Choosing Wisely®

An initiative of the ABIM Foundation

AMDA – The Society for Post-Acute and Long-Term Care Medicine™

THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE™

Fifteen Things Physicians and Patients Should Question

1 Don't insert percutaneous feeding tubes in individuals with advanced dementia. Instead, offer oral assisted feedings.

Strong evidence exists that artificial nutrition does not prolong life or improve quality of life in patients with advanced dementia. Substantial functional decline and recurrent or progressive medical illnesses may indicate that a patient who is not eating is unlikely to obtain any significant or long-term benefit from artificial nutrition. Feeding tubes are often placed after hospitalization, frequently with concerns for aspirations, and for those who are not eating. Contrary to what many people think, tube feeding does not ensure the patient's comfort or reduce suffering; it may cause fluid overload, diarrhea, abdominal pain, local complications, less human interaction and may increase the risk of aspiration. Assistance with oral feeding is an evidence-based approach to provide nutrition for patients with advanced dementia and feeding problems.

2 Don't use sliding scale insulin (SSI) for long-term diabetes management for individuals residing in the nursing home.

SSI is a reactive way of treating hyperglycemia after it has occurred rather than preventing it. Good evidence exists that SSI is neither effective in meeting the body's physiologic insulin needs nor is it efficient in the long-term care (LTC) setting in medically stable individuals. Use of SSI is associated with more frequent glucose checks and insulin injections, leads to greater patient discomfort and increased nursing time and resources. With SSI regiments, patients may be at risk from wide glucose fluctuations or hypoglycemia when insulin is given when food intake is erratic.

3 Don't obtain urine tests until clinical criteria are met.

Clinical uncertainty surrounding asymptomatic bacteriuria (ASB) and/or pyuria is the major driver for overtreatment of Urinary Tract Infections (UTI) in PALTC, (Nace). Colonization (a positive bacterial culture without signs or symptoms of a localized UTI) is a common problem in PALTC facilities that contributes to the over-use of antibiotic therapy in this setting, leading to an increased risk of diarrhea or other adverse drug events, resistant organisms, and infection due to Clostridioides difficile. An additional concern is that the finding of asymptomatic bacteriuria may lead to an erroneous assumption that a UTI is the cause of an acute change of status, hence failing to detect or delaying the timely detection of 5 signs and symptoms likely indicative of uncomplicated cystitis. These include dysuria, and one or more of the following: frequency, urgency, supra-pubic pain or gross hematuria. In the presence of dysuria and one or more sign/symptom, collection of a urine culture is indicated.

4 Don't prescribe antipsychotic medications for behavioral and psychological symptoms of dementia (BPSD) in individuals with dementia without an assessment for an underlying cause of the behavior.

Careful differentiation of cause of the symptoms (physical or neurological versus psychiatric, psychological) may help better define appropriate treatment options. The therapeutic goal of the use of antipsychotic medications is to treat patients who present an imminent threat of harm to self or others, or are in extreme distress – not to treat nonspecific agitation or other forms of lesser distress. Treatment of BPSD in association with the likelihood of imminent harm to self or others includes assessing for and identifying and treating underlying causes (including pain; constipation; and environmental factors such as noise, being too cold or warm, etc.), ensuring safety, reducing distress and supporting the patient's functioning. If treatment of other potential causes of the BPSD is unsuccessful, antipsychotic medications can be considered, taking into account their significant risks compared to potential benefits. When an antipsychotic is used for BPSD, it is advisable to obtain informed consent.

Refer to F-758: Free from Unnecessary Psychotropic Medications/PRN Use. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

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5

Don't routinely prescribe lipid-lowering medications in individuals with a limited life expectancy.

Hypercholesterolemia, or low HDL-C, is an important risk factor for all-cause mortality, coronary heart disease mortality, hospitalization for myocardial infarction or unstable angina in persons older than 70 years. In fact, studies show that elderly patients with the lowest cholesterol have the highest mortality after adjusting other risk factors. In addition, a less favorable risk-benefit ratio may be seen for patients older than 85, where benefits may be more diminished and risks from statin drugs more increased (cognitive impairment, falls, neuropathy and muscle damage).

6

Don't place an indwelling urinary catheter to manage urinary incontinence.

The most common source of bacteremia in the post-acute and long-term care (PA/LTC) setting is the bladder when an indwelling urinary catheter is in use. The federal Healthcare Infection Control Practices Advisory Committee (HICPAC) recommends minimizing urinary catheter use and duration of use in all patients. Specifically, HICPAC recommends not using a catheter to manage urinary incontinence in the PA/LTC setting. Appropriate indications for indwelling urinary catheter placement include acute retention or outlet obstruction, to assist in healing of deep sacral or perineal wounds in patients with urinary incontinence, and to provide comfort at the end of life if needed.

7

Don't recommend screening for breast, colorectal or prostate cancer if life expectancy is estimated to be less than 10 years.

