Choosing Wisely in LTC

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Ontario Long Term Care Clinicians. Practical Pearls in LTC
October 22, 2023

Faculty/Presenter Disclosure

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- **Relationships with financial sponsors:**
  - **Any direct financial relationships including receipt of honoraria:** None
  - **Memberships on advisory boards or speakers' bureau:**
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    - **Advisor for Choosing Wisely Canada LTC Steering Committee –** Unpaid
  - **Patents for drugs or devices**: None
  - **Other: financial relationships/investments:** None

Disclosure of Financial Support

- **This program has received no financial or in-kind support from any organization**

- **<u>Potential for conflict(s) of interest</u>:**
  - **None**

Mitigating Potential Bias

- N/A

Faculty/Presenter Disclosure

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- **Relationships with financial sponsors:**
  - **Any direct financial relationships including receipt of honoraria:**
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  - **Patents for drugs or devices**: None
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- **This program has received no financial or in-kind support from any organization**

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Mitigating Potential Bias

- N/A

Faculty/Presenter Disclosure

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  - **Any direct financial relationships including receipt of honoraria: McMaster University (re Ontario Osteoporosis Strategy), OCFP**
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Disclosure of Financial Support

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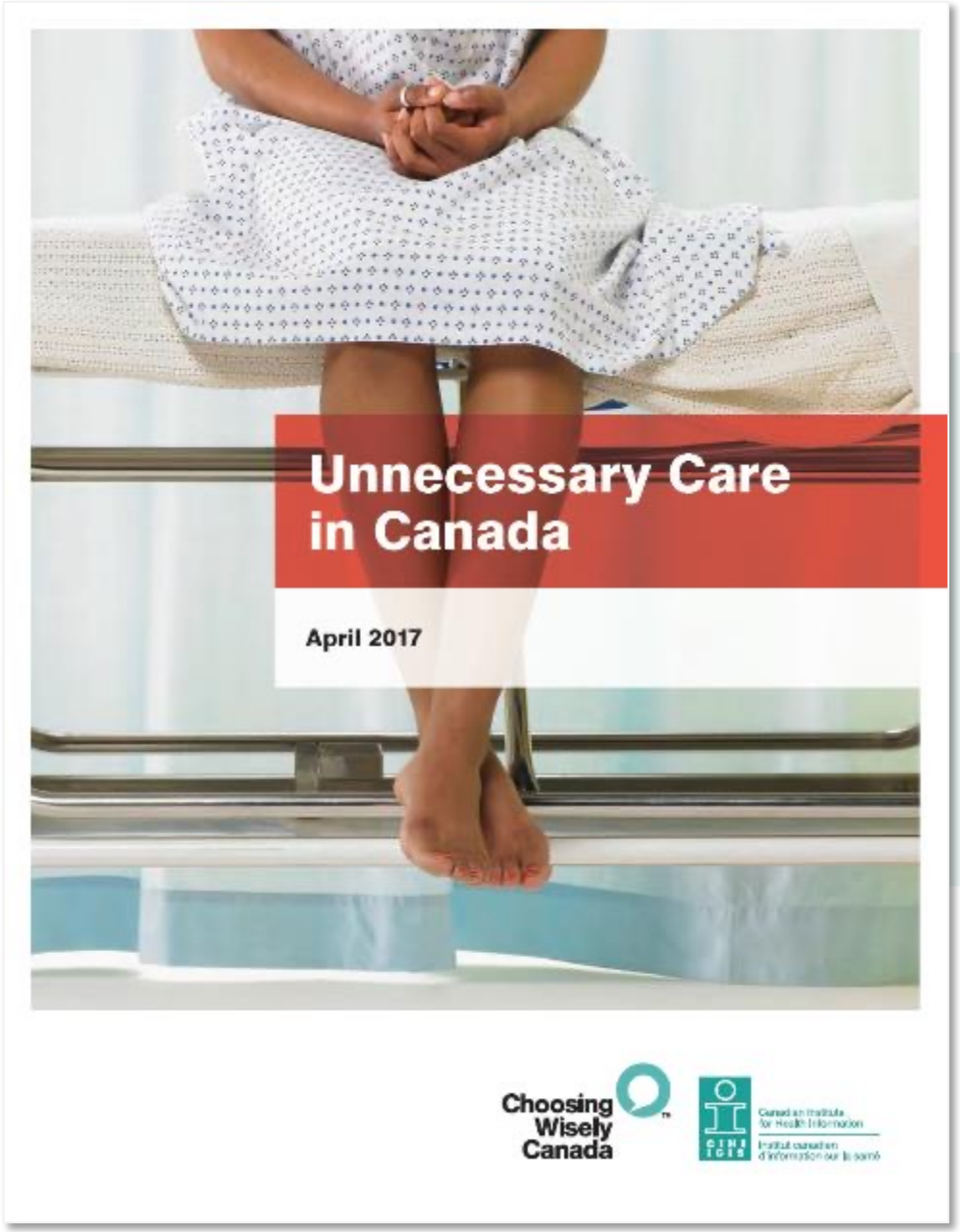
- **<u>Potential for conflict(s) of interest</u>:**
  - **None**

