Off Label Prescribing and Polypharmacy

Albert Riddle, MD, CMD
President
Riddle Medical Group

Poll Question

How important is it for you to feel empowered in your daily activities?

A. Not important
B. Somewhat important
C. Important
D. Very important

An ambulatory resident who does not require assistance with feeding and is able to make his needs known is sitting in the dining room of the facility eating his dinner. He finishes his main course, decides that he is full and gets up to go back to his room. A C.N.A. who is feeding a dependent resident sees him stand and notices that he has not touched his dessert.

C.N.A.: “Mr. R, you are not done yet. You didn’t eat your dessert”
An ambulatory resident who does not require assistance with feeding and is able to make his needs known is sitting in the dining room of the facility eating his dinner. He finishes his main course, decides that he is full and gets up to go back to his room. A C.N.A. who is feeding a dependent resident sees him stand and notices that he has not touched his dessert.

C.N.A.: “Mr. R, you are not done yet. You didn't eat your dessert”

Mr. R: “I am finished” (as he turns to leave the dining room).

C.N.A.: “Mr. R you have to finish your dessert. Let me call the nurse to help you” (she then calls for a nurse to come and help him).

Mr. R: “I'm not stupid, I don't need help. I hate this place. I have to get out of here and get some air or I'm going to kill someone” He raised his walker and seemed like he was going to throw it just as the nurse, who had been called to help him, arrived.
Stat Psychiatric Consult Ordered

Information Provided to the psychiatrist by the staff
(all based on this isolated event)

HPI: Patient is easily agitated and becomes threatening. Raised walker and threatened to toss it. Very confused and angry. He resists care and is verbally and physically abusive. He gets anxious and agitated at night.

Co-morbidities: Hypertension, Dementia, Depression, Anxiety, Diabetes Mellitus.

Medications: Paxil (MDD and Panic), Namenda (AD), Exelon (AD), Norvasc (htn) and Apropra (htn)

Psychiatric Assessment

This resident has dementia with depression and a behavior disturbance.

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I would also like to add Depakote ER 250 mg at bedtime. If this is not helping in 2 weeks, consider increasing the dose to 500 mg at bedtime.
Psychiatric Assessment

This resident has dementia with depression and a behavior disturbance. It is possible that his agitated depression may be under medicated. It is worth trying an increase in Paxil to 20 mg. I would also like to add Depakote ER 250 mg at bedtime. If this is not helping in 2 weeks, consider increasing the dose to 500 mg at bedtime. Finally, you can add Ativan 0.25 mg twice daily to reduce anxiety.

Don’t forget to check Valproic Acid levels.

Poll Question

How do you think this case was handled?

A. Well done  
B. The C.N.A. should have let him go.  
C. The psychiatrist made too many changes at once.  
D. Diabetics should not be offered dessert

Objectives

• Discuss the following issues:
  – Factors that affect behavioral issues in the elderly
  – National goals to reduce use of antipsychotic and other psychoactive medications in LTC
  – Assessment and management of distressed behaviors
  – Implications of the current regulatory environment
Enemies of the Mind

- **Baseline Status**
  - Lifelong behaviors/habits
  - Psychiatric chemical imbalance
  - Baggage and long-term memories

- **Coping Mechanisms**
  - Dealing, Adjusting, and Concealing

- **Physiological and Functional Impairment**
  - Endothelial instability – Brain infarcts
  - Loss of memory
  - Loss of visual function
  - Loss of hearing function
  - Loss of strength, endurance, and mobility
  - Loss of bowel and bladder control

- **Co-Morbid Conditions**
  - Hypomania
  - Mania
  - Depression
  - Anxiety
  - Panic
  - Chronic medical issues
  - Delirium

- **Impact of Time**
  - Loss of senses and feedback
  - Confusion/Delusions (feedback?)
  - Loss of support (family and friends)
  - Loss of defenses/empowerment

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**Antipsychotic Use for Elderly Nursing Home Residents: OIG Report**

*Posted by Roy on Sunday, January 29, 2012*

**Quote #1**

"I believe that behavior itself is not a disease. Simply put, behavior is communication, in people whose ability to communicate with words is limited (such as patients with dementia), communication tends to be more nonverbal (i.e. behavioral). Our challenge is to figure out what they are trying to say, and if they are in distress, to identify the underlying causes and precipitants. Many of the behaviors that are commonly observed in patients with dementia and that are often labeled as difficult, challenging, or bad, such as agitation, wandering, yelling, inappropriate urination, and hitting are typically reactive, almost reflexive behaviors that occur in response to a perceived threat or other misunderstanding among patients who by definition of their underlying illness have an impaired ability to understand....."
Quote #1 - Continued

“Patients with dementia often have trouble comprehending their environment, resulting in misperceptions that are often perceived as threats. In most instances, the key to behavior management in dementia is environmental modification, especially the human environment, which may be as simple as changing our approach and our response in order to prevent and minimize distress. The fundamental basis of caring is to have acceptance and respect for persons.”

