Reduce the use of Atypical Anti-Psychotics (AAPs) in Nursing Facilities by 15% by 12/12

Improve the appropriate and effective use of psychotropic medications for elderly adults as part of the holistic strategy to improve health outcomes

KEY DRIVER DIAGRAM - draft
Project Name: NF AAP Utilization QI Project
Team Leaders: Drs. Bonnie Burman-Kantor (ODA) & Mary Applegate (OHP)

SMART AIM
Reduce the use of Atypical Anti-Psychotics (AAPs) in Nursing Facilities by 15% by 12/12

GLOBAL AIM
Improve the appropriate and effective use of psychotropic medications for elderly adults as part of the holistic strategy to improve health outcomes

KEY DRIVERS
- Public Awareness
- Clinical Expertise tied to Quality Improvement
- Data Transparency & Feedback
- Special Populations
- Family Centered Care
- Payment & Policy
- Access to non-medication alternatives

INTERVENTIONS
- Launch public awareness and education campaign
- Engage stakeholders (NFs, associations, families, prescribers, community centers, AAAs, APS, social workers) to provide input into education materials & processes
- Include Prevention & alternative Strategies to AAPs
- Create cognitive and provider-based initiatives from existing guidelines for AAP use in this population, including step-down therapies
- Disseminate evidence-based Practice guidelines for diagnosis & treatment of dementia
- Provide practice alert systems in EHRs/Pharmacy
- Engage clinicians & NFPs in peer pressure processes
- Establish collaborative to support QI, CME in conjunction with academic & professional organizations including Nurses and mid-level providers
- Include pharmacists, as required team member
- Telemedicine, innovative IT applications
- Workforce development

- Monthly meaningful prescribing & feedback profiling
- Engage Drug & Pharmacy Benefit Managers
- Public reporting, prior authorization requirements
- Reduce at hospitals or to those with Dementia and Mental Health diagnoses
- Target High volume prescribers & providers
- Target Geographic trends

- Begin informed consent process with joint decision making
- Family mentorship
- Routine behavioral assessment and follow up
- Amend quality incentive program
- Tie quality to licensure requirements
- Improve availability, access & knowledge of alternatives
- Promote early screening and intervention, routine assessment & IT solutions
- Promote marketing requirements to include non-drug options

Improving Dementia Care and Reducing Unnecessary Use of Antipsychotic Medications in Nursing Homes
Alice Bonner, PhD, RN
Division of Nursing Homes
Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services
December 17th, 2012
Why this Initiative? Why Now?

 Improving Dementia Care - Background

- High prevalence rates of antipsychotic drug use in nursing home residents have been reported in several studies. Much of the use is in residents with a diagnosis of dementia.

- According to CMS’s QM/QI report, between July and September 2010, 39.4% of nursing home residents nationwide who had cognitive impairment and behavioral issues but no diagnosis of psychosis or related conditions received antipsychotic drugs.

- In addition to dangers associated with antipsychotic medications for the elderly, it can also be expensive to consumers and Medicare. Atypical antipsychotic drugs cost more than $13 billion in 2007 – nearly 5% of all U.S. drug expenditures.
Antipsychotic Medications in Nursing Homes – Prescribing Issues

- In one study, 17.2% had daily doses exceeding recommended levels. And 17.6% had both inappropriate indications and high dosing (Briesacher, 2005)

- The likelihood of a resident to receive an antipsychotic medication was related to the facility-level antipsychotic prescribing rate, even after adjustment for clinical and socio-demographic characteristics (Chen et al., 2010)

Antipsychotic Medication Use Varies by State

Source: MDS National Quality Indicator System - 3.0
CMS’ National Partnership to Improve Dementia Care

- CMS developed a national partnership to improve dementia care and optimize behavioral health.
- By improving dementia care and person-centered, individualized interventions for behavioral health in nursing homes, CMS hopes to reduce unnecessary antipsychotic medication use in nursing homes and eventually other care settings as well.
- While antipsychotic medications are the initial focus of the partnership, CMS recognizes that attention to other potentially harmful medications is also an important part of this initiative.

