

Teams Help Reduce Psychoactive Drug Doses

BY SHERRY BOSCHERT

FROM THE ANNUAL MEETING OF THE AMERICAN MEDICAL DIRECTORS ASSOCIATION

LONG BEACH, CALIF. – Using interdisciplinary teams in a systematic way can help nursing homes meet requirements that they stop excessive use of psychoactive medications in residents.

Three reports from the meeting showed how facilities are using interdisciplinary teams to comply with Federal Health Regulations for Long-Term Care Facilities rule 329 (F-Tag 329), which mandates that “each resident’s medication regimen must be free from unnecessary drugs,” and to comply with state regulations such as California’s State Operations Manual Appendix PP, which requires consideration of gradual dose reductions to avoid unnecessary medications.

At a 230-bed long-term care facility in San Antonio, an interdisciplinary team approach reduced antipsychotic use by 74%, anxiolytic use by 23%, and stimulant use by 13% within 6 months, Dr. Kunle Adedeji and associates reported in a poster presentation.

The facility had been contracting with a psychiatry group to provide mental health services and collaborate with the medical director on all psychoactive prescriptions. The new interdisciplinary team included the facility’s medical director, consulting pharmacist, director of nursing, nurse manager, Minimum Data Set coordinator, two social service representatives, and the consulting psychiatry group’s nurse practitioner.

The team met monthly to review the cases of all residents who were pre-



TDr. Jay S. Luxenberg, of the Jewish Home in San Francisco, says the team approach has helped improve documentation.

scribed psychoactive drugs within the preceding month. Members discussed concerns about each patient, made recommendations for reducing or discontinuing medications, and made sure that each psychoactive drug prescription had a specific diagnosis linked to it.

The use of antipsychotics had been slightly higher in the facility than state and national averages before the multidisciplinary team formed. But 6 months later, usage was down to 6% of residents, far below those averages, reported Dr. Adedeji of the University of Texas Health Science Center, San Antonio.

The team’s efforts were supplemented by systematic implementation of non-pharmacologic treatments such as offering residents “busy boxes” or gardening to reduce agitation. The team implemented protocols for discontinuation of “as needed” medications for anxiety and sleep management. Floor staff underwent training in managing residents with de-

mentia and behavioral problems.

Psychoactive Drug Doses Reduced

At a 150-bed skilled nursing facility in Hendersonville, N.C., 6 months of an interdisciplinary team approach reduced use of antipsychotics by 54%, reduced anxiolytic use by 54%, reduced the use of hypnotics more than twice per

week by 64%, and decreased psychiatric discharges to hospitals by 72%, Mark Coggins, Pharm.D., and his associates reported in a separate poster presentation.

The interdisciplinary team included a consultant pharmacist, nurse, social worker, dietician, therapy staff, and activity staff. They met twice weekly to discuss individual needs and interventions for residents who were on psychoactive drugs or whom staff identified as having weight loss, disruptive behaviors, pressure ulcers, or falls.

The attending physicians accepted the team’s recommendations 93% of the time, said Dr. Coggins of Golden Living Centers, Inman, S.C.

The incidence of untreated depression dropped by 47%, and the proportion of residents experiencing increased symptoms of depression or anxiety fell by 10%.

Better Documentation, Better Surveys

Even without measuring outcomes, using a multidisciplinary team approach can help nursing homes stay in compliance with requirements for regular consideration of gradual dose reductions, geriatrician Jay S. Luxenberg said in an oral presentation.

At the 430-bed Jewish Home, San Francisco, where Dr. Luxenberg serves as medical director, an interdisciplinary team doing weekly “drug rounds” reviews residents on psychoactive drugs, so that each of those residents is reviewed at least every 6 months.

The team – the medical director, two psychiatrists, a nurse practitioner, a pharmacist, and usually representatives of the floor unit’s social workers or nurses – assesses drug indications, documentation, consent, efficacy parameters, side effects, nonpharmacologic strategies, and previous or ongoing gradual dose reductions.

