Use of Antipsychotic Medication in Nursing Homes

Written comments for Kansas Senior Care Task Force by Tracy Davies, DNP, APRN, ANP, GNP-BC, PMHNP-BC

Dear Committee,

Thank you for the opportunity to share my insights on this important topic. I am a dually board-certified nurse practitioner in geriatrics and in psychiatric mental health, and formerly a state nursing home surveyor, and nursing home administrator. I have been practicing in Kansas for 17 years.

Clinical overview of this topic has already been addressed by Dr. Adma. The focus of my comments therefore will not duplicate this information but will highlight some of the factors associated with translating evidence and putting recommendations into practice.

Extent of the problem

Up to 90% of people with a dementing illness may at some point experience behavioral and psychological symptoms (BPSD). Psychosis is one of the most significant single predictors that the person will be placed in a nursing home (Martinez-Ramirez et al., 2016). The number and severity of symptoms contributes to the difficulty in caring for people in the nursing home. These symptoms are associated with poor outcomes, high levels of distress for the individual and their caregivers, contribute to hospitalizations, inappropriate use of medications, and increased costs of care (Cerejeira, et al 2012).

Decision to use or deprescribe antipsychotics or other psychotropic medications

The decision to use or deprescribe antipsychotics or other psychotropics in people who live in nursing homes and are experiencing BPSD, a primary psychiatric disorder, or related problem is a complex undertaking. This is due to the challenges presented with needing to consider multiple intervening variables. What is important to consider is how we implement the decision to address the problem. We have information in the literature aptly summarized by Dr. Adma's written testimony to guide us regarding differentially diagnosing symptoms and assessing problematic behaviors from a multidimensional perspective, and we have regulatory guidance from CMS for the protection of vulnerable people living in nursing homes. What seems to fail to adequately address the issue of antipsychotic use is implementation. How we mobilize the information and systems effectively to achieve this goal. Addressing barriers to the coordination of care will greatly improve our ability to address this problem. Barriers identified in the literature (Moth, et al, 2021; Reeve, et al, 2015) include the following themes:

- Operationality and routines
- Lack of resources and qualifications
- Patient-related outcomes
- Policies including support and buy-in from nursing home leadership
- Collaboration between physicians and nursing home staff

- Inadequate guidelines
- Incomplete medical histories
- Lack of time
- Avoidance of negative consequences
- Established beliefs in the benefits and harms of medication use
- Diminished decision-making capacity, difficulties with comprehension and communication increasing involvement of caregivers and difficulties establishing goals of care

What nursing home residents need:

- A multidisciplinary team that can conduct a comprehensive, multidisciplinary assessment of needs on a ongoing basis. Including access to appropriately trained mental health specialists regardless of their location.
- Systems that work together without significant barriers. Including time for providers to communicate, elimination of rigidly applied global polices such as restricted formularies, step therapy or first fail, gradual dose reduction medication policies if deemed by their provider as inappropriate for their clinical situation.
- Quality of life-a sense of purpose and agency over decisions that are important to them.
- Recognition that behaviors are related to unmet needs and their dementing illness poses a barrier to communicating those needs.

What clinicians need:

- Specific information that helps inform clinical decisions.
- A knowledgeable caregiver who can provide necessary history to attend every appointment. The nursing home resident is often a poor historian due to memory problems, has poor insight into their symptoms and disruptive behaviors and cannot provide the level of detail and context necessary for clinical decision making.
- Information needs to be made available before the scheduled appointment.
- Specific symptoms and disruptive behavioral problems need to be identified and the frequency, intensity, and duration of these symptom targets need to be documented and discussed at each clinical visit.
- Contextual information is equally important. An assessment of antecedents and consequences associated with the problematic symptoms and behaviors is necessary to help guide treatment planning, especially for nonpharmacological interventions and if as needed medications are to be used.
- Examinational data such as vital signs, including orthostatic vital signs, weight, food and hydration intake and elimination patterns are important.
- Current medication lists, notation of any recent changes in physical symptoms or medications.
- Elimination of barriers to prescribing medications deemed appropriate for the unique individual's clinical situation. Ex: restricted formularies, first fail, step therapy, long acting injectable antipsychotics in younger people in NFMH.
- Information about the daily activities/routines/stimulation that may be relevant.

- To know how to document clinical review and medical justification for treatment decisions acceptable to meet needs of the nursing home regulatory environment. This information needs to be available from the outset of treatment for periodic review to determine if the initial indication continues or has changed. This information needs to be communicated to any new provider that may be assuming care for the problem.

What direct caregivers need:

- Training-
- Understanding BPSD and proactive nonpharmacological interventions.
- How what they do makes a difference in preventing problems e.g. hydration & nutrition/toileting schedules/comfort/interaction and environmental management
- How to assess and manage disruptive behaviors and properly describe them.
- Safety-
- Adequate staffing and rotation break from particularly difficult assignments.
- Know what to do to avoid being injured by violent outbursts.
- Ability to debrief after dealing with challenging behaviors.
- Recognition-
- To feel valued for what they do. Positive reinforcement for what they do well.
- Involvement and ownership in decisions about care delivery.
- What care coordinators need:
    - To know how to appropriately interpret and utilize regulatory guidance, assessment tools, clinical documentation from all sources to plan, coordinate, evaluate and communicate the effectiveness of care.

References

Cerejeira, J., Lagarto, L., & Mukaetova-Ladinska, E. B. (2012). Behavioral and psychological symptoms of dementia. *Frontiers in Neurology, 3,* 73. https://doi.org/10.3389/fneur.2012.00073

Martinez-Ramirez, D., Okun, M. S., Jaffee, M. S. (2016). Parkinson's disease psychosis: Therapy tips and the importance of communication between neurologists and psychiatrists. *Neurodegenerative Disease Management, 6*(4), 319-30. doi: 10.2217/nmt-2016-0009.

Moth, A.E., Hølmkjær, P., Holm, A. et al. (2021). What makes deprescription of psychotropic drugs in nursing home residents with dementia so challenging? A qualitative systematic review of barriers and facilitators. *Drugs Aging, 38,* 671–685. https://doi.org/10.1007/s40266-021-00875-1

Reeve, E., Simon Bell, J, H. Hilmer, S. (2015). Barriers to optimising prescribing and deprescribing in older adults with dementia: A narrative review. *Current Clinical Pharmacology, 10*(3), 168-177.