antipsychotic Reduction Resident Prioritization Tool
2. Hand in Hand from CMS
3. Nhqualitycampaign.org
4. NE QIN-QIO website
Conclusions

- The goal should always be to provide dementia care without antipsychotics – the goal should be 0%
- There are always opportunities to improve antipsychotic rates
- Improving the education, approach and culture towards antipsychotic use is essential to reduce antipsychotic medication rates
Thank you – Questions?
References

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