LTC NEWS+VIEWS
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# Addressing Tardive Dyskinesia in Long-Term Care Facilities: Screening, Impact Assessment, and a Treatment Option

TD SCREENING AND ASSESSMENT OF IMPACT

## Screening for Tardive Dyskinesia (TD) and Assessing Its Impact on Residents in the Long-Term Care (LTC) Setting

TD, regardless of its severity, can profoundly affect residents' well-being. Therefore, it is crucial to routinely screen for abnormal movements in residents who are at risk for TD. If movements are suspected, a formal assessment should be made, followed by appropriate treatment to manage the symptoms.

TREATMENT

## AUSTEDO XR® for Effective and Tolerable Control of TD Symptoms

AUSTEDO XR is a VMAT2 inhibitor approved for the treatment of TD and chorea associated with Huntington's disease. This article highlights key findings from the pivotal clinical trials of AUSTEDO® (deutetrabenazine) tablets, including symptom control, long-term results, and safety profile. It also discusses the metabolic profile of AUSTEDO XR, which allows for few restrictions related to drug-drug interactions.

EXPERT COMMENTARY

## Expert Commentary With Dr Amita Patel and Ms Cindy Fronning

**Amita Patel, MD, CMD, MHA, CPE**
Geriatric Psychiatrist
Private Practice
Dayton, Ohio

**Cindy Fronning, RN, GERO-BC, CDONA, FACDONA, RAC-CT, IP-BC, AS-BC, ELFA, CALN**
NADONA Master Trainer and
Executive Director
Lebanon, Ohio

This newsletter is produced by Teva Pharmaceuticals, and Dr Amita Patel and Ms Cindy Fronning were compensated by Teva for their insights.

## INDICATIONS AND USAGE

AUSTEDO XR® (deutetrabenazine) extended-release tablets and AUSTEDO® (deutetrabenazine) tablets are indicated in adults for the treatment of chorea associated with Huntington's disease and for the treatment of tardive dyskinesia.

## IMPORTANT SAFETY INFORMATION

**Depression and Suicidality in Patients with Huntington's Disease: AUSTEDO XR and AUSTEDO can increase the risk of depression and suicidal thoughts and behavior (suicidality) in patients with Huntington's disease. Balance the risks of depression and suicidality with the clinical need for treatment of chorea. Closely monitor patients for the emergence or worsening of depression, suicidality, or unusual changes in behavior. Inform patients, their caregivers, and families of the risk of depression and suicidality and instruct them to report behaviors of concern promptly to the treating physician. Exercise caution when treating patients with a history of depression or prior suicide attempts or ideation. AUSTEDO XR and AUSTEDO are contraindicated in patients who are suicidal, and in patients with untreated or inadequately treated depression.**

**Please see additional Important Safety Information throughout and click here or visit www.AUSTEDOhcp.com to read/print the full Prescribing Information, including Boxed Warning, for AUSTEDO XR.**

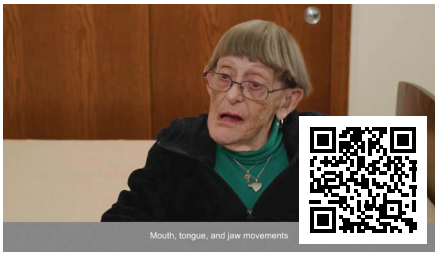
TD SCREENING AND ASSESSMENT OF IMPACT

# Screening for Tardive Dyskinesia (TD) and Assessing Its Impact on Residents in the Long-Term Care (LTC) Setting

## TD and Associated Risk Factors

TD is a persistent and potentially debilitating disorder characterized by involuntary hyperkinetic movements of the face, trunk, and extremities **(Video 1)**. It is caused by chronic exposure to dopamine receptor blocking agents (DRBAs), including antipsychotic drugs (APDs), antiemetics, and prokinetics.[1-3] In a meta-analysis that examined the prevalence of TD in patients taking APDs, approximately 1 in 3 patients treated with typical APDs and up to 1 in 5 patients treated with atypical APDs developed TD.[4] Besides exposure to DRBAs, several other factors, as listed in **Figure 1.1**, increase the risk of TD especially in older adults.[5,6]

**Video 1. Scan QR code to view TD movements in the face, trunk, and extremities**




## Screening for TD and Assessment of Its Impact

Residents at risk should be routinely screened for abnormal movements.[7] Screening can begin by observing the resident and asking questions to assess the resident's awareness of abnormal movements and their impact.[7,8] Residents can be observed either during routine clinical encounters or in the resident's natural environment, such as the dining room or during recreational activities. This can be performed by any staff member at the LTC facility. If TD is suspected, the staff should be encouraged to contact a prescriber for a formal diagnosis.

