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Details:

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2009-10

(session year)

Senate

(Assembly, Senate or Joint)

Committee on ... Public Health, Senior Issues, Long-Term Care, and Job Creation (SC-PHSILTCJC)

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Gigi Godwin (LRB) (November/2011)

Senate

Record of Committee Proceedings

Committee on Public Health, Senior Issues, Long-Term Care, and Job Creation

Assembly Bill 526

Relating to: requiring informed consent before administration of psychotropic medication to a nursing home resident who has degenerative brain disorder.

By Representatives Meyer, Townsend, Pasch, Gunderson, A. Ott, Nerison and Wood; cosponsored by Senator Holperin.

April 14, 2010	Referred to Committee on Public Health, Senior Issues, Long-Term Care, and Job Creation.
April 22, 2010	Failed to concur pursuant to Senate Joint Resolution 1.

John Wagnitz
Committee Clerk

Date?

Testimony Capital Hearing
AB 526

Greeting: Good Morning, chair Krusck and members of the committee. Thank you for the opportunity of speaking to you in support of this bill.

Introduction:

- Physician
- Geriatrician & dementia specialist for 35 years
- Certified Medical Director of LTC
- Past President of WAMD
- Relevant to this testimony you should know that I am currently working with Dane County, the South Madison Coalition & the Alzheimer Alliance of Wisconsin on the *Dane County Dementia Support Team,* a project that:
  - Facilitates the discharge of dementia patients who have been admitted Mendota Mental Health Hospital for behavioral problems, back into the community
  - Prevents emergency discharges from nursing homes to Mendota because of dementia-related behaviors

Comments:

Important points underlying the need for this bill:

- Antipsychotics are not FDA approved for the treatment of behavioral problems or psychosis secondary to dementia
- Numerous clinical studies of effectiveness show at best they are no more that 30% effective in reducing behavior; most studies show no benefit

- Side effects of these drugs are significant and occasionally result in permanent neurological disabilities, such as Parkinson's symptoms or EPS.
    - A number of studies of use of these drugs with dementia patients show an increase in dementia symptoms, such as confusion & increased memory loss
- Therefore, physicians who prescribe these drugs for dementia patients are using them "off label"
    - Families & decision makers need to know that these drugs are not FDA approved
    - They need to be aware of the identified risks as defined by the "black box warning"
- In weighing the risks of antipsychotic drugs, deciders need to know what other alternative treatments are an option, and what the risks/consequences are of not treating with antipsychotics. There also needs to be an emergency process if the protocol cannot be followed.
    - This bill addresses these concerns
- Behavioral problems in dementia patients are not due to mental illness as we define it:
    - Damage to brain from pathology of dementia
    - See the world differently
    - Cannot express their needs
    - They have the same behaviors that you & I do, but the circumstances or setting is different.
        - (If see most of the same behaviors at rush-hour on the beltline around Madison)
    - Have other medical problems not addressed (pain)
- Facility staff, families & physicians want a quick fix for behavioral problems—(this is why they seek medications)
    - This is the model for other conditions such as hypertension or diabetes

- In my 35 years of experience with dementia patients
  - There is no quick fix for behavior issues
  - Drugs, esp antipsychotics, are usually not effective, make the patient worse or decrease QOL
  - Behavior issues will respond to staff education about dementia and a person-centered-approach to care for the resident
    - This is the policy and approach by AMDA (attached article)
    - We have a number of nursing homes and CBRF's in Wisconsin that are antipsychotic-free for dementia patients

Conclusion:

- This bill will bring "daylight" to the issue of treating behavioral problems with antipsychotics by
  - mandating accurate forms from DHS to inform family members and healthcare deciders on known risks and warnings by the FDA of these drugs
- It will also make the process of obtaining informed consent consistent with what is in place for the mental health population who also receive these drugs

- *It is my hope that by improving the process of informed consent for the use of antipsychotic medications for dementia patients, we will start turning the management of behavior away from drug management to person-centered care for persons with dementia*

Thank you again for the opportunity of addressing this committee, and I welcome any questions.

Dedicated To Long Term Care Medicine

AN OFFICIAL PUBLICATION OF THE AMERICAN MEDICAL DIRECTORS ASSOCIATION

Caring for the Ages

A Monthly Newspaper for Long-Term Care Practitioners

In This Issue

Overused Antipsychotics Remain an LTC Challenge

Profession is working to reduce use of drugs.

BY JOANNE KALDY

A recent article in the Chicago Tribune carried the headline "Nursing Home Doctors Untouched Even as Facilities Are Cited."

For a series of stories this fall, reporters combed nursing home inspection reports and found 1,200 violations concerning psychotropic drugs in Illinois since 2001. The A-section articles suggested that physicians have been prescribing the powerful medications inappropriately and without retribution.

