Antipsychotic medication use in nursing home residents has long been the subject of scrutiny and controversy. Originally approved by the Food and Drug Administration for schizophrenia, these drugs have had a history of being utilized off-label for a variety of conditions. The advent of atypical antipsychotics, largely for reasons other than the original agents, helped in accelerating the use and cost of this type of medication.

Under the principle of “psychobehavioral metaphor,” this class of medication was prescribed for conditions bearing some resemblance to psychosis, including behaviors seen in demented people. Terms such as dementia-related behaviors and behavioral and psychological symptoms of dementia (BPSD) arose to try to categorize such “behaviors,” along with a variety of scales designed to classify and quantify them.

The underlying difficulty in attempting to study and pharmacologically treat such behaviors is the fact that they are not necessarily medical conditions but rather responses of a cognitively and/ or psychologically impaired individual to an action, environment, person, or stimulus, and they therefore require considerable effort on the part of the interdisciplinary team to treat effectively.

There is no doubt that this class of medication is overutilized to treat BPSD. Estimates vary, but about 25% of nursing home residents nationally are treated with antipsychotic medications. In 2010, more than 17% of nursing home patients had daily doses exceeding the American Geriatrics Society list recommendations. The usage of these medications dramatically varies from home to home based on many factors, including but not limited to resident characteristics, staff numbers and training, home culture, and prescriber habits. The cost of atypical antipsychotic use to Medicare is staggering: about $17 billion per year in all sites of service.

Adding another layer of complexity is the fact that atypical antipsychotic medications do have certain FDA indications that are common and at times difficult to capture off-label use. All these drugs have indications for schizophrenia and bipolar disorder, while aripiprazole also has indications for depression (when used with an antidepressant) and autism.

In attempting to define behaviors and their root causes, it often appears to be a mixture of items that may include F-329 indications.

As an example, a moderately or severely demented person with an unclear past psychiatric history currently on antidepressant therapy may pace incessantly, be verbally disruptive, not eat or sleep well, perseverate or ruminate on the past, and be increasingly incapable of participating in previous activities. It can be difficult to discern whether the use of an antipsychotic that results in some improvement and mild sedation is treating bipolar disease, refractory depression, BPSD, or some combination, versus merely acting as a mild chemical restraint. If an exact cause-effect relationship is not always clear to the prescriber, it is easy to see how it is unclear during the survey process.

Laws and Regulations
Current surveyor guidance on antipsychotic use, found at F-Tag 329, delineates how carefully these medications should be utilized. Unfortunately, it is clear that all the steps that should be followed are not always being done or documented. Antipsychotic use can be very time-consuming to initiate appropriately, require a high level of training to use correctly, and demand extensive follow-up to meet regulatory requirements. Many nursing homes seem to lack the tools needed to define and manage these complex aspects of coordinated, conservative, and medical care needed for BPSD, or they simply take shortcuts.

The possible dangers of antipsychotic medications have come to the attention of the public and Congress. The findings of potential serious adverse effects including dysphagia, aspiration, stroke, cardiac events, and premature death have been highlighted in the popular press and resulted in Congress considering legislation that could limit the use of such medications among nursing home residents. Such bills have not yet been brought to the floor of either the House or Senate, but they do emphasize the need for professional long-term care organizations to proactively ensure appropriate use of these medications.

Spurred by the outcry of concern, the Centers for Medicare & Medicaid Services on May 30 announced the Partnership to Improve Dementia Care, an initiative to ensure appropriate care and use of antipsychotic medications for nursing home patients. This partnership has set a national goal of reducing use of antipsychotics in nursing home residents by 15% by the end of 2012. CMS, industry, and advocacy partners are taking several steps to achieve this goal of improved care, which will be enacted by state-run groups.

AMDA has already taken an active role in various processes:

1. Enhanced training: CMS has developed Hand in Hand, a training series for nursing homes that emphasizes person-centered care, prevention of abuse, and high-quality care for residents. CMS is also providing training for state and federal surveyors.
2. Increased transparency: CMS made data on each nursing home’s antipsychotic drug use available on Nursing Home Compare starting in July.
3. Alternatives to antipsychotic medication: CMS is emphasizing nonpharmacologic alternatives for residents, including consistent staff assignments, increased exercise or time outdoors, monitoring and managing acute and chronic pain, and individualized activities.

Let’s hope that these efforts will help achieve the 15% reduction this year. Longer term, CMS is conducting research to better understand the decision to use or not use antipsychotic drugs in residents with dementia. A study is underway in 20-25 nursing homes.

Challenges Ahead
New quality measures related to the use of antipsychotics are being proposed for the Nursing Home Compare website. As currently envisioned, however, they will exclude antipsychotic use only for certain FDA-approved uses such as schizophrenia, Tourette’s syndrome, and Huntington’s disease, but not bipolar disorder or refractory depression.

A consortium of long-term care organizations, including AMDA, is petitioning CMS to exclude all FDA indications from the quality measure, which was designed to show use only for atypical use in BPSD. CMS has expressed concern that bipolar disorder will be overdiagnosed to lower quality-measure scores, but given well-established criteria for diagnosis, the consortium feels that overdiagnosis can be dealt with through the survey process.

As part of its initiative, CMS will be conducting a special video-education program for state surveyors. On May 30 the Training Program on the CMS National Partnership to Improve Dementia Care and Reduce Unnecessary Antipsychotic Drug Use in Nursing Homes. Among many issues, it will emphasize the need to do root cause analysis, provide accurate diagnosis, utilize nonpharmacologic approaches, provide person-centered care, consider risks and benefits of pharmacologic therapy, and conduct gradual dose reductions at appropriate intervals.

Adequate resident education, family communications, and the need to interview the attending physician and medical director will also be considered. AMDA is providing input for the program’s materials. While there is no new interpretive guidance being issued related to F-329, it is clear that CMS intends to utilize current guidance to more closely scrutinize the possible inappropriate use of psychoactive medications.

It is important to note that while this initiative focuses on atypical antipsychotics, it is also concerned with the use of any psychoactive medication that may be used as a chemical restraint. Any medication that is used for the convenience of the nursing staff or nursing home without the primary goal of maintaining or improving the psychological or physical function of the resident is considered an unnecessary medication and can be cited under F-329. Simply switching an antipsychotic to another psychoactive medication without a clear benefit reason to the resident is not the goal of this initiative.

There is no doubt that atypical antipsychotics can help the right person at the right time to achieve the highest practicable level of function. It is equally clear that these medications have not always been thoughtfully and appropriately prescribed. It will be incumbent on nursing facilities and prescribers to ensure that a thorough root cause analysis is done, that nonpharmacologic treatments are used, that families are informed of the risks and benefits of such medications, and that the medication’s utility is regularly reconsidered.

This is an ideal opportunity for the medical director to be a champion of best practices in the management of BPSD in general and antipsychotic medication specifically. AMDA will continue to be at the forefront of educational efforts, and the organization supports its members in becoming involved in their states’ initiatives to reduce atypical antipsychotic use and provide best practices for managing BPSD.

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