> Any staff member at the LTC facility can observe movements, and if they suspect TD, they should contact a prescriber for a formal diagnosis.

The Abnormal Involuntary Movement Scale (AIMS), a 12-item scale, is the standard tool for evaluating the severity of abnormal movements.[9-11]

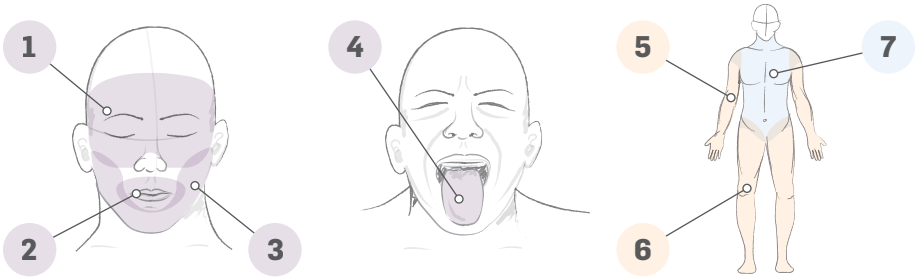
- Items 1 through 7 assess the severity of involuntary movements in the orofacial region, upper and lower extremities, and the trunk **(Figure 1.2)** on a 0 (none) to 4 (severe) scale
- Item 8 assesses the overall severity of movements and is scored as the highest single score of items 1 to 7
- Items 9 and 10 assess the impact by measuring incapacitation and awareness, respectively
- Items 11 and 12 assess dental status, as dental issues can result in movements that look like TD

When performing the AIMS exam, the resident should ideally be seated comfortably on a firm chair without arms.[11] However, some accommodations may be required to support the resident's needs or circumstances. For example, when performing the AIMS exam on a

**Figure 1.1. Several Factors Increase the Risk of Developing TD in Older Adults[5,6]**

- Dose and duration of antipsychotics
- Mood disorder
- Increasing age
- Substance use disorder
- Women, especially postmenopausal
- Acute dystonia from antipsychotic use
- Intellectual disabilities or central nervous system injury
- Clinically significant parkinsonism or akathisia (inability to stay still)

**Figure 1.2. Body Regions Assessed by Items 1 to 7 of the AIMS Exam[9-11]**




| | |
|---|---|
| Facial & Oral Movements | 1. Muscles of facial expression |
| | 2. Lips and perioral area |
| | 3. Jaw |
| | 4. Tongue |
| Extremity Movements | 5. Upper (arms, wrists, hands, fingers) |
| | 6. Lower (legs, knees, ankles, toes) |
| Trunk Movements | 7. Neck, shoulders, hips |

**Table 1.1. Activation Maneuvers Can Help Reveal Movements[12,14,15]**

| Ask resident to | Observe |
|---|---|
| Tap thumb to forefinger with both hands, first with the mouth closed, then open | Face and tongue |
| Extend arms in front of body and count backward | Hands and arms |
| Walk in a straight line with usual gait and posture | Hands, arms, tongue, face |

bedbound or a wheelchair-bound resident, an assistant may be needed to reduce the risk of falls **(Video 2)**.

During screening and assessment, activation maneuvers can be used to more clearly assess and bring out abnormal movements, especially those that are subtle. Activation applies physical and/or cognitive tasks to distract the resident, thus helping to reveal abnormal movements in areas not being activated.[12,13] **Table 1.1** shows examples of some routinely used activation maneuvers. When providing instruction to cognitively impaired residents, the examiner may need to demonstrate the activation maneuvers so that the resident can mimic them.

The American Psychiatric Association recommends performing an AIMS examination every 6 months for residents taking APDs. An AIMS examination should be performed upon initiation of an APD, upon exacerbation of preexisting movements, and every 12 months for other residents. It should also be conducted during gradual dose reduction (GDR) of an APD, as TD symptoms can be unmasked when the medication is reduced.[5,16]

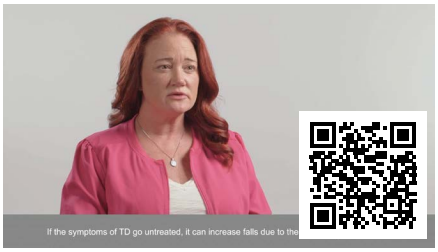
**Video 2. Scan QR code to view AIMS accommodations for a bedbound resident**

## Assessing the Impact of TD

The impact of TD can be multifaceted, affecting residents' physical, psychological, and social/recreational functioning.[17,18] Residents in LTC facilities are especially at risk from the physical impacts of TD, including an increased risk of falls due to issues with gait and balance and difficulty performing activities of daily living (ADL), such as eating, speaking, sleeping, and dressing.[17,19] TD may negatively affect the facility's star rating by impacting the following 4 assessed quality measures[20] **(Video 3)**:

- Percentage of residents experiencing 1 or more falls with major injury
- Percentage of residents whose need for help with ADL has increased
- Percentage of residents whose ability to move independently has worsened
- Number of outpatient emergency department (ED) visits per 1000 long-stay resident days

**Video 3. Scan QR code to view impact of TD on facilities**




Deteriorating physical health of residents can burden the staff, taking away their time from other important tasks.

