Choosing Wisely®

An initiative of the ABIM Foundation

15 Things Physicians & Patients Should Question

Ali Mirza, MD, CMD

Disclosure

- Nothing to disclose as a possible conflict of interest
- Non generic names mentioned when headings were copied
- I may be lying about the number 15

Learning Objectives

1) Introduce the Choosing Wisely campaign
2) How it applies to Long term care
3) Help identify the barriers for following the recommendations
4) Encourage physician patient communication

- The goal of the ABIM Foundation's *Choosing Wisely* campaign was to spark conversations between clinicians and patients about what tests, treatments, and procedures are needed – and which ones are not.
- It began in 2012 with nine national specialty societies (representing 375,000 clinicians) offering 45 examples of tests or treatments that were commonly used in their fields but lacked strong supporting evidence.
- Between 2012 and 2023, more than 80 specialty societies highlighted additional examples.

80+

SPECIALTY SOCIETY PARTNERS

700+

RECOMMENDATIONS OF TESTS AND TREATMENTS THAT SPECIALTY SOCIETIES SAID WERE OVERUSED OR UNNECESSARY

30+

COUNTRIES REACHED

RESEARCH ARTICLE
EVIDENCE-BASED MEDICINE HEALTH AFFAIRS VOL. 36, NO. 11: GLOBAL HEALTH POLICY

Choosing Wisely Campaign: Valuable For Providers Who Knew About It, But Awareness Remained Constant, 2014–17