Mitigating Potential Bias

- N/A

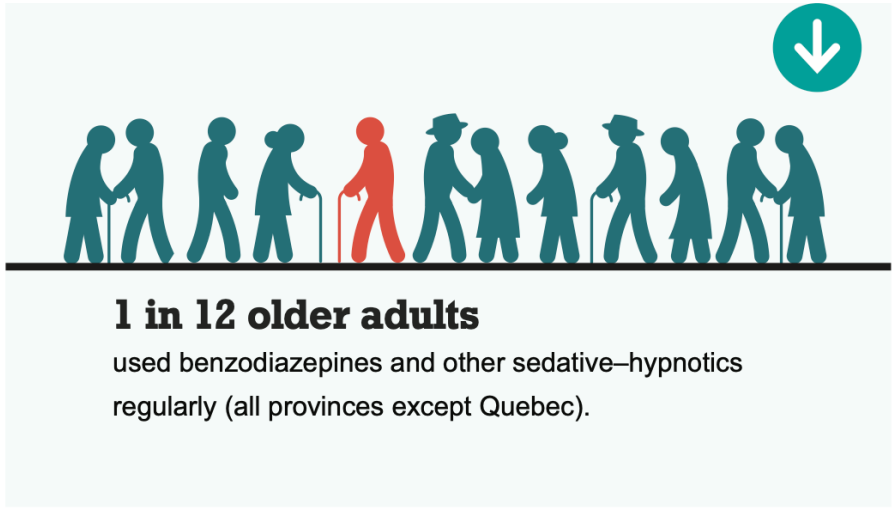
Objectives

1. Describe Choosing Wisely Canada recommendations for LTC residents
2. Examine approaches to avoid unnecessary hospital transfers and encourage goals of care conversations in LTC
3. Recognize approaches to avoiding potentially harmful medications for LTC residents



The report found that up to 30% of the tests, treatments and procedures associated with the 8 selected CWC recommendations are potentially unnecessary.

An example of unnecessary care



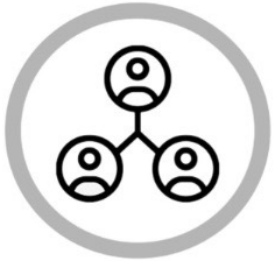
MORE IS NOT ALWAYS BETTER

www.ChoosingWisely.ca

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care.

What is unique about CWC?

