Antipsychotic Use in the Elderly: What, Me Worry?

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Objectives

- Upon completion of this presentation, the attendee will:
  - Know the current, complex CMS requirements related to the use of antipsychotics in the elderly
  - Describe multiple alternatives for the use of antipsychotics in various situations
  - Incorporate the Beers Criteria and behavior management in the elderly resident
  - Discuss differences in medication metabolism in the elderly

Antipsychotic Use in Long Term Care

- In 2009, according to one study, 70% of the 56,577 residents 65 and older residing in Florida nursing homes took an antipsychotic medication.

(Ahn and Horgas, 2013)

Black Box Warning

- **INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS.**
- Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks), largely in patients **taking atypical antipsychotic drugs**, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death 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. **Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality.** The extent to which the findings of increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patients is not clear.

Approved Diagnosis

- Appropriate (FDA Approved) Use for Antipsychotic Medications
  - Schizophrenia
  - Schizo-affective disorder
  - Delusional disorder
  - Psychotic mood disorders (mania and depression with psychotic features)
  - Acute psychotic episodes

Rothman, M (2011)

Approved Diagnosis

- Appropriate Use for Antipsychotic Medications •
  - Acute psychotic episodes
  - Brief reactive psychosis
  - Schizophreniform disorder
  - Atypical psychosis
  - Tourette's disorder
  - Huntington's disease
  - Short term (7 days) treatment of hiccups, nausea, vomiting, or pruritus

Rothman, M. (2011)

Side Effects of Antipsychotics

- The National Institute of Mental Health lists the following as some of the potential side effects of antipsychotics
  - Drowsiness
  - Dizziness
  - Restlessness
  - Constipation
  - Blurred vision

(National Institute of Mental Health, 2016)

CMS Initiative

- Reduce antipsychotic use by 25% by the end of 2015
- Reduce antipsychotic use by 30% by the end of 2016

(CMS, 2013)

Meeting the Regulations

- Changing the mind set
  - How can we better treat the resident who has dementia?
  - Are mood antipsychotics really the answer?
  - Can we do better by the residents we care for?
  - Do we have an appropriate diagnosis for the drugs ordered?
  - Are we monitoring the behaviors we are giving the drug for?
  - Are we really seeing the reasons causing the behaviors?

Latest Numbers

- Health News Florida (2015) reports that antipsychotic drug use is at 21.7 % in FL nursing homes.
- The Casper Report shows the Comparison Group State Average fro the period of 08/01/2016-01/31/17 to be at 18% (2.2% short stay and 15.8% long stay)

Watts, L. (2014)
Casper Report (2017)

Meeting the Regulations

- Dementia Care Principles
  - Person- centered care
  - Quality and quantity of staff
  - Evaluation of new or worsening behaviors
  - Individualized approaches to care
  - Involve resident and/or their representative in approaches to manage behaviors

(CMS, 2013)

Dementia and Behaviors

- What are the behaviors we are trying to reduce?
  - Wandering
  - Aggression
  - Agitation

(Ahn and Horgas, 2013)

Dementia and Behaviors

- Wandering
  - Movement that is not purposeful, can be frequent, repetitive
  - Associated with risk of falls, elopement, or getting lot unless accompanied by another person

(Ahn and Horgas, 2013)

Dementia and Behaviors

- Aggression
  - Verbal abuse
  - Threatening behavior
  - Physical abuse

(Ahn and Horgas, 2013)

Dementia and Behaviors

- Agitation
  - Irritability
  - Restlessness
  - Frustration
  - Excessive anger
  - Constant demands for attention and reassurance
  - Repeated movement or questions

(Ahn ad Horgas, 2013)

Impact of Behaviors

- Injury
- Hospitalization
- Decreased quality of life
- Death

(Ahn and Horgas, 2013)

Causes of Disruptive Behaviors

- Pain
- Hunger/Thirst
- Loneliness
- Anger
- Frustration
- Loss of Independence
- Loss of functional ability
- Over stimulation
- Need to use bathroom
- Fear
- Fatigue
- Illness (new or worsening)

Are we Treating Behaviors Correctly?

- Awake at night
- Nervousness
- Hollering out

- Sleeping pill
- Anti-anxiety med
- Anti-anxiety and maybe a sleeping pill if it happens at night time too

Are we Treating Behaviors Correctly?

- Hallucinations
- Delusions
- Antipsychotics
- Antipsychotics

Are we Treating Behaviors Correctly?

- Physical and verbal abuse
- Anti-anxiety, antipsychotics

Resident Centered Care

- CMS requires nursing homes to provide an environment that is supportive and promotes comfort as well as recognizes the residents' individual needs and preferences.
- Requires facilities to have staff in sufficient quantity and quality to meet these needs and preferences

(CMS, 2013)

Resident Centered Care

- Requires a thorough evaluation of new or worsening behaviors by the interdisciplinary team, including the resident's physician, to identify and address any treatable cause of the new or worsened behavior.

(CMS, 2013)

Resident Centered Care

- Requires individualized approaches to care as the first line of intervention when behaviors are noted or worsen. Seeing behaviors as a way of communication for the resident may help reduce or eliminate the behavior

(CMS, 2013)

Resident Centered Care

- Requires residents and residents' representatives be involved in potential approaches to address noted behaviors. These discussions should be documented in the residents' medical record.

(CMS, 2013)

How Effective Are You?

- How are you trying to decrease psychotropic use in your facilities?