Yet many facilities in Illinois and nationwide have implemented behavioral management programs and other initiatives to minimize the use of these medications.

So are nursing facilities failing in their efforts?

Yes and no, according to Christie Teigland, PhD, director of health informatics and research for the New York Association of Homes and Services for the Aging. "We're seeing a downward trend in the use of these medications. This started after the [Food and Drug Administration] issued the first black box warning in 2005 for atypical antipsychotics.

"We have New York State data on over 650 nursing homes, and starting in 2006, off-label use started to go down but at a very slow pace."

On the other hand, Dr. Teigland also noted that "about 25% of residents still are treated off label with these drugs in nursing homes nationwide."

Work to Be Done

Dr. Teigland, who has done research examining antipsychotic use among Illinois nursing home residents, said that neither the growing body of evidence against the use of these medications nor the F-tag 329 insistence that nursing facility residents be free of unnecessary drugs has had much of an impact on antipsychotic use or avoidance of the drugs.

"This is a case where some physicians seem to be ignoring much of the evidence," she said. "It's time we really figured out what the behaviors are about and address them accordingly. We need education about these issues and how to solve them. ... Many people in a facility

See **Antipsychotics** • *page 2*

COURTESY FINGER LAKES CENTER FOR LIVING

Matching activities to resident needs has helped the Finger Lakes Center for Living (Auburn, N.Y.) eliminate antipsychotic drug use for its dementia patients.

Nursing Home Physicians Could Get Fee Hike

Facilities' Efforts

Antipsychotics • *from page 1*

have drug knowledge, but few have real knowledge or understanding of nondrug alternatives."

Another concern to Dr. Teigland is that "nurses sometimes demand these drugs" because they need a quick fix of a problem that an agitated resident is causing. "Behaviors are about something, and you have to figure out the root causes. This takes time." Yet "staff often don't have a week for behavioral management to work. They want or need a solution now."

While drugs sometimes are necessary to keep residents safe, Dr. Teigland's research suggests that antipsychotics still are being used for behaviors that could be addressed otherwise. "In our research, behaviors associated with antipsychotic use were issues such as wandering and resisting care," she said.

With time, these behaviors can be addressed without drugs, she said. "You have to keep people busy, and you have to determine when and why residents get agitated so that you can prevent these situations."

Dr. Teigland's research on this subject has turned up some interesting—and, as yet, unexplained—trends. "We found that residents in for-profit facilities were 20% more likely to be on antipsychotics. We also discovered that Hispanic patients are more likely to get these drugs."

Drug-Free Goal

Numerous facilities nationwide are successfully reducing antipsychotic drug use. One is Finger Lakes Center for Living in Auburn, N.Y.

According to Adeline M. Bovee, RN, DNS, director of nursing, "We identified reducing antipsychotic use as a quality improvement we wanted to address. We looked at patients with a diagnosis of dementia and antipsychotic use. We had pharmacy reports, and we brought in [a registered nurse] to do in-depth pain assessments" because unrecognized pain often triggers or causes behavioral issues.

"We found evidence that some of these patients likely had pain because of problems such as spinal stenosis." With such information in hand, the team discussed possible solutions, said Dr. Bovee.

"We started by making sure we have routine pain medications in place and attempted to reduce antipsychotic drug use," she added. "We also looked at behavioral interventions, starting with a social history."

'Behaviors are about something, and you have to figure out the root causes. This takes time.' Yet 'staff often don't have a week for behavioral management to work.'

For example, one resident would wander the halls of the facility and look into others' rooms. Staff found out that he had been a mail carrier, so they arranged with the activities department to give him some mail to sort. Once he had an activity to focus on, his intrusive behavior stopped.

Another resident had been acting out, and staff discovered he had injured his back in a car accident years earlier. Once they treated his back pain, his behavior problems disappeared.

After a year, the facility celebrated the elimination of antipsychotic use for all dementia patients.

Dr. Bovee stressed that it took much dedicated work to reach this goal. "We realized that we could only do this one patient at a time, and we couldn't just reduce everyone's antipsychotics at once."

Staff buy-in has been "great," said Dr. Bovee. For example, social workers have taken the lead in helping families understand why medications are sometimes necessary and involving relatives in a resident's behavioral management. Everyone thus ends up sharing a commitment to reducing or eliminating antipsychotic drugs. Now, "when a physician writes an antipsychotic order, you'd think it was a five-alarm fire," she said. Dr. Bovee noted that physicians, too, generally embraced the facility's efforts to reduce antipsychotic use.

Zero antipsychotic use is difficult and probably not realistic for many facilities, said Dr. Bovee. "Some residents have other diagnoses and have been on these drugs for a long time. Taking them off or attempting reductions doesn't necessarily work."