Clinician led



Bottom-up approach

Evidence-based

Simple

Choosing Wisely Canada in LTC

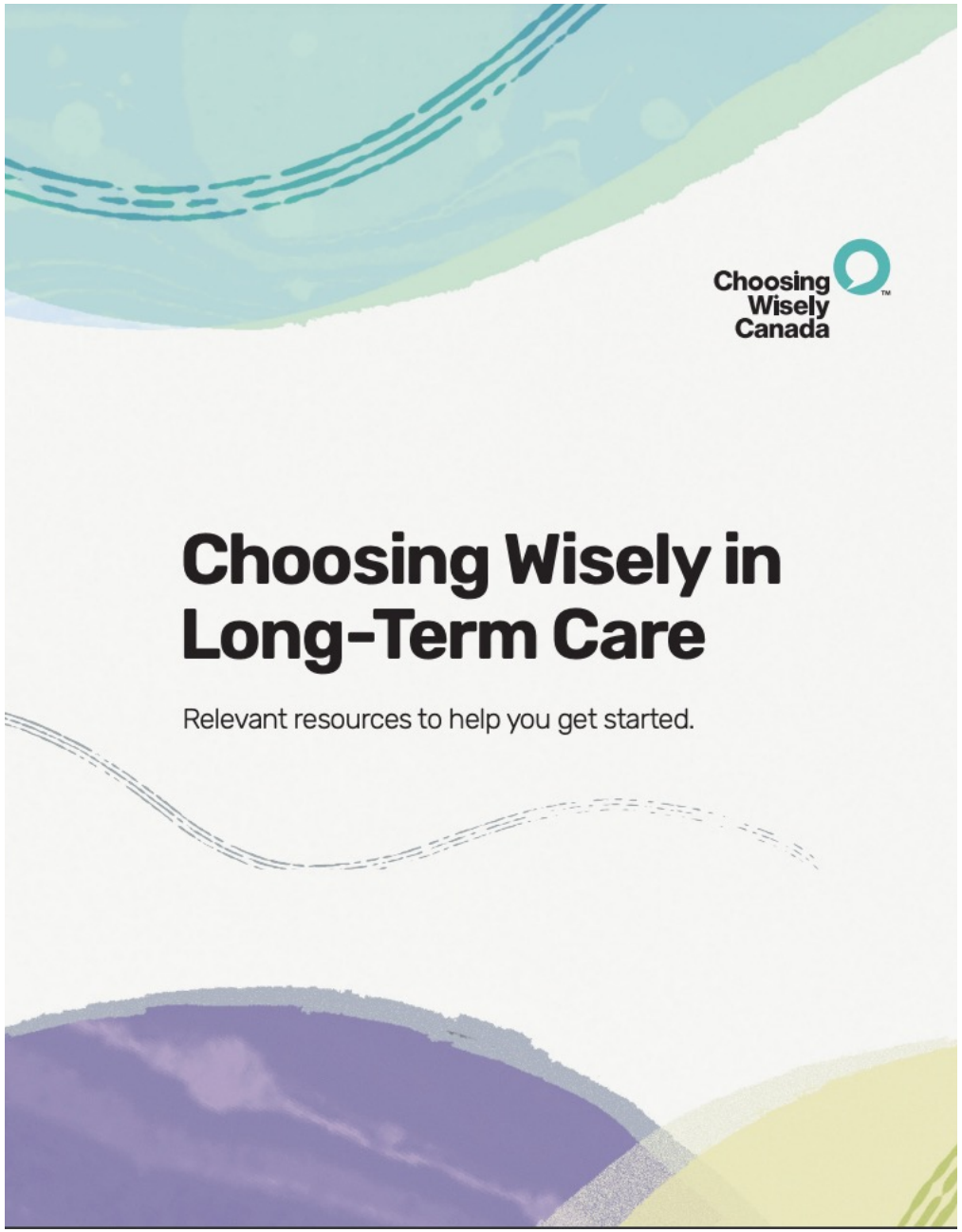
- CIHI has illustrated that long-term care settings are an area of interest for potential improvement
- Patients are more complex, have more comorbidities, and there is more uncertainty with the stewardship of their care
- 54% of patients in long-term care in Canada have dementia, making it difficult to communicate emerging illnesses
- Temptation to overtreat in this setting, to risk avoiding community spread in the home

Barriers to Appropriate Care in LTC

- Limited histories in cognitively impaired patients
- Blunted febrile responses in older patients
- Difficulty distinguishing infection from comorbidity mimickers
  - eg, pneumonia VS congestive heart failure and COPD
  - eg, venous stasis VS cellulitis
  - eg, altered mental status from dementia VS sepsis
- Variability in access to radiology and laboratory testing
- Off-site physicians
  - up to half of antibiotic prescriptions called in by phone

Nicolle *ICHE* 2000; Crnich *Drugs Aging* 2015; Katz *Arch*

- Check out the LTC Toolkit here! https://choosingwiselycanada.org/toolkit/choosing-wisely-ltc/



Long-Term Care

Make a change at your long-term care facility by putting recommendations into practice.

