Reducing Antipsychotics for Dementia Patients in Nursing Homes

A CLOSER LOOK AT QUALITY

Lynda Beth Milligan, MD, FAAFP, CPE, CHQCM; Michael Moody, MD; David Nelsen, MD, MS; Steven Strode, MD, MEd, MPH; J. Gary Wheeler, MD, MPS

BY KIM GARNER, MD, JD, MPH; PRASAD PADALA, MD, MS; and SHEILA COX-SULLIVAN, PHD, RN

Approximately 19.4 percent of patients with dementia residing in nursing homes in the United States receive antipsychotic medications. This rate is decreasing. In the fourth quarter of 2014, Arkansas had the third highest rate of change in the nation, declining to 17.9 percent.1

Antipsychotic medications have many appropriate uses including treatment for psychotic disorders such as schizophrenia, psychotic symptoms such as delusions and hallucinations, and behavioral and psychological symptoms of dementia (BPSD) in certain situations. Regrettably, second generation antipsychotics (SGAs) are often used at higher doses than recommended and for longer duration than needed.2 The use of SGAs to treat behavior associated with dementia is an off-label use, generally not supported by research and associated with higher rates of cerebrovascular accidents.3

As a result, the Food and Drug Administration (FDA) has issued a “black box” warning for SGA use in older persons with dementia. In addition, SGAs increase the risk of death, falls with fractures, hospitalizations and other morbidity resulting in poorer health and higher healthcare costs.4

Reasons to reduce use of SGAs and encourage alternative strategies for responding to the challenge of BPSD.

ASSESSMENT OF BPSD SYMPTOMS

Behavior and psychological symptoms are typically identified by nursing staff. They should conduct a thorough assessment of the patient with specific attention on the context of the behavioral occurrence. This assessment should consider the behavior or symptoms from the patient’s perspective. In addition, any activities that may have precipitated the behavior need to be reviewed in deriving a specific treatment approach. There are several frameworks to assess BPSD; one popular method is ABC. Antecedents (A), behaviors (B) and consequences (C) are considered for each episode of BPSD to gather information about patient, caregiver and environmental contributions to BPSD.5

Another important framework to assess BPSD is as a manifestation of “unmet needs.” Unmet needs can be environmental, such as excessive stimulation (noise, number of people, clutter), under-stimulation (boredom, poor lighting), issues of room temperature (too hot or cold), and difficulties finding a desired location (bathroom, his/her own room, or a dining room). A thorough medical assessment must also be completed to rule out any medical issues contributing to BPSD. The differential diagnosis should include infections, constipation, urinary retention and/or unrecognized pain.3

NONPHARMACOLOGICAL MANAGEMENT OF BPSD SYMPTOMS

Substantial evidence shows that nonpharmacologic management of BPSD can yield high levels of patient and caregiver satisfaction, quality of life improvements and reductions in behavioral symptoms. Nonpharmacologic treatments involve either a general or targeted approach in which precipitating conditions of a specific behavior are identified and modified (see Table 1).

An important but often inadequately utilized approach to reduce behavioral and psychological symptoms is physical activity. With training, simple activities such as taking routine daily walks with staff can enhance feelings of well-being and improve sleep. Purposeful psychomotor activities with interest or meaning to the patient and graded to their capabilities (e.g., executive function, motor abilities) can reduce agitation and other BPSD. For example, a patient with interest in fishing may be able to organize a tackle box, sort plastic equipment, look through a fishing magazine or watch a video on fishing. Purposeful and
regular activities that tap into previous interests and memory can be utilized. There is evidence these approaches effectively decrease the incidence of BPSD. Programs such as Simple Pleasures (http://www.health.ny.gov/diseases/conditions/dementia/edge/interventions/simple/) or STAR-VA have effectively decreased the severity and frequency of BPSD.

Another key aspect is to refrain from using physical restraints. Providers should discourage this practice at every opportunity, particularly since restraints are also associated with increased falls, more rapid cognitive decline, decreased mobility and death.

PHARMACOLOGY FOR BPSD SYMPTOMS

There are no FDA-approved medications for BPSD and second-generation antipsychotics (SGAs) have modest benefits at best. In addition, patients with dementia are predisposed to greater side effects from SGAs. For these reasons, non-pharmacologic treatments should always be tried first. However, if antipsychotic medications are used, they should be used in an appropriate and safe manner. Best practices in the use of any antipsychotic should include ongoing clinical management and provider documentation of:

- Appropriate indication with specific goal of therapy
- Monitoring effectiveness in achieving goal by repeated assessment of BPSD
- Monitoring for adverse effects
- Lowest effective dose for shortest possible duration

FUTURE EFFORTS

The CMS is monitoring antipsychotic use and has a goal to decrease the off-label use of SGAs. Other organizations have joined the effort to provide guidance on appropriate antipsychotic prescribing in nursing facilities. Recently, the National Partnership to Improve Dementia Care reported that the first goal of a 15 percent national reduction in SGA use for the treatment of dementia has been met. The partnership has set new goals of a 25 percent reduction by 2015 and 30 percent reduction by 2016.

Dr. Garner is board certified in family medicine, geriatrics and hospice and palliative medicine. Dr. Cox-Sullivan is a doctorate level nurse. Dr. Padala is board certified in psychiatry, geriatric psychiatry and psychosomatic medicine at the Department of Veterans Affairs VISN 16 Geriatric Research Education and Clinical Center (GRECC) and the Department of Geriatrics at the University of Arkansas for Medical Sciences.

REFERENCES


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