•Carrie H. Colla and
•Alexander J. Mainor
AFFILIATIONS
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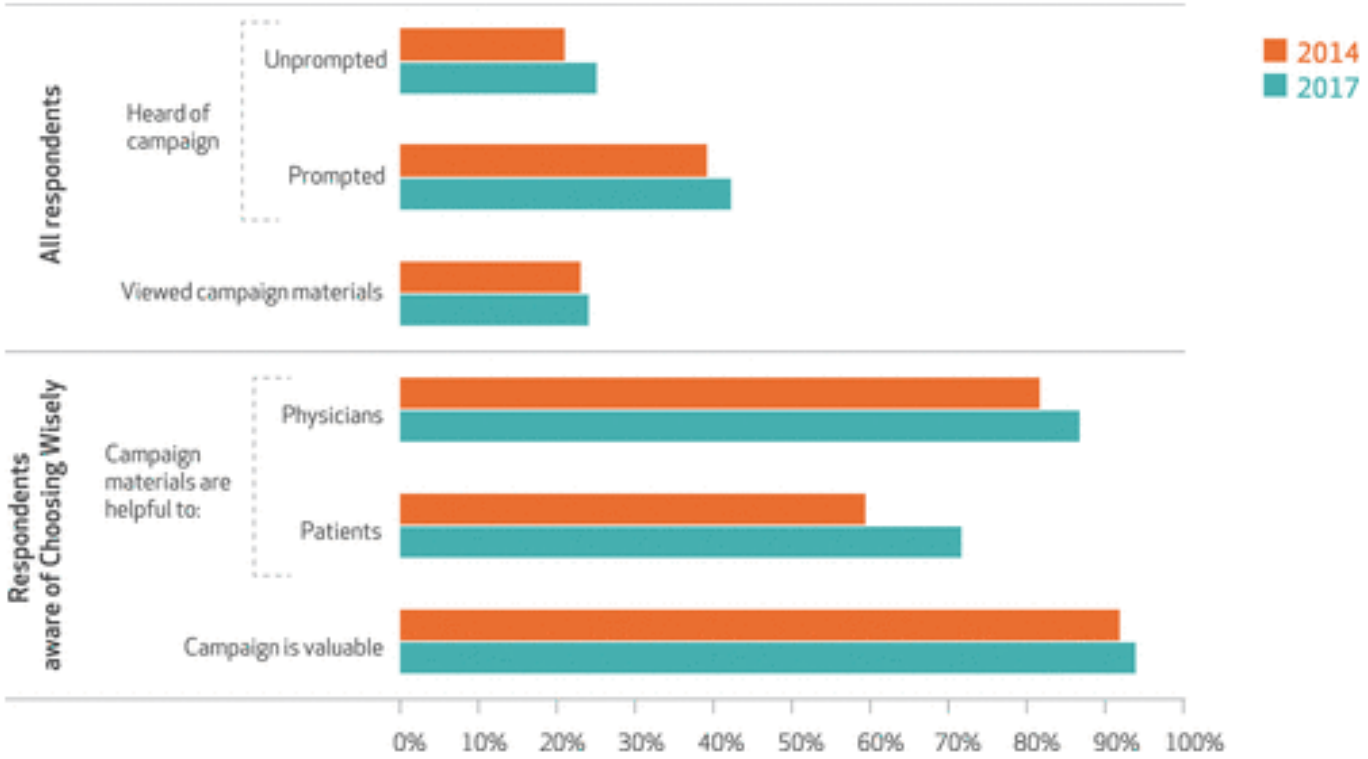
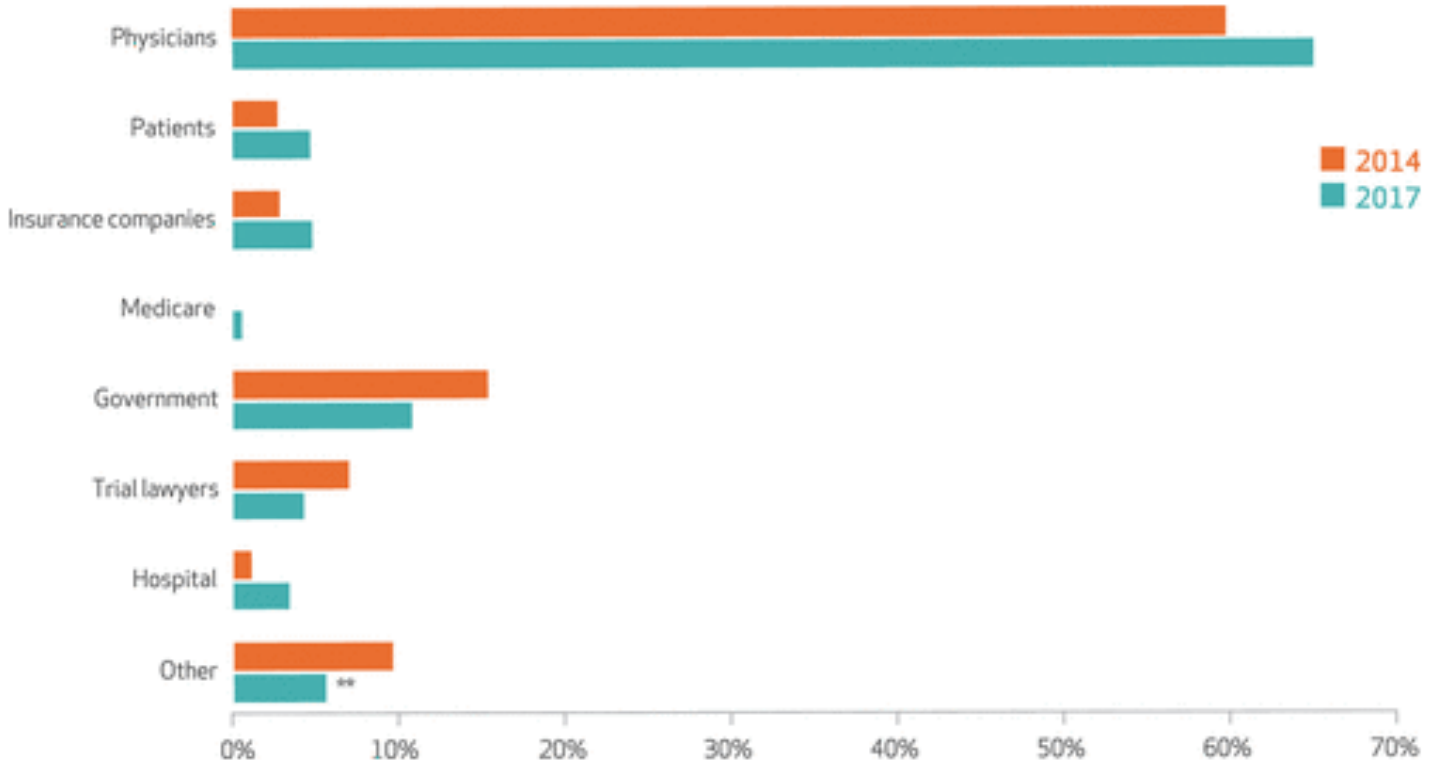
Exhibit 1 Percentages of physicians aware of the Choosing Wisely campaign and viewing it favorably, 2014 and 2017



