Transforming Care for the Elderly: ensuring seniors receive appropriate and person-centred care

Session 3: Tools & Resources to Improve Prescribing – Canadian and International Perspectives
Welcome

With us today:

Dr. Kaye Phillips
Senior Director, CFHI

Dennis Cleaver
Executive Director, Seniors Health Strategic Clinical Network,
Alberta Health Services

Dr. Wendy Levinson
Chair, Choosing Wisely Canada
Professor of Medicine,
University of Toronto

Dr. Justin Turner
Assistant Director, Canadian Deprescribing Network (CaDeN)
Postdoctoral research fellow,
Centre de Recherche Institut Universitaire de Gériatrie de Montréal.
At the end of today’s webinar, we hope that you:

• Have increased knowledge about how Canadian organizations and groups are improving prescribing and care outcomes for seniors …and how they are collaborating to share their networks and tools

• Know where to access tools that can help front line providers advance efforts to improve prescribing

• Have more strategies and tools to engage providers in conversations about appropriateness of interventions, like medications, to make more informed care decisions
The Need for Appropriate Use of Antipsychotics

Evidence demonstrates that antipsychotic medications:

- Do not help manage most symptoms and behaviours associated with dementia

- Can be associated with side effects that can negatively affect quality of life, such as sleepiness, confusion, dizziness, increased susceptibility to falls and cognitive impairments.

- If the medication is no longer of benefit (and/or may be causing harm) – Deprescribe
CFHI’s AUA Collaboratives

Spreading Success Across Canada

Originated by Cynthia Sinclair and Joe Puchniak (Winnipeg Regional Health Authority) through CFHI’s EXTRA: Executive Training Program (2012)
CFHI’s AUA Collaboratives: The AUA Intervention
May 2014-Oct 2015: CFHI’s pan-Canadian Appropriate Use of Antipsychotic (AUA) Collaborative

- Reduce inappropriate use of antipsychotics in nursing homes
- Improve the quality and experience of dementia care for nursing home residents, families and staff
- Build individual and organizational capacity in designing, implementing, evaluating, sustaining and spreading resident-centred and data-driven dementia care innovations
March 2016-May 2018: CFHI-NBANH New Brunswick AUA Scale Collaborative- 2 phases

- Partnership between CFHI & NBANH to scale bilingual NB collaborative across all 66 NB nursing homes

- **Phase 1** [Feb 2016-May 2017]: 15 nursing homes

- **Phase 2** [Feb 2017-May 2018]: 46 homes

- Promising Early Results in the Phase I homes
Appropriate Use of Antipsychotics - Canadian Connections (AUA – CC)

Dennis Cleaver, Executive Director
Seniors Health Strategic Clinical Network
Alberta Health Services
Why is there an AUA – CC Group?

- The Appropriate Use of Antipsychotics - Canadian Connections came together as an informal pan-Canadian group to share information that would benefit provincial and national groups striving to improve appropriate prescribing in long term care, in particular the appropriate use of antipsychotics.

- Sharing / Learning Together
Objectives

- Provide a forum for members to share information around efforts across the country to improve the appropriate use of antipsychotics in LTC (i.e. initiatives, networks, training, events, research)
- Create opportunities to learn from one another
- Discuss local and national trends and reporting in this area
- Expand the discussion to include other classes of medications of interest
Current Participants:

- AB – Alberta Health and Alberta Health Services
- BC – BC Patient Safety and Quality Council, Vancouver Island Health Authority and Shared Care Polypharmacy
- MB – Interlake-Eastern Regional Health Authority and Winnipeg Regional Health Authority
- ON – Health Quality Ontario
- SK – Ministry of Health and Saskatoon Health Region
- NB – New Brunswick Association of Nursing Homes and York Care Centre
- NL – Eastern Health and Western Health
- CaDeN – Canadian Deprescribing Network
- CFHI – Canadian Foundation for Healthcare Improvement
- CIHI – Canadian Institute for Health Information
The group is co-lead by Alberta Health Services, the Canadian Foundation for Healthcare Improvement and the Canadian Institute of Health Information. Questions about the work of the group or on membership can be directed to:

Dennis Cleaver, Alberta Health Services (dennis.cleaver@ahs.ca)
Connie Paris, Canadian Institute for Health Information (cparis@cihi.ca)
Kaye Phillips, Canadian Foundation for Healthcare Improvement (Kaye.Phillips@cfhi-fcass.ca)
Examples of what we are sharing
AUA Toolkit – AHS

