Antipsychotic Use In Nursing Home Residents

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FINANCIAL DISCLOSURE

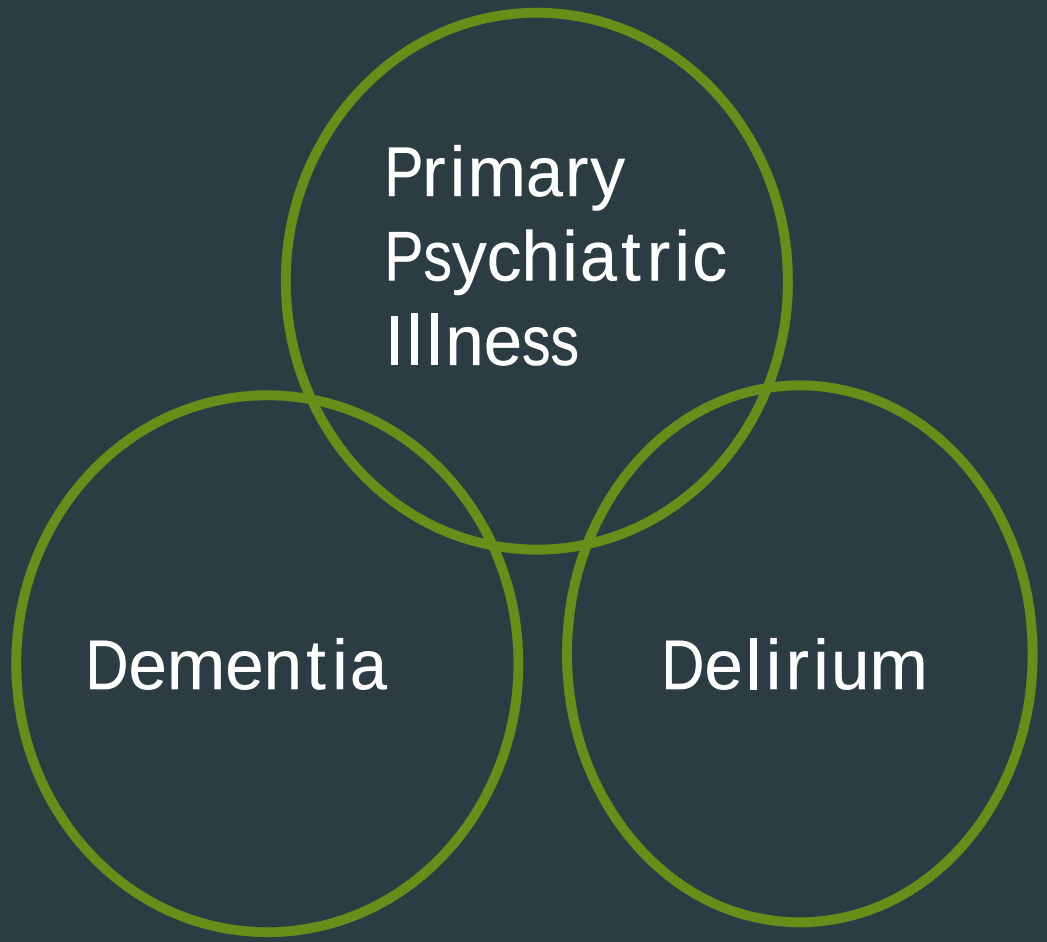
Dr. Kannan discloses that he is a consultant for Allergan and Assurex, is on the speakers bureau for Avanir and Acadia, and that he intends to discuss off-label uses of a commercial product and will disclose this to the audience.

WHAT IS THE ISSUE?