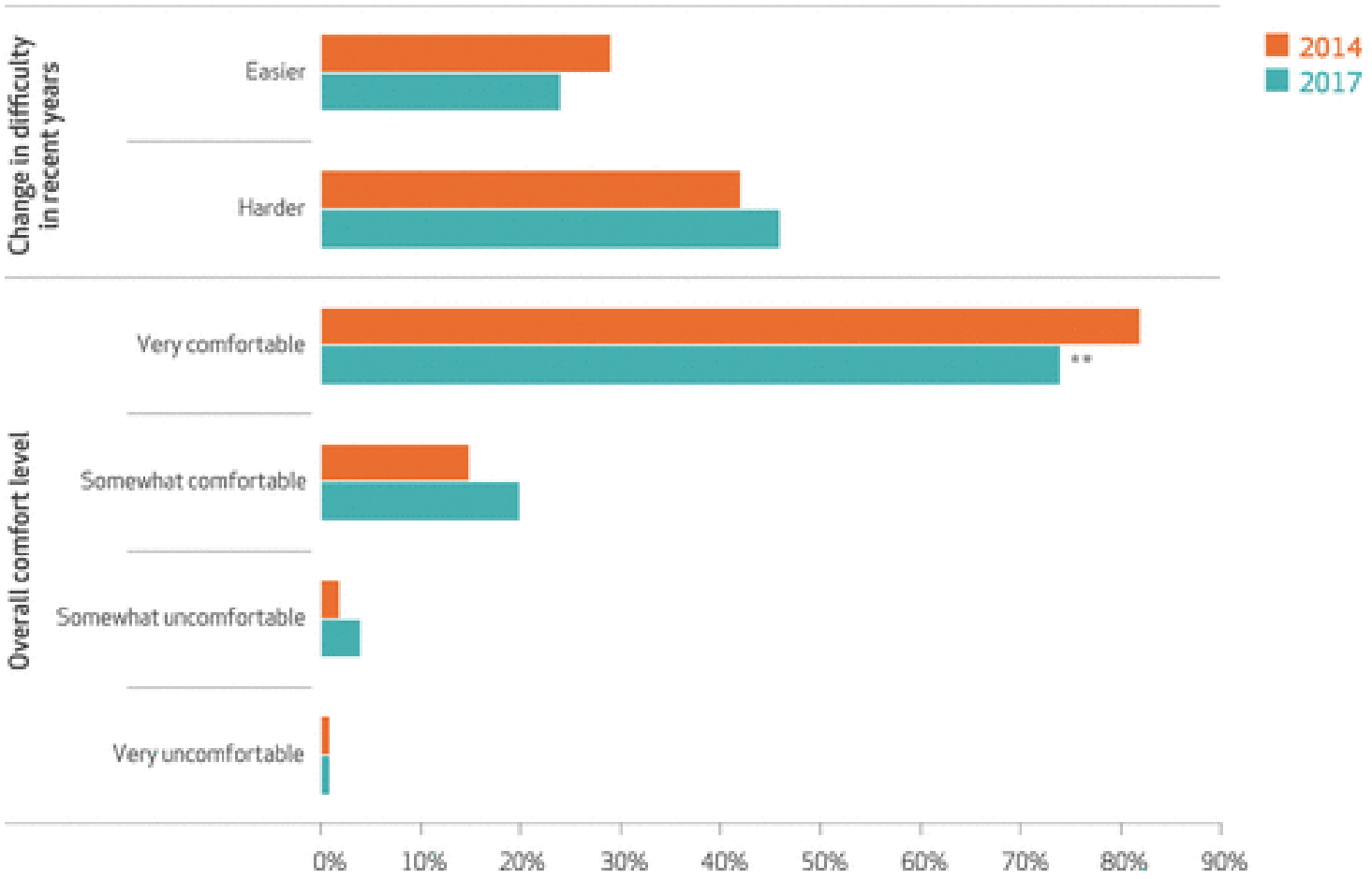
SOURCE Authors' analysis of data for 2014 and 2017 from ABIM Foundation surveys. NOTES "Unprompted" means without being prompted by hearing a description of the campaign. "Prompted" means hearing the description.

Exhibit 2 Percentages of physicians identifying the entity in the best position to address unnecessary care, 2014 and 2017



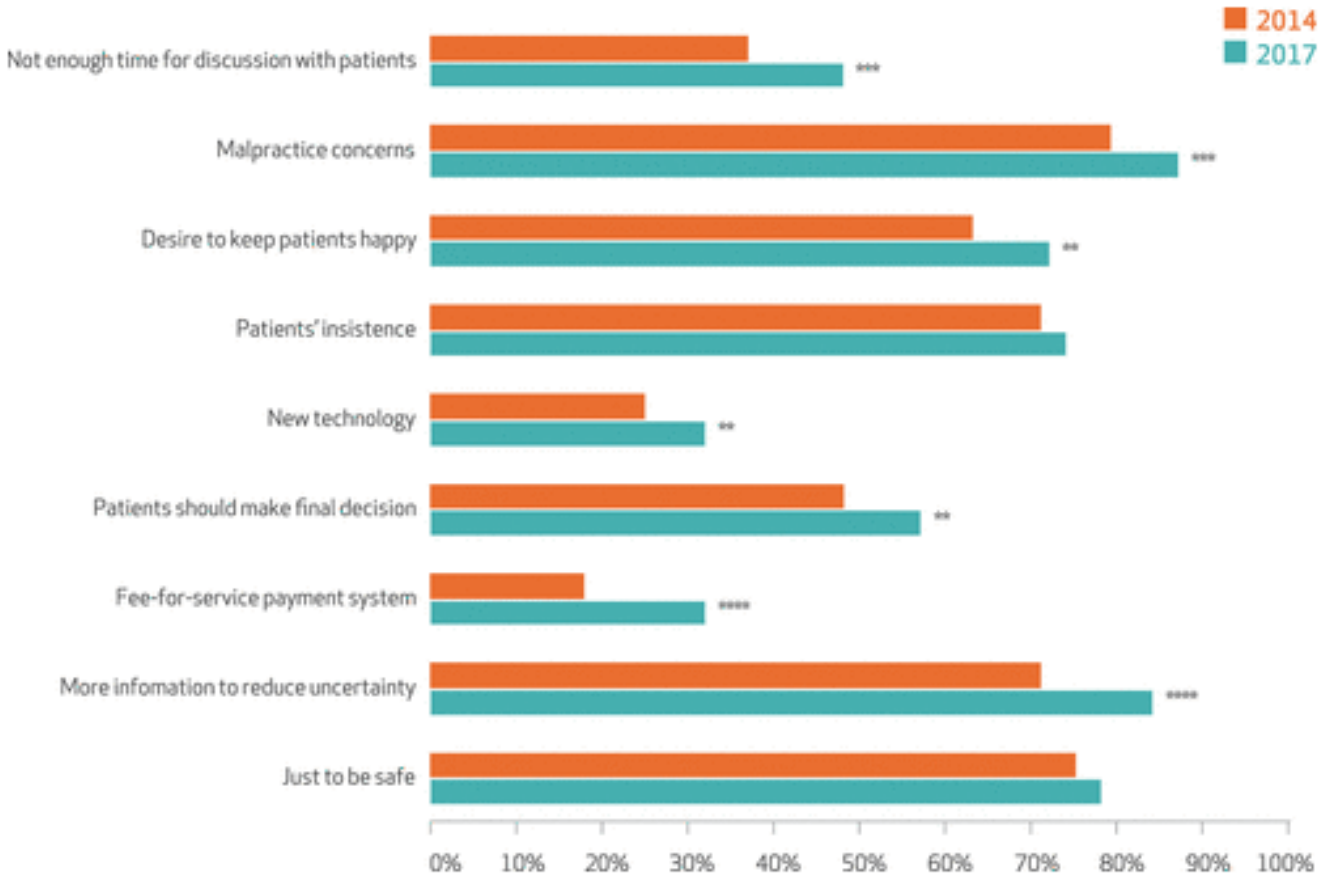
SOURCE Authors' analysis of data for 2014 and 2017 from ABIM Foundation surveys. NOTES No respondents in either year thought that drug companies were in the best position to address unnecessary care. No respondents in 2014 thought that Medicare was, either. $^{**}p < 0.05$