Partnership Overview

- The Partnership promotes the three “R's”
  - Rethink – rethink our approach to dementia care
  - Reconnect – reconnect with residents via person-centered care practices
  - Restore – restore good health and quality of life
CMS Updates on the National Initiative: A Public-Private Partnership

• Proactive efforts include collaboration with partner organizations around:
  – provider and prescriber training
  – surveyor training, review of surveyor guidance, protocols and challenges related to assessing compliance in these areas
  – research
  – quality measurement, public reporting
  – communication strategies such as local and national conference presentations, press releases
  – development of dissemination strategies in states and regions and a sustainable national plan for ongoing monitoring and evaluation of these issues
Partnership Overview

• Multidimensional approach includes:
  
  – Public Reporting
    • Rates of nursing homes’ antipsychotic drug use available on Nursing Home Compare (long-stay prevalence; short-stay incidence)
    • First year goal: reduce prevalence rate of antipsychotic drug use in long-stay nursing home residents by 15% by end of 2012

Nursing Home Compare Quality Measures

• Measure: Percentage of Long-Stay Residents Who are Receiving Antipsychotic Medication

• Description: The percentage of long-stay residents (>100 cumulative days in the nursing facility) who are receiving antipsychotic medication

• Measure: Percentage of Short-Stay Patients Who Have Antipsychotics Started – Incidence

• Description: The percentage of short-stay residents (<=100 cumulative days in the nursing facility) who have antipsychotic medications started after admission
Partnership Overview

- **Research**
  - Conduct research to better understand how the team makes decisions to use antipsychotic drugs in residents with dementia
    - Study factors that influence prescribing patterns and practices
    - Implement approaches to improve overall health of residents with dementia based on results of study
  - Facilitate sharing of research findings; research workgroup

- **New grants since partnership began**
  - Commonwealth Fund small grant to compile evidence-based research on use of non-pharmacological approaches in persons with dementia – to assist providers in accessing evidence-based information on these approaches and implementing them in practice (develop a toolkit)
  - Review deficiency citations at F329 to better understand how surveyors cite non-compliance related to unnecessary antipsychotic medication use

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Partnership Overview

- **Training**
  - **Hand in Hand**
    - DVD series. Provides direct care workers with training that emphasizes person-centered care, prevention of abuse and individualized approaches to care of persons with dementia *(FREE. Distributed to all nursing homes in December 2012; many partner organizations to receive soon as well)*
  - **One Stop Shopping**
    - Multiple training programs/materials available for providers, clinicians, consumers and surveyors on Advancing Excellence website and several association, university websites as well.
    - [www.nhqualitycampaign.org](http://www.nhqualitycampaign.org)
    - Many thanks to Miranda Meadows and Kris Mattivi at CFMC and Michele Laughman at CMS
    - Site is dynamic – new information added frequently
Resources and Tools

Background

Overview of Initiative to Improve Behavioral Health and Reduce the Use of Antipsychotic Medications in Nursing Home Residents

The initiative to improve behavioral health and reduce the use of antipsychotic medications in nursing homes is an important and timely effort to improve care and reduce the use of antipsychotic medications. The initiative is supported by a variety of stakeholders, including federal agencies, state governments, and industry partners.

State Initiatives and Presentations

New York State Initiative to Improve Dementia Care Continuity of Care Leadership Coalition Louisiana Dementia Partnership L.E.A.D.E.R.S. (Louisiana Enhancing Aging with Dignity and Empowerment and Respect)

Individual Tools and How-To's

SAMPLE NURSING HOME READINESS AND PREPAREDNESS ASSESSMENT

Provider Self-Assessment

A list of questions for direct caregivers and nursing home leadership to assist in preparing for the approach to dementia care.

Provider Checklist

A suggested list of questions for provider use to assess their readiness for dementia care.

Provider Flow Diagram

A flow chart with suggested steps for implementing quality improvement efforts to reduce inappropriate use of antipsychotics.

SAMPLE RESIDENT ASSESSMENT FORMS

Questions to Consider in Interdisciplinary Team Review of Individual Dementia Care Plans Partnership to Improve Dementia Care in Nursing Homes

Psychosocial In-Service: Interdisciplinary Medication Review Dr. Kaye Leibra
### ADVANCING EXCELLENCE IN AMERICA'S NURSING HOMES

#### SAMPLE MEDICATION POLICY

**Sample Psychotropic Medication Policy**

Dr. Marylin Leake

#### PRACTICE GUIDELINES

- **Dedicated to Long Term Care Medication Excerpts from AMDA Dementia Clinical Practice Guidelines**
- **American Medical Directors Association (AMDA)**
- **Action for Improving Dementia Care in Nursing Homes**
  - **American Medical Directors Association (AMDA)**
  - **American Psychiatric Association Practice Guidelines**
  - **American Psychiatric Association (APA)**
- **Dementia Care Practice Recommendations**
  - **Alzheimer's Association**

