New Concepts in Antipsychotic Stewardship

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Speaker Disclosures

Dr. Posar has no relevant financial relationships

Dr. Shackson has no relevant financial relationships

Dr. Heiser has no relevant financial relationships

Learning Objectives

By the end of the presentation, participants will be able to:

- Objective 1: Importance of differentiating between neurologic versus psychiatric etiologies of BPSD
- Objective 2: Importance of “neurology forward” individualized treatment planning
- Objective 3: Appropriate pharmacological & non-pharm treatment modalities

Topic 1: Neuropsychiatric vs. Psychiatric Diagnoses

- Over 80% of LTC patients have a neurocognitive disorder
- 95% of these patients have no history of serious mental illness (SMI)
- Their psychiatric status is an expression of a primary neurological disorder **(<u>NOT</u> a primary psychiatric disorder!)**

Topic 1: Neuropsychiatric vs. Psychiatric Diagnoses

- 98% of Dementia patients residing in Long-Term Care Facilities (LTCF) will develop at least one DSM-5 Axis I Psychiatric condition (MDS Data)
- 70% of these patients will exhibit severe symptoms
- Severe = CMS qualified diagnosis for acute inpatient psychiatric hospital admission
- Greater than 50% of these severe patients will have multiple episodes

Neuropsychiatric vs. Psychiatric Diagnoses

- The Challenge: prevent or mitigate Behavioral and Psychological Symptoms of Dementia (BPSD) without chemical restraint in neurologic patients with progressive or non-progressive neurocognitive disease

- Proven primary neurologic-based pharmacotherapy will support this challenge

- Effective neurologic-based pharmacotherapy is dependent on accurate diagnosis

The Clinical Presentation of Neuropsychiatric Illnesses Across Varied Types of Dementia

- "Pure" Alzheimer's Dementia (AD) is uncommon
- Characterized by slow progression and predictable psychiatry
- Early stages of AD: Anosognosia and mild to moderate depression
- Mid to late-stage AD is characterized by increased anxiety
- Highly responsive to neuro-pharmacology

The Clinical Presentation of Neuropsychiatric Illnesses Across Varied Types of Dementia

- "Alzheimer's Disease (AD):
  - 20% of Alzheimer's Disease brains have only AD
  - 25% of AD brains have 2 causes
  - 55% of AD brains have 3 or more causes

The Clinical Presentation of Neuropsychiatric Illnesses Across Varied Types of Dementia

- “Mixed Dementia = Alzheimer’s + Vascular Dementia (VaD)
- Severe Behavioral and Psychological Symptoms of Dementia (BPSD)
- Psychosis, Agitation and Aggression
- Seizures, PBA, Akathisia and Mood Lability
- Neuropharmacology and selective psychiatric medication

The Clinical Presentation of Neuropsychiatric Illnesses Across Varied Types of Dementia

- "Alzheimer's Dementia and TDP-43 (LATE)
- Greater than 10% of AD cases
- Rapidly progressive + severe BPSD
- Psychosis, Agitation, Aggression and Sexual Acting Out (SAO)
- Highly responsive to Neuropharmacology & specific, limited Psychiatric Intervention

The Clinical Presentation of Neuropsychiatric Illnesses Across Varied Types of Dementia

- Parkinson's Disease Dementia and Lewy Body Disease Dementia
- Both: Psychosis is early and common
- PD/PDD sensitive to Medication-induced psychosis
- Complex neuro-psych assessment - PD medication vs. Lewy Body Psychosis
- Acetylcholinesterase Inhibitors (ACEI) are the core treatment

The Clinical Presentation of Neuropsychiatric Illnesses Across Varied Types of Dementia

- Fronto-Temporal Dementia and Vascular Dementia
- Behavioral, Agrammatic, Semantic
- Logopenic = limbic predominant AD
- Highly variable clinical presentation
- Variable Histopathology
- Unresponsive to neuropharmacology
- Psychiatric medication – “treat what you see”
- Frequent re-assessment and therapeutic adjustment

The Clinical Presentation of Neuropsychiatric Illnesses Across Varied Types of Dementia

Complex secondary conditions

- Medication
- Delirium
- Pseudo-Bulbar Affect (PBA)
- Partial Complex Epilepsy (non-convulsive seizures)
- Cerebral Adrenergic Dysfunction (e.g., sundowning)
- Recurrent microvascular events
- OSA & Primary REM disorder
- Akathisia

The Clinical Presentation of Neuropsychiatric Illnesses Across Varied Types of Dementia

Dementia diagnosis is becoming increasingly complex

- Alzheimer's Disease (AD)
- Vascular Dementia – macro/micro
- Mixed Dementia
- Lewy Body Disease (LBD)
- Parkinson's Disease Dementia (PDD)
- Limbic-Predominant Age-Related TDP43 Encephalopathy (LATE)
- Fronto-temporal Dementia
    - Behavioral variant, agrammatic, semantic, logopenic
- Primary Age-Related Tauopathy (PART)
- Huntington's Disease
- Normal Pressure Hydrocephalus
- Traumatic Brain Injury (TBI)
- Encephalopathies (toxic, metabolic, etc.)

