Antipsychotic Medication Use in Illinois Skilled Nursing Facilities: A RATIONAL APPROACH TO CHANGE

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The mentally ill population, when compared to older adults with dementia, have very different presentations and needs. However, the diverse needs of mentally ill and demented SNF/SMHRF patients blur as mentally ill patients age in place.
observations from these key informants, supported by relevant data and literature, was employed in order to define the problem. Priorities and recommendations for action were identified. Four areas of interest were delineated: Illinois SNF resident characteristics, SNF facility characteristics, clinician characteristics, and practice issues related to pharmacologic and non-pharmacologic interventions.

**Illinois SNF Resident Characteristics**

In Illinois, the mentally ill population is thought to contribute to increased APM use. Indeed, the highest use of APM in Illinois is associated with Long Term Care of mentally ill patients in institutions for mental disease (IMD) or specialized mental health rehabilitation facilities (SMHRF). Increased use of APM in this population further complicates the ability to accurately quantify the problem among older adults.

Table A. 1 APM USE in ILLINOIS SNF vs SMHRF

<table>
<thead>
<tr>
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<th>Total # of Illinois SNF</th>
<th>Average percent of APM use in SNF</th>
<th>Total # Illinois SMHRF</th>
<th>Average percent of APM use in SMHRF</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>762</td>
<td>23.54%</td>
<td>24</td>
<td>88.15%</td>
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In 2005, according to the SNF Minimum Data Set (MDS), Illinois had one of the highest number of mentally ill admissions to SNFs in the US, when mental illness was defined as schizophrenia and bipolar disease (IL 3.7% vs US 2.7%). When the definition of mental illness included depression and anxiety, the Illinois SNF admission rate ranking dropped below the US average (IL 24.1% vs US 27.4%). In Illinois, the average age for an admission to a SNF is 77, but the average age for a mentally ill admission to a SNF is 62. Studies have shown that greater use of APM is found in SNF/SMHRF that have younger male residents with diagnoses of schizophrenia or bipolar disorder.

The mentally ill population, when compared to older adults with dementia, have very different presentations and needs. However, the diverse needs of mentally ill and demented SNF/SMHRF patients blur as mentally ill patients age in place. Accordingly, based on the above data, one might expect that with time, more older adult SNF residents in Illinois with dementia will also have serious comorbid mental disorders.

**SNF Characteristics and Clinician Characteristics**

The prescribing culture of the SNF affects the likelihood of a resident being prescribed an APM. Residents newly admitted to a SNF were more likely to be prescribed an APM depending on the overall APM prescribing rate of the facility (even after adjustment for clinical and sociodemographic variables).
Therefore, facility factors such as organizational culture may play a role in APM prescription rates. Prescribers in SNFs have varied credentials and backgrounds. APNs are increasingly practicing in SNFs. Physicians who see patients at SNFs may be geriatricians, internists, or specialists representing many disciplines. The Government Accountability Office (GAO) reported that 66% of the overall APM prescriptions for Medicare Part D patients were prescribed by internists and family medicine physicians, and 16% were written by psychiatrists or neurologists; 5% of APMs for SNF patients were prescribed by APNs and physician assistants, while the remaining were prescribed by other specialties.¹⁴

Staffing and patient mix may also negatively impact an older adult patient population already hampered by a progressively lowered stress threshold, thus setting the stage for potentially catastrophic behavioral reactions.¹⁵ Increasingly, older adults on the continuum from mild cognitive impairment to advanced dementia are presenting to SNFs from the acute care settings for rehabilitation. While hospitalized, some may have been treated with APMs for delirium.

Nurses in SNFs are often less educated licensed practical nurses (LPN) and registered nurses (RN) from two-year diploma programs. Nurse and certified nursing assistant (CNA) turnover is high. There are staff shortages. Temporary nurses often fill gaps. These staff may not be adequately equipped to handle the medical and psychiatric complexities of SNF residents. Nationwide, and in Illinois, there are more corporately owned than private/non-profit owned SNFs. Private/non-profit owned SNFs generally have lower APM use.¹⁶ Perhaps non-profit facility stability, with progressive, well-informed administrators, directors of nursing (DON), and low staff turnover rates contribute to lower rates of APM use.

In May 2015, The Annual Maudsley debate focused on the safety of psychotropic medication. One commentator stated that the medications should not be used, while the other countered this opinion citing safety versus risk. The dissenting opinion suggested the replacement of medication with behavioral intervention provided by well-trained staff. Given medical economics and staffing challenges, how realistic is it to have enough staff who are adequately trained? The Maudsley debate also discussed the notion that many individuals with mental disorders, which includes dementia/neurocognitive disorder with behavioral disturbance, as defined in the DSM-5, have comorbid medical conditions that contribute to both morbidity and mortality.¹⁷,¹⁸ Additionally, Maust et al studied APM and other psychotropic medication in relation to mortality risk in dementia; confounding factors were comorbidity, institutional treatment, and potential delirium contributing to disease severity and increased mortality. Substantial caution and monitoring was emphasized when prescribing APM to older adults.¹⁹

**Practice Issues: Moving the Initiative Forward**

Clinicians face a dilemma of how to balance patient care needs against policy mandates. Is the selection of an arbitrary
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number/percent by which APM prescriptions should be reduced wise balanced against maintaining safety for residents and others? In a famous case, a World War II veteran in a Long Term Care environment died of injuries sustained when law enforcement was called by a facility unable to adequately control the individual with behavioral intervention.

To meet the complex needs of persons with dementia in a SNF, baccalaureate-prepared nurses should be actively recruited. Recently, an expert panel study identified required competencies that a baccalaureate-prepared registered nurse needs to have that may increase quality of care in SNFs. Baccalaureate prepared nurses can provide essential team leadership skills, and role modeling to improve care in a SNF.