#### COMPREHENSIVE TOOL KITS

- **The AltFACTS Quality Initiative**
  - **American Health Care Association (AHCA)**
- **The Campaign to STOP Chemical Restraints in Nursing Homes**
  - **California Advocates for Nursing Home Reform (CANHR)**
- **Improving Antipsychotic Appropriateness in Dementia Patients (AL-ADAPT)**
  - **Ohio Geriatric Education Center**

#### CONSUMER INFORMATION

**Assessment and Care Planning: The Key to Quality Care**
- National Consumer Voice for Quality Long-Term Care

**Individualized Assessment with Behavior Symptoms: Consumer Fact**
- The National Consumer Voice for Quality Long-Term Care

**Use of Antipsychotic Drugs in Nursing Homes**
- The National Consumer Voice for Quality Long-Term Care

**How to Deal with Challenging Behaviors**
- Alzheimer's Association

#### EVIDENCE-BASED RESEARCH

- **A Systematic Evidence Review of Non-pharmaceutical Interventions for Behavioral Symptoms of Dementia**

#### BOOKS & ARTICLES

- **Swallowing Trouble Some Behaviors**
  - (Article) Rhee, P. Massachusetts Alzheimer’s Association Chapter Newsletter, Spring 2005

- **Habitat Therapy: A New StarSpace**

- **Dementia Beyond Drugs: Changing the Culture of Care**

- **Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults**
  - (Article) American Geriatrics Society. JAGS 2012

- **Unbridled Use of Antipsychotic Medications: National management of irrationality**
Partnership Overview

• Multidimensional approach includes:
  
  – **Partnerships and State-based Coalitions**
    • Engage the ongoing commitment and partnership of stakeholders including state survey agency and Medicaid agencies, provider groups, resident advocates, professional associations, QIOs, LANES, consumer groups, ombudsman and others
    • Involve residents and families (“Nothing about us, Without us!”)
    • Create or support existing individual state coalitions, LANES or collaboratives that will identify and spread best practices
    • Amazing, grass roots work in many states already

Frequently Asked Questions

• Is there an expectation that every facility will reduce the rate of antipsychotic use by 15%?
  – Answer: No. That is a national target. Some facilities will reduce their rate by more than that, some less. There may be valid reasons why some facilities have higher than average rates of antipsychotic use, based on their population

• Should pharmacists change their approach to recommending gradual dose reductions (GDR) in stable residents?
  – Answer: the approach has always been and should continue to be that the clinical team documents a systematic process for evaluating the ongoing use of the medication and clinical rationale for why a stable resident should remain on an antipsychotic. A conversation with the physician or prescriber is often helpful. Surveyors will ask about individualized approaches other than medication as well.
The Survey Process

• Will surveyors be looking more intensively at persons with dementia who are on antipsychotics?
  – Surveyor guidance has been revised with input from several professional associations (AHCA, AMDA, ASCP, NADONA, AAGP, AGS and others), advocates and other stakeholders. Surveyors will include residents with dementia who are receiving an antipsychotic in their sample.
  – Surveyors will look for the same systematic process that providers and practitioners should be using to determine the underlying causes of behaviors in persons with dementia.
  – Surveyors will look to see that care plans include plans for residents with dementia that address behaviors, include input from the resident (to the extent possible) and/or family or representative and that those plans are consistently carried out.

• Surveyors are looking for a systematic process to be evident and for that process to be followed for every resident

Systematic Process

• Get details about the patient's behavioral expressions of distress (nature, frequency, severity, and duration) and the risks of those behaviors, and discuss potential underlying causes with the care team and family

• Exclude potentially remediable causes of behaviors (such as delirium, infection or medications), and determine if symptoms are severe, distressing or risky enough to adversely affect the safety of residents
Systematic Process

- Try environmental and other approaches that attempt to understand and address behavior as a form of communication in persons with dementia, and modify the environment and daily routines to meet the person's needs.

- Assess the effects of any intervention (pharmacological or non-pharmacological) identify benefits and complications in a timely fashion. Adjust treatment accordingly.

Systematic Process

- For those residents for whom antipsychotic or other medications are warranted, use the lowest effective dose for the shortest possible duration, based on findings in the specific individual.