- >1.5 Million NH Residents
- 80% have a psychiatric diagnosis
- Up to 80% have dementia with behavioral issues

DEMENTIA

- 6 million patients
- 400,000 new cases
- 1 in 5 people over the age of 65


Primary Psychiatric Illness
Dementia
Delirium

DECEMBER 2015

- APA practice guidelines on the use of antipsychotics to treat agitation or psychotics in patients with dementia

APA GUIDELINES (cont'd)

- Assess type, frequency, pattern, severity and timing of symptoms
- Assess for pain and other potential modifiable contributing factors
- Individualize both pharmacological and non-pharmacological treatments
- Assess response to treatment at regular intervals

MANAGEMENT OF BEHAVIORAL ISSUES IN NH

- Medical status – PCP/Medical Director
- Psychiatric Issues
- Management of Psychotropics
- Non-phamacological Approaches

CAUTIONARY NOTE:

- Patients with major psychiatric illness (e.g. schizophrenia/ bipolar disorder are in NH)
- Need ongoing meds often

NON-PHARMACOLOGICAL APPROACHES

- More research needed
- Few studies with small sample sizes, inadequate controls

PHARMACOLOGICAL OPTIONS

- No FDA approved dugs for dementia related behavioral dyscontrol
- Guidelines are focused on judicious use of antipsychotic medications when dementia patients develop agitation, psychosis, etc.
- Does NOT apply to patients with prior psychiatric illness and/or acute delirium

- 2005 FDA warning on atypical autopsychotics regarding increased mortality risk when used to treat behavior issues in dementia patients
- 2008 same warning for conventional antipsychotic agents
- Since the warning was issued fewer dementia patients have been given antipsychotics
- Use of Acetylcholinesterase inhibitors and antidepressants has increased

- Despite warnings, 60-80% of dementia patients exhibit delusions, hallucinations, agitation and aggression
  - THEREFORE JUDICIOUS USE OF ANTIPSYCHOTICS IN CERTAIN CLINICAL CIRCUMSTANCES IS APPROPRIATE

- Remember “Do No Harm” mandate is not necessarily extending longevity but improving quality of life
- Thoughtful, careful, limited use of antipsychotic may be appropriate clinical consideration
- NIMH CATIE – Alzheimer’s Disease research indicated risks of atypical antipsychotics was similar to placebo

AGITATION/AGGRESSION IN NH PATIENTS

- Frequent
- Distressing to patient, family, and staff
- Major management challenge in Alzheimer's
- Antipsychotics widely used to treat agitation/aggression. Limited to short term use

CHALLENGE OF ANTIPSYCHOTICS

- Increased risk of falls, stroke, and/or death
- 2012 National Partnership to improve dementia care in NH to reduce unnecessary antipsychotic use
- Use 24% of NH residents in 2011 dropped to 16% in 2017
- Use dropped in All 50 states

ANTIPSYCHOTIC SIDE EFFECTS THAT ARE MORE COMMON IN OLDER PATIENTS

- Cardiovascular changes (prolonged QTs, arrhythmia, stroke, sudden death)
- Hematologic Changes (bleeding alterations, reduced white blood counts and platelets, altered bone metabolism)
- Metabolic/endocrine changes (metabolic syndrome, type2 diabetes mellitus, weight gain)
- Electrolyte imbalance (hyponatremia)
- Extrapyramidal symptoms and tardive dyskinesia

ANTIPSYCHOTIC SIDE EFFECTS THAT ARE MORE COMMON IN OLDER PATIENTS (cont'd)

- Adverse effects that may be related to peripheral and central anticholinergic effects (constipation, urinary retention, cognitive dysfunction, delirium)
- Adverse effects that may be related to antiadrenergic effects (postural hypotension, falls and fractures)
- Adverse effects that may be related to antihistaminic effects (sedation, dry mouth, pneumonia)
- Drug-drug interactions due to medical comorbidity and co-prescribed somatic therapies for medical conditions
- Generally, medical comorbidity becomes more prominent and antipsychotics need to be co-prescribed carefully to avoid interactions with other medications for medical conditions

- The prescribing of mediation for an off-label indication is a common practice and does not necessarily reflect inappropriate prescribing

OFF LABEL PRESCRIBING

- 21% of all medication are prescribed off label
- 46% of cardiac mediations used off label
- 31% of Psychiatric medications used for off label indications

- The prescribing of a medication in the presence of a “Black Box” warning in the FDA labeling is not necessarily inappropriate.

