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FAQs from our Webinar
All Aboard! Staying on Track to Optimize Psychotropic Medications

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1. How do you ask or suggest prescribers not to write certain orders during their visits when they just come to see the patient? For example, they may write an order for a high dose of a psychotropic and have their reasoning for it, but the team may feel differently.

Matt: One option would be to engage the medical director at your next QAPI meeting and establish a prescribing protocol that will involve the IDT team. In addition, I think providing IDT input about the resident prior to the visit or making information easy to access regarding the residents "typical" behaviors or baseline they won't be as influenced by their visit that particular day in regards to changing or prescribing psychotropic medications.

Nena: I agree with Matt's suggestion. Another option is to provide lunch and if possible go to them or have them come to you for some structured "regulatory updates" using the SOM phase 3 as reference and review the requirements. Invite your consultant pharmacist to join in person or by phone/zoom! Let them know you'll help them comply by making suggestions and providing indications.

2. In tracking behaviors, how much detail do we need to "define" the behavior to be effective in documentation and tracking?

Matt: The behavior needs to be as specific as you can make it. For example, we should try to avoid ever using "agitation" as a behavior. Instead ask the question how do you know the resident is agitated? Your answer is the behavior we should be monitoring (e.g. rapid speech, swearing,). Another one is "anxiety" – it is better to state "should be evidenced by: xxx"

3. Substance use disorders and antipsychotic use seem to me to be increasing. Are you seeing more of this?

Matt: Yes. We know use of psychotropics has increased and we are also seeing more residents with severe psychotic illness and/or substance use disorders being admitted to nursing homes.

4. Would you be able to send additional resources for a psychotropic stewardship program?

Matt: PharMerica is developing a psychotropic stewardship program which should be available before the end of the year. Please reach out if you would like more details.

5. Is there any plan from CMS to do more to hold hospitals and physicians (in the hospital and community) accountable for inappropriate prescribing?

Matt: CMS regulates only the nursing homes. Thus the onus is on us to create standards/P&Ps that hold them accountable.

6. Need clarification on Melatonin one more time. CMS identified it as a supplement and yet consents are obtained from residents in LTC for use as a sedative/hypnotic. So if doing this, does it need to be reviewed every 90 days? What is the best way to manage Melatonin use?

Matt: CMS classifies melatonin as a dietary supplement; therefore it would not meet the definition of a medication or psychotropic medication and would not require written/signed consents (unless there are state specific guidelines that are more stringent). Every medication and supplement always requires informed consent – the question is whether written consent is required in your specific state or not. In my experience, the best way to monitor melatonin is to have a goal of therapy when starting and monitor the response to see if it has been effective (this could be resident reporting feeling more rested in the mornings, a standardized sleep hygiene assessment or even staff tracking the number of hours slept). This then should be evaluated on a periodic basis to see if the resident is still benefiting.

7. The surveyor did not accept our documentation and prescriber note about not having GDR annually. They want GDR every year no matter what the resident condition and said we can resume the previous dosage if it is not working with GDR dosage.

Matt: GDR requirements will change slightly with new guidance; however, twice within the first year in two separate quarters will remain. Yearly thereafter was replaced by modest increments over an adequate period of time to minimize withdrawal symptoms and monitor for symptom recurrence.

Per the regulation §483.45(e)(2), residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

Remember, in order for a dose reduction to be clinically contraindicated, certain criteria have to be met. Here is the interpretive guidance in Appendix PP:

- For any individual who is receiving a psychotropic medication to treat expressions or indications of distress related to dementia, the GDR may be considered clinically contraindicated for reasons that include, but that are not limited to:
    - The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility; and
    - The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior.

- For any individual who is receiving a psychotropic medication to treat a disorder other than expressions or indications of distress related to dementia (for example, schizophrenia, bipolar mania, depression with psychotic features, or another medical condition, other than dementia, which may cause psychosis), the GDR may be considered clinically contraindicated for reasons that include, but that are not limited to:
    - The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or exacerbate an underlying medical or psychiatric disorder; or
    - The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or exacerbate an underlying medical or psychiatric disorder.

For example, if treating behaviors related to dementia, a failed prior GDR is required as there are no clinical standards of practice to support the use. With current guidance in place, if a dose reduction wasn't attempted and failed within the prior year for a resident with dementia, depending on the circumstances, it could have resulted in a citation.

8. I have a question regarding gabapentin and nicotine patches. I understand that these are considered psychotherapeutic medications. Should they also go through the process?

Matt: Currently, they would not be considered psychotropic medications. When Phase 3 is enacted this fall, it will depend on the indication for use. If the indication is something that is typically treated with a psychotropic or involves any type of "behavior", it will be considered a psychotropic and be held to the same guidance.

New Guidance:
Categories of medications which affect brain activity include antihistamines, anti-cholinergic medications, and central nervous system agents used to treat conditions such as seizures, mood disorders, pseudobulbar affect, and muscle spasms or stiffness. The requirements pertaining to psychotropic medications apply to these types of medications when their documented use appears to be a substitution for another psychotropic medication rather than for the original or approved indication.

For example, if a resident is prescribed valproic acid and the medical record shows no history of seizures but there is documentation that the medication is being used to treat agitation or other expressions of distress, then the use of valproic acid should be consistent with the psychotropic medication requirements under §483.45(e).

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