- Monitor for potential side effects, therapeutic benefit with respect to specific target symptoms/expressions of distress.
  - Inadequate documentation: "Behavior improved." "Less agitated." "No longer asking to go home."
  - Include specifics, why they behaviors were harmful/dangerous/distressing and what the person is now able to do (positive) as a result of the intervention

- Try tapering the medication when symptoms have been stable or adjusting doses to obtain benefits with the lowest possible risk.
The Survey Process

- Input from nursing assistants, nurses, social workers, therapists, family and other caregivers working closely with the resident is essential. Input from all three shifts and weekend caregivers is also important in “telling the story.”
- Surveyors will look at communication between shifts, between nurses and practitioners or prescribers.
- Surveyors will also look at whether medications prescribed by a covering practitioner in an urgent situation are re-evaluated by the primary care team.
- *Surveyors will look at whether or not other psychopharmacologicals are prescribed if/when antipsychotic medications are discontinued or reduced.*

Clinical Teams are Asking Questions such as:

- How do I handle this situation?
- How do I find out about person-centered approaches and how do we train our staff?
- Should we use a medication? If so -
  - Which medications should we use?
  - How much should we give, and how often?
  - How do we know whether those medications are working or causing complications?
  - When should we start or stop those medications?
“How can we reduce our rate of antipsychotic use in persons with dementia...”

• Look at the big picture – consider dementia care principles
• Focus on each individual resident and use a careful, systematic process to evaluate his/her needs.
• During off-site preparation, surveyors will review the antipsychotic rate in the facility. Surveyors will ask staff about the facility’s approach to persons with dementia.
• QIOs will be increasingly involved in phase II of the current (10th) SOW.

“How can we reduce our rate of antipsychotic use in persons with dementia...”

• Consider forming a behavioral health committee or team for dementia care practices. Include the consultant pharmacist, medical director, administrator, DON, recreational and other therapy staff, social worker, direct care partners/staff (CNAs)
  – Also include behavioral health specialists/consultants if possible
  – Resident, family members when facility policies/practices (not individuals) are being discussed
• Begin by looking at each resident with dementia who is on an antipsychotic and considering the case in detail. Look for underlying causes of the behaviors. Consider whether a GDR may be indicated and communicate with the practitioner. Tools on AE. National experts are available.
“How can we reduce our rate of antipsychotic use in persons with dementia…”

- Use this team to examine nursing home practices related to dementia care and behavioral health
- Consider programs such as Hand in Hand
  - Produced by CMS, this is a six-hour series of DVDs with training for nursing assistants on abuse prevention and dementia care.
- OASIS, Habilitation therapy, others
- Contact your QIO

CMS Challenge to Our Partners

- Share your existing work/resources with national leadership
  - Curricula on dementia, behavioral health, reducing unnecessary medications
- Consider ways to communicate with members and encourage engagement around this issue
- Work with CMS to sustain and expand local, state, regional and national workgroups or collaboratives around this issue
Q&A, Discussion and Next Steps

- Set 2013 goals for the national initiative
- Continue engaging partners at the local, state, regional and national level
- Develop and refine quality measures
- Continue to conduct outreach to nursing homes

What if we don’t have a lot of geriatric training or experience?

- [www.nhqualitycampaign.org](http://www.nhqualitycampaign.org)
- [www.ascp.com](http://www.ascp.com)
- [www.amda.com](http://www.amda.com)
- [www.ahcancal.org](http://www.ahcancal.org)
- [www.leadingage.org](http://www.leadingage.org)
- [www.americangeriatrics.org](http://www.americangeriatrics.org)
- [www.alz.org](http://www.alz.org)
- HRSA funded GECs to enhance dementia training
Questions?

Thank you!

DNH_BehavioralHealth@cms.hhs.gov
– CMS staff can put you in touch with state coalition leads and state-level resources

Alice Bonner
Director, Division of Nursing Homes
Survey and Certification Group
Centers for Medicare & Medicaid Services
Alice.Bonner@cms.hhs.gov

Partnership to Improve Dementia Care:
The Role of Your Consultant Pharmacist

Joseph G. Marek, RPh CGP FASCP
• Omnicare Clinical Services
  • Clinical Manager,
    • Northern & Central Ohio
• American Society of Consultant Pharmacists (ASCP)
  • Board of Directors
What Should You Expect from Your Consultant Pharmacist?