Exhibit 3 Percentages of physicians who were comfortable discussing low-value care with patients, 2014 and 2017



SOURCE Authors' analysis of data for 2014 and 2017 from ABIM Foundation surveys. $^{**}p < 0.05$

Exhibit 4 Percentages of physicians identifying reasons for provision of low-value care, 2014 and 2017



SOURCE Authors' analysis of data for 2014 and 2017 from ABIM Foundation surveys. $^{**}p < 0.05$ $^{***}p < 0.01$ $^{****}p < 0.001$

- The estimates of awareness of the Choosing Wisely campaign in this survey were considerably lower than other estimates.
- Primary care providers have shown greater awareness of the campaign than specialists.
- Reports of the following barriers to reducing the use of low-value care:

❑ Malpractice concerns,
❑ Patient demand for services,
❑ Concern about missing a serious diagnosis,
❑ Community standards of care,
❑ Lack of time to engage patients in shared decision making,
❑ Number of tests and treatments recommended by specialists,
❑ Proliferation of clinical performance measures with uncertain links to quality of care,
❑ Financial incentives.

Choosing Wisely in relation to Long Term Care

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CHOOSING WISELY AND THE AMERICAN GERIATRICS SOCIETY

1. Don't recommend percutaneous feeding tubes in patients with advanced dementia; instead offer oral assisted feeding.
2. Don't use antipsychotics as the first choice to treat behavioral and psychological symptoms of dementia.
3. Avoid using medications other than metformin to achieve hemoglobin A1c <7.5% in most older adults; moderate control is generally better.
4. Don't use benzodiazepines or other sedative-hypnotics in older adults as first choice for insomnia, agitation, or delirium.
5. Don't use antimicrobials to treat bacteriuria in older adults unless specific urinary tract symptoms are present.
6. Don't prescribe cholinesterase inhibitors for dementia without periodic assessment for perceived cognitive benefits and adverse gastrointestinal effects.
7. Don't recommend screening for breast, colorectal, prostate, or lung cancer without considering life expectancy and the risks of testing, overdiagnosis, and overtreatment.
8. Avoid using prescription appetite stimulants or high-calorie supplements for treatment of anorexia or cachexia in older adults; instead, optimize social supports, discontinue medications that may interfere with eating, provide appealing food and feeding assistance, and clarify patient goals and expectations.
9. Don't prescribe a medication without conducting a drug regimen review.
10. Don't use physical restraints to manage behavioral symptoms of hospitalized older adults with delirium.

Choosing Wisely®

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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 functi decline and recurrent or progressive medical illnesses may indicate that a patient who is not eating is unlikely to obtain any significant or long benefit from artificial nutrition. Contrary to what many people think, tube feeding does not ensure the patient's comfort or reduce suffering; it cause fluid overload, diarrhea, abdominal pain, local complications, less human interaction and may increase the risk of aspiration. Assistance 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 managemer 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 mee 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 m frequent glucose checks and insulin injections, leads to greater patient discomfort and increased nursing time and resources. With SSI regimens, patie 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.

