PharMerica Follow Up Psychotropic Stewardship Webinar

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Thank you for attending our recent webinar on January 31st. Our expert speakers Jeff Herr, David Phillips, and Matthew Palmer would like to share additional educational content on this important topic.

Follow Up Questions & Answers

Q. When considering a time out, do you actually stop the medication cold?

A. The "timeout" is merely a time point in therapy (e.g., at initiation, upon admission, after a number of days, etc.) for a clinician to pause and review/confirm the appropriateness and optimization of the psychotropic regimen (not to be confused with a medication vacation/holiday, where therapy is deliberately interrupted for a determined period). Upon review, the medication may be continued or changed (increased, decreased, or discontinued) based on the clinician's findings. If the determination is made to discontinue, how to do so is dependent on the resident's individual situation.

There may be times when stopping a psychotropic medication without a taper is warranted (e.g., serious ADEs, currently taking lowest available dose, history of no use or minimal use, etc.); however, in most cases, an appropriate taper would be recommended to avoid withdrawal and/or other ADEs. What is considered an appropriate taper should also be individualized based on resident and medication factors – duration of use, half-life, etc. Deprescribing tools, such as the US Deprescribing Research Network, offer algorithms to assist in tapering medications towards discontinuation. Also, always remember that "G" in GDR is for GRADUAL!

Q. I've seen an increase in antiseizure medication being used as mood stabilization in long-term care settings. How does this look for facilities attempting to remain compliant with psychotropic stewardship?

A. This exact issue was addressed by CMS in the Phase 3 update that went into effect on October 24, 2022. "Psychotropic Medications and Antipsychotic Medications (F758 Only Guidance) In accordance with §483.45(d)(4) and as clarified in the section above on Indication for Use, residents must not receive any medications which are not clinically indicated to treat a specific condition. The medical record must show documentation of the diagnosed condition for which a psychotropic medication is prescribed (§483.45(e)(1)). All medications included in the psychotropic medication definition may affect brain activities associated with mental processes and behavior. Use of psychotropic medications, other than antipsychotics, should not increase when efforts to decrease antipsychotic medications are being implemented. Risks associated with psychotropic medications still exist regardless of the indication for their use (e.g., nausea, insomnia, itching), therefore the requirements pertaining to psychotropic medications in §483.45(e) apply to the four categories of drugs (anti-psychotic, anti-depressant, anti-anxiety and hypnotic) listed in §483.45(c)(3) without exception. Other medications not classified as anti-psychotic, anti-depressant, anti-anxiety, or hypnotic medications can also affect brain activity and should not be used as a substitution for another psychotropic medication listed in §483.45(c)(3), unless prescribed with a documented clinical indication consistent with accepted clinical standards of practice and in accordance with §483.45(d)(4). 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 it should be consistent with the psychotropic

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medication requirements under §483.45(e). Residents who take these medications must be monitored for any adverse consequences, specifically increased confusion or over-sedation, as required by §483.45(d)(3). Concerns related to the use of the medications noted here would be investigated at F757, Unnecessary Medications, if the medication is being used for its original or approved indication and not primarily as a psychotropic medication."

Q. Do we have to have family approval by regulation to perform GDRs?

A. Federal regulations do not require informed consent; however, check your local state regulations as they may be more restrictive. Always do what is in the best interest of the resident. They are the patient, not the family.

Q. How do you suggest consultant pharmacist approach a patient with notes from prescriber that indicate they don't want a GDR? Should they still put the recommendations in?

A. In our opinion, best practice would be to generate the recommendation documenting the resident's history, including brief summary of the provider's documentation if appropriate, and request reevaluation and consideration for a GDR. If the GDR is declined, it is important that the prescriber provides an adequate response rationalizing why it should not be done. This creates additional documentation for review by a surveyor, which hopefully will avoid further investigation. Also, things change over time to the point that a GDR may be warranted, so the recommendation may be accepted.

Q. How do you get family/patient buy-in? I am a prescriber and we have a hard time with families and patients and frequently hear "we don't want meds changed because mom/dad is doing well on them."

A. When families object to medication changes, it is often because they are comfortable with the resident's current affect, unaware of the potential benefits that can be realized by reduction in psychotropic use and wary of negative repercussions. Helpful speaking points should focus on the long-term negative consequences of unnecessary psychotropic burden ("you may not notice overt symptoms now, but over time...") as well as the potential benefits of psychotropic tapering. Be specific about what behavioral changes you are focused on improving. Then offer the medication changes as a trial. Family members knowing that you are receptive to their concerns and open to a dynamic approach to the resident's medications may increase buy-in.

Q. When we do a GDR and we notice immediately that it is ineffective, do we need to wait the full 30 days to change it back?

A. This is a great opportunity to engage your pharmacist as many psychotropic medications have a long half life, resulting in a very slow tapering of medication levels over several days to weeks. If you immediately (within a couple days) notice a change after a GDR, reach out to your pharmacist to see if the change is likely due to the recent GDR or if we should be looking for other causes. If the medication is short acting and you get confirmation from your pharmacist or provider that the quick change is related to the GDR, then there is no regulation or standard of practice requiring us to wait 30 days to change it back. We want to do what is clinically in the best interest of the resident at all times.

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Q. One of the greatest barriers in psychotropic stewardship are the medical providers who refuse or don't cooperate with the concept/plan. What suggestions can you give us for them to join?

A. Involve them in your IDT psychotropic stewardship program and psych meetings. Empower them to participate with the team and to understand the goal.

Q. Under psychotropic timeout, would it be advantageous to begin the resident on non-pharmacological interventions before admission before prescribing psychotropics to manage the symptoms?

A. With the exception of an emergent issue, at all times, we would want to begin with non-pharmacological interventions prior to prescribing medications. This is supported by CMS guidance and standards of practice.

Q. What about an elder who is an undiagnosed person who was diagnosed after admission? How can this be handled?

A. Specifically related to schizophrenia, which CMS is focused on: Schizophrenia typically presents itself at a younger age; older adults are very rarely newly diagnosed with schizophrenia. However, if the evaluation and clinical rationale is documented by the provider using standards of practice (i.e. DSM/APA guidelines), there should be no issues with the provider adding a diagnosis and beginning treatment. This would be common for someone to have an episode of depression after entering a skilled nursing facility, for example. I would suggest that a new schizophrenia or bipolar diagnosis after admission to a skilled nursing facility would be exceedingly rare.

For more learning opportunities for the long-term care industry, view our upcoming webinars.

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