Challenges for Physicians

The neuropsychiatric and behavioral management of dementia is a growing problem for physicians seeing patients in nursing homes, Lory E. Bright-Long, MD, CMD, of the department of psychiatry at the State University of New York Stony Brook. "People often come into nursing homes because they are wandering, resistive, and/or aggressive at home. Now the facility has ... to deal with this—and promptly."

The changing nature of long-term care residents as well as practitioners further complicates the issue, said Dr. Bright-Long.

"The patients and the care they require are increasingly complex, and there is a constant influx of professionals who are new to nursing homes and the biopsychosocial care required for many residents," she said.

"When patients have depression or cognitive deficits, they are sicker with their cardiovascular-pulmonary-metabolic problems than individuals who don't have mental health issues," said Dr. Bright-Long. "Conversely, when patients have medical issues that are complicated by depression, anxiety, dementia, their morbidity and mortality is higher. So we have to be addressing mental health issues in comprehensive ways."

Doing so isn't always easy for physicians, especially when nurses and family members expect or want a prescription, said AMDA past-president David Smith, MD, CMD. "I had a call today from a good nurse about a patient's behavior," he said. "She asked me what drug I would prescribe. I said that I needed to know what is causing the behavior before I could make any treatment decision."

Dr. Smith recalled when he refused to prescribe an antipsychotic that staff at another nursing facility wanted for a combative resident. The family changed to another physician who would write the prescription.

"The resident became a zombie, and they considered that an improvement," said Dr. Smith. "I called the 800 line, and the surveyors didn't see anything wrong with it either. ... It's not just the physicians or nursing home staff. It's systemic, because people don't understand the complex clinical situations of these residents."

Dr. Smith stressed that many behaviors in residents, although they can be odd, are not harmful and don't call for medications.

For example, he said, "We had a patient who at night thought [that] her wheelchair was a buggy and she was driving horses with her son next to her." Since the woman wasn't hurting herself or others, staff let her enjoy her ride.

However, added Dr. Smith, "if a behavior causes distress for the resident or a danger to him or her or others, it may be necessary to use drug therapy. But we should use proper dose reductions and only use it for as long as necessary."

Senior contributing writer Joanne Kaldy is a freelance writer in Hagerstown, Md., and a communications consultant for AMDA and other organizations.

Caring for Consumers 12/2009

The Truth About Pyschotropic Drugs

Lory Bright-Long, MD, CMD, shares some facts about psychotropic drugs

Psychotropic medications are those that affect the mind and emotions. They include antipsychotics, antidepressants, and anti-anxiety drugs. When most people talk about psychotropics, they are referring to the antipsychotics. These medications generally are used to treat serious mental illnesses, such as psychosis. Sometimes these drugs are needed in long term care facilities to treat behaviors that are dangerous to residents/patients and caregivers.

It is important to know the truth about these medications so that you can work with the physician to decide whether they are right for your family member/friend. First, nursing facility staff cannot give a psychotropic drug without a physician's order and an appropriate diagnosis. No one can give your family member/friend these drugs just because he/she is restless or upset.

Your family member/friend and/or his/her legal decision maker (e.g., an adult child with power of attorney) must be told about the medication's risks. The doctor will explain that some psychotropics can make a person dizzy, drowsy, and confused. Some of these drugs can cause tardive dyskinesia, movement such as rocking or chewing that the person can't control or stop, and Parkinson's disease-like symptoms (such as shaking or rigidity). The person or his/her decision maker may be asked to sign a consent form stating that he/she/they understand(s) the risk and approves the drug's use.

By working with the doctor, you can make sure that your family member/friend only gets the medications he/she needs and only for the time period he/she needs them.

▶Questions to Ask Your Physician:

- Are there any treatments besides drugs that might help my family member/friend? How can I help?
- Why is this drug needed? How will it help?
- What would/could happen if my family member/frien doesn't take this medication?
- What non-drug treatments have been tried?

▶What You Can Do:

- Talk with the physician and facility staff about what might be causing behavior problems and how to solve them. (For example, if dad is wandering during the day, it may help staff to know that he was a postal carrier and spent his days delivering mail.)
- Bring pictures and other life mementos to the facility; help staff to know your family member/friend—hobbies, likes/dislikes, fears, etc.
- Work with staff to make sure your family member/friend gets foods, activities, etc. that bring them pleasure. Bring him/her gifts and things you know will make him/her happy.
- Watch for/report any medication side effects you see to the nurse or physician.

For more information:

- Psychotropic Drug Use in Nursing Homes: www.globalaging.org/health/us/2005/edna-travis.htm
- Mr. EF, Who Throws Things at Staff in Anger: www.caringfortheages.com/article/S1526-4114(09)60233-X/fulltext
- Patient-Centered Approach Sharpens AD Care: More Facilities Balance Pharmacologic and Nonpharmacologic Methods to Slow Cognitive Decline: www.caringfortheages.com/article/S1526-4114(07)60088-2/fulltext

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