It then presents recommendations to the attending physician about whether a gradual dose reduction would be appropriate, and the attending must document agreement or give a rationale for not accepting the recommendation, according to Dr. Luxenberg.

“So far, that has helped us tremendously” in improving documentation and avoiding deficiencies on annual surveys by regulators, Dr. Luxenberg said. “Surveyors are very generous when you have documented well. We need to step away from the defense that the person is doing well, so we don’t want to change anything. A lot of our physicians have that as a gut feeling. The surveyors won’t buy that.”

The speakers and investigators said they have no conflicts of interest. ■

Deep Brain Stimulation Shows Promise for OCD and TRD

BY ROXANNA GUILFORD-BLAKE

FROM THE ANNUAL MEETING OF THE AMERICAN ASSOCIATION FOR GERIATRIC PSYCHIATRY

SAVANNAH, GA. – Deep brain stimulation shows potential for treatment of geriatric psychiatric disorders, particularly treatment-resistant depression and obsessive-compulsive disorder.

Deep brain stimulation (DBS), an effective therapy for Parkinson’s disease and essential tremor, may hold promise for treatment of geriatric psychiatric disorders, Dr. Paul Holtzheimer said in a symposium on neuromodulation therapies at the meeting.

Research into DBS for treatment-resistant depression (TRD) and for obsessive-compulsive disorder (OCD), as well as for other psychiatric disorders, has been advancing, noted Dr. Holtzheimer of the depart-

ment of psychiatry and behavioral sciences at Emory University, Atlanta. But more studies into efficacy, mechanisms of action, and side-effect profile – and especially long-term effects – are needed.

DBS delivers targeted electrical stimulation into the brain through a device that consists of an electrode connected to an insulated wire, inserted through a small opening in the skull. The wire is run under the skin of the head, neck, and shoulder, connecting the electrode to an implantable pulse generator (a “pacemaker”), which is implanted near the collarbone.

One advantage of a DBS device is that it can be tuned, Dr. Holtzheimer said. The electrode has four contacts, allowing the stimulation level to be adjusted and revised.

Implantation is a relatively

safe procedure – “as simple as it can be,” Dr. Holtzheimer said – with a low complication rate (around 10%). The most common complication is infection; stroke is a less common but far more worrisome one, he said.

The progress is encouraging, but the lack of randomized, placebo-controlled data means that long-term safety and efficacy have yet to be established.

Early research in TRD suggests efficacy and safety for subcallosal cingulate, ventral capsule/ventral striatum (VC/VS), and nucleus accumbens targets. Dr. Holtzheimer called the results so far “reasonably positive.” Multicenter trials are underway for the subcallosal cingulate and VC/VS targets.

The OCD data also suggest reasonable efficacy and safety

for the VC/VS, inferior thalamic peduncle, and subthalamic nucleus targets, but not the nucleus accumbens.

In 2009, the Food and Drug Administration approved a humanitarian device exemption for the use of DBS to treat OCD (VC/VS target).

The progress is encouraging, but the lack of randomized, placebo controlled data means that long term safety and efficacy have yet to be established, Dr. Holtzheimer cautioned. Moreover, safety and efficacy have yet to be tested in geriatric populations, and those patients are not part of the ongoing trials.

There’s no reason to believe that DBS would be less safe or effective in geriatric populations, observed another member of the neuromodulation panel, Dr. William McDonald, professor of psychiatry and be-

havioral sciences at Emory University.

Looking ahead, questions abound, Dr. Holtzheimer acknowledged: Is late-onset depression a completely different biology from depression in younger populations? Can clinicians extrapolate efficacy to an older population?

He also pointed out that it may take months of DBS therapy before it becomes effective. It does not replace medications or psychotherapy, but it may enhance other therapeutic approaches, such as cognitive-behavioral therapy, he said.

Meanwhile, researchers are starting to look at other psychiatric indications for DBS. For example, research is underway in Toronto to explore its use in dementia, Dr. Holtzheimer said.

Dr. Holtzheimer is a consultant for St. Jude Medical: Neuromodulation, a site of one of the trials for DBS in TRD. ■