The Clinical Presentation of Neuropsychiatric Illnesses Across Varied Types of Dementia

6-Step Treatment Approach

- Neurologic, Psychiatric, and Psychological Diagnostic and Clinical Status Evaluation
- Patient Total Pharmacology Review & Adjustment
- Initiate Neurological Pharmacotherapy
- Reassess Psychiatric & Global Clinical Status
- Initiate and/or Amend Psychiatric & Psychologic Treatment based on current assessment
- Frequent Neurologic, Psychiatric, Psychologic Assessments with therapeutic adjustments

Impact of “Neurology Forward” Clinical Paradigm

- Interdisciplinary Antipsychotic Stewardship Between Operator and Neurobehavioral Consultant
  - 68% decrease in antipsychotic utilization within 5 months of protocol initiation
  - Equivalent or improved clinical outcomes
- Decreased referrals for acute inpatient psychiatric care
- Improved survey results

LTC/AL Dementia Diagnoses

- Alzheimer's
- Macrovascular
- Parkinson’s Disease Dementia
- Lewy Body
- Fronto-Temporal Dementias
- LATE
- Huntington’s Disease Dementia
- Traumatic Brain Injury

Comorbid Secondary Diagnoses

- Pseudobulbar Affect
- Partial Complex Seizures
- Obstructive Sleep Apnea
- Primary Rem Disorder
- Cerebral Adrenergic Overload

Neurologic BPSD Mitigation

- Acetylcholinesterase Inhibitors
- NMDA Blocker-Memantine
- SSRI
- Dextromethorphan/Quinidine
- Antiepileptics
- Alpha and Beta-adrenergic Blockers

Effective Psychiatric Treatments for Major Neurologic Cognitive Disorders

- Dependent on effective primary care and neurologic treatments
- Thoughtful neurologic diagnosis and treatment is critical
- Primary care and psychiatric treatment must consider the primary neurological diagnosis
- Polypharmacy often contains medications that can exacerbate BPSD or counteract neurologic medications

Effective Psychiatric Treatments for Major Neurologic Cognitive Disorders

- Some psychiatric treatments can worsen overall condition both by class of medications and/or individual medications
- Some psychiatric treatments can negatively impact the patient's overall neurologic status-such medications include benzodiazepines, antipsychotics and anticholinergics
- Effective treatments require the focus to be on evidence-based safer medications

Effective Psychiatric Treatments for Major Neurologic Cognitive Disorders

- Depression, Anxiety, and Mood-Stabilization-sertraline, Escitalopram
- Insomnia - Trazadone, Mirtazapine
- Anxiety – Lorazepam, Clonazepam
- Psychosis – Risperidone, Olanzapine, Pimavanserin
- Bipolar – Valproic Acid, Carbamazepine, Oxicarbazepine

Behavioral Triggers and Clinical Management of LTCF Residents with Psychiatric and Neuropsychiatric Diagnoses

Objective: Identify affective disorders and behavioral triggers and specific steps to improve clinical management of long-term care facility (LTCF) residents with psychiatric & neuropsychiatric diagnoses

Behavioral triggers & clinical management of LTCF residents with psychiatric & neuropsychiatric diagnoses

Role of Behavioral Health Staff

- Administer normed, validated instruments as part of the initial psychological evaluation to help determine accurate diagnosis and clinical status

- Consistent re-assessment of patient functioning and identify changes before significant decompensation occurs including re-testing

- Patient's clinical status evolves daily/weekly/monthly

- Insight-based therapy ineffective

- Utilize Evidence-based therapeutic approaches as part of the treatment process to support rational use of psycho pharmacology

Take Home Messages

- Primary neurologic with secondary neuropsychiatric disorder requires neuropharmacology first (neurology forward)
- BPSD much more responsive to psychiatric treatment following neurologic treatment
- Frequent re-assessment and treatment adjustments required secondary to progression of primary neurologic disorder
- Diagnoses and treatments can evolve with disease progression

Abstract 1

Interdisciplinary Antipsychotic Stewardship Between Operator and Neurobehavioral Consultant

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Abstract 1

Abstract Text: Interdisciplinary Antipsychotic stewardship Between Operator and Neurobehavioral Consultant

Background: Antipsychotic utilization in skilled nursing facilities (SNFs) is a major focus of regulatory compliance and a key theme in resident care. At first, improvements via national rate lowering initiatives were effective but as of late reductions have slowed. Due to a slowing of industry-wide advancements in the care of behavioral and psychological symptoms of dementia (BPSD), the Federally mandated patient centered care initiative has not widely incorporated "best practices for BPSD care. This has opened an opportunity for innovations in clinical care of BPSD. In a shared initiative with this operator, we have implemented a joint program focused on rigorous clinical diagnosis and "best practices" in pharmacology support, specifically aimed at assessing and reducing antipsychotic use whenever appropriate.