- Long-Term Care Recommendations
- Using Antibiotics Wisely
- Serious Illness Conversations
- QI Resources

Long-Term Care Recommendations

Developed by the Canadian Society for Long Term Care Medicine, these recommendations identify tests and treatments commonly used and could expose patients to harm.

View Recommendations

Long-Term Care Recommendations:
www.choosingwiselycanada.org/long-term-care/

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

CSLTCM | Canadian Society for Long-Term Care Medicine

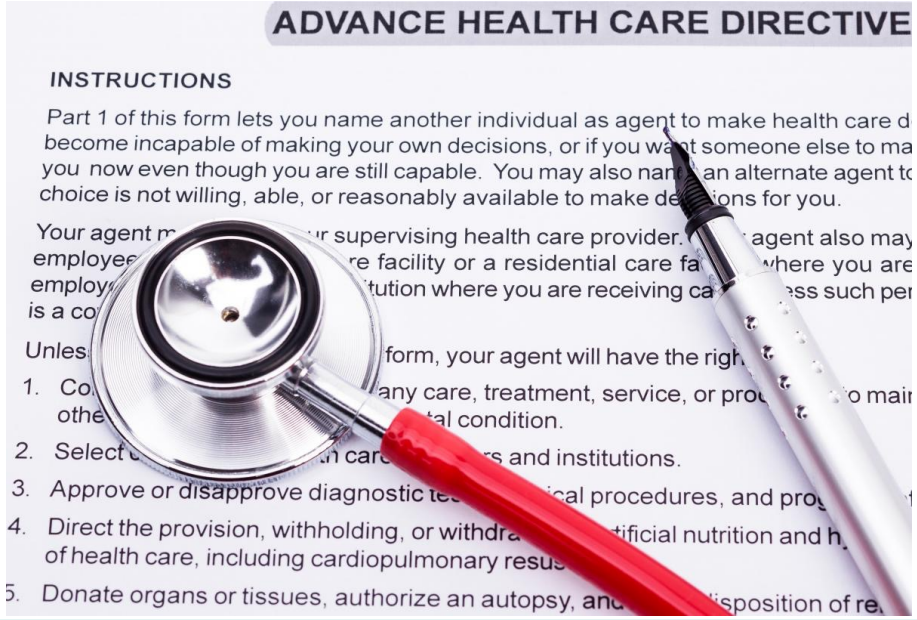
CANADIAN NURSES ASSOCIATION

Choosing Wisely Canada LTC Recommendations (March 2021) 7 areas of potential over-use

- Hospital transfers – care not available in LTC and aligned with goals of care
- Use of Antipsychotics
- Urine Culture and urine dipstick
- Insertion of feeding tube in advanced dementia
- Continuation of chronic medications if no reasonable long term benefit
- Lab testing
- Use of virtual care

Hospital Transfers

1. Don’t send the frail resident of a nursing home to the hospital without reviewing goals of care and advance directives with the resident or substitute decision-maker, unless their urgent comfort and medical needs cannot be met in their care home.

