How does tardive dyskinesia (TD) impact residents at your long-term care facility?

Uncover the impact and importance of managing TD
Have you seen residents with these abnormal movements? It could be TD.

TD is a medication-induced movement disorder associated with prolonged exposure to dopamine receptor blocking agents (DRBAs), including antipsychotics.

Actor portrayals

LIPS/TONGUE
Puckering, pouting, smacking

JAW
Biting, clenching, or side-to-side movements

EYES/FACE
Excessive blinking or squinting again and again

TORSO
Rocking, leaning back, or torso and hip shifting

UPPER LIMBS
Twisting hands or dancing fingers

LOWER LIMBS
Stretched toes, gripping feet, ankle twisting

The movements of TD have distinct characteristics
Repetitive, purposeless movements
Irregular, dance-like movements
Slow, snake-like, writhing movements
TD may affect more than one area of the body—not just the face\textsuperscript{1,2}

The Abnormal Involuntary Movement Scale (AIMS) exam can be used to assess symptom severity across multiple areas of the body

1. Muscles of facial expression (forehead, eyebrows, periorbital area, cheeks)
2. Lips and perioral area
3. Jaw
4. Tongue
5. Upper extremities (arms, wrists, hands, fingers)
6. Lower extremities (legs, knees, ankles, toes)
7. Trunk (neck, shoulders, hips)

Find expert-led guidance on conducting the AIMS exam at MIND-TD.com
TD can affect any resident treated with a DRBA\textsuperscript{5}

Overall prevalence of antipsychotic use in long-term care facilities may be up to $23\%$\textsuperscript{6,a}.

\textsuperscript{a}Medicare Part D claims data; long-stay residents age $\geq 65$ years.

### MEDICATIONS THAT MAY REQUIRE MONITORING FOR TD

<table>
<thead>
<tr>
<th>FIRST-GENERATION ANTIPSYCHOTICS\textsuperscript{7}</th>
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DRBA, dopamine receptor blocking agent.

For educational purposes only. Not intended as an exhaustive list of medications that may require monitoring for TD.
Are your residents at increased risk for TD?

Older individuals treated with antipsychotics have a greater risk for TD, even when treated with lower doses for a shorter duration\(^9\)-\(^14\)

**Cumulative incidence of TD in older individuals exposed to first-generation antipsychotics\(^{10,b}\)**

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<th>Time</th>
<th>Incidence</th>
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<td>After 1 year</td>
<td>25%</td>
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<td>After 2 years</td>
<td>34%</td>
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<td>After 3 years</td>
<td>53%</td>
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\(^b\)Based on an analysis of neuroleptic-naïve patients ≥55 years (n=261).

While anyone treated with a DRBA can develop TD, the following patient types may be associated with increased risk:

**Patient risk factors for TD:**
- Aged 50 or older\(^{10}\)
- Substance use disorder\(^{15}\)
- Being postmenopausal\(^{16}\)
- Diagnosis of mood disorder\(^{17}\)

**Treatment risk factors for TD:**
- Cumulative exposure to antipsychotics\(^{15}\)
- Treatment with anticholinergics\(^{15}\)
- History of acute drug-induced movement disorder symptoms\(^{15}\)
- Potency of antipsychotics\(^{16}\)
TD may negatively impact residents’ daily lives19

- **Stigmatization**: Abnormal and involuntary movements may make residents feel stigmatized socially
- **Isolation**: Abnormal and involuntary movements may cause residents to isolate themselves
- **Functional impact**: TD movements can impact residents’ ability to perform daily activities

Uncover the impact TD has on your residents

Use empathetic, open-ended questions to help residents recognize and accept their involuntary movements. This can help uncover the impact TD has on the way your residents think, feel, and act.

**THINK** - When you first noticed these movements, what did you think of them?

**FEEL** - How do the movements make you feel?
Have family members or others noticed your movements? If so, what did they say?

**ACT** - How do these movements affect your daily life, such as getting dressed, eating, or sleeping?
Do you find yourself participating less often in group activities or physical therapy because of your movements?
Residents’ care may also be impacted by TD

Prioritizing patient-centered practices is essential to ensuring safe, effective care that follows CMS guidance and quality measures.

Quality measures that may be associated with TD symptoms:

% of residents:
- Experiencing one or more falls with major injury
- Whose ability to move independently worsened
- Whose need for help with daily activities has increased
  - Examples of daily activities include:
    - Bathing
    - Grooming
    - Dressing
    - Eating
    - Using the toilet
    - Moving around in bed
    - Moving from bed to chair

Older adults are also especially at risk from the physical impacts of TD, including impaired gait and balance, which can lead to falls.
Monitoring for TD in long-term care facilities is multidisciplinary.

All members of the care team can help recognize and report symptoms of TD.

**ADMISSION**
- Nurse
- Admitting physician
- Advanced practice practitioner
- Assessment and care plan

**INITIAL RESIDENT ASSESSMENT AND CARE PLAN**
- Nurse
- Admitting physician
- Advanced practice practitioner
- Assessment and care plan

**ACTIVITIES OF DAILY LIVING**
- Nursing assistants
- RN/LPNs
- Activities staff
- Physical therapy/occupational therapy/speech

**PHYSICIAN VISITS**
- Consultant psychiatrist
- Admitting physician
- Advanced practice practitioner

**DRUG REGIMEN REVIEWS**
- Consultant pharmacist

**MDS REVIEW AND ONGOING CARE PLANNING**
- MDS coordinator
- All clinical staff
**TD clinical guidelines and recommendations**

**Screen regularly for TD**

*2020 American Psychiatric Association guidelines*  
1. Screen for TD before starting or changing patients’ DRBA treatment  
2. Monitor for signs of TD at each visit  
3. Conduct a structured TD assessment every 6 to 12 months, depending on patient’s risk, and if new or worsening movements are detected at any visit

**Preserve stable antipsychotic regimens**

*2013 American Academy of Neurology guidelines*  
- There is a lack of clear evidence to support or refute withdrawing or switching antipsychotics to treat TD  
- Changing a patient’s antipsychotic regimen may destabilize the underlying psychiatric condition

*2020 American Psychiatric Association guidelines*  
- TD may persist, and may even worsen, despite reduction in dose or discontinuation of antipsychotics

**Treat first line with VMAT2 inhibitors**

*Systematic review of new evidence since 2013 American Academy of Neurology guidelines*  
- New generation VMAT2 inhibitors should be recommended as first-line treatment for TD

*2020 American Psychiatric Association guidelines*  
- Treatment with a VMAT2 inhibitor is recommended in patients with moderate to severe or disabling TD  
- VMAT2 inhibitors can also be considered in patients with mild TD

*2020 Delphi Panel consensus recommendations*  
- Treatment of TD with a VMAT2 inhibitor should be considered as part of a comprehensive treatment plan

**TALK TO YOUR PATIENTS ABOUT MANAGING THEIR TD**

There are treatment options. Learn about one at TDtreatmentoption.com.
TD can affect any resident treated with a DRBA\(^5\)

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CMS provides guidance around appropriate use of antipsychotics in residents with the goal of limiting use to appropriate patients.\(^2\) CMS also recognizes that a subset of residents with chronic psychiatric/neurological conditions may require prolonged antipsychotic therapy.

LEARN MORE TIPS FOR SCREENING FOR TD AT MIND-TD.COM
Uncover the impact TD may have in your long-term care facility

Monitoring for TD is multidisciplinary

- Antipsychotics carry risk for developing TD
- Older patients treated with antipsychotics have a greater risk for TD, even when treated with lower doses for a shorter duration
- Routine screening may help identify residents with TD