# MDS Alert

## Medication Management: Get A Step Ahead Of Controversy Over Antipsychotic Use In Nursing Homes

Here's how to show you're doing the appropriate risk management.

Not only have antipsychotics been getting a lot of negative press lately, but surveyors are scrutinizing use of these medications more closely. That means your facility needs to get a solid handle on its antipsychotic use and whether these meds are helping -- or hurting -- residents.

The reality: This summer, the **Food & Drug Administration** began requiring conventional antipsychotics to carry a "black box" warning that the drugs increase risk of death in elderly patients with dementia. "Atypical" antipsychotics have had a similar black box warning since 2005.

Get the 'Rest of the Story' About Antipsychotic Prevalence

For facilities to know their true prevalence of antipsychotic use, they need to understand how the quality indicator for antipsychotic use in the absence of psychotic or related conditions works, stressed **Christie Teigland, PhD**, at the 2008 **American Medical Directors Association** annual meeting.

The QI captures residents who received an antipsychotic (coded in Section O4) one or more days in the seven-day lookback for the target MDS assessment. There is a risk adjustment that categorizes residents as being at high risk for being on these drugs if they have short-term memory loss (B2a = 1) and impaired daily decision-making ability (B4 > 0) and certain behaviors. The latter include one or more of the following daily or less than daily: verbally abusive behavioral symptoms (E4bA > 0); physically abusive behavioral symptoms (E4cA > 0); or socially inappropriate/disruptive behavior (E4dA > 0).

Everyone else goes in the low-risk group, which means they are viewed as not being at risk for being on an antipsychotic but are taking one, said Teigland, director of health informatics and research at the **New York Association of Homes & Services for the Aging**/EQUIP for Quality.

Nail down the exclusions: A number of conditions exclude the resident from the quality indicator looking at antipsychotic use, including ICD-9-CM codes recorded in I3 for designated mental illnesses, as well as Tourette's syndrome and Huntington's disease, checking schizophrenia in Section I1 or hallucinations in Section J (for the specific ICD-9-CM codes, go to http://www.qtso.com/download/mds/qiqm_rpt/Appendix_A_Technical_Specs_v1.1.pdf). Thus, the measure doesn't identify specifically the rate of antipsychotic use in the facility. But it does identify "off label use," noted Teigland. The FDA has never approved use of antipsychotics for treatment of dementia-related psychosis or behavioral issues.

Do the math: To get an accurate picture of what's going on in your facility, look at the facility's total prevalence of antipsychotic use without any of the exclusions for mental illness diagnoses or hallucinations, advises Teigland. "Due to these exclusions, the prevalence of use on the QI can look like the prevalence is relatively low." But "these drugs aren't safe for elderly people regardless of their diagnoses," she says.

Cautionary example: One facility in New York State reported a 1 percent prevalence of antipsychotic use. Yet its true prevalence was really around 48 percent because the residents taking the medication all had diagnoses excluding them, Teigland tells **Eli.** "This type of scenario is one where surveyors might take a closer look at what's going on." Also, given that antipsychotic use among dementia residents is also typically much higher, look at the rate of use among the dementia population separately, as well, Teigland advises. "The CMS QI includes all residents and can mask high rates of use among dementia residents."

MDS coding check: While a resident with schizophrenia receiving an antipsychotic will be excluded from the QI looking at antipsychotic use, Teigland sees nursing facilities fail to carry forward that diagnosis on MDSs over time.

Examine Other QIs/QMs

An ongoing NYAHSA study has found that residents on antipsychotics have much higher fall rates and are more likely to decline functionally than those not on the medications.

Clinical application: When doing a pharmacy review, correlate antipsychotics to falls, ADL decline, incontinence and cognitive decline, Teigland suggests. Residents on antipsychotics also tend to have a lower level of participation in activities, she notes.

Troubling findings: The NYAHSA study found that residents who are either on an antipsychotic when they come in or are put on one don't show an improvement in behavioral symptoms after one year, says Teigland. "In fact, those put on an antipsychotic after admission to the nursing home had worse behaviors at the end of the year," according to the study.

It's not just about the use of antipsychotics, however, cautioned **Cornelius Foley, MD**, a medical director who co-presented with Teigland. If the facility isn't using antipsychotic medications very much, does it have a high number of residents with behaviors affecting others? If so, the facility isn't managing behaviors effectively, he noted.

Follow F329 Requirements

"Facilities always have to justify the use of antipsychotic medications," says attorney **Joanne Lax**, with **Dykema** in Bloomfield Hills, MI. "They should have looked at the environmental factors, potential physiological factors -- everything -- that could be causing [a resident's] behavioral symptom before deciding to go to an antipsychotic." Also monitor the effect of the med to see if it's helping the targeted behavior(s) -- or causing side effects, Lax adds. She notes that "surveyors are more in tune to looking at whether the facility has documentation to that effect under the revised survey guidance for F329."

Identifying and promoting residents' normal daily rhythms, including wake-up times, has been found to reduce a tremendous amount of agitation in nursing homes, says consultant **Barbara Frank**. Other common causes of residents' agitation include use of chair alarms, hunger and pain, says Frank, co-founder of **G&F Consulting** in Warren, RI.

Clinical tip: Even if a resident is experiencing hallucinations or delusions, evaluate whether these are causing the person distress before deciding whether an antipsychotic is needed. For example, "there are such things as happy delusions that don't really bother the patients but may alarm the caregivers," says **Kitty Anderson**, a consulting pharmacist in Salt Lake City.

Take MDS credit where credit's due: Don't forget to code your intervention programs for mood, behavior and cognitive loss in Section P2. These include a Special Behavior Symptom Evaluation Program coded at P2a, defined as "a program of ongoing, comprehensive, interdisciplinary evaluation of behavioral symptoms (such as the symptoms described in Item E4). The purpose of such a program is to attempt to understand the 'meaning' behind the resident's behavioral symptoms in relation to the resident's health and functional status, and social and physical environment. The ultimate goal of the evaluation is to develop and implement a plan of care that serves to reduce distressing symptoms," states the RAI user's manual.