Asymptomatic bacteriuria (ASB) and/or pyuria is common in residents in PALTC and is the major driver for overuse of antibiotics for Urinary Tra Infections (UTI), leading to an increased risk of adverse drug events, resistant organisms, and infection due to Clostridioides difficile. Due to the hi rate of bacterial colonization of urine in older adults, it is important to avoid obtaining a urinalysis or urine culture unless the resident has sign symptoms suggestive of UTI such as dysuria, and one or more of the following: frequency, urgency, suprapubic pain or gross hematuria. An additi concern is that the finding of bacteriuria/pyuria without urinary symptoms (ASB) may lead to an erroneous assumption that a UTI is the cause of acute change of status, hence failing to detect or delaying the timely detection of an alternative source of infection.

4 Don't prescribe antipsychotic medications for behavioral and psychologic symptoms of dementia (BPSD) in individuals with dementia unless management of potential underlying causes fails to respond to best treatment practices. Only use for symptoms that severely impact quality of life or safety from self and/or others, in lowest dose possible and with frequent re-assessment for necessity and efficacy.

Careful differentiation of cause of the symptoms (physical or neurological versus psychiatric, psychological) may help better define appropriat treatment options. The therapeutic goal of the use of antipsychotic medications is to treat patients who present an imminent threat of harm to sel 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; constipatio 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 significa 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

Released September 4, 2013 (1–5); March 20, 2015 (6–10); #8 updated July 2, 2015; #3, 4, 5 & 8 updated July 1, 2019; November 22, 2020 (11–15); #4, 9, 10, & 13 updated July 6, 2021; Updated July

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

Hypercholesterolemia is an important risk factor for all-cause mortality, coronary heart disease mortality, hospitalization for myocardial infarction or unstable angina in persons with known CAD (i.e., secondary prevention) and among those up to age 75 years without prior CV events (i.e., primary prevention), for whom statins may have additional benefits. The strength of association between cholesterol and events is weaker in those with advanced age, and competing risks play a greater role particularly among those with frailty, comorbidity, physical or cognitive decline, or limited life expectancy. Both primary and secondary prevention should aim to achieve a net-benefit, balancing potential harm(s) of polypharmacy and side effects, and in some cases discontinuation may be reasonable. However, discontinuation of secondary prevention statin therapy should only be done after careful discussion of risk/benefit. Among high risk patients (i.e. with diabetes or multiple CV risk factors), without functional decline in whom there is a benefit to continuation of therapy but who develop side effects, consideration could be given to dose reduction.

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

Bacteremia are most commonly caused by UTIs in the post-acute and long-term care (PALTC) setting, the majority of which are catheter-related. 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 PALTC 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. Use of screening tests in patients with the shortest life expectancies is common even though they are the least likely to survive long enough to benefit from the intervention and the most likely to suffer complications of the intervention. 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). 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?"), and it is critical to elicit whether the patient's values and goals include pursuing a treatment if an abnormality is found. 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 PALTC are particularly at risk for CDI due to advanced age, frequent hospitalizations and frequent antibiotic exposure. Only symptomatic patients with diarrhea should be tested for C. difficile. Furthermore, 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 as well as prolonged isolation. To limit the spread of C. difficile, care providers in the PALTC setting should concentrate on early detection of symptomatic patients and the consistent use of proper infection control practices including the use of gloves, hand hygiene (with an alcohol-based hand rub or soap and water), contact precautions, and environmental cleaning with a sporicidal agent.

9 Don't recommend aggressive or hospital-level care for frail individuals 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. Multiple studies have shown an increase in cognitive decline following hospitalization, especially admissions involving intensive care and those in which delirium was identified. These risks are often more significant for patients in the PALTC setting, who are more likely to be frail, have multimorbidity, functional limitations, and dementia. Therefore, for some frail older adults, 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 and indications. 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. 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.

10 Don't initiate aggressive antihypertensive treatment in frail individuals ≥60 years of age. For frail individuals with hypertension, multiple medical comorbidities, and limited life expectancy, use clinical judgment, incorporate patient/family preferences, and evaluate risk/benefit in deciding on medication(s) and the intensity of control.

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, and data supports treating more aggressively to a goal SBP of <140mm Hg in community-dwelling individuals ≥75 years of age with elevated cardiovascular risk. However, more data is needed to guide treatment of hypertension in frail older adults in the post-acute and long-term care setting. Target SBP and DBP levels should be based on shared decision-making with the patient, with particular consideration of physiologic age and the presence of underlying coronary artery disease. Antihypertensive therapy may not be appropriate to initiate in some patients with severe frailty or geriatric syndromes, as moderate or high-intensity treatment of hypertension has been associated with an increased risk of serious falls and injury in frail older adults, and low BP targets have added risk for syncope in the context of dehydration, especially during periods of high ambient heat, diminished thirst sensitivity, as well as polypharmacy with other medications (Parkinson's, etc). 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. Careful initiation of a single agent with subsequent monitoring and evaluation for side effects can decrease the risk of adverse outcomes.

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 potential adverse events with long-term PPI use, including pneumonia, fracture, chronic kidney disease and bacterial infections such as Clostridioides 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 prescribe or continue sedative hypnotics such as Restoril or Ambien, diphenhydramine (Benadryl), benzodiazepines, or Serotonin Modulators (Trazadone) for long-term treatment of sleep disorders in geriatric populations. Consider the use of nonpharmacological interventions (e.g., physical activity, a regular schedule or cognitive behavioral therapy.)