Methods: In three targeted buildings, all patients identified as receiving antipsychotic medication were enrolled in a specific assessment and treatment protocol designed to mitigate antipsychotic use where possible. Diagnoses were reviewed by Clinical Psychology, Psychiatry, Consultative Gerontology (where indicated) and building Social Service. Additionally, behavioral documentation for each resident was reviewed, and a team approach to polypharmacy, all psychotropic medications, and antipsychotic reductions were implemented. Data was verified by facility pharmacy records, and reports detailing the proportion of residents taking antipsychotic medications were generated in January, March, and July of 2021.

Results: Prior to full implementation of the protocol (January 2021) antipsychotic rates were 32%, 14% and 18% .in the three buildings. Immediately following initial review, rates were noted to be similar to baseline (Table 1). After implementation of clinical protocols, we found that the proportion of residents using antipsychotic medications declined to 9.6%, 4.2% and 6.3% respectively (Table 1 Figure 1). In addition, there were no noted harms nor deteriorations related to the discontinuation of these medications.

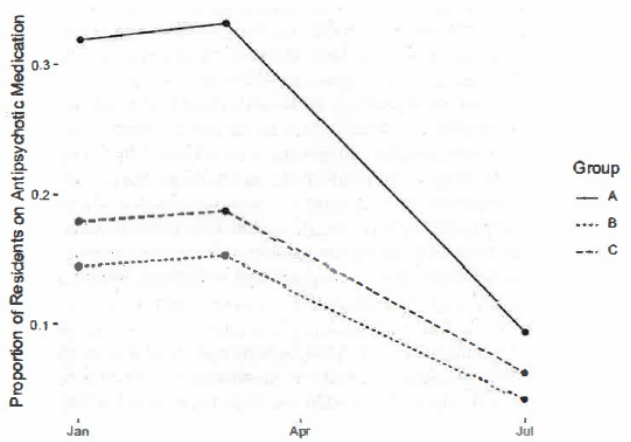
Conclusion: Implementation of a shared cooperative clinical protocol between the SNF facility staff and clinical treatment team resulted in a reduction of anti psychotic use of more than 65% with no noted harms nor clinical decline.

Abstract 1

Table 1:

Facility	January	March	July
A	32%	33.30%	9.60%
B	14%	15.20%	4.20%
C	18%	18.70%	6.30%

Figure 1:



Abstract 2

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The Rate of Use of Acetylcholinesterase Inhibitors and/or the NMDA Antagonist Memantine in Long Term Care Dementia Patients at Risk for BPSD

Background: According to the CDC, 47.8% of long-term care residents have dementia and 98% of these residents are at risk for Behavioral and Psychological Symptoms of Dementia (BPSD). Acetylcholinesterase Inhibitors (AChEIs) and the NMDA blocker memantine separately provide improvements in cognition, function, and BPSD associated with dementia. Data indicates that treatment with an AChEI and memantine in combination would be more beneficial for cognition, function, and BPSD than either drug separately. GuideStar Eldercare (GSE), a Neuropsychiatric Behavioral service agrees that this medication combination mitigates the development and severity of BPSD. We sought baseline data on long term care residents with dementia that are on either an AChEI, memantine, or both, to establish baseline information for clinical protocol development. We conducted this study to measure the levels of compliance with the standard of care that AChEI's and/or memantine be provided for the majority of dementia patients.

Abstract 2

Method: GSE selected four buildings that were new to our services. An audit of all residents to whom we had chart access was completed. Criteria included established dementia and AChEI and/or memantine use prior to initiation of our services. A ratio of those residents with a qualifying dementia diagnosis compared to those with AchEI and/or memantine use was calculated.

Results: Data review demonstrated: Building A, Michigan-35 residents with dementia, 8 (23%) residents on medications, and 27 (77%) not on medications. Building B, Ohio-41 residents with dementia, 8 (20%) residents on medications, and 33 (80%) not on any medications. Building C, Indiana-26 residents with dementia, 3 (12%) residents on medications, and 23 (88%) not on medications. Building D, Michigan-20 residents with dementia, 8 (40%) on medications, and 12 (60%) not on medications.

Conclusion: Of 122 total patients, 27 were on medications (22%) and 95 were not on any medications (78%). We believe this presents opportunity to initiate AChEI and memantine as the standard of care for almost all dementia residents yielding significant improvement in their BPSD clinical status.

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