Jonathan M. Evans, MD, MPH, FACP, CMD
Vice President
American Medical Director’s Association

Quote #2

“Medications are used often as the first intervention because family members, care givers, nurses, and doctors in ALL settings lack information on training regarding alternatives. To merely target this one class of drug as the “problem to be fixed” will have the unintended consequence of increasing the use of other risky medications such as benzodiazepines, anti-seizure medications and sedative hypnotics, all of which have side effects that include confusion, falls, and risk of death. Furthermore, if the focus is only on the nursing home, we will create barriers to access for care that patients and families desperately need. In some states, such as California where consent rules regarding the use of any psychoactive medications in nursing homes are in place, some nursing homes have declined admissions because of a history of behavioral problems…..”

Cheryl Phillips, MD
AGSF Senior VP for Advocacy

Quote #2 - Continued

“…..requiring psych meds, creating real challenges for caregivers and often requiring patients to stay for long periods in the acute care hospital. The solution to this challenge is not a short-term fix, but rather a two-fold strategy that involves systemic application of non-pharmacological behavioral interventions as the first line of treatment, with close monitoring for appropriate and limited use of medications when the non-pharmacological approaches have not worked.”

Cheryl Phillips, MD
AGSF Senior VP for Advocacy
Quote #3

“Despite the severity and frequency of these symptoms, there is currently no FDA approved therapy used to treat behavioral and psychotic symptoms of dementia. As a result, many types of medications, including atypical antipsychotics, have been used “off-label” in an attempt to mitigate these symptoms. In 2005, the FDA examined this issue and found that the use of atypical antipsychotics in people with dementia over 12 weeks helped to reduce aggression, but was also associated with increased mortality.”

Recommendations of the Alzheimer’s Association

A. Education and training on psychosocial interventions for all professional caregivers.
B. Consider the following prior to starting antipsychotic therapy
   A. Identify and remove triggers for behaviors and psychotic symptoms of dementia.
      A. Pain
      B. Under- or Over-Stimulation
      C. Disruption of routine
      D. Infection
      E. Change in caregiver
   B. Initiate non-pharmacologic alternatives as first line of therapy for control of behaviors.
   C. Assess severity and consequences of behavior(s)

Consequences

<table>
<thead>
<tr>
<th>Limited Consequences</th>
<th>More Severe Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>• If there is no or low risk for harm to individual or caregiver, non-pharmacologic therapy should be initiated.</td>
<td>• High-risk behaviors such as frightening hallucinations, delusions, or hitting.</td>
</tr>
<tr>
<td>• It is not appropriate to use antipsychotic agents for these cases.</td>
<td>• Some behaviors may be so frequent and escalating that they result in harm and will, in essence, limit the life-expectancy and or quality of life.</td>
</tr>
<tr>
<td></td>
<td>• For these cases, a short-term trial of an antipsychotic may be useful with regular re-evaluation for appropriate discontinuation.</td>
</tr>
</tbody>
</table>
Case Study

- 80 year old female
- Resided at facility for 7 months
- History of Herniated vertebral disc, Spinal stenosis, osteoporosis, depression and dementia.