- The standards for use of unnecessary drugs in nursing homes, issued by the Centers for Medicare & Medicaid Services, are considered general guidelines and not absolute rules.

- In BPSD (Behavioral & Psychological Symptoms of Dementia), non-pharmacological approaches are generally preferred as initial therapy WHEN possible.

APPROACH TO BPSD

- What, when, where behavior occurred
- Assess physical/medical, psychological and pain
- Individualize treatment approaches to address the person's needs
- Include family in care plans

ANTIPSYCHOTIC ADVERSE EFFECTS

- Neurotoxicity
- Sedation
- Dysphagia, aspiration, pneumonia, dizziness
- Dysequilibrium, balance issues, falls
- NMS
- TD (increased rate in elderly and women)
- Metabolic syndrome

ANTIPSYCHOTIC ADVERSE EFFECTS (cont'd)

- Seizures
- Sudden cardiac death
- Cognitive decline

GENERAL STRATEGIES

- Minimize environmental change
  - Stability is essential
    - Limit number of caregivers that work well with a resident
    - Videotape successful staff during difficult encounters to educate other staff
    - Minimize the number of room changes
    - Structure breeds improvement
    - Addition of medications within the first 4 weeks after a change in environment not likely to be helpful

GENERAL STRATEGIES

- Not every intervention works with every resident
- Not every intervention works every time
- The key is flexibility
- Often the environment triggers the behavior
- Look around to see what is happening on the unit

BEHAVIORAL PROBLEMS

- Patients are in nursing homes for a reason which are mainly neuropsychiatric (dementia) issues, yet historically, most nursing homes embraced medical caregiving, not psychiatric caregiving.
  - Many NH workers have been trained in medical, not psychiatric environments
  - Better information and instruction is now available about psychiatric problems in the nursing home
  - When the paradigm of psychiatric care is embraced, the way the caregivers look at patients changes dramatically
  - This approach is now expected in long-term care environments

WHY NOT JUST GIVE THEM A PILL???

- Often it does not work
  - Antipsychotics in dementias provide modest benefit.
    - Same with mood stabilizers, antidepressants often used to treat behavioral symptoms, yet there is no FDA approved agent for this issue.
    - Some behavioral problems do not respond well to medications.
      - Wandering/pacing
      - Restlessness/fidgeting
      - Poor self care
      - Disrobing
      - Pulling/picking at dressings, devices
      - Hoarding/stealing

IS IT DUE TO A PSYCHIATRIC PROBLEM??

- Mood
  - 20-50% of all demented patients will suffer with depression
    - Mania can also occur as a result of dementia
  - 50% of all nursing home patients have some type of depression
  - Anxiety
    - 25-40% of demented patients will display anxiety
  - Psychosis
    - Delusions and hallucinations are common in dementia
      - 25-45% of all demented patients will experience psychosis
      - 80% in late stage Parkinson's

COULD IT BE DUE TO A MEDICAL CAUSE??

- New symptoms?
  - New pain from a fracture, UTI, hyponatremia, dehydration
- Exacerbation of old symptoms?
  - COPD-related worsening congestive heart failure hypoxia may appear like anxiety
- Medications?
  - Narcotics, muscle relaxants, chemotherapy, antidepressants, antipsychotics, benzodiazepines

APPROACH TO BEHAVIORAL PROBLEMS

- Is it new or old?
  - Beginning last night or been there since they moved in six months ago?
    - Acute onset makes one more concerned about a medical etiology
    - If it has followed them from facility to facility YOU may need to adapt
- Assess if this is a symptom of an unmet need, a medical problem, or a psychiatric problem

APPROACH TO BEHAVIORAL PROBLEMS (cont'd)

- Unmet need?
  - Hunger, thirst, mobility, relief of pain, boredom, loneliness
- An environmental trigger?
  - Overstimulation/understimulation
  - Particular people
  - Light levels
  - Roommate, moved rooms

WHAT MAKES A BEHAVIOR A PROBLEM??