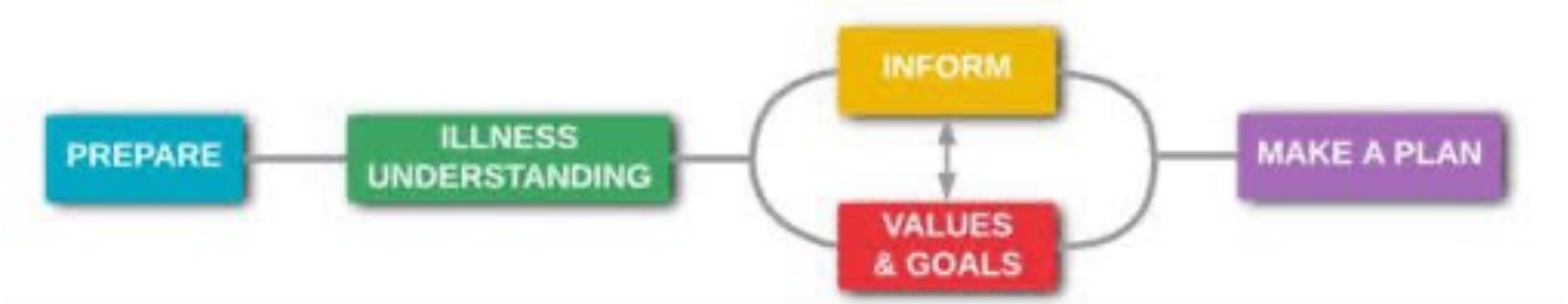


Hospital Transfers

- Transfers to hospital may result in increased morbidity
- Canadian study noted that 47% were considered avoidable
- Transfers are to the ER which are usually unfamiliar and stressful environments
- Have Goals of Care conversations early!
- Hazards of unnecessary hospitalization include:
  - Delirium
  - Hospital acquired infection
  - Medication side effects
  - Sleep disturbances
  - Deconditioning

Hospital Transfers and Goals of Care

- Speak Up Ontario Guidance with Goals of Care LTC Guide



Choosing Wisely Canada - Serious Illness Conversation Guide "Time to Talk"

1. Set up the conversation
2. Assess understanding and preferences
3. Share prognosis
4. Explore Key Topics
5. Close the conversation
6. Document your conversation
7. Communicate with key clinicians

Antipsychotics

2. Don’t use antipsychotics as first choice to treat behavioural and psychological symptoms of dementia.

Antipsychotics

- Antipsychotics are commonly prescribed for behavioural symptoms for residents with dementia
- Antipsychotics can cause serious harm, including premature death
- These medications should be limited to cases where non-drug measures have been tried and failed
- Frequently review attempts at reduction or discontinuation to reduce harm

CEP Centre for Effective Practice | Canadian Foundation for Healthcare Improvement / Fondation canadienne pour l'amélioration des services de santé

How Antipsychotic Medications are Used to Help People with Dementia

A Guide for Residents, Families, and Caregivers

Use of Antipsychotics in Behavioural and Psychological Symptoms of Dementia (BPSD) Discussion Guide

This tool is designed to help providers understand, assess, and manage residents in LTC homes with behavioural and psychological symptoms of dementia (responsive behaviours), with a focus on antipsychotic medications. It was developed as part of Centre for Effective Practice's Academic Detailing Service for LTC homes. This tool integrates best-practice evidence with clinical experience, and makes reference to relevant existing tools and services wherever possible.

Important principles include:

- Being resident-centred,
- Being mindful of benefits, risks and safety concerns,
- Using an interprofessional team approach and validated tools,
- Prescribing conservatively, and,
- Reassessing regularly for opportunities to deprescribe medications that are no longer needed.

As always, efforts must be made to individualize any treatment decisions for the resident, with consideration given to caregivers, family members, as well as LTC staff.

Identify BPSD Symptom Clusters[1, 2]

Psychosis	Aggression	Agitation	Depression	Mania	Apathy
Delusions	Defensive	Dressing/undressing	Anxious	Euphoria	Amotivation
Hallucinations	Resistance to care	Pacing	Guilty	Irritable	Lacking interest
Misidentification	Verbal	Repetitive actions	Hopeless	Pressured speech	Withdrawn

Centre for Effective Practice https://cep.health/clinical-products/antipsychotics-and-dementia-primary-care-edition/

When Psychosis isn't the Diagnosis:
A Toolkit for Reducing Inappropriate Use of Antipsychotics in Long Term care