- Developed to support the provincial implementation of the AUA project in Alberta (LTC and Supportive Living)
- Content Includes:
  - Clinical information to support clinicians:
    - Strategies to gradually reduce antipsychotics
    - Non-pharmacologic interventions ideas
    - Materials to use in conversations with family/alternate decision making
  - ‘Quality Improvement’ resources to support frontline change teams at each site
  - Action Plans & Measurement Strategies
AUA Toolkit

- Each grey bar opens to many resources
  - Links to other webpages, PDF resources
- Good news stories posted
  - Helpful to build awareness and desire
- Post “curbside consultation” reports
  - Sustainability strategy
  - Monthly phone in review of difficult behaviours
Choosing Wisely – Toolkit on antipsychotics

- Choosing Wisely Canada collaborated with AHS AUA project team to developed Antipsychotic Toolkit for the CWC web page

- Excellent title!

- Focused on the key steps to supporting changes by frontline teams
Choosing Wisely Canada Regional Network Program

Dr. Wendy Levinson, MD, OC
Choosing Wisely Canada is a campaign to help clinicians and patients engage in conversations about unnecessary tests and treatments and make smart and effective choices to ensure high-quality care.
What is unique about CWC?

• Clinician led
• Bottom up approach
• Focused on common clinical conditions
• Simple
# Campaign approach

<table>
<thead>
<tr>
<th>Clinicians</th>
<th>Patients</th>
<th>Medical education</th>
<th>Implementation</th>
<th>Measurement</th>
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<tbody>
<tr>
<td>• Societies develop lists</td>
<td>• Develop patient materials</td>
<td>• Mobilize students and trainees</td>
<td>• Support adoption of recommendations in care settings</td>
<td>• Measure rates of overuse</td>
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<tr>
<td>• Disseminate through multiple channels</td>
<td>• Disseminate broadly through multiple channels</td>
<td>• Integrate resource stewardship as a core competency</td>
<td>• Build regional improvement capacity</td>
<td>• Build research capacity</td>
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Recommendations by category (n = 165)

- Tests: 53%
- Treatments: 43%
- IMAGING 20%
- Medication 15%
- Procedures 4%
In addition to CWC’s ‘When Psychosis Isn’t the Diagnosis’ Antipsychotic Toolkit:

**Toronto Western Family Health Team**
- Results:
  - Patients Prescribed PPIs ↓ 26%
  - 93% of Patients Had Their PPIs Reassessed

**Sinai Health System – in hospital**
- Results:
  - Sedative-hypnotic prescriptions ↓ 40%

De-prescribing Benzodiazepines and Z-drugs for the primary care setting being developed
Questions

Physician Website: http://www.choosingwiselycanada.org/

Patient Website: http://choosingwisely.ca/
Who is CaDeN?

• The Canadian Deprescribing Network is a group of patient advocates, health care professionals, researchers and health policy leaders. There are 2 overarching goals:

1. Reduce harm by reducing inappropriate medication use by 50% by 2020

2. Promote health by ensuring access to safer pharmacological or non-pharmacological therapies

Tannenbaum et al. 2017 Can J Aging
Empowering patients and families

• EMPOWER brochures, designed to motivate patients and families by providing new knowledge and challenging beliefs

http://deprescribing.org/resources/deprescribing-information-pamphlets/
QUIZ
ANTIPSYCHOTIC DRUGS

1. Antipsychotic medication is sometimes prescribed to treat sleep problems or disruptive behaviors in people with dementia.
   - TRUE  - FALSE

2. The dose of antipsychotic medication is related to the occurrence of side effects.
   - TRUE  - FALSE

3. Antipsychotics are the drug of choice for sleep problems.
   - TRUE  - FALSE

4. Antipsychotic drugs are the best available option to treat disruptive behaviors in people with dementia.
   - TRUE  - FALSE
1. TRUE

Antipsychotic drugs are sometimes prescribed to treat disruptive behaviors in people with dementia or insomnia. However, new research shows that people who take antipsychotic drugs are putting themselves at:

- A higher risk of memory and concentration problems
- An increased risk of falls and fractures (hip, wrist)
- An increased risk of having a stroke
- A higher risk of dizziness, confusion, diabetes, weight gain, high cholesterol

2. TRUE

The dose of the drug is related to the occurrence of side effects. Even at small doses, all antipsychotic drugs slow your brain performance and reflexes.