- Clinical and Regulatory Expertise
- Leadership and Support
- Education of the Multidisciplinary Team
- Resources and Tools

Consultant Pharmacists

_Three Core Strengths_:

- Knowledge and skills in geriatric pharmacotherapy
- Expertise in treating our frail seniors in the long-term care setting or other settings
- Patient Advocates - Protecting the health and quality of life of America’s seniors through medication management
Consultant Pharmacists - Clinicians

- Consider the most appropriate and effective medication therapy for each resident
- Identify, resolve and prevent medication-related problems
- Ensure regulatory compliance with SOM guidelines
- Provide medication utilization data, analysis & guidance to each facility

Leadership and Support

- Participation with the multidisciplinary team to achieve the mutual goal of enhancing the care and treatment of residents with dementia by providing:
  - Collaboration in the medication management for each individual resident
  - Guidance & participation in the Multidisciplinary Medication Management Meeting
Education for Multidisciplinary Team

- Antipsychotic Education through In-Servicing:
  - “Considerations for Reducing and Eliminating Antipsychotic Medications for Behaviors in Elderly Nursing Home Residents with Dementia”
- Non-Pharmacological (non-drug) interventions tip sheets
- The AHRQ report Executive Summary: “Off-Label Use of Atypical Antipsychotics- An Update”.

Education for Medical Director and Prescribing Physicians

Reviewing the CMS Initiative and Regulatory Requirements through:

- SOM Guidance
- Clinical References or Research
- Prescriber Guide for Dose Reductions
- AMDA’s Letter to Prescribers from Dr. Matthew Wayne, President AMDA
Resources and Tools

• Treatment Algorithms
  ▪ Reduction of Antipsychotic Medication in Dementia Residents Receiving for Behavioral Symptoms

• Multidisciplinary Assessment Tool
  ▪ Antipsychotic Use in Dementia Assessment Form

• Gradual Dose Reduction Tracking Report
  ▪ Documents indications for use, therapy start date, and next gradual dose reduction due date

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Algorithm for Reducing or Eliminating Antipsychotics for Residents with Behavioral Symptoms of Dementia

Resident Receiving Antipsychotic for Behavioral Symptoms

Assess ongoing use of non-pharmacologic interventions throughout process. Minimize use or discontinue use of medications with anticholinergic properties. Assess for depressive symptoms (PHQ-9 score on MDS 3.0). Assess for intercurrent illnesses that may be causing or contributing to behaviors (i.e., pain, constipation). Assess for condition that may have caused or contributed to behaviors that is now resolved (i.e., delirium due to UTI, etc.)

If antipsychotic GDR tolerated, request further GDR in 3 – 4 months.

Monitor for behavioral symptoms and adverse medication effects. Request GDR attempt in 3 – 4 months if behaviors have improved or stabilized.

If symptoms re-emerge, assess effectiveness of non-pharmacologic interventions. If ineffective, recommend addition or dosage adjustment of adjunctive medication (e.g., antidepressant, etc.). Avoid recommending increase in antipsychotic dose if possible. If symptoms improve, consider antipsychotic GDR in 3 – 4 months.

Where: GDR=gradual dose reduction, MDS=minimum data set, PHQ-9=patient health questionnaire, UTI=urinary tract infection.
Antipsychotic Use in Dementia Assessment

(Compliments of CommuniCare Family of Companies and Omnicare, Inc.)

Antipsychotic Use in Dementia Assessment – page 2.

(Compliments of CommuniCare Family of Companies and Omnicare, Inc.)
Resources and Tools

- Tools to Monitor Facility Success
  - **Antipsychotic Utilization Report** –
    - Trending information including acceptance rate for Consultant Pharmacists recommendations.
  - **Progress report towards CMS goal of 15% reduction**
    - Facility-specific report
Progress towards Goal in State of Ohio
Omnicare Serviced Facilities

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<th>Description</th>
<th>Percentage</th>
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<td>Percent of long-stay residents who received an antipsychotic medication - 3 quarter average (4/1/2011-12/31/2011)</td>
<td>26.15%</td>
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<tr>
<td>Percent of long-stay residents who received an antipsychotic medication - 3 quarter average (10/1/2011-6/30/2012)</td>
<td>26.35%</td>
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<td>October 2012 percent Omnicare Data</td>
<td>22.11%</td>
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<td>Facilities have met or exceeded a 15% reduction as of October 2012</td>
<td>49.0%</td>
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<td>Facilities 50% or more towards a 15% reduction as of October 2012</td>
<td>11.6%</td>
</tr>
<tr>
<td>Average Pct to Goal of 15% Reduction</td>
<td>103.00%</td>
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Summary

- Consultant Pharmacists can assist you:
  - Clinical & regulatory expertise
  - Multiple resources and tools
  - Collaboration with your multidisciplinary team, including your medical director and psychiatrist
  - In-servicing/Education of multidisciplinary team
  - Reports & Tools to monitor success
Dementia Care & Anti-Psychotics
Just The Facts Ma’am

December 17, 2012
Ronald A. Savrin, MD, MBA, FACS
Medical Director, Ohio KePRO
THE MEASURE

- **Numerator**
  Long-stay residents who received antipsychotics

- **Denominator**
  All long-stay residents except those with exclusions.