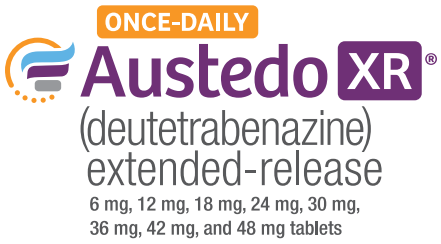
Guidelines recommend assessing the overall impact of TD on the resident's life and functioning in the social, physical, and psychological/psychiatric domains at every clinical encounter. They also suggest not correlating impact with the severity of movements, as subtle TD symptoms can have a significant impact.[7,19] In an interim analysis of 286 patients enrolled in the IMPACT-TD Registry, an ongoing, real-world, phase 4, 3-year longitudinal study, 98% of patients experienced the impact of TD on some aspect of their life, of which >50% experienced moderate to severe impact. Additionally, 54% and 61% of patients with very mild and mild TD, respectively, experienced moderate to severe impact, indicating that TD, irrespective of severity, has a broad functional effect that can substantially impact the patient's life.[21]

> Assessment of impact should be a routine part of clinical practice, and treatment with a vesicular monoamine transporter type 2 (VMAT2) inhibitor should be considered if the symptoms, irrespective of severity, are impacting the resident.

## Summary

Regular screening and assessment of residents at risk for TD is the standard of care. Any member of the staff can look for abnormal movements. If abnormal movements are identified, the resident should be formally assessed for TD symptoms and their severity using the AIMS. In addition, the impact of TD on the resident's life should be evaluated, and treatment with a VMAT2 inhibitor should be considered if the symptoms, irrespective of severity, are impacting the resident.[5] ■

To further your knowledge about TD screening, assessment, and diagnosis, scan the QR code to visit the ConnecTD website. Also available through www.AUSTEDOHCP.com.




TREATMENT

# AUSTEDO XR for Effective and Tolerable Control of TD Symptoms

Tardive dyskinesia (TD) is a side effect of long-term exposure to dopamine receptor blocking agents (DRBAs), such as antipsychotic drugs (APDs), antiemetics, and prokinetics.[1-3] Age is a critical risk factor, with the incidence of TD in older adults being 5 times greater than in younger adults.[1] Therefore, residents in long-term care (LTC) facilities who are taking APDs should be routinely monitored for TD symptoms and treated appropriately.[4,5]

Vesicular monoamine transporter 2 (VMAT2) inhibitors, such as AUSTEDO XR, are the only FDA-approved medications for the treatment of TD.[6]

In this article, we will discuss data from the clinical trials for AUSTEDO and the unique metabolic profile of AUSTEDO XR, which allows for its coadministration with strong CYP3A4/5 inducers and strong CYP3A4/5 and CYP2D6 inhibitors. We also outline the dosing recommendations and information on how to get residents started on AUSTEDO XR.

## Efficacy and Safety of AUSTEDO (Pivotal Clinical Trials and Long-Term Open-Label Extension Study)

The efficacy and safety profile of AUSTEDO was established in two 12-week, randomized, double-blind, placebo-controlled pivotal clinical trials, ARM-TD (Aim to Reduce Movements in Tardive Dyskinesia) and AIM-TD (Addressing Involuntary Movements in Tardive Dyskinesia). The studies included adult patients up to 81 years of age.[7-9] The primary efficacy endpoint in both studies was the change in Abnormal Involuntary Movement Scale (AIMS) total score (sum of items 1 through 7) from baseline (defined for each patient as the value from the day 0 visit) to Week 12.[8-10]

VMAT2 inhibitors, such as AUSTEDO XR, are the only FDA-approved medications for the treatment of TD.