Many patients residing in the LTC setting are elderly and frail, with multimorbidity and limited life expectancy. Although research evaluating the impact of screening for breast, colorectal and prostate cancer in older adults in general and LTC residents in particular is scant, available studies suggest that multimorbidity and advancing age significantly alter the risk-benefit ratio. Preventive cancer screenings have both immediate and longer term risks (e.g., procedural and psychological risks, false positives, identification of cancer that may be clinically insignificant, treatment-related morbidity and mortality). Benefits of cancer screening occur only after a lag time of 10 years (colorectal or breast cancer) or more (prostate cancer). Patients with a life expectancy shorter than this lag time are less likely to benefit from screening. Discussing the lag time ("When will it help?") with patients is at least as important as discussing the magnitude of any benefit ("How much will it help?"). Prostate cancer screening by prostate-specific antigen testing is not recommended for asymptomatic patients because of a lack of life-expectancy benefit. One-time screening for colorectal cancer in older adults who have never been screened may be cost-effective; however, it should not be considered after age 85 and for most LTC patients older than 75 the burdens of screening likely outweigh any benefits.

8

Don't obtain a C. difficile toxin test to confirm "cure" if symptoms have resolved.

Patients residing in PA/LTC facilities are particularly at risk for CDI because of advanced age, frequent hospitalizations and frequent antibiotic exposure. However, only symptomatic patients should be tested. Furthermore, studies have shown that C. difficile tests may remain positive for as long as 30 days after symptoms have resolved. False positive "test-of-cure" specimens may complicate clinical care and result in additional courses of inappropriate anti-C. difficile therapy. To limit the spread of C. difficile, care providers in the PA/LTC setting should concentrate on early detection of symptomatic patients and the consistent use of proper infection control practices, including hand washing with soap and water, contact precautions, and environmental cleaning with 1:10 dilution of sodium hypochlorite (bleach) prepared fresh daily.

9

Don't recommend aggressive or hospital-level care for a frail elder without a clear understanding of the individual's goals of care and the possible benefits and burdens.

Hospital-level care has known risks, including delirium, infections, side effects of medications and treatments, disturbance of sleep, and loss of mobility and function. These risks are often more significant for patients in the PA/LTC setting, who are more likely to be frail and to have multimorbidity, functional limitations and dementia. Therefore, for some frail elders, the balance of benefits and harms of hospital-level care may be unfavorable. To avoid unnecessary hospitalizations, care providers should engage in advance care planning by defining goals of care for the patient and discussing the risks and benefits of various interventions, including hospitalization, in the context of prognosis, preferences, indications, and the balance of risks and benefits. Advance directives such as the Physician Orders for Life Sustaining Treatment (POLST) paradigm form and Do Not Hospitalize (DNH) orders communicate a patient's preferences about end-of-life care. Patients with DNH orders are less likely to be hospitalized than those who do not have these directives. Patients who opt for less-aggressive treatment options are less likely to be subjected to unnecessary, unpleasant and invasive interventions and the risks of hospitalization.

10

Don't initiate antihypertensive treatment in frail individuals ≥60 years of age for systolic blood pressure (SBP) <150 mm Hg or diastolic blood pressure (DBP) <90 mm Hg.

There is strong evidence for the treatment of hypertension in older adults. Achieving a goal SBP of 150mm Hg reduces stroke incidence, all-cause mortality and heart failure. There is less consistent evidence that lower BP targets are beneficial for high-risk patients, especially frail patients in the post-acute and long-term care setting. Target SBP and DBP levels should be based on shared decision-making with the patient as there is data supporting benefit in treating more aggressively to a goal SBP of <140mm Hg in community-dwelling individuals ≥75 years of age with elevated cardiovascular risk. Using a reliable, representative method of taking blood pressures with special attention to orthostatic hypotension is important, as orthostatic hypotension has been associated with increased mortality and cardiovascular events. In addition, moderate or high-intensity treatment of hypertension has been associated with an increased risk of serious falls and injury in frail older adults.

11

Don’t continue hospital-prescribed stress ulcer prophylaxis with Proton-Pump Inhibitor (PPI) therapy in the absence of an appropriate diagnosis in the post-acute and long-term care (PALTC) population.

In the absence of an appropriate diagnosis for the use of PPI’s long-term in PALTC populations, stop hospital prescribed medications for stress prophylaxis, as literature does not support PPI use for stress ulcer prophylaxis outside the Intensive Care Unit setting. It is important to determine the indication for use and balance potential harm versus benefit recognizing known adverse events with long-term PPI use, including pneumonia, diminished vitamin absorption and bacterial infections such as Clostridium Difficile.

12

Don’t order routine follow up chest imaging for post-acute and long-term care residents with community acquired pneumonia whose symptoms have resolved within 5–7 days.

Radiographic findings tend to lag behind clinical response. Obtaining routine follow up chest radiograph in patients with CAP who have responded to prescribed therapy is therefore not indicated and does not improve care outcomes. This approach is similar to that outlined by the American Thoracic Society (ATS) and Infectious Diseases Society of America (IDSA), both of whom recommend not obtaining a follow-up chest radiograph in patients whose symptoms have resolved within five to seven days.