- **Exclusions**
  - Schizophrenia
  - Tourette’s Syndrome (current or prior assessment)
  - Huntington’s Disease

THE BOX

**WARNING**

*Increased Mortality in Elderly Patients with Dementia-Related Psychosis* — Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks) in these patients revealed a risk of death in the drug-treated patients of between 1.6 to 1.7 times that seen in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. This drug is not approved for the treatment of patients with dementia-related psychosis.
“Of a total of seventeen placebo controlled trials performed with olanzapine (Zyprexa), aripiprazole (Abilify), risperidone (Risperdal), or quetiapine (Seroquel) in elderly demented patients with behavioral disorders, fifteen showed numerical increases in mortality in the drug-treated group compared to the placebo-treated patients.”

“These studies enrolled a total of 5106 patients, and several analyses have demonstrated an approximately 1.6-1.7 fold increase in mortality in these studies. Examination of the specific causes of these deaths revealed that most were either due to heart related events (e.g., heart failure, sudden death) or infections (mostly pneumonia).”

FDA 4/11/2005 (emphasis added)

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Medicare NH residents - 14% atypical antipsychotic

- 83% were for OFF-LABEL Use (no psychosis)
- 88% Black Box warning applied (dementia)
- 51% of claims were erroneous (no accepted indication)
- 22% Not in accordance with CMS standards
  - Excessive Dose – 10.4%
  - Excessive Duration – 9.4%
  - Without Indications – 8.0%
  - Inadequate Monitoring – 7.7%
  - Adverse Consequences – 4.7% (18.2% multiple)
The Issue

Antipsychotics Used - FOUR Possibilities

- Diagnosis → Used On-Label for Specific Dx
- Diagnosis → Used Off- Label for Specific Dx
  - Evidence DOES Support Drug for Diagnosis
- Diagnosis → Used Off- Label for Specific Dx
  - Evidence DOES NOT Support Drug for Diagnosis
- No Specific Diagnosis - ??

The Evidence

Meta-analysis 2011

Psychosis, Agitation, Global Behavioral Symptoms in Dementia

BENEFITS

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<th>Drug</th>
<th>Standardized Mean Difference (95% CI)</th>
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<td>Olanzapine</td>
<td>.12 (.00 -.25)</td>
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<td>Quetiapine</td>
<td>.11 (.02 -.24)</td>
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<tr>
<td>Risperidone</td>
<td>.19 (.00 -.38)</td>
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Pooled Analysis:
Neuropsychiatric Inventory (NPI) Score –
  35% improvement Compared to Baseline (30%)
  3.41 points above placebo (4.0)

JAMA. 2011;306(12):1359-1369
### The Evidence
#### Meta-analysis 2011

#### Psychosis, Agitation, Global Behavioral Symptoms in Dementia

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<td></td>
<td>(0.58 – 2.55)</td>
<td>(1.08 – 5.61)</td>
<td>(0.53 – 2.30)</td>
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<td>(0.05-10.48)</td>
<td>(0.33 – 7.44)</td>
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<td></td>
<td>(0.68 – 2.57)</td>
<td>(3.50 – 138.55)</td>
<td>(0.46 -3.08)</td>
<td>(1.96 – 4.70)</td>
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JAMA. 2011;306(12):1359-1369

### The Evidence
#### AHRQ – Sept 2011

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<td>Psychosis</td>
<td>Low</td>
<td>Mixed</td>
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<td>Low</td>
<td>Mod-High</td>
<td>Mixed</td>
<td>Mod-High</td>
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http://www.effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?
The Issue

- Diagnosis $\rightarrow$ FDA Approved On-Label Use
- Diagnosis $\rightarrow$ Off-Label Use for Specific Dx
  - Evidence DOES Support Drug for Diagnosis
- Diagnosis $\rightarrow$ Off-Label Use for Specific Dx
  - Evidence DOES NOT Support Drug for Diagnosis
- No Specific Diagnosis
“While off label prescribing in this context does not always constitute inappropriate prescribing, use of antipsychotic drugs do have significant health risks in this population”