Patients in the ARM-TD study showed a significant improvement in AIMS total score from baseline ($P$=0.019) at Week 12 vs placebo (3.0-point reduction vs 1.6-point reduction). Results were consistent with those observed in AIM-TD at Week 12.[8-10]

Long-term safety of AUSTEDO was studied in RIM-TD (Reducing Involuntary Movements in Participants With Tardive Dyskinesia), an open-label, long-term maintenance study in patients who successfully completed ARM-TD or AIM-TD. AUSTEDO was discontinued for 1 week and then started at a dose of 12 mg/day, and subsequently titrated weekly for up to 6 weeks. The dose was increased in a response-driven manner until an allowable dose was reached, a clinically significant adverse event (AE) occurred, or adequate dyskinesia control was achieved. Patients were followed for approximately 3 years.[11]

Among the 335 patients evaluated, 257 were 21-64 and 78 were ≥65 years. All patients received treatment at baseline and 160 received treatment through

the end of Week 145. Mean dose at Week 145 was similar for both age groups. For both age groups, there was a rapid response beginning at Week 2 as assessed by improvement in the AIMS. Thereafter, increasing improvement was observed for about 3 years **(Figure 2.1)**.[11,12]

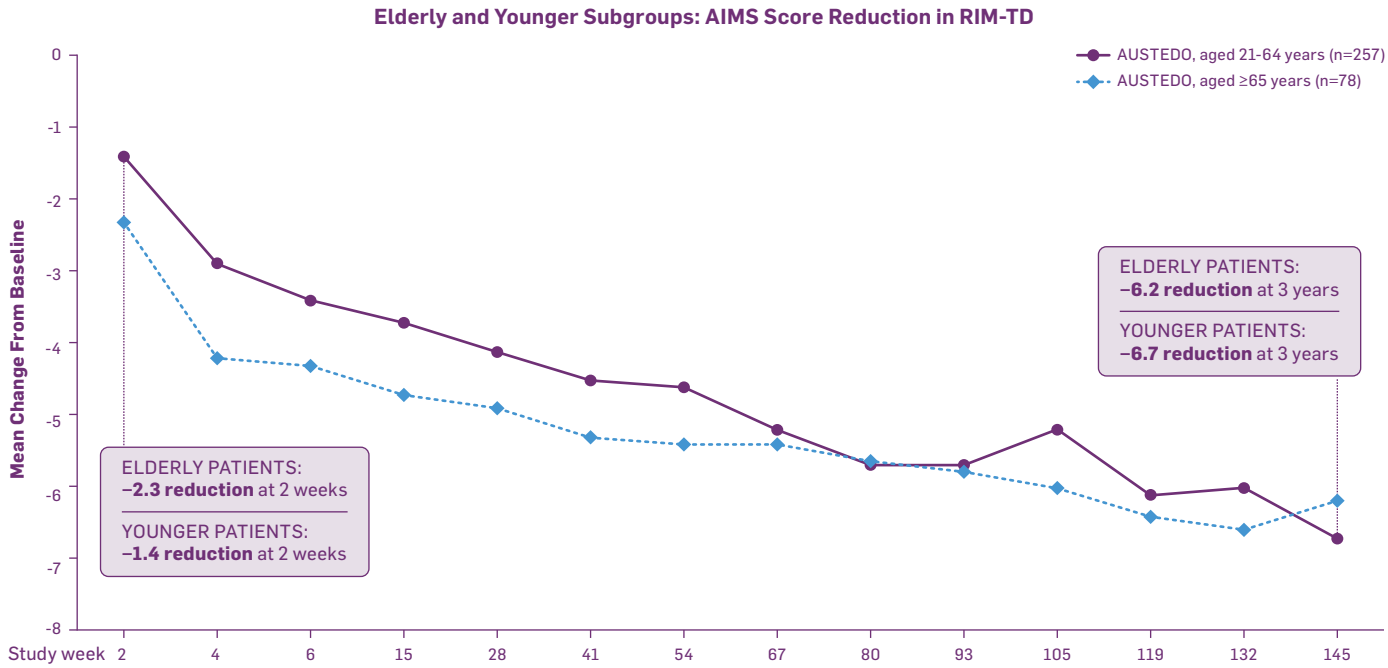
The most common AEs reported by patients treated with AUSTEDO® (deutetrabenazine) tablets (≥2% and greater than placebo) in the AIM-TD and ARM-TD are shown in **Table 2.1**.[7] Discontinuation due to AEs occurred in 4% of patients taking AUSTEDO vs 3% of patients taking placebo.[8] Dose reduction due to AEs was required in 4% of patients taking AUSTEDO vs 2% of patients taking placebo.[7] Once patients were titrated to their maintenance dose, dry mouth, nausea, and hypertension were no longer reported in AIM-TD and somnolence and dry mouth were no longer reported in ARM-TD.[10] Adverse reactions with AUSTEDO XR are expected to be similar to those with AUSTEDO twice daily (BID).[7]

## Considerations for Potential DDIs

Due to older age and comorbid conditions, polypharmacy is highly prevalent in residents, exposing them to an increased risk of drug-drug interactions (DDIs). A systematic review of 44 studies reported that 91%, 74%, and 65% of residents took more than 5, 9, and 10 medications, respectively, and mean number of medications

AUSTEDO XR® (deutetrabenazine) extended-release tablets demonstrated sustained results across 3 years for older and younger patients.