The percentage of APM use in SNFs must be accurately reported. Does the minimum data set (MDS) accurately capture the scope and types of mental illness/dementias? Would a requirement for meeting DSM criteria more accurately capture data on types of mental illness and dementias found in our SNFs? Grossberg stated that 90% of the SNF population has a comorbid psychiatric disorder. Bonner et al studied 204 residents, only 15% of whom had a psychiatric diagnosis, and suggested that each resident needs an individualized assessment for physical aggression, verbal aggression, and problems with daily care. Of those with a psychiatric diagnosis, 60% had psychotic symptomatology. When families were involved in the plan of care it was found that less APM was used.

Patients who present a harm to self or others, may require pharmacologic intervention to be instituted. When the GAO reported overuse of neuroleptics in the geriatric population, Constantine G. Lyketsos, MD, was quoted as saying:

For extreme hard to manage behavioral symptoms the most effective treatment we have right now are APMs. Penalizing nursing homes, care providers, or patients for using these drugs is not the way to get better treatment. We are not going to get there by passing some kind of fiat or decision.

Clinicians can prescribe APM only when supported by a sound assessment. Treatment should be started at the lowest effective dose, while monitoring patients for symptomatic response and adverse side effects. Behavioral measures can be concurrently implemented. The long-term goal is gradual dosage reduction (GDR) as the patient improves. To prevent relapse, it may be necessary to continue treatment at the lowest effective dose. Grossberg and Devanand et al both presented data on psychiatric relapse related to gradual APM dosage reduction, reinforcing the wisdom of using the lowest effective dose. Grossberg emphasized that treatment may need to last for 1 year or longer due to the high risk of relapse in dementia patients with psychosis and agitation.

Discussion

Clinicians can prescribe APM only when supported by a sound assessment and accurate psychiatric diagnosis. Given the limited psychopharmacologic resources available for the treatment of BPSD, clinicians are charged with responsibly providing safe and effective treatment to patients. When used judiciously, in concert with behavioral interventions, APM is an invaluable resource for patient care and disease management.

Amin examined the impact of behavioral interventions on psychotropic reduction rates. Music and recreation were modestly helpful. Recurrence of behaviors affected 33% of the patient population, and 5% of the patient population required ongoing treatment with neuroleptic medication. Sollins listed CMS recommendations for disturbed behavior that included: safe supervised areas for unrestricted movement; relief of boredom and pain; monitoring environmental lighting, noise, and temperature; consistent staff familiar with patients; adequate staffing based on patient needs; ongoing training/supervision on management of agitated, combative, aggressive, and anxious patients; and knowing how and when to obtain assistance in managing a resident with behavior symptoms.

Bell reported good clinical response to Lexapro, a selective serotonin reuptake inhibitor (SSRI), versus traditional APM in demented patients with behavioral disturbance. Use of SSRIs may hold promise for relief of anxiety and agitation associated with dementia. It may also be useful to look specifically at prescribing patterns and documented rationales of specific groups of prescribers for the use...
of psychotropic medications.\textsuperscript{26}

Simmons et al offered a brief case presentation of an 85-year-old male residing in a SNF with BPSD. The authors showed how five non-pharmacologic intervention resources: the Serial Trial Intervention (STI) Teaching Manual, the Nursing Home Toolkit, the Hand in Hand Toolkit for Nursing Homes, the Advancing Excellence in America’s Nursing Homes Campaign, and the University of Iowa Geriatric Education Center could be utilized to ameliorate BPSD. Directors of nursing and administrators may review such resources and customize assessment tools to meet the needs of their residents. More analyses of non-pharmacologic interventions are needed.\textsuperscript{27}

Legislation at the state and national level may be required to appropriate funds for improvements in staffing and clinical training. In Illinois, legislators are currently unable or unwilling to appropriate funding. Stakeholders must communicate regularly with legislators to make the needs of SNF patients known.

The presence of baccalaureate-prepared nurses has been linked with better outcomes for patients in the acute care setting. There are no such studies regarding SNFs. According to Morgan et al, standardization of care requires widespread commitment to evidence-based practice, patient education, and integration of behavioral health across specialties despite any practical and financial challenges.\textsuperscript{28} With limited time and money, the most effective interventions will be simple and require little formal training to implement. Moving forward, monies will need to be well spent to ensure a high quality of care that includes both behavioral intervention and, when necessary, a rationale based use of psychotropic medication.

Conclusions

In Illinois, The CGAPN Committee to Reduce Antipsychotic Use in Illinois SNF provided a platform for stakeholders to describe factors contributing to APM use in Illinois, while promoting scholarly work and dissemination of knowledge so that its impact might reach beyond the state’s borders. It is hoped that the efforts of CGAPN lead to collaboration between CGAPN and other professionals representing clinicians and administrator stakeholders in Illinois and beyond. Such collaborations have the potential to provide a unified strong forum for further analysis of APM use, advocacy for SNF patients, and engagement of elected officials and other stakeholders. The Illinois State Coalition might consider dividing the state into regions with volunteer regional directors. Regional Directors could engage and challenge SNF administrators, physicians/APNs, DON, and others to develop a rational approach to APM use in their facilities.

More research is needed to elucidate reasons for higher APM use in Illinois and other states. In Illinois APM use in SNF versus SMHRF may be reported separately for further analysis of APM use. A side by side analysis of states with high APM use might be useful to show the presence of similarities and differences. Nurse practitioners consulting with DON’s in SNFs have an opportunity/mandate to provide team leadership, education, and guidance to administrators, nursing team, physicians, families, and patients to improved dementia care. Finally, stakeholders must vote for legislators who support measures that improve SNF care.

References


