Dear Hospitalist Leader,

The Society of Hospital Medicine (SHM) supports the efforts of the Center for Medicare & Medicaid Services (CMS) and other organizations to improve care provided to elderly nursing home residents under a new behavioral health initiative aimed at curbing off-label antipsychotic drug use in patients with dementia. This effort is in response to the May 2011 release of the Department of Health and Human Services Office of Inspector General (OIG) report Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents. This report found that in some circumstances antipsychotic medications are used to treat patients with dementia for off-label reasons (e.g. “behaviors”) or against FDA black box warnings despite potential dangers to the health of the patient.

We write to encourage you to partner with others in your clinical work environment to reduce the use of antipsychotics for treating behavioral problems in patients with dementia. We believe that hospitalists have an important role to play in this initiative; hospital-based clinicians frequently care for patients with dementia and are responsible for medications prescribed during a patient’s hospitalization and at discharge.

Hospitalists are leaders for improving clinical care and enhancing quality. In this role, hospitalists can educate staff and other clinicians about the appropriate use of antipsychotic medications. Educational efforts should detail non-pharmacological interventions available to address behavioral concerns associated with dementia as well as the risks and side effects of antipsychotic medications used in patients with dementia. While there is an established, evidence-based role for antipsychotic medications in managing psychoses such as schizophrenia and bipolar mania, as well as for acute delirium in the inpatient setting, inappropriate, off-label, long-term use of these medications in persons with dementia can be dangerous.

Occasionally the use of antipsychotic medications in patients with dementia may be appropriate, particularly when behaviors imminently threaten the safety of the patient or the safety of others. In such circumstances, the patient (and healthcare proxy) should be informed of the risk of using this class of medication prior to administration, and if used, antipsychotics should be time-limited. Evidence from the randomized DART-AD trial suggests that discontinuing antipsychotics in patients with dementia is associated with lower mortality and emphasizes the importance of limiting exposure to these medications. Hospitalists should ensure that appropriate, short-term use of antipsychotics for delirium is not followed by inappropriate long-term use at the time of discharge.

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While use of antipsychotics for acute delirium in the inpatient setting may be appropriate in certain instances, ‘as needed’ or PRN use in the hospital may not meet standards of safe use and appropriate monitoring for older patients. When used, additional attention should be given to ensure that antipsychotics are not inadvertently dosed at excessive levels for elderly patients or used without appropriate assessment of QTc. Specifically, higher doses of antipsychotics (e.g., haloperidol dosed at >3 mg/day) may lead to over-sedation, prolongation of the QT interval or other adverse events in the geriatric population and may mask underlying organic causes of disorientation.

Hospitalists should work with their local hospital administration and quality improvement teams to incorporate order sets that use lower, safer doses of conventional or atypical antipsychotics, and should consider removing these medications from standing order sets altogether unless paired with appropriate assessment and monitoring. A safer approach may be a standing order for the clinician to be alerted at the first signs of agitation or delirium so that the patient can be evaluated for organic causes and treated quickly and appropriately.

In addition to education of appropriate interventions at the point of care, hospitalists should collaborate with nurses, pharmacists and hospital administration to develop and implement system-based practices to monitor and track antipsychotic use both in the hospital and at the time of discharge. Review and modification of standing order sets, implementation of automatic stop dates for antipsychotics in patients with dementia and medication alerts in electronic health record systems are examples of system changes that should be considered to reduce inappropriate antipsychotic use. Hospitalists and other hospital-based clinicians should consistently inform patients and their families of the risks and FDA black box warnings related to the use of these medications, and alternative strategies for managing behavioral problems in patients with dementia should be utilized.

SHM is an advocate for improving inpatient and post-acute care by standardizing system-based practices, educating clinicians and other hospital personnel, and further developing strong relationships with patients and their caregivers. Increased prescriber training and system practice changes will help reduce unnecessary antipsychotic drug prescribing. SHM looks forward to an ongoing collaboration with members and hospital leaders on this important patient safety issue.

Sincerely,

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President
Society of Hospital Medicine

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Senior Vice President
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**In Brief: Antipsychotic Use in Patients with Dementia**

In 2008, the U.S. Food and Drug Administration (FDA) issued a black box warning for conventional and atypical antipsychotics indicating that these medications are not indicated for treatment of psychosis in elderly patients with dementia ([http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm110212.htm](http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm110212.htm)). Some of the risks of both conventional and atypical antipsychotics in elderly patients identified by the FDA include:

- Increased risk (60-70 percent) of death in older adults with dementia.
- Prolongation of the QT interval on the electrocardiogram, particularly with intravenous haloperidol use.
- Increased risk of stroke and TIAs.
- Worsening cognitive function.

**FDA Black Box Warning**

- Work to ensure that appropriate, short-term use of antipsychotics for dementia-related psychosis is not followed by inappropriate long-term use at the time of discharge.
- Work with hospital administration and QI teams to incorporate order sets that use lower, safer doses of conventional or atypical antipsychotics paired with appropriate assessment and monitoring.
- Collaborate with other providers to create a systems-level approach to monitor and track antipsychotic use in the hospital and at discharge.
- Ensure that patients and caregivers are consistently informed of the risks related to antipsychotics.
- Educate on and put into practice the use of alternative strategies for managing behavioral problems in patients with dementia, as appropriate.