“reduce the unnecessary use of antipsychotic agents by refocusing the interdisciplinary team on a better understanding of the root cause of dementia related behaviors”

Guidelines

- Use only if antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in Medical Record

- Unless Clinically contraindicated:
  - Institute Gradual Dose Reductions
  - Provide Behavioral Interventions
Reducing the Use of Antipsychotic Medications: First Steps on the Quality Improvement Journey

December 17, 2012
Leasa Novak, LPN, BA
QM: Percent of Long-Stay Residents Receiving an Antipsychotic Medication

- Reported on Nursing Home Compare; derived from Minimum Data Set (MDS) 3.0 assessments
- Numerator
  - Long-stay residents receiving antipsychotic medication
- Denominator
  - All residents with target assessment, except those with exclusions
- Exclusions
  - Dashes in Section N0400A or N0410A
  - Residents with one or more of the following diagnoses in Section I:
    - Schizophrenia
    - Tourette’s Syndrome
    - Huntington’s Disease

The Big Picture
What We Know

- Individualized care is still the goal.
  - Nursing Home Reform Law (OBRA ’87)
- Quality improvement strategies exist and can help lower QM rates.
  - Systematic processes for improvement
- Systemic issues can impede improvement efforts.
  - Disengaged leadership
  - “Unjust” culture or un-empowered staff
  - Chronic turnover
- Resources and assistance are available.

What We Think

- Strategies for reducing antipsychotic medications may be similar to strategies for reducing physical restraints.
  - Must focus on residents who receive antipsychotic medication for reasons other than FDA-approved indications or evidence-based off-label uses.
- We have a lot to learn! (All of us.)
  - F-329, F-501
  - Best practices for dementia care
  - Diagnoses, medications
  - Human needs (physiological, safety, connection, etc.)
  - Quality Assurance/Process Improvement (QAPI)
Where We Are

- **State rate on NH Compare: 25.3%***
  - Does NOT include residents with Dx of Schizophrenia, Tourette’s Syndrome or Huntington’s Disease
  - DOES include other residents receiving antipsychotic med:
    - Off-label use
    - Addressing behavioral symptom(s)
- **An initial challenge to reduce rates by 15%**
- **Residents who have complex care needs**
  - A difficult task in a difficult landscape
- **Opportunities**
  - *Hand in Hand* dementia training package
  - Federal and state initiatives
  - Nursing Home Quality Care Collaborative

* Nursing Home Compare, 12/7/12

Where We’re Going

- **Quality Improvement**
  - Systematic processes
  - No knee-jerk reactions, band-aids or quick fixes
- **Education**
  - Diagnoses, medications, human needs
  - Leadership, regulations, quality improvement
  - Facility processes
  - Facility goals, expectations
- **Collaboration/Partnerships**
  - Disseminate resources, best practices
  - Share successes and lessons learned
Digging In

General QI Principles

- Understand the data and relevant issues
- Conduct facility assessment and root cause analysis (RCA)
- Engage in process improvement cycles
- Provide education
- Monitor progress
- Celebrate successes
Understanding the Data

- CASPER reports
- NH Compare measures
- Other data

Understanding the Relevant Issues

- Regulations/MDS Coding
- Prescribing concerns
- Human needs
Conducting a Facility Assessment

- Review facility policies/assessment forms
- Observe actual staff practices
- Assess culture

Conducting a Root Cause Analysis

Determine gaps, barriers and strengths:

- Facility level
  - Culture/organizational practices
  - Prescribing practices
  - Knowledge gaps
  - “Behavior” management
- Resident level
  - How many residents receive AP for off-label use?
  - How many residents can begin GDR?
  - How many residents have:
    - Unmet human needs
    - True behavioral symptoms
    - Side effects
Sample Log

<table>
<thead>
<tr>
<th>Name</th>
<th>Rx</th>
<th>Dx</th>
<th>FDA-approved indication?</th>
<th>Off-Label Use?</th>
<th>Plan GDR?</th>
<th>Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary</td>
<td>Zyprexa</td>
<td>Bi-polar</td>
<td>Yes</td>
<td>-</td>
<td>Yes</td>
<td>Anxious</td>
</tr>
<tr>
<td>Betty</td>
<td>Geodon*</td>
<td>Dementia</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Anxious</td>
</tr>
<tr>
<td>Albert</td>
<td>Abilify*</td>
<td>Depression</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Suicidal</td>
</tr>
<tr>
<td>Paul</td>
<td>Mellaril</td>
<td>Schizo.</td>
<td>Yes</td>
<td>-</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Martha</td>
<td>Risperdal</td>
<td>Dementia</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Confused</td>
</tr>
<tr>
<td>John</td>
<td>Haldol*</td>
<td>Alzheimer's</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Sundowning</td>
</tr>
<tr>
<td>Steven</td>
<td>Seroquel</td>
<td>Dementia</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Combative</td>
</tr>
</tbody>
</table>

*Prescribed after admission.