**Figure 2.1. Sustained Results Across 3 Years for Elderly and Younger Patients[12,*]**




21-64 years of age=younger; ≥65 years of age=elderly.[12]

**Patients in the RIM-TD study received the AUSTEDO BID formulation.**

*In a post hoc subgroup analysis of the RIM-TD open-label extension.[12]

## IMPORTANT SAFETY INFORMATION (CONTINUED)

**Akathisia, Agitation, and Restlessness:** AUSTEDO XR and AUSTEDO may increase the risk of akathisia, agitation, and restlessness. The risk of akathisia may be increased by concomitant use of dopamine antagonists or antipsychotics. If a patient develops akathisia, the AUSTEDO XR or AUSTEDO dose should be reduced; some patients may require discontinuation of therapy.

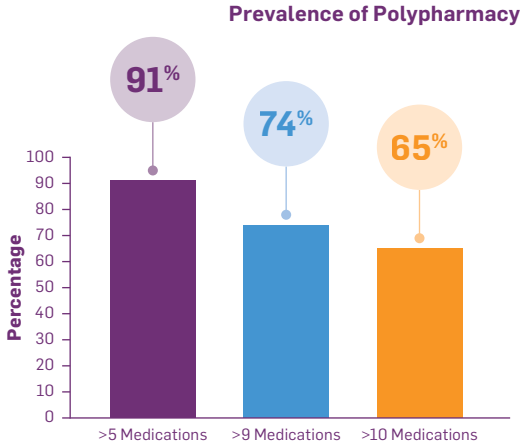
**Please see additional Important Safety Information throughout and click here or visit www.AUSTEDOhcp.com to read/print the full Prescribing Information, including Boxed Warning, for AUSTEDO XR.**

**Table 2.1. Adverse Events Reported in ≥2% of Patients Treated With AUSTEDO[7,10,*]**

| Adverse Event | AUSTEDO (n=279) | Placebo (n=131) |
|---|---|---|
| Headache | 5% | 8% |
| Somnolence | 4% | 7% |
| Diarrhea | 4% | 4% |
| Nasopharyngitis | 4% | 2% |
| Fatigue | 4% | 5% |
| Insomnia | 4% | 1% |
| Anxiety | 4% | 5% |
| Upper respiratory tract infection | 3% | 4% |
| Dry mouth | 3% | 5% |
| Nausea | 2% | 7% |
| Weight increased | 2% | 3% |
| Urinary tract infection | 2% | 2% |
| Depression/dysthymic disorder | 2% | 1% |
| Akathisia/agitation/restlessness | 2% | 1% |
| Arthralgia | 2% | 1% |

*Patients in the pivotal studies received the AUSTEDO BID formulation. Adverse events with AUSTEDO XR are expected to be similar to AUSTEDO BID.[7]

**Figure 2.2. Polypharmacy Is Highly Prevalent in LTC Facilities[13]**




- In LTC facilities, 91%, 74%, and 65% of residents are taking more than 5, 9, and 10 medications, respectively
- Mean number of medications ranges from 3.8 to 16.6 per resident

**Polypharmacy exposes residents to an increased risk of adverse DDIs**

†A total of 44 studies published between January 2000 and September 2014 were included in this systematic review.

ranged from 4 to 17 per resident **(Figure 2.2)**.[13] This makes it critical to review residents' clinical and medication history when choosing a therapy for residents with TD.

The metabolic profile of AUSTEDO XR allows for no DDI-related restrictions with strong CYP3A4/5 inducers and inhibitors. With strong CYP2D6 inhibitors and metabolizers, AUSTEDO XR can be titrated up to 36 mg/day. Therefore, AUSTEDO XR should be considered for treating TD in residents who are taking these agents **(Table 2.2)**.[7] Additionally, there is no need to reduce the dose of P-glycoprotein (P-gp) substrate with AUSTEDO XR.[7]

## One Pill, Once Daily for All Doses (12 to 48 mg/day)

AUSTEDO XR is a once-daily pill available in 12 mg, 18 mg, 24 mg, 30 mg, 36 mg, 42 mg, and 48 mg extended-release tablets.[7] As seen in the lower part of **Figure 2.3**, the recommended starting dose of AUSTEDO XR is 12 mg/day for TD with the flexibility to increase at weekly intervals by 6 mg/day until effective and tolerable symptom control is reached (48 mg maximum dose).[7] The average dose in the pivotal clinical trials was >36 mg/day for both younger (21-64 years) and older (≥65 years) patients.[8,11]