Medications

<table>
<thead>
<tr>
<th>Medication</th>
<th>Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lexapro 5 daily</td>
<td>MDD</td>
</tr>
<tr>
<td>Aricept 10 mg daily</td>
<td>Dementia</td>
</tr>
<tr>
<td>Namenda 10 mg BID</td>
<td>Dementia</td>
</tr>
<tr>
<td>Percocet 7.5/325 TID</td>
<td>Back Pain</td>
</tr>
<tr>
<td>Tylemol 600 mg every 6 hours as needed</td>
<td>Pain</td>
</tr>
<tr>
<td>Ultram 50 mg every 6 hours as needed</td>
<td>Pain</td>
</tr>
<tr>
<td>Lidoderm patch to lower back BID</td>
<td>Back pain</td>
</tr>
<tr>
<td>Bowel regimen per protocol</td>
<td></td>
</tr>
</tbody>
</table>
Poll Question

Based on MDS data, the following applies to this resident:

A. Cognitive impairment
B. Cognitive impairment and Depression
C. Cognitive impairment, depression, and delirium
D. Cognitive impairment, depression, and psychosis
E. Cognitive impairment, delirium, and psychosis
Labs

<table>
<thead>
<tr>
<th>Date</th>
<th>Glu</th>
<th>Na</th>
<th>K</th>
<th>BUN</th>
<th>Cr</th>
<th>Osmo</th>
<th>WBC</th>
<th>Hg</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/12/12</td>
<td>83</td>
<td>140</td>
<td>3.8</td>
<td>38</td>
<td>2.03</td>
<td>281</td>
<td>9.83</td>
<td>14.0</td>
</tr>
</tbody>
</table>

L/S Spine Films: Lumbar scoliosis with DDD
Negative urine culture. On a prior urine culture she grew 100,000 E. Coli but was not treated as there were no localizing symptoms.

Nursing Care Plan

Periodically exhibits episodes of frustration and anger. Husband visits on occasion and generally reports that his wife's mood is good.

<table>
<thead>
<tr>
<th>Date</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/12/12</td>
<td>Can be verbally and physically aggressive</td>
</tr>
<tr>
<td>1/30/12</td>
<td>Anger and frustration toward staff</td>
</tr>
<tr>
<td>1/11/12</td>
<td>Kicked by another resident after that resident began yelling at another resident. No injuries.</td>
</tr>
</tbody>
</table>

Psychiatric Consultation

January 2012

- **Current Behavior:**
  - Patient would benefit from anxiolytic to help with her increased agitation. 1 Stat dose has been ordered and given.
- **Assessment:**
Psychiatric Consultation
January 2012

• Plan:
  – Continue Lexapro 5 mg
  – Continue Aricept and Namenda
  – Continue Ativan 5 mg Q12 PRN as ordered

Nursing Care Plan
Periodically exhibits episodes of frustration and anger. Husband visits on occasion and generally reports that his wife's mood is good.

Psychiatric Consultation
May 2012

• Current Behavior:
  – Continues to display periods of anger with some intrusiveness. Needs redirection. Anxious at times. Altered sense of awareness of surroundings. Wants to help other residents.
• Assessment:
  – Dementia of Alzheimer's Type. Staff reports increased agitation and aggressive behaviors with confusion, intrusiveness, no insight, and she is difficult to redirect. Limited sleep lately.
Psychiatric Consultation
May 2012

- Plan:
  - D/C Lexapro
  - Trial Seroquel 12.5 mg BID for aggression with agitation
  - Seroquel 25 HS PRN for agitation
  - Continue Aricept and Namenda as ordered
  - Follow up in 1-3 weeks

Nursing Care Plan

Periodically exhibits episodes of frustration and anger. Husband visits on occasion and generally reports that his wife's mood is good.

<table>
<thead>
<tr>
<th>Date</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/7/12</td>
<td>13 observation working well.</td>
</tr>
<tr>
<td>6/12/12</td>
<td>Continues to have intrusive behaviors. Decreased attempts to move another resident. Some response to redirection. She now thinks that her husband is her father.</td>
</tr>
</tbody>
</table>

Psychiatric Consultation
June 2012

- Revised Plan:
  - D/C Lexapro
  - D/C Aricept
  - D/C Namenda
  - Start Trazodone 50 mg HS for depression
  - Follow-up in one week
One Week Later

• Now thinks that she has given birth.
• New onset of crying episodes, especially in the morning.

Poll Question

Based on MDS data and history the following applies to this resident

A. Cognitive impairment
B. Cognitive impairment and Depression
C. Cognitive impairment, depression, and delirium
D. Cognitive impairment, depression, and psychosis
E. Cognitive impairment, delirium, and psychosis

QUESTIONS?

You can ask questions in 2 ways

The Web Platform
Type your question into the box on the lower left hand side of your screen then click on the "Send" button to submit your Question.