3. FALSE

Antipsychotic medication was developed primarily to treat schizophrenia and bipolar disease. These medications were never intended to treat insomnia or disruptive behaviors in people with dementia.

4. FALSE

Antipsychotic medication masks the symptoms of agitation in patients with dementia without addressing the underlying cause. The risks associated with these drugs are serious. This brochure gives you alternative solutions.
ALTERNATIVES

If an antipsychotic drug is being taken to improve sleep, there are lifestyle changes that can help.

- **Exercise.** Physical activity helps people sleep better. But avoid vigorous activity for several hours before bedtime.
- **Keep a routine.** Try to go to bed and wake up at about the same time every day, even on weekends.
- **Try not to eat right before bedtime.** Eat three hours or more before going to bed.
- **Avoid caffeine after 3 p.m.** Some people need to to avoid caffeine even earlier. Avoid consuming nicotine as it is a stimulant and might keep you awake.
- **Limit alcohol.** Alcohol causes sleepiness at first, followed by wakefulness.
- **Create the right environment.** Keep the bedroom peaceful and quiet. Avoid mental excitement before bedtime. Do not read or watch TV in bed. Do so in a chair or on a couch.
- **Check out the website Sleepwell Nova Scotia (sleepwells.ca), which offers online cognitive behavioural therapies to improve sleep.**
- **See our brochure, How to get a good night’s sleep without medication (http://www.cmhaqc.ca/fichie/pdf/Sleep_brochure.pdf).**

ALTERNATIVES

If an antipsychotic drug is being used to treat disruptive behaviors in people with dementia, try these alternative solutions.

- **Keep a daily routine.** People with dementia often become restless or irritable around dinner time.
  1. Do activities that use more energy earlier in the day, such as bathing.
  2. Eat the biggest meal at midday.
  3. Set a quiet mood in the evening, with soft lighting, less noise, and soothing music.
- **Help the person exercise everyday.** Physical activity helps use nervous energy. It improves mood and sleep.
- **Don't argue with a person who's distressed.**
  1. Distract the person with music, singing, dancing, soft blankets or other comforts.
  2. Ask the person to help with a simple task, such as setting the table or folding clothes.
  3. Take the person to another room or for a short walk.
- **Plan simple activities and social time.** Boredom and loneliness can increase anxiety. Adult daycare programs can provide activities for older people. They also give caretakers a break.
MRS. ROBINSON’S STORY
She has been taking Quetiapine, an antipsychotic drug, to treat her insomnia.

“I am 65 years old and took Quetiapine for 10 years. A few months ago, I fell in the middle of the night on my way to the bathroom and had to go to the hospital. I was lucky and, except for some bruises, I did not hurt myself. I read that Quetiapine puts me at risk for falls. I did not know if I could live without Quetiapine as I always have trouble falling asleep and sometimes wake up in the middle of the night.

I spoke to my doctor who told me that my body needs less sleep at my age — 6 hours of sleep per night is enough. That’s when I decided to try to taper off Quetiapine. I spoke to my pharmacist who suggested I follow the step-by-step tapering program (on the last page).

I also applied some new sleeping habits I discussed with my doctor. First I stopped exercising before bed; then I stopped reading in bed, and finally I got out of bed every morning at the same time whether or not I had a good nights sleep.

I succeeded in getting off Quetiapine. I now realize that for the past 10 years I had not been living to my full potential. Stopping Quetiapine has lifted a veil, like I had been semi-sleeping my life. I have more energy and I don’t have so many ups and downs anymore. I am more alert: I don’t always sleep well at night, but I don’t feel as groggy in the morning. It was my decision! I am so proud of what I have accomplished. If I can do it, so can you!”

MR. SMITH’S STORY
He had been taking Quetiapine, an antipsychotic drug, to help treat his symptoms of dementia.

Three years ago Mr. Smith, 78 years old, was diagnosed with Alzheimer’s disease. He lives with his wife. At first he had memory lapses, made mistakes paying the bills, and got lost looking for where he parked the car. Last year he started wandering out of the house and physically resisted when his wife tried to bring him back inside. In the evenings he would not go to bed, was restless and became verbally abusive when told to go back to sleep.

The doctor prescribed Quetiapine to control Mr. Smith’s wandering and aggressive behaviours. Quetiapine also helped him go to sleep at night. His daughter read that the side effects of antipsychotic medication can be serious for persons with dementia. She realized that her father was more drowsy and withdrawn since the Quetiapine was started, and that his gait was unsteady, putting him at risk for falls. She and her mother decided to taper Mr. Smith off the Quetiapine, under the supervision of their doctor and pharmacist.