Once-daily AUSTEDO XR may be taken at any time of day with or without food. AUSTEDO XR tablets should be swallowed whole and not chewed, crushed, or broken.[7]

## IMPORTANT SAFETY INFORMATION (CONTINUED)

**Parkinsonism:** AUSTEDO XR and AUSTEDO may cause parkinsonism in patients with Huntington's disease or tardive dyskinesia. Parkinsonism has also been observed with other VMAT2 inhibitors. The risk of parkinsonism may be increased by concomitant use of dopamine antagonists or antipsychotics. If a patient develops parkinsonism, the AUSTEDO XR or AUSTEDO dose should be reduced; some patients may require discontinuation of therapy.

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### Table 2.2. Metabolic Profile Allows for Few Restrictions Related to Drug-Drug Interactions[10,14]

**No dose restrictions up to 36 mg/day for patients starting AUSTEDO XR® (deutetrabenazine) extended-release tablets**

| | AUSTEDO XR | Ingrezza® (valbenazine) |
|---|---|---|
| Strong CYP3A4/5 inducer | No dose restriction | Concomitant use is not recommended |
| Strong CYP3A4/5 inhibitor | No dose restriction | 40 mg/day lowest dose available |
| Strong CYP2D6 inhibitor (or if patient is a poor CYP2D6 metabolizer) | Up to 36 mg/day | 40 mg/day lowest dose available |
| P-gp substrate (eg, calcium channel blockers, statins, antimicrobials, and digoxin) | No dose adjustment to P-gp substrate required | Dose adjustment to P-gp substrate may be required |

*These differences should not be construed to imply differences in safety, efficacy, or clinical outcome.*

**No clinically significant QT prolongation up to the maximum recommended dose of AUSTEDO (48 mg/day).**

### Figure 2.3. 4-Week Titration Kit Available Through Prescription[10]

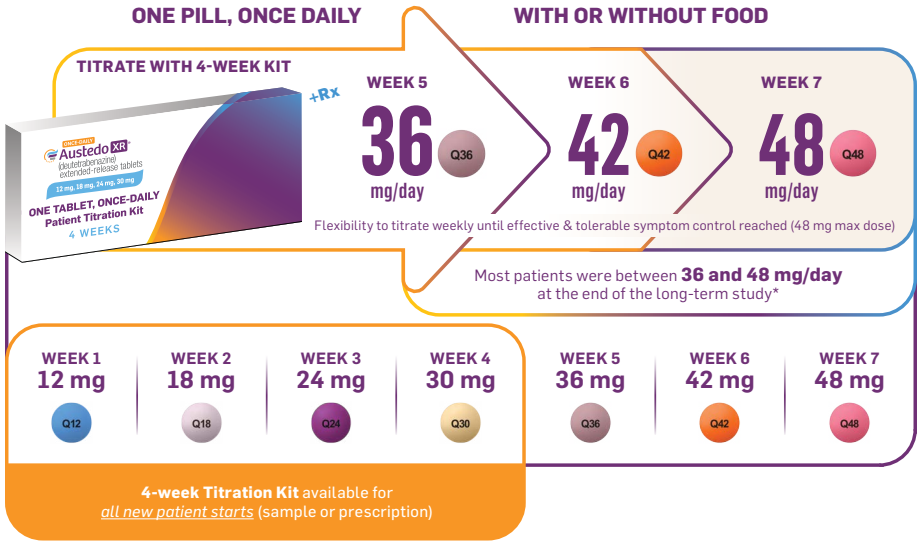


*Image shown is not the actual 4-week Titration Kit. Tablets not shown to actual size.*

**Patients in the pivotal and long-term studies received the AUSTEDO BID formulation.**
**52% of patients at Week 145.*

## Getting Your Residents Started on AUSTEDO XR

Residents can get started on AUSTEDO XR with a prescription for the 4-week Titration Kit at no cost using the 30-Day Free Trial Voucher. Upon completion of the kit, higher doses of AUSTEDO XR (up to a maximum dose of 48 mg/day) may be prescribed to ensure the patient receives the daily dose that is most effective and tolerable **(Figure 2.3, upper part)**.[10]

## Summary

Residents in LTC facilities frequently have multiple comorbidities requiring a variety of medications, increasing the risk of DDIs.[13] However, healthcare professionals do not need to adjust the dosing of AUSTEDO XR due to potential DDIs for patients taking strong CYP3A4/5 inducers and inhibitors. Additionally, the dosage of AUSTEDO XR can be maintained at up to 36 mg/day for patients on strong CYP2D6 inhibitors.[7]

AUSTEDO XR is a one pill, once-daily treatment for TD that provides flexibility to titrate until effective and tolerable symptom control is achieved.[7] ■

## IMPORTANT SAFETY INFORMATION (CONTINUED)

**Sedation and Somnolence:** Sedation is a common dose-limiting adverse reaction of AUSTEDO XR and AUSTEDO® (deutetrabenazine) tablets. Patients should not perform activities requiring mental alertness, such as operating a motor vehicle or hazardous machinery, until they are on a maintenance dose of AUSTEDO XR or AUSTEDO and know how the drug affects them. Concomitant use of alcohol or other sedating drugs may have additive effects and worsen sedation and somnolence.