The Telephone
Press *1 on your telephone and the operator will place you into the phone queue.
Delirium

- State of acute confusion
- Common in older adults with acute medical illness
- The elderly person with dementia is at greater risk because of pre-existing cognitive impairment and sensitivity to stressors such as medical illnesses and medication side effects

Screening for Delirium

- Confusion assessment method (CAM) included in the MDS 3.0
  - Negative “CAM” screening does not rule out delirium (high number of false negative tests)
  - Continue to consider delirium if CAM is negative but the person still seems more confused than usual
The Next Steps

- Consider the possible causes related to impaired sensory input (seeing and hearing) that are often overlooked
  - Not wearing glasses or hearing aid
  - Vision has changed and glasses need to be changed
  - Hearing aid is not working
  - Ear wax is interfering with ability to hear

Medical Evaluation

- Common Potential Medical Conditions Causing Delirium
  - Pneumonia
  - Urinary Tract Infection
  - Pain
  - Constipation
  - Skin Ulcers
  - Myocardial Infarction
  - Stroke

Physical Signs

- Vital signs
  - Fever and elevated heart rate may indicate infection
  - Elevated heart rate and low blood pressure may indicate sepsis
Laboratory Evaluation

- Immediate
  - Blood Glucose
  - Urinalysis
- Delayed
  - Electrolytes
  - Chemistry Panel (Cr, BUN, Glucose)
  - CBC

Evaluate Need for Devices

- IV Lines
- Catheters
- Restraints

Use of these items may restrict normal movement and cause further confusion and agitation. There is also risk for harm if attempts are made to pull the lines out.

Evaluate Existing Medications

- Consider the following issues
  - Drug induced cognitive impairment
    • Anticholinergic Load
  - Medication induced electrolyte disturbance
  - Recent medication additions that may alter metabolism of a drug that the person has been taking for a while
  - Withdrawal reaction to a recently discontinued medication
Anticholinergic Load

- Medications of Particular Concern
  - Bladder and GI antispasmodics
  - Antihistamines
  - Certain antipsychotics
  - Tricyclic antidepressants
  - Movement disorder medications

Anticholinergic Load

- Medications not typically considered
  - Prednisone
  - Furosemide
  - Digoxin
  - Amlodipine

Benign/ Harmless?

- These medications have been shown to adversely affect cognition and create behavioral disturbance
  - Antivirals
  - Antifungals
  - Antibiotics
Atypical Antipsychotic Profile

<table>
<thead>
<tr>
<th>Medication</th>
<th>Anticholinergic Effects</th>
<th>Sedation</th>
<th>EPS</th>
<th>Orthostatic Hypotension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clozapine (Clozaril)</td>
<td>High</td>
<td>High</td>
<td>Low</td>
<td>Moderate</td>
</tr>
<tr>
<td>Olanzapine (Zyprexa)</td>
<td>High</td>
<td>High</td>
<td>Low</td>
<td>Moderate</td>
</tr>
<tr>
<td>Quetiapine (Seroquel)</td>
<td>High</td>
<td>Moderate</td>
<td>Low</td>
<td>Moderate</td>
</tr>
<tr>
<td>Risperdone (Risperdal)</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
</tbody>
</table>

Management of Delirium

- Identify and treat the underlying problem
- Remember that once the underlying medical problem is under control, it may still take time before the delirium resolves
- Maintain a calm and clear environment
- Give constant reorientation
- Maintain adequate hydration
- Normalize the sleep-wake cycle
- Maintain safety

Medication Management of Delirium

- Antipsychotics
- Benzodiazepines/ Sedative Hypnotics
- Cholinesterase Inhibitors
Activities of Daily Living

BEHAVIOR MANAGEMENT

Behavior Disturbances

Behaviors

- Wandering
- Screaming
- Aggression
  - Verbal
  - Physical

Where do they occur

- Toilet
- Dining Room
- Bath/shower

Step 1: Evaluating Cause

- Unmet physical need?
- Unmet psychological need?
- Environmental cause?
- Psychiatric cause?
Step 2: Non-Pharmacologic Interventions

- Adjust caregiver approaches
- Change the environment
- Use evidence based interventions
Step 3

- Monitor response
- Document response, in detail, in the medical record
- Adjust interventions as needed

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SUCCESSFUL INTERVENTIONS
Mr. B pushes his chair away from the dinner table and rises to leave after taking only a few bites of food. "Aren't you hungry today?" asks the nurse who walks towards him. He puts his hand up as if to keep her away, frowns, glances around, and walks out of the room. This is not the first time he has made an early departure from the active and sometimes noisy dining area.