Process Improvement

- Develop a team: MD/DO, RPh, Nursing, Social Services, Activities, etc.
- Establish meeting structures
- Set a goal and create Facility Action Plan
  - Review individual residents and determine changes to care plan
  - For more challenging areas, select process change(s)
    - Pilot-test the change
    - Evaluate results
    - Determine next steps (adopt, adapt, abandon)
    - Repeat steps as needed
  - Include education plan
Possible “Change” Areas

- **Pilot-testing:**
  - “Behavior”/symptom assessment / care planning
  - Nursing documentation of behaviors, side effects
  - Non-pharmacologic interventions
  - Social services/activities assessments
  - Residents’ activity plans
  - AIMS scales
  - Pharmacy review process
  - GDR documentation
  - Process for requesting/prescribing new medications

Education

- **Staff**
  - Diagnoses and nursing interventions
    - Psychiatric diagnoses
    - Dementia diagnoses
  - Antipsychotic medications
    - Indications, contraindications, warnings
    - Side effects
  - Non-pharmacologic interventions / “behavior” management

- **Residents/families**
  - Quality improvement goals
  - Facility protocols
  - Non-pharmacologic interventions
Monitor progress
Check in with staff
Celebrate successes

DON’T …

Assume staff are skilled in providing effective dementia care.
Rotate assignments for nurses and STNAs.
Permit extreme environmental noise, especially alarms.
Ignore staff burnout. Burnout can lead to decreased empathy, which can ultimately lead to unmet resident needs.
Contribute to a culture of blame. Instead, focus on creating a positive culture of teamwork and appreciation.
Underestimate the effectiveness of non-pharmacologic approaches.
### Restraint Rates
- 1991: 21.1% *
- 2012: 1.9% **

### Antipsychotic Rates
- 2011: 25.3% ***

### Interventions
- Safety needs
- Individualized care
- Attention to seating
- "Gate-keeping" controls
- Active reduction efforts

### Interventions
- Human needs
- Individualized care
- Attention to Dx & Rx
- Prescribing controls
- GDRs

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** CASPER data, 2012.
*** Nursing Home Compare data, Ohio rate 2012

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### Antipsychotic Rates
- 2011: 25.3% ***

### Interventions
- Human needs
- Individualized care
- Attention to Dx & Rx
- Prescribing controls
- GDRs

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** CASPER data, 2012.
*** Nursing Home Compare data, Ohio rate 2012

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### Resources
Presentations/Training Materials:
- Advancing Excellence in America's Nursing Homes campaign https://www.nhqualitycampaign.org/star_index.aspx?controls=dementiaCare
- CMS dementia training package – arriving soon! – Hand in Hand

Tools:
- Facility-Level Review:
  - https://www.nhqualitycampaign.org/files/Partnership%20Provider%20Assessment%20Form%207%2027%2012.pdf
  - https://www.nhqualitycampaign.org/files/Partnership%20Interdisciplinary%20Review%207%2027%2012.pdf
- Resident-Level Review:
  - https://www.nhqualitycampaign.org/files/MULTIDISCIPLINARY%20MEDICATION%20MANAGEMENT%20COMMITTEE.docx
Questions
OHIO APPROACH
STATE OFFICES
Organization and Momentum for Quality Improvement

Central Station
Access to subject matter expertise and tools (e.g., dementia treatment guidelines)
Data portal

Repository for Systems Changes
Improvements in the health care delivery system that may be identified (e.g., access to psychiatric expertise, even virtually)
PROCESS FOR LEARNING COLLABORATIVE

- Identify Champions
- Gather Teams
- Collect and Analyze Data
- Monthly Teleconferences
  - Subjects of Interest
  - Promising & Best Practices
- Quarterly Webinars
- Yearly Summary & Lessons Learned

Conversation
CO-CHAIRS

Mary S. Applegate MD, FAAP, FACP       Beverley Laubert
Medicaid Medical Director                State LTC Ombudsman

Mary.applegate@jfs.ohio.gov       blaubert@age.ohio.gov

THANK YOU