**Please see additional Important Safety Information throughout and click here or visit www.AUSTEDOhcp.com to read/print the full Prescribing Information, including Boxed Warning, for AUSTEDO XR.**

# Expert Commentary With Dr Amita Patel and Ms Cindy Fronning

**Amita Patel, MD, CMD, MHA, CPE**
Geriatric Psychiatrist
Private Practice
Dayton, Ohio

**Cindy Fronning, RN, GERO-BC, CDONA, FACDONA, RAC-CT, IP-BC, AS-BC, ELFA, CALN**
NADONA Master Trainer and Executive Director
Lebanon, Ohio

This newsletter is produced by Teva Pharmaceuticals, and Dr Amita Patel and Ms Cindy Fronning were compensated by Teva for their insights.

**Q: What usually triggers you or someone on staff to screen for tardive dyskinesia (TD) in a resident?**

**Dr Patel:** In a long-term care setting, referrals for evaluation usually occur when the impact of movements leads to difficulties in activities of daily living, such as swallowing, speech, ambulation, and increased falls. An assessment may also be triggered if the resident is on dopamine receptor blocking agents.

**Ms Fronning:** I agree, noticing a change in a resident's abilities to perform activities of daily living and increased care needs are usually triggers to further observe and screen for TD. These changes are usually first noticed by a certified nursing assistant, or CNA, who closely works with the resident and helps them with their daily tasks. Other triggers may include observing involuntary movements such as shaking, toe tapping, or piano fingers, but in most cases, changes in behavior and abilities are noticed before the involuntary movements.

**Q: How often do you screen and assess residents who are at risk for TD? What best practices have been identified?**

**Dr Patel:** For residents at risk of TD, I usually do an assessment using the Clinical Global Impression scale at every visit, complemented by a formal quarterly evaluation using the Abnormal Involuntary Movement Scale, or AIMS, test. Assessments are conducted more frequently for residents who are undergoing gradual dose reduction of their antipsychotic drug, as reduction of an antipsychotic can unmask TD. In those patients, I recommend 1 to 2 assessments within a period of 4 to 6 weeks following discontinuation of the antipsychotic.

**Ms Fronning:** I'd like to add that, as a best practice, I encourage my nursing staff to assess for TD as part of the Minimum Data Set (MDS) process, a standardized assessment tool that's required on admission, periodically, and on discharge to assess the health status of the residents. This makes sure screening for TD is not missed. We also have a procedure in place to screen for TD in any new resident coming into the facility, as antipsychotics are frequently discontinued prior to their admission.

**Q: Could you describe the role of the various staff in the screening and assessment of TD in residents at risk?**

**Ms Fronning:** The primary responsibility for determining a plan and educating the staff on screening for TD and its impact lies with the Director of Nursing. At our facility, we try to provide consistent education to all staff members interacting with the residents, including CNAs, staff nurses, nurse managers, social workers, and activity staff. This makes each staff member responsible for knowing and reporting any involuntary movement or its impact. Once reported, a formal assessment is carried out by the nurse and clinician.

**Dr Patel:** I completely agree with Cindy that every staff member should be educated on the disease

## IMPORTANT SAFETY INFORMATION (CONTINUED)

**Hyperprolactinemia:** Tetrabenazine elevates serum prolactin concentrations in humans. If there is a clinical suspicion of symptomatic hyperprolactinemia, appropriate laboratory testing should be done and consideration should be given to discontinuation of AUSTEDO XR and AUSTEDO.

**Please see additional Important Safety Information throughout and click here or visit www.AUSTEDOhcp.com to read/print the full Prescribing Information, including Boxed Warning, for AUSTEDO XR.**

symptoms and the impact to ensure residents with TD are appropriately identified and treated.

**Q: What assessment(s) do you use to screen for TD in residents at risk?**
**Ms Fronning:** AIMS is the standard assessment used to evaluate the severity of TD symptoms. We frequently use AIMS in combination with the Impact-TD Scale, which assesses the impact of symptoms on the physical, social, psychological, and recreational domains.