Response: Staff accepts that he knows when the stimulation is too much and accommodate his wish to leave.

Intervention: A plate of food and a glass of milk are delivered to his room where the nurse coaxes him, "Try this nice sandwich. It's grilled cheese, your favorite." When he takes a bite, she continues to cue him: "Now how about a drink of cold milk?" Mr. B then proceeds to eat most of his meal.

Source: www.nursingcenter.com

“No, no, no! I'm not like that! Leave me alone!” screams Mr. B as the nurse tries to remove his pajama top. "But you can't run around all day in your PJ's Mr. B. Let's get you dressed," the aid replies. "Don't touch me you slut!” he yells as he pushes her hand away.

Response: The aid leaves the resident and describes the situation, using direct quotes, to the remainder of the care team.

Intervention: His reference to "not being like that" and name calling suggest that the caregiver's sex might play a role. A male nurse or aide is sought and he is able to help Mr. B remain calm while he is dressed and groomed.

Source: www.nursingcenter.com

“Miss W walks down the hall, calling out “Where am I? Where am I? Is it alright?” Her cries become louder and louder and she has a frightened look on her face.

Intervention: The nurse moves towards her and establishes eye contact before saying anything. Once she is sure she has established eye contact she says in a soothing voice, “Ms. W, I’m glad to see you. I need your help. Can you come with me please?” She extends her hand and smiles. Ms. W continued to look confused, but pauses. The nurse continues, “Come to the kitchen. I have some cookies for you to taste.” Ms. W still looks a bit puzzled but begins to walk toward the kitchen with the nurse.

Source: www.nursingcenter.com
"Mrs. C is helped to the bathroom, but only after a lot of cues and gentle encouragement. She is about to have a shower and this frequently results in combative behavior. The nurse and C.N.A., trying to get through this as quickly as possible, accidentally spray water into Mrs. C's face. As this happens, Mrs. C quickly grabs and pinches the nurse as she is the closest one to her. She then clenches her fist and begins striking out, hitting both caregivers.

**Intervention:** The nurse quickly apologizes, saying, "I'm sorry. You're safe with us. Here, hold this over your eyes" and she hands Mrs. C a washcloth to cover her face.

Source: www.nursingcenter.com

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**No Response...Now What?**

- Delirium Ruled Out
- No response to non-chemical interventions
- Unable to match resident to a meaningful activity
- Redirection does not work
- NOTHING WORKS! Staff is getting beat up!

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**Systematic Approach Needed**

- Does the behavior pose risks to the resident or others or is the resident severely distressed?
  - If the answer is yes, drug therapy may be the only viable therapeutic option.
Prescribing Antipsychotics

**Appropriate Targets**
- Physically aggressive behavior
- Hallucinations
- Delusions (Not to be confused with memory problems)
- Severe distress

**Inappropriate Targets**
- Wandering
- Poor self-care
- Restlessness
- Nervousness
- Mild Anxiety
- Fidgeting

Delusions vs. Impaired Memory

- Thinking that your husband is your father
  - Getting agitated because you think, without reason, that your spouse is having an affair
- Not recognizing a son or daughter when they visit
  - Thinking that a visiting family member is an imposter
- Misplacing an item
  - Accusing someone of stealing something that you have misplaced

What to Do and What to Expect

- Clearly document target symptoms and how they respond to treatment
- Remember that symptoms may change over time with or without treatment
- Do not expect an immediate response
- Any immediate response that is seen is probably due to sedation
- Do not ask for higher doses to quickly. Depending on the drug, response can take up to one week to occur.
Medication Therapy

• Continue non-medication interventions
• Monitor drug therapy
  – Behavior response
  – Adverse medication reactions
• Consider dose reduction and discontinuation if
  – The medication is not effective
  – There are side effects
  – Behaviors improve

Where do you begin? Reach for the low hanging fruit.