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 proiong 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.

Post-acute and long-term care practitioners should prescribe opioids based on thoughtful inter-professional assessment indicating a clear indication for opioid use. Periodic review to evaluate risk factors for potential harms of long-term opioid therapy should be incorporated into the individualized plan of care. For 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. 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 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 PALTC 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 PALTC 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.

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 of 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.

9/4/13	List 1-5
3/20/15	List 6-10
7/1/19	Updated # 3, 4, 5, 8
11/22/20	List 11-15
7/6/21	Updated # 4, 9, 10, 13
7/28/22	Update List

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

- Artificial nutrition does not prolong life
- It does not improve quality of life
- Substantial functional decline and recurrent or progressive medical illnesses
- A patient who is not eating is unlikely to obtain any significant or long-term benefit from artificial nutrition.
- 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, agitation, local complications, less human interaction, possible need for restraint, 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 regimens, patients may be at risk from wide glucose fluctuations or hypoglycemia when insulin is given when food intake is erratic.
- Moderate diabetic control is better. A1c >7.5

3- **Don’t obtain urine tests until clinical criteria are met.**

- Asymptomatic bacteriuria (ASB) and/or pyuria is common in residents in PALTC
- Overuse of antibiotics for UTIs
- Increase risk of adverse drug events, resistant organisms, and C.diff
- High rate of bacterial colonization of urine in older adults
- Avoid obtaining a urinalysis or urine culture unless the resident has signs or symptoms suggestive of UTI such as dysuria, and one or more of the following: frequency, urgency, suprapubic pain or gross hematuria. (Revised McGeer Criteria)
- ASB 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 an alternative source of infection.

Revised McGeer Criteria

TABLE 5. Surveillance Definitions for Urinary Tract Infections (UTIs)

Criteria	Comments
A. For residents without an indwelling catheter (both criteria 1 and 2 must be present)	UTI should be diagnosed when there are localizing genitourinary signs and symptoms and a positive urine culture result. A diagnosis of UTI can be made without localizing symptoms if a blood culture isolate is the same as the organism isolated from the urine and there is no alternate site of infection. In the absence of a clear alternate source of infection, fever or rigors with a positive urine culture result in the noncatheterized resident or acute confusion in the catheterized resident will often be treated as UTI. However, evidence suggests that most of these episodes are likely not due to infection of a urinary source.
1. At least 1 of the following sign or symptom subcriteria	
a. Acute dysuria or acute pain, swelling, or tenderness of the testes, epididymis, or prostate	
b. Fever or leukocytosis (see Table 2) and at least 1 of the following localizing urinary tract subcriteria	
i. Acute costovertebral angle pain or tenderness	
ii. Suprapubic pain	
iii. Gross hematuria	
iv. New or marked increase in incontinence	
v. New or marked increase in urgency	
vi. New or marked increase in frequency	
c. In the absence of fever or leukocytosis, then 2 or more of the following localizing urinary tract subcriteria	
i. Suprapubic pain	
ii. Gross hematuria	
iii. New or marked increase in incontinence	
iv. New or marked increase in urgency	
v. New or marked increase in frequency	
2. One of the following microbiologic subcriteria	Urine specimens for culture should be processed as soon as possible, preferably within 1–2 h. If urine specimens cannot be processed within 30 min of collection, they should be refrigerated. Refrigerated specimens should be cultured within 24 h.
a. At least 10^5 cfu/mL of no more than 2 species of microorganisms in a voided urine sample	
b. At least 10^2 cfu/mL of any number of organisms in a specimen collected by in-and-out catheter	
B. For residents with an indwelling catheter (both criteria 1 and 2 must be present)	Recent catheter trauma, catheter obstruction, or new-onset hematuria are useful localizing signs that are consistent with UTI but are not necessary for diagnosis.
1. At least 1 of the following sign or symptom subcriteria	
a. Fever, rigors, or new-onset hypotension, with no alternate site of infection	
b. Either acute change in mental status or acute functional decline, with no alternate diagnosis and leukocytosis	
c. New-onset suprapubic pain or costovertebral angle pain or tenderness	
d. Purulent discharge from around the catheter or acute pain, swelling, or tenderness of the testes, epididymis, or prostate	
2. Urinary catheter specimen culture with at least 10^5 cfu/mL of any organism(s)	Urinary catheter specimens for culture should be collected following replacement of the catheter (if current catheter has been in place for >14 d).

NOTE. Pyuria does not differentiate symptomatic UTI from asymptomatic bacteriuria. Absence of pyuria in diagnostic tests excludes symptomatic UTI in residents of long-term care facilities. cfu, colony-forming units.

