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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[1]

Actor portrayals

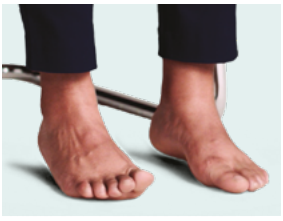
LIPS/TONGUE
Puckering, pouting, smacking[1,2]

JAW
Biting, clenching, or side-to-side movements[1,2]

EYES/FACE
Excessive blinking or squinting again and again[1,2]

TORSO
Rocking, leaning back, or torso and hip shifting[1,2]

UPPER LIMBS
Twisting hands or dancing fingers[1,2]



LOWER LIMBS
Stretched toes, gripping feet, ankle twisting[1,2]

The movements of TD have distinct characteristics[3,4]

Repetitive, purposeless movements

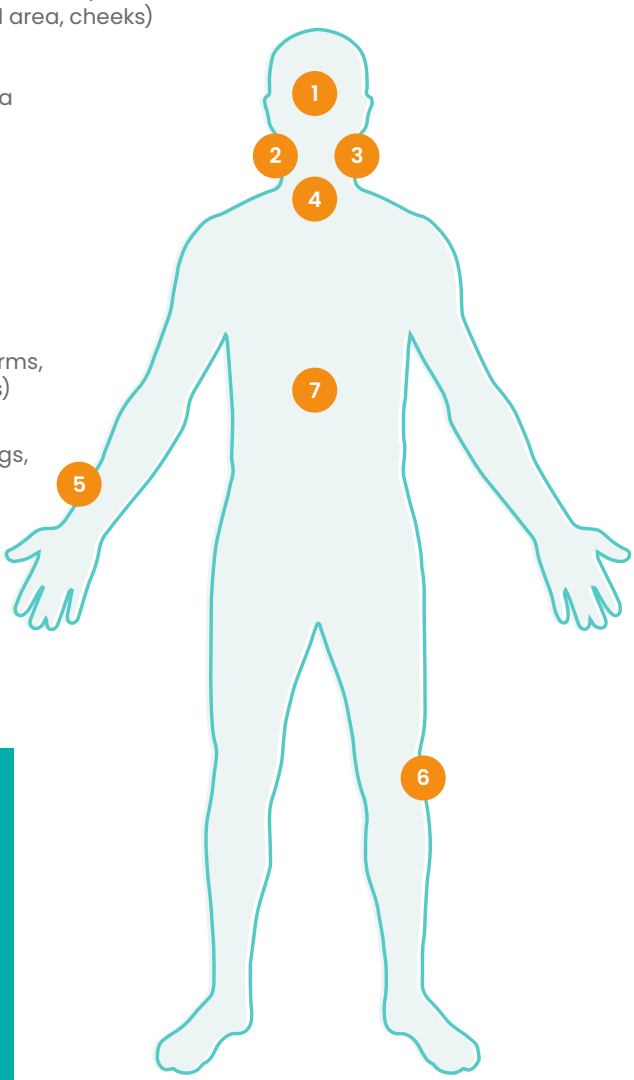
Irregular, dance-like movements

Slow, snake-like, writhing movements

TD may affect more than one area of the body—not just the face[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[5]

Overall prevalence of antipsychotic use in long-term care facilities may be up to

[a]Medicare Part D claims data; long-stay residents age ≥65 years.

MEDICATIONS THAT MAY REQUIRE MONITORING FOR TD

FIRST-GENERATION ANTIPSYCHOTICS[7]

- Chlorpromazine *(Thorazine)*
- Molindone *(Moban)*[8]
- Fluphenazine *(Prolixin)*
- Loxapine *(Loxitane)*
- Haloperidol *(Haldol)*
- Perphenazine *(Trilafon)*
- Thioridazine *(Mellaril)*
- Thiothixene *(Navane)*
- Trifluoperazine *(Stelazine)*

SECOND-GENERATION ANTIPSYCHOTICS[7]

- Aripiprazole *(Abilify)*
- Asenapine *(Saphris)*
- Brexpiprazole *(Rexulti)*
- Cariprazine *(Vraylar)*
- Clozapine *(Clozaril)*
- Iloperidone *(Fanapt)*
- Loxapine *(Loxitane)*
- Lumateperone *(Caplyta)*
- Lurasidone *(Latuda)*
- Olanzapine *(Zyprexa)*
- Paliperidone *(Invega)*
- Pimavanserin *(Nuplazid)*
- Quetiapine *(Seroquel, Seroquel XR)*
- Risperidone *(Risperdal)*
- Ziprasidone *(Geodon)*

OTHER DOPAMINE RECEPTOR BLOCKING AGENTS[1]

- Prochlorperazine *(Compazine, Compro)*
- Promethazine *(Phenergan, Promethegan, Phenadoz)*
- Trimethobenzamide *(Tebamide, Tigan)*
- Thiethylperazine *(Torecan)*
- Metoclopramide *(Reglan)*

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]

25%	34%	53%
AFTER 1 YEAR	AFTER 2 YEARS	AFTER 3 YEARS

[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[18]

TD may negatively impact residents' daily lives[19]

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[20]

Quality measures that may be associated with TD symptoms[20]

% 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[19]

Monitoring for TD in long-term care facilities is multidisciplinary[21]

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[22]

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[23]

- 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[22]

- 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[24]

- New generation VMAT2 inhibitors should be recommended as first-line treatment for TD

2020 American Psychiatric Association guidelines[22]

- 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[25]

- 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.[21] 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

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Uncover the impact TD may have in your long-term care facility

Monitoring for TD is multidisciplinary[21]

- Antipsychotics carry risk for developing TD[5]
- Older patients treated with antipsychotics have a greater risk for TD, even when treated with lower doses for a shorter duration[9-14]
- Routine screening may help identify residents with TD[2,22]

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