GRADUAL DOSE REDUCTION

Tracking Medication Changes

<table>
<thead>
<tr>
<th>Date</th>
<th>Medication Change</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/18/2012</td>
<td>Akin 0.25 mg TID</td>
<td>Admission medication</td>
</tr>
<tr>
<td>7/18/2012</td>
<td>Risperdal 0.5 mg Qd2</td>
<td>Admission medication</td>
</tr>
<tr>
<td>7/18/2012</td>
<td>Ambrisentane</td>
<td>Admission medication</td>
</tr>
<tr>
<td>7/19/2012</td>
<td>Risperdal reduced to 0.25 BID</td>
<td>See 7/19/12 psych consult</td>
</tr>
<tr>
<td>7/19/2012</td>
<td>Risperdal increased to 0.5 BID</td>
<td>Hitting, loss of appetite. See behavior care plan update of 7/19/12.</td>
</tr>
<tr>
<td>7/20/2012</td>
<td>Akin increased to 0.5 TID</td>
<td>Not responding to increased dose of Risperdal. See behavior care plan update of 7/20/12.</td>
</tr>
</tbody>
</table>
GDR Requirements: General Principles

- **Rationale:** finding the appropriate dose and duration while minimizing risk for ADR
- May be indicated when resident’s clinical condition has improved or stabilized
- May be indicated when the underlying causes of the original target symptoms have resolved
- May be indicated when non-pharmacologic interventions, including behavior interventions, have been effective in reducing symptoms

GDR Requirements: Responsibilities

- **Consultant Pharmacist**
  - Monthly drug regimen review
    - Should evaluate dose, duration, continued need and emergence of adverse consequences for all medications.
- **Practitioner**
  - When evaluating the residents progress
    - Review total plan of care, orders, and response to medication
    - Decide if continuing, modifying, or discontinuing a medication is appropriate
- **Facility**
  - MDS review to evaluate mood, function, behaviors and other domains affected by medication

Sometimes, the decisions are not clear.

- Treatment decisions and care provided must be resident centered.
- Someone with a history of multiple episodes of depression may need an antidepressant indefinitely.
Progression of Major Depressive Disorder

- Euthymia
- Progression to Disorder
- Response
- Remission
- Relapse

**Treatment Phase**
- Acute
- Continuation/Maintenance

**Treatment Goals**
- Achieve Remission
- Delay Time to Relapse

**Presentation of Geriatric Depression**

- Prominent Anxiety, Somatization, and Irritability
- Increased risk for use of Benzodiazepines if Anxiety not managed
- Failure to Thrive
- Possible hallucinations and delusions
- Pacing
- Frustration and intolerance
- Memory failure emphasized

**GDR Requirements: Antipsychotics**

- Within the first year of admission to facility on an antipsychotic or after initiation of an antipsychotic for an established resident.
  - GDR must be attempted in 2 separate quarters with at least one month between attempts, unless clinically contraindicated.
    - Has resulted in a misunderstanding regarding quarterly psych visits and confusion about time frame for GDR.
  - After the first year, A GDR must be attempted annually except where clinically contraindicated.
GDR Requirements: Antipsychotic Contraindications

Behavior Symptoms
- The resident’s target symptoms returned or worsened after the most recent attempt at GDR within the facility.
- The physician has documented the clinical rationale for why any additional attempted GDR at this time would likely to impair the resident’s function or increased distressed behavior.

Psychiatric Disorder
- The continued use is in accordance with relevant standards of practice and the MD has documented the clinical rationale for why any attempted GDR would impair function or cause psychiatric instability by exacerbating an underlying psychiatric disorder.
- Target symptoms returned or worsened after a GDR within the facility and the MD has documented a rationale for why an additional GDR at this time would impair function or exacerbate an underlying psychiatric disorder.

GDR Requirements: Sedatives/Hypnotics

- For as long as a resident remains on these agents and it is used routinely and beyond the manufacturer’s recommendations for duration of use, the facility should attempt to taper the medication quarterly unless clinically contraindicated.
- Clinically contraindicated means:
  - Continued use is in accordance with relevant current standards of practice and Physician documented the clinical rationale for why reduction would lead to impaired function or would exacerbate an existing medical or psychiatric condition.
  - Target symptoms returned or worsened after the most recent taper attempt within the facility and MD documented clinical rationale for why GDR would impair function or exacerbate an underlying condition.

GDR Requirements: Psychopharmacologic Medications other than Antipsychotics and Sedatives/Hypnotics

- Within the first year of admission to facility on an antipsychotic or after initiation of an antipsychotic for an established resident.
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  - Has resulted in a misunderstanding regarding quarterly psych visits and confusion about time frame for GDR.
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THANK YOU FOR ATTENDING
Please take a moment to complete this brief webinar evaluation

CLICK HERE