Suspected UTI Protocol - *without catheter*

DYSURIA or **FEVER** or **WBC** blood or **2 OF** or **Other**

+ 1 (FEVER)

- Frequency
- Urgency
- Incontinence
- Hematuria
- Pain Suprapubic or Renal

+ 1 (WBC blood)

- Frequency
- Urgency
- Incontinence
- Hematuria
- Pain Suprapubic or Renal

2 OF

- Frequency
- Urgency
- Incontinence
- Hematuria
- Pain Suprapubic or Renal

Other

* Call MD/NP/PA
* Obtain U/A with C/S
* May straight cath if necessary
* IVF or Clysis unless contraindicated
* Consider CBC and BMP
* MD/NP/PA may start Abx pending C/S result

* Call MD/NP/PA
* Monitor fluid intake
* Encourage oral fluids
* Consider IVF or clysis
* Vitals Q shift
* Re-evaluate in 24 hrs

Catheter

1 OF

- FEVER or CHILLS
- Mental Status Change
- DISCHARGE
- HEMATURIA
- Pain Suprapubic or Renal
- New HYPOTENSION

* Call MD/NP/PA
* U/A with C/S
* IVF or Clysis
* CBC and BMP
* Abx

4- **Don’t prescribe antipsychotic medications for behavioral and psychological symptoms of dementia (BPSD) in individuals with dementia unless management of potential underlying causes fails to respond to best treatment practices. Only use for symptoms that severely impact quality of life or safety from self and/or others, in lowest dose possible and with frequent re-assessment for necessity and efficacy.**

- 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
- Goal is not to treat nonspecific agitation or other forms of lesser distress
- Assessing for and identifying and treating underlying causes (including pain; constipation; 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.

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

- Hypercholesterolemia is an important risk factor for all-cause mortality, coronary heart disease mortality, hospitalization for myocardial infarction or unstable angina in persons with known CAD (i.e., secondary prevention) and among those up to age 75 years without prior CV events (i.e., primary prevention), for whom statins may have additional benefits.
- The strength of association between cholesterol and events is weaker in those with advanced age, and competing risks play a greater role particularly among those with frailty, comorbidity, physical or cognitive decline, or limited life expectancy.
- Both primary and secondary prevention should aim to achieve a net-benefit, balancing potential harm(s) of polypharmacy and side effects, and in some cases discontinuation may be reasonable.
- However, discontinuation of secondary prevention statin therapy should only be done after careful discussion of risk/benefit.
- Among high-risk patients (i.e. with diabetes or multiple CV risk factors), without functional decline in whom there is a benefit to continuation of therapy but who develop side effects, consideration could be given to dose reduction.

6- Don’t place an indwelling urinary catheter to manage urinary incontinence.

- Bacteremia are mostly caused by UTIs in the PALTC setting
- Majority of which are catheter-related.
- 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 PALTC setting.
- Appropriate indications for indwelling urinary catheter placement include:
  - Acute retention or outlet obstruction
  - Assist in healing of deep sacral or perineal wounds in patients with urinary incontinence
  - 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.

- Most residents are elderly and frail, with multimorbidity and limited life expectancy.
- 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).
- 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?"),
- Critical to elicit whether the patient's values and goals include pursuing a treatment if an abnormality is found.
- Prostate cancer screening by PSA 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.

- PALTC residents are at risk due to advanced age, frequent hospitalizations and frequent antibiotic exposure.
- Only symptomatic patients with diarrhea should be tested for C. difficile.
- 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 as well as prolonged isolation.
- Limit the spread of C. difficile with early detection of symptomatic patients and the consistent use of proper infection control practices including the use of gloves, hand hygiene, contact precautions, and environmental cleaning with a sporicidal agent.

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

- High risk of delirium, infections, side effects of medications and treatments, sleep disturbance, and loss of mobility and function.
- Increase in cognitive decline especially admissions involving intensive care and those in which delirium was identified.
- Risks are more significant for PALTC patients who are more likely to be frail, have multimorbidity, functional limitations, and dementia.
- Balance of benefits and harms of hospital-level care may be unfavorable.
- 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 and indications.
- 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.
- Advance Directives / MOLST

10- Don’t initiate aggressive antihypertensive treatment in frail individuals ≥60 years of age. For frail individuals with hypertension, multiple medical comorbidities, and limited life expectancy, use clinical judgment, incorporate patient/family preferences, and evaluate risk/benefit in deciding on medication(s) and the intensity of control.

- Strong evidence for the treatment of HTN in older adults.
- Achieving a goal SBP of 150mm Hg reduces stroke incidence, all-cause mortality and heart failure
- Data supports treating more aggressively to a goal SBP of <140mm Hg in community-dwelling individuals ≥75 years of age with elevated cardiovascular risk.
- However, more data is needed to guide treatment of HTN in frail older adults in the post-acute and long-term care setting.
- Target SBP and DBP levels should be based on shared decision-making with the patient, with particular consideration of physiologic age and the presence of underlying CAD
- Antihypertensive therapy may not be appropriate to initiate in some patients with severe frailty or geriatric syndromes, as moderate or high-intensity treatment of HTN has been associated with an increased risk of serious falls and injury and low BP targets have added risk for syncope in the context of dehydration, especially during periods of high ambient heat, diminished thirst sensitivity, as well as polypharmacy with other medications
- Orthostatic hypotension has been associated with increased mortality and cardiovascular events.
- Careful initiation of a single agent with subsequent monitoring and evaluation for side effects can decrease the risk of adverse outcomes.