They started keeping a daily routine, doing home exercises and balance training with Mr. Smith each morning. A big meal was given at mid-day and then his wife took him out most afternoons to keep him active. In the evening, she would put on music and ask him to help put away the dishes or fold the clothes. They extended bedtime to 11 p.m. After one month of tapering, Mr. Smith was less agitated and slept soundly. Both he, his wife and their children were happier with his interactions and involvement with the family.
TAPERING-OFF PROGRAM

We recommend that you follow this schedule under the supervision of your doctor or pharmacist to taper off your antipsychotic medication.

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<tr>
<th>WEEKS</th>
<th>TAPERING SCHEDULE</th>
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<td>1 &amp; 2</td>
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<td>3 &amp; 4</td>
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<tr>
<td>5 &amp; 6</td>
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<tr>
<td>7 &amp; 8</td>
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</tbody>
</table>

Explanations
- Full dose
- Half dose
- No dose

5 QUESTIONS TO ASK YOUR HEALTH CARE PROVIDER

1. Do I need to continue my medication?
2. How do I reduce my dose?
3. Is there an alternative treatment?
4. What symptoms should I look out for when I stop my medication?
5. Who do I follow up with and when?

Questions I want to ask my health care provider about my medication

Use this space to write down questions you may want to ask:
More tools to improve appropriateness

- Medstopper.com
- Resources to improve sleep
- Deprescribing guidelines and algorithms
  - Evidence-based
  - Inter-professional guideline development teams
  - Decision-support algorithms developed

Farrell et al, Methodology for developing deprescribing guidelines, PloS ONE, 2016
Antipsychotic (AP) Deprescribing Algorithm

**Why is patient taking an antipsychotic?**

- Psychosis, aggression, agitation (behavioural and psychological symptoms of dementia - BPSD) treated ≥ 3 months (symptoms controlled, or no response to therapy).
- Primary insomnia treated for any duration or secondary insomnia where underlying comorbidities are managed.
- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder
- Acute delirium
- Tourette's syndrome
- Tic disorders
- Autism
- Less than 3 months duration of psychosis in dementia
- Mental retardation
- Developmental delay
- Obsessive-compulsive disorder
- Alcoholism
- Cocaine abuse
- Parkinson's disease psychosis
- Adjunct for treatment of Major Depressive Disorder

**Recommend Deprescribing**

- Strong Recommendation (from Systematic Review and GRADE approach)
- Taper and stop AP (slowly in collaboration with patient and/or caregivers; e.g., 25%-50% dose reduction every 1-2 weeks)
- Stop AP Good practice recommendation

**Monitor every 1-2 weeks for duration of tapering**

- **Expected benefits:**
  - May improve alertness, gait, reduce falls, or extrapyramidal symptoms
- **Adverse drug withdrawal events** (closer monitoring for those with more severe baseline symptoms):
  - Psychosis, aggression, agitation, delusions, hallucinations

**If BPSD relapses:**

- **Consider:**
  - Non-drug approaches (e.g., music therapy, behavioural management strategies)
- **Restart AP drug:**
  - Restart AP at lowest dose possible if resurgence of BPSD with re-trial of deprescribing in 3 months
  - At least 2 attempts to stop should be made
- **Alternate drugs:**
  - Consider change to risperidone, olanzapine, or aripiprazole

**If insomnia relapses:**

- **Consider**
  - Minimize use of substances that worsen insomnia (e.g., caffeine, alcohol)
  - Non-drug behavioural approaches (see reverse)
- **Alternate drugs**
  - Other medications have been used to manage insomnia. Assessment of their safety and effectiveness is beyond the scope of this deprescribing algorithm. See AP deprescribing guideline for details.
### Commonly Prescribed Antipsychotics