13

Don’t routinely continue sedative hypnotics (Restoril, Ambien), diphenhydramine (Benadryl), benzodiazepines, or Serotonin Modulators (Trazadone) for long-term treatment of insomnia in geriatric populations. Consider the use cognitive behavioral therapy as an alternative.

Use of diphenhydramine (or other first generation antihistamines), benzodiazepines or sedative hypnotics with anticholinergic side effects should be avoided as the data suggests these drugs may cause confusion and delirium in the short term, and some have been associated with an increased risk of dementia with long-term use. These drugs are associated with a five-fold increase in adverse cognitive events, an increase in adverse psychomotor events and are associated with an increased risk of falls. The 2019 updated Beers criteria for potentially inappropriate medications for use in older adults recognized these medications as problematic.

14

Don’t routinely prescribe or continue acetyl cholinesterase inhibitors or N-Methyl-D-Aspartate antagonists in patients with advanced dementia.

Use of acetyl cholinesterase inhibitors in mild to moderate dementia or NMDA antagonists in moderate to severe dementia may help with Behavioral and Psychological Symptoms of Dementia (BPSD) but have not been shown to prolong life. Once an individual is institutionalized, review of the risks and benefits of the medications should be reviewed periodically and de-prescribed when no longer demonstrating benefit to the patient. Acetyl cholinesterase inhibitors can worsen anorexia and NMDA receptor agonists are not indicated with severe renal insufficiency, both of which could be present in the older population.

15

Don’t provide long-term opioid therapy for chronic non-cancer pain in the absence of clear and documented benefits to functional status and quality of life.

Long-term use of opioids is common in the PALTC setting. The Society’s 2018 Position Statement on the use of opioids states that nursing home practitioners who prescribe opioids should do so based on thoughtful inter-professional assessment indicating a clear indication for opioid use.

For admitted residents on long term opioid therapy for chronic pain (not for cancer, palliative care, or end-of-life), tapering plans should be individualized and should minimize symptoms of opioid withdrawal while maximizing pain treatment with non-pharmacologic therapies and non-opioid medications.

Periodic review to evaluate risk factors for potential harms should be incorporated into the individualized plan of care. In addition, clinicians should offer alternative behavioral therapies, non-opioid analgesics and other non-pharmacologic treatments whenever available and appropriate.

How This List Was Created (1–5)

AMDA – The Society for Post -Acute and Long-Term Care Medicine convened a work group made up of members from the Clinical Practice Steering Committee (CPSC). Members of the CPSC include board certified geriatricians, certified medical directors, multi-facility medical directors, attending practitioners, physicians practicing in both office-based and nursing facility practice, physicians in rural, suburban and academic settings, those with university appointments, and more. It was important to AMDA that the workgroup chosen represent the core base of the AMDA membership. Ideas for the "five things" were solicited from the workgroup. Suggested elements were considered for appropriateness, relevance to the core of the specialty and opportunities to improve patient care. They were further refined to maximize impact and eliminate overlap, and then ranked in order of potential importance both for the specialty and for the public. A literature search was conducted to provide supporting evidence or refute the activities. The list was modified and a second round of selection of the refined list was sent to the workgroup for paring down to the final "top five" list. Finally, the work group chose its top five recommendations before submitting a final draft to the AMDA Executive Committee, which were then approved.

How This List Was Created (6–10)

The AMDA *Choosing Wisely®* endeavor utilized a similar procedure as published in JAMA Intern Med. 2014;174 (40:509-515 - A Top 5 List for Emergency Medicine for our five items.

The AMDA Clinical Practice Steering Committee acted as the Technical Expert Panel (TEP).

Phase 1 – The Clinical Practice Steering Committee (CPSC) along with the Infection Advisory Committee clinicians brainstormed an initial list of low-value clinical decisions that are under control of PA/LTC physicians that were thought to have a potential for cost savings.

Phase 2 – Each member of the CPSC selected five low-value tests considering the perceived contribution to cost (how commonly the item is ordered and the individual expense of the test/treatment/action), benefit of the item (scientific evidence to support use of the item in the literature or in guidelines); and highly actionable (use decided by PA/LTC clinicians only).

Phase 3 – A survey was sent to all AMDA members. Statements were phrased as specific overuse statements by using the word "don't," thereby reflecting the action necessary to improve the value of care.

Phase 4 – CPSC members reviewed survey results and chose the five items.

For more information, visit www.paltc.org.

How This List Was Created (11–15)

The AMDA Choosing Wisely project utilized procedures similar to previous workgroups.

In Phase 1 – The Clinical Practice Steering Committee (CPSC) solicited recommendations from members of the Society's five subcommittees.

In Phase 2 – Each member of the CPSC reviewed the submitted recommendations (with the goal to selecting the best five recommendations) considering the perceived contribution to cost, benefit of the item and scientific evidence to support use of the item in the literature or in guidelines. Based on the feedback of the CPSC, the recommendations were narrowed to five, revised, and supporting evidence was added.

Phase 3 – The revised five recommendations and sources were reviewed by the CPSC for final approval, and then approved by the Board of Directors.

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