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 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 potential adverse events with long-term PPI use, including pneumonia, fractures, chronic kidney disease and bacterial infections such as C. 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 prescribe or continue sedative hypnotics such as Restoril or Ambien, diphenhydramine (Benadryl), benzodiazepines, or Serotonin Modulators (Trazadone) for long-term treatment of sleep disorders in geriatric populations. Consider the use of nonpharmacological interventions (e.g., physical activity, a regular schedule or cognitive behavioral therapy.)

- Use of first-generation antihistamines, benzodiazepines or sedative hypnotics with anticholinergic side effects should be avoided
- They cause confusion and delirium in the short term
- 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
- Use of Benzos should be reserved for alcohol withdrawal, delerium tremens, or severe generalized anxiety disorder unresponsive to other therapies

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 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
- NMDA receptor agonists are not indicated with severe renal insufficiency
- Clinicians, caregivers and patients should discuss cognitive, functional and behavioral goals of treatment prior to beginning a trial of cholinesterase inhibitors
- Advance care planning, patient and caregiver education about dementia, diet and exercise and non-pharmacologic approaches to behavioral issues are integral to the care of patients with dementia
- If goals of treatment are not attained after a reasonable trial (e.g., 12 weeks), then consider discontinuing the medication
- Benefits of long-term therapy have not been well-established

12.1. **Mechanism of Action** Current theories on the pathogenesis of the cognitive signs and symptoms of Alzheimer's disease attribute some of them to a deficiency of cholinergic neurotransmission. Donepezil hydrochloride is postulated to exert its therapeutic effect by enhancing cholinergic function. This is accomplished by increasing the concentration of acetylcholine through reversible inhibition of its hydrolysis by acetylcholinesterase. There is no evidence that donepezil alters the course of the underlying dementing process.

Mechanism of Action and Pharmacodynamics Persistent activation of central nervous system N-methyl-D-aspartate (NMDA) receptors by the excitatory amino acid glutamate has been hypothesized to contribute to the symptomatology of Alzheimer's disease. Memantine is postulated to exert its therapeutic effect through its action as a low to moderate affinity uncompetitive (open-channel) NMDA receptor antagonist which binds preferentially to the NMDA receptor-operated cation channels. There is no evidence that memantine prevents or slows neurodegeneration in patients with Alzheimer's disease.

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.

- PALTC practitioners should prescribe opioids based on thoughtful inter-professional assessment indicating a clear indication for opioid use.
- Periodic review to evaluate risk factors for potential harms of long-term opioid therapy should be incorporated into the individualized plan of care.
- For residents on long term opioid therapy for chronic pain (not for cancer, palliative care, or end-of-life), tapering plans should be individualized
- Plan should minimize symptoms of opioid withdrawal while maximizing pain treatment. Clinicians should offer alternative behavioral therapies, non-opioid analgesics and other non-pharmacologic treatments whenever available and appropriate.

Bonus from AGS

AGS 8- Avoid using prescription appetite stimulants or high-calorie supplements for treatment of anorexia or cachexia in older adults; instead, optimize social supports, provide feeding assistance and clarify patient goals and expectations.

- Unintentional weight loss is a common problem for medically ill or frail elderly.
- Although high-calorie supplements increase weight in older people, there is no evidence that they affect other important clinical outcomes, such as quality of life, mood, functional status or survival.
- Use of megestrol acetate results in minimal improvements in appetite and weight gain, no improvement in quality of life or survival, and increased risk of thrombotic events, fluid retention and death.
- Beers criteria lists megestrol acetate and cyproheptadine as medications to avoid in older adults.
- Systematic reviews of cannabinoids, dietary polyunsaturated fatty acids (DHA and EPA), thalidomide and anabolic steroids, have not identified adequate evidence for the efficacy and safety of these agents for weight gain.
- Mirtazapine is likely to cause weight gain or increased appetite when used to treat depression, but there is little evidence to support its use to promote appetite and weight gain in the absence of depression.

AGS 9- Don’t prescribe a medication without conducting a drug regimen review.

- Older patients disproportionately use more prescription and non-prescription drugs than other populations
- Increased risk for side effects and inappropriate prescribing
- Polypharmacy may lead to diminished adherence, adverse drug reactions and increased risk of cognitive impairment, falls and functional decline.
- Medication review identifies high-risk medications, drug interactions and those continued beyond their indication.
- Medication review elucidates unnecessary medications and underuse of medications and may reduce medication burden.
- Annual review of medications is an indicator for quality prescribing in vulnerable elderly.

Conclusion

1. Feeding tubes
2. Sliding scale insulin
3. Urine test w/o UTI criteria
4. Antipsychotics
5. Lipid lower Rx
6. Foley cath for Incontinence
7. Cancer screening
8. C.diff post test
9. Aggressive/hospital level care
10. BP control
11. PPIs
12. Follow up CXR
13. Sedative hypnotics
14. Dementia Rx
15. Opiods

- Appetite stimulant
- Polypharmacy

That’s it
I promise

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