MDS Alert

Medication Management: Expand Your Efforts to Taper, Discontinue Meds Under F329

If you're only doing this for antipsychotics (O4a), watch out.

To taper or not to taper a resident's meds ... the prescribing dilemma has become bigger under the revised F329 survey guidance (unnecessary medications).

The first step: Review all a resident's psychoactive medications coded in Section O4. Consider a gradual dose reduction for the medications if they are being used to manage behaviors or treat psychiatric symptoms, advises **Matthew Wayne, MD, CMD,** chief medical director, **Elias Jennings Senior Care Network** in Cleveland.

Don't stop there: Also consider anticonvulsants if they are being used to address behavioral symptoms or mental illness, adds Wayne.

Coding reminder: Don't count an anticonvulsant as an antipsychotic in O4 even when it's used for that purpose. The RAI user's manual says to code a drug in O4 according to its pharmacological classification -- not how it's used.

Evaluate Cognitive Enhancers

The revised F329 guidelines don't mandate a dosage reduction for the cognitive enhancers, says Wayne. Even so, make sure such meds are appropriate and continue to benefit the resident -- just as you would for any medication, he advises.

"The point at which you stop a cognitive enhancer is very personalized and based on the resident/family goals," says Wayne. "But at some point the benefits of the medication, which can slow cognitive and functional decline or maintain functional status, may no longer be worth the cost and side effects," he points out.

Examples: Acetylcholinesterase inhibitors such as donepezil (Aricept) can cause GI effects, including anorexia and weight loss or diarrhea, leg cramps and vivid dreams or even nightmares, says Wayne. Memantine (Namenda), an NMDA receptor antagonist, can cause agitation, confusion, somnolence and dizziness, although usually patients tolerate the drug well, he adds.

When Tapering, Documentation Is Key

Carefully assess and document the effect of tapering an antipsychotic or other psychoactive medication, suggests **Chris Puri, JD**, in Nashville, TN. "The facility needs good documentation that tapering the medication led to certain outcomes," he says. For example, did the resident's behavioral symptoms worsen in a way that affected his functional status and participation in basic care?

"If a resident has a diagnosed major mental illness, such as schizophrenia, that's been well controlled by antipsychotics, the physician should document that," adds **Adam Rosenblatt, MD**, a geropsychiatrist at **Johns Hopkins**. "Some people don't differentiate between trying to taper or withdraw an antipsychotic for a behavioral symptom versus reducing or eliminating a medication for a long-standing chronic mental illness."

Good point: "People don't say let's stop a person's Coumadin and see if he has another stroke. The same principle applies to tapering psychoactive medications for a person with a history of a severe mental illness, such as [major depression with psychotic features or schizophrenia]," says Rosenblatt.

Preempt unwarranted F tags: Educate surveyors that tapering patients off antidepressants too soon doesn't follow the

standard of care. "Clinically, we provide a nine- to 12-month initial course of antidepressant therapy for the first episode of depression," says **William Simonson, PharmD**, a consultant in Suffolk, VA.

"After multiple recurrences [of depression], the resident may require life-long therapy," Simonson adds. "Pharmacists should be aware of the proper duration of antidepressant therapy and be prepared to make a case that the patient requires longer therapy [if surveyors suggest otherwise]."

Improve Your Odds of Success

Say you try to taper a psychoactive medication, such as an anti-anxiety agent. If all the factors that stimulate anxiety are still present, "you won't be as successful as you would be if you restore the resident's [customary] routine and eliminate some of the potential causes of psychosocial distress," says **Barbara Frank**, co-founder of **B&F Consulting** in Warren, RI.

Example: A person with dementia who can't decipher written words well anymore always gets agitated and disoriented when she tries to find her room.You can provide visual cues, such as a picture on her door "of her and her husband from a time she remembers and a quilt from home on her bed, to help her find her room," suggests Frank.

Staff who care for a resident on a regular basis can "track what sets the person off and make alterations environmentally" to address behavioral symptoms "in lieu of medication," she adds.