Beers List

- Dr. Mark Beers in 1991
- Updates in the Journal of American Geriatrics Society
- Drugs are categorized as strong, moderate or weak negative effects on the geriatric population, over 65 years of age.

2017 Beers List Update

CLASS	EFFECT
1ST Generation Antihistamines	Confusion, Dry mouth
Nitrofurantin	Pulmonary Toxicity
Barbiturates	Dependence
Benzodiazipines	Delirium, Falls, Fractures

BEERS List Caution

- Antipsychotics, SSRIs, SSNIs:
  - SIADH (Syndrome of Antidiuretic Hormone) and Hyponatremia

How Are We Doing?

According to the Academy of Managed Care Pharmacy, 25.7% of commercially insured people are prescribed opioids simultaneously with benzodiazipines.

What would happen if we added an antipsychotic?

Polypharmacy

- According to the Veterans Affairs, half of all deaths were due to drug combinations in 2009

- BMJ 2015; 350:h2698, doi: 10.116/bmj.h2698

Dementia Vs. Delirium

- Dementia is a progressive decline in memory and at least one other cognitive area in an alert person:. attention, orientation, judgment, abstract thinking and personality.
- Dementia is rare in under 50 years of age and the incidence increases with age; 8% in >65 and 30% in >85 years of age.

Delirium

- Delirium is an acute disorder of attention and global cognition (memory and perception) and is treatable. The diagnosis is missed in more than 50% of cases. The risk factors for delirium include age, pre-existing brain disease, and medications.

Delirium

- D Dementia
- E Electrolyte disorders
- L Lung, liver, heart, kidney, brain
- I Infection
- R Rx Drugs
- I Injury, Pain, Stress
- U Unfamiliar environment
- M Metabolic

Diagnosing Dementia

- 1.By determining the probable cause, treatable disorders can be identified, such as medication toxicity (.
- 2.There are symptoms and comorbidities that are treatable, such as depression, delirium, delusions, hallucinations, and agitation.
- 3.Caregivers must be identified and environmental issues taken into consideration.

Features of Delirium

- •Acute onset (hours/days) and a fluctuating course
- •Inattention or distraction
- •Disorganized thinking or altered level of consciousness

Psychosis

- Psychosis is characterized by an impaired relationship with reality.
- A symptom of serious mental disorders. People who are psychotic may have either hallucinations or delusions.

Psychosis

- Disorganized way of thinking
- Unclear speech pattern
- Paranoia
- Hostility
- Suspicion
- Unrealistic sense of superiority (grandiosity)
- Delusional behavior (false beliefs)
- Hallucinations (hearing, seeing or feeling things that are not there)

Types of Psychosis

- Post operative
- Narcotic related
- Head injury
- Dementia
- Others

TREATMENT OF PSYCHOSIS

- ANTIPSYCHOTICS?
- Must think about what the symptoms are and what should or should not be treated.

Best Treatment of Psychosis?

What are Antipsychotics?

- Antipsychotics also known as neuroleptics or major tranquilizers, are a class of medication primarily used to manage psychosis, principally in schizophrenia and bipolar disorder. They are increasingly being used in the management of non-psychotic disorders. Antipsychotics are usually effective in relieving symptoms of psychosis in the short term.

New' Antipsychotics
(Since 1990)

- **clozapine (Clozaril/Denzapine/Zaponex)**
- **risperidone (Risperdal)**
- **olanzapine (Zyprexa)**
- **quetiapine (Seroquel)**
- **ziprasidone (Geodon, Zeldox)**
- **aripiprazole (Abilify)**

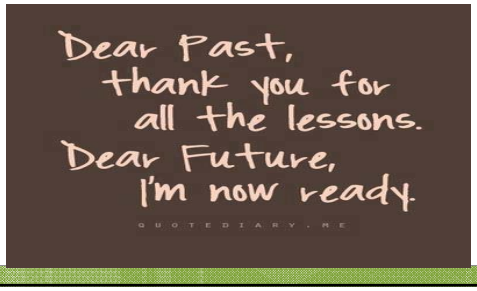
Old vs New

- Dopamine antagonism is the only property shared by ALL licensed antipsychotics
- No compound that does not block dopamine is licensed as an antipsychotic
- Message : It's dopamine, dummy!
- **The only thing that's new is that there has been nothing new** (i.e. radically different) in antipsychotic psychopharmacology since the introduction of chlorpromazine

What is new?

- Less frequent dosing
- Less of the parkinsonism effect

What is the Same?



What Do You Think?

90 year old female, previously dependent on opioids, sees pain management and is restarted on Tramadol 50 mg TID prn pain.

Also has insomnia and takes Ambien 10 qhs

Also augments sleeper with Xanax .25 mg qhs

Also augments sleeper with Melatonin 5 mg qhs.

Case Study

- What is she at risk for?
- What are options for her care?
- What is the best approach?

Case Study

- 97 year old female recovering from a hip fracture. She is seen in her room talking alone and appears to be petting a dog.
- She is smiling and states there are also women in beautiful dresses with their gorgeous dogs.

What do you think?

- What is she at risk for?
- What are options for her care?
- What is the best approach?

Case Study

- 78 year old man post knee replacement, is awake all night seeing snakes in his bed. The pillows are on the floor and the bed is torn apart. He frantically tries to protect you from the snakes that are all around him.

What do you do?

- What is he at risk for?
- What are options for her care?
- What is the best approach?

References

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