<table>
<thead>
<tr>
<th>Antipsychotic</th>
<th>Form</th>
<th>Strength</th>
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<tbody>
<tr>
<td>Chlorpromazine</td>
<td>T</td>
<td>IM, IV</td>
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<tr>
<td></td>
<td></td>
<td>25, 50, 100 mg</td>
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<td></td>
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<td>12.5 mg/mL</td>
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<tr>
<td>Haloperidol (Haldol)</td>
<td>T</td>
<td>IM, IV</td>
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<td>0.5, 1, 2, 5, 10, 20 mg</td>
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<td>2 mg/mL</td>
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<td>100 mg/mL</td>
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<tr>
<td>Loxapine (Kytril, Loxapine)</td>
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<td>IM, IV</td>
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<td></td>
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<td>1.25, 2.5, 5, 10, 15, 20 mg</td>
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<td>40 mg/L</td>
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<td>100 mg/mL</td>
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<tr>
<td>Antipiprazole (Abilify)</td>
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<td>IM, IV</td>
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<td>2, 5, 10, 15, 20, 30 mg</td>
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<td>Clozapine (Clozine)</td>
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<td>Olanzapine (Zyprexa)</td>
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<td>5, 10, 15, 20 mg</td>
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<td>40 mg/mL</td>
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<td>Paliperidone (Invega)</td>
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<td>IM, IV</td>
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<td>3, 6, 9 mg</td>
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<td>50 mg/mL</td>
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<td>150 mg/mL</td>
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<tr>
<td>Quetiapine (Serquel)</td>
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<tr>
<td>Risperidone (Risperdal)</td>
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<td>0.5, 1, 2, 3, 4, 5 mg</td>
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<td>4 mg/mL</td>
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<tr>
<td>Antipsychotic side effects</td>
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</table>
- APs associated with increased risk of:
  - Metabolic disturbances, weight gain, dry mouth, dizziness
  - Somnolence, drowsiness, Injury or falls, hip fractures, EPS, abnormal gait, urinary tract infections, cardiovascular adverse events, death
- Risk factors: higher dose, older age, Parkinson’s, Lewy Body Dementia

### Engaging patients and caregivers

Patients and caregivers should understand:
- The rationale for deprescribing (risk of side effects of continued AP use)
- Withdrawal symptoms, including BPSD symptom relapse, may occur
- They are part of the tapering plan, and can control tapering rate and duration

### Tapering doses

- No evidence that one tapering approach is better than another
- Consider:
  - Reduce by 25%, 50%, 75% of original dose on a weekly or biweekly basis and then stop; or
  - Consider slower tapering and frequent monitoring in those with severe baseline BPSD
- Tapering may not be needed if low dose for insomnia only

### Sleep management

**Primary care:**
1. Go to bed only when sleepy
2. Do not use your bed or bedroom for anything but sleep (or intimacy)
3. If you do not fall asleep within 20-30 min at the beginning of the night or after an awakening, exit the bedroom
4. If you do not fall asleep within 20-30 min on returning to bed, repeat #3
5. Use your alarm to awaken at the same time every morning
6. Do not nap
7. Avoid caffeine after noon
8. Avoid exercise, nicotine, alcohol, and big meals within 2 hrs of bedtime

**Institutional care:**
1. Pull up curtains during the day to obtain bright light exposure
2. Keep alarm noises to a minimum
3. Increase daytime activity and discourage daytime sleeping
4. Reduce number of naps (no more than 30 min and no naps after 2pm)
5. Offer warm drink (decaf), warm milk at night
6. Restrict food, smoking before bedtime
7. Have the resident toilet before going to bed
8. Encourage regular bedtime and rising times
9. Avoid waking at night to provide direct care
10. Offer backrub, gentle massage
Engaging and sharing

When? April 26th

Where? Institut universitaire de gériatrie de Montréal

Questions? Contact Isabelle Reid at isabelle.reid@criugm.qc.ca
• Justin.Turner@criugm.qc.ca

• For more information, visit Deprescribing.org

“I feel a lot better since I ran out of those pills you gave me.”
Questions?

Please submit your questions/comments electronically using the “Chat Box” on the bottom of your webinar screen.
Thank you for joining CFHI’s OnCall Series
Transforming Care for the Elderly: Ensuring seniors receive appropriate and person-centred care!

Free recordings available @ www.cfhi-fcass.ca

Session 1 [Nov. 30, 2017]: Appropriate Use of Antipsychotics in Long Term Care: Practices, Outcomes and Lessons Learned from CFHI’s Pan-Canadian Antipsychotic Reduction Collaborative

Session 2 [Jan. 27, 2017]: Engaging pharmacists and interdisciplinary care teams to improve prescribing of antipsychotics and to curtail polypharmacy

Session 3 [Feb 8, 2017]: Tools & Resources to Improve Prescribing – Canadian and International Perspectives
Upcoming Webinars

February 27th: CFHI’s Open Call for Innovations in Palliative Care

March 8th: The Specialist is Always In: Better patient care through remote Consultation

April 12th: Creating Engagement-capable Environments in Healthcare for Innovation and Improvement

REGISTER NOW
Thank you!