**Dr Patel:** I agree. AIMS is used by most facilities as it is also a requirement for the MDS.

**Q: When you perform the AIMS examination, what modifications have you had to make for residents who use a wheelchair or are bedbound, or are cognitively impaired?**
**Dr Patel:** We often need to adjust or make modifications to the AIMS exam to meet the specific needs of our residents. For instance, residents who use wheelchairs should not be asked to stand or walk to minimize the risk of falls. Those who are bedbound can be observed from the side and should be assisted to sit up when necessary. Additionally, for residents with cognitive impairments, we sometimes have to perform the activation maneuver and encourage the resident to mimic our movements.

**Ms Fronning:** The considerations that Dr Patel notes should be communicated to the staff when educating them on how to perform the AIMS.

**Q: We know that TD can impact various aspects of residents' lives, regardless of the severity of movements. How do you assess the impact of TD in residents?**
**Ms Fronning:** Observing changes in behavior is usually the first indicator that TD symptoms are impacting the resident. Changes in behavior can include reluctance to engage in social activities like eating in the dining room or participating in events such as bingo. We also see difficulties with simple tasks like holding objects or swallowing, and they feel embarrassed being around other residents.

**Dr Patel:** Residents frequently report embarrassment because of their TD symptoms. One of my residents had difficulty eating and reported that she "wears her food." As a result, she was embarrassed to eat with other residents in the dining room. Another resident was unable to apply makeup, something that made her feel confident; maneuver her bingo chips; and do her artwork, resulting in her social withdrawal.

**Q: How does TD impact the staff?**
**Ms Fronning:** The care needs for residents with TD can be substantial. These residents often need help with everyday activities such as feeding, dressing, and moving around, frequently necessitating support from multiple staff members. They may also require assistance with walking or transportation, such as using a wheelchair, to complete daily activities. TD symptoms, irrespective of severity, affect the overall well-being of the resident, and the increased care needs of these residents can increase the staff's workload.

**Q: How does TD impact the facility?**
**Dr Patel:** TD symptoms, such as impaired ability to walk independently, increased need for assistance with daily activities, and falls resulting in injuries, can affect the quality measures used to determine the 5-star rating of a long-term care facility. Such symptoms can lead to a decline in patient mobility and safety, thereby negatively influencing these ratings. Additionally, complications arising from TD, like swallowing difficulties, may lead to aspiration pneumonia or weight loss, resulting in increased hospitalization rates that can further adversely impact the facility's rating. Residents facing these challenges also tend to exhibit high utilization of physical, occupational, and speech therapy, which affects the facility's overall resource utilization.

**Q: Are there any special considerations for treating TD in residents?**
**Dr Patel:** Any resident in our facility who is impacted by TD is treated. One challenge we face with treating TD is for residents in prolonged hospice care, as many hospices do not allow initiation of new medications.

## IMPORTANT SAFETY INFORMATION (CONTINUED)

**Binding to Melanin-Containing Tissues:** Deutetrabenazine or its metabolites bind to melanin-containing tissues and could accumulate in these tissues over time. Prescribers should be aware of the possibility of long-term ophthalmologic effects.

**Please see additional Important Safety Information throughout and click here or visit www.AUSTEDOhcp.com to read/print the full Prescribing Information, including Boxed Warning, for AUSTEDO XR.**

**Ms Fronning:** In my opinion, there is a need for increased awareness and education among facilities to correctly recognize TD and ensure that it is treated.

**Q: How does the potential for drug-drug interactions play into treatment selection for TD?**

**Dr Patel:** Careful consideration of comorbid medications is essential when assessing the impact of drug-drug interactions. It is especially critical for residents as they are typically on multiple medications, thereby influencing treatment choices.

**Q: What has been your experience with AUSTEDO XR, a VMAT2 inhibitor, for the treatment of TD in residents?**

AUSTEDO XR® (deutetrabenazine) extended-release tablets offers a one pill, once-daily dosing regimen with 7 approved dose options, enabling clinicians to adjust the dose as needed to achieve symptom control while maintaining tolerability.

**Dr Patel:** AUSTEDO XR offers a flexible one pill, once-daily dosing regimen with 7 approved doses, enabling clinicians to adjust the dose as needed to achieve optimal symptom control while maintaining tolerability. AUSTEDO XR has no dose restriction when used alongside strong CYP3A4/5 inducers or inhibitors. However, if a patient's treatment plan includes a strong CYP2D6 inhibitor or if the patient is genetically a poor CYP2D6 metabolizer, the daily dose of AUSTEDO XR should not exceed 36 mg/day, which still provides 5 doses to maintain flexibility when treating these patients. ■

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