- Dysfunction and Context
  - More calls if:
    - Physical symptoms directed towards others
    - Verbal symptoms directed towards others
  - Fewer calls if:
    - The resident talks all the time but never raises their voice
    - The resident sleeps too much
    - The resident is too weak to hurt anyone when they are aggressive
- These behaviors can be symptomatic of the same needs as the more disruptive behaviors

WHAT MAKES A BEHAVIOR A PROBLEM?? (cont'd)

- Dysfunction
  - Changes in the day-to-day functioning of the resident and peers due to the behavior
    - Aggression towards others so severe that it puts their placement in jeopardy by harming others or themselves
    - Disruptive vocalizations so intense that their safety is at risk from the aggressive peers
    - Generalized restlessness so profound it leads to a fall and hip fracture in a resident with gait problems

TYPES OF BEHAVIOR A PROBLEMS

- Other than agitation
  - Aggression
    - Towards self, residents or staff
    - Focused or random
    - Hypersexuality
      - Verbal, physical or both
    - Sleep difficulties
      - Up all night, asleep all day
      - Fragmented sleep

TYPES OF BEHAVIOR A PROBLEMS

- Agitation
  - General restlessness
    - Near-constant, no cues noted
  - Specific restlessness
    - Such as with dressing, bathing, feeding
  - Disruptive vocalizations
    - Yelling, question, swearing
  - Disrobing
  - Hoarding/stealing
    - Especially new onset with the dementia
  - Wandering/pacing 20%

INTRODUCTION TO TD

- Why is TD important historically?
  - A permanent side effect
  - Medicolegal ramifications
  - Less prevalent with second generation antipsychotic (SGA) use
- Why is TD an issue now?
  - TD rates are likely higher than suspected
  - SGA use is remarkably high
  - Approved TD treatments are emerging replacing older off-label approaches

RISK FACTORS FOR TD

- Exposure to D2 antagonists
- Female gender
- Increased age
- Mood disorder
- Previous brain injury
- Diabetes
- Early EPS

TD DIAGNOSIS

- TD consists of involuntary athetoid/choreic movements of the tongue, lips, face, trunk, and extremities that occur in patients treated long-term (after at at least a few weeks) with D2R antagonists
  - Grimacing, tongue movements, lip smacking, lip puckering, pursing of the lips, excessive eye blinking
  - Rapid, involuntary movements of the limbs, torso, and fingers less often

Citrome L et al. American journal of Managed Care. 2007-13 (Suppl): 1-12, Lerner V, Miodownik C, Crr Psychiaytry Rep. 2011; (13)4:295-304, Brasic JRE Medscape Aug 8, 2015., Jeste DV & Wyatt RJ. AM J Psychiatry. 1981; 138:297-309.

IS IT TD??

- More Likely
  - Tongue protrusions, fly catcher tongue
  - Isolated smacking, puckering
  - Mouth/jaw opening, closing, lateral movements
- Less Likely
  - A severe or rapidly evolving syndrome
  - Vivid piano player movements only
  - Localized, fixed dystonia only
  - Isolated dyskinesia of lower body

IS TD MORE SUBTLE WITH SGA??

- Watch for subtle findings
  - Lip wetting
  - Lip biting
  - Lip/mouth stereotypy
  - Only upon activation (AIMS testing)

TD TREATMENTS, DISCONTINUING ANTIPSYCHOTICS

- Does switching/stopping ameliorate TD?
  - Remission rates (2%)
  - Response rates (13-20%)
  - There is limited evidence to suggest reversibility of TD
    - Upon switching to an atypical antipsychotic
    - And conflicting data for switching to clozapine

QUESTIONS???