Steps to avoid unnecessary antipsychotic use

1. Establish an inter-professional team
2. Agree on appropriateness criteria
   - Severe delusions/hallucinations
   - Behaviours that put others at risk of injury
3. Educate care staff as to reasons for responsive behaviours
   - Environmental
   - Medical/biological
   - Basic physical needs
   - Psychosocial

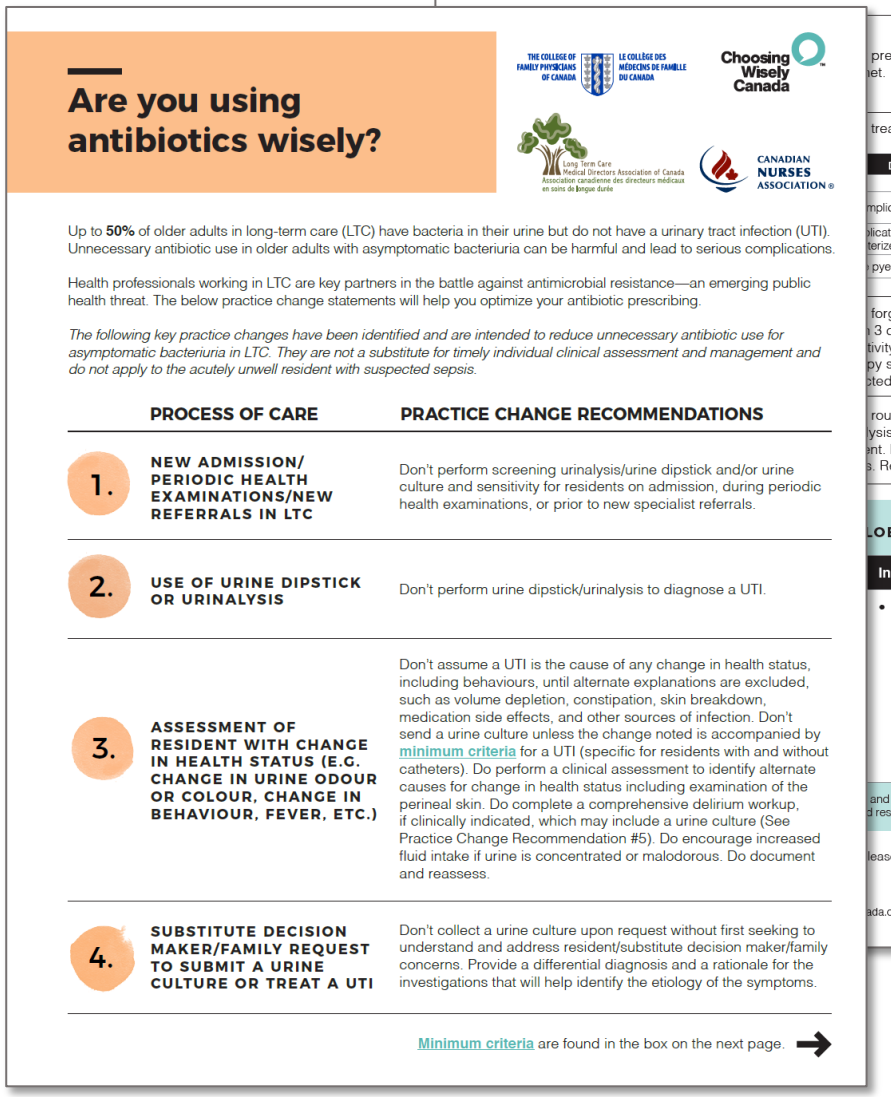
Steps to avoid unnecessary antipsychotic use

4. Inform and involve family
5. Establish a regular medication review process
6. Taper residents off potentially inappropriate antipsychotic prescriptions
7. Implement supportive strategies

Urinary Tract Infections

3. Don’t do a urine dip or urine culture unless there are clear signs and symptoms of a urinary tract infection (UTI).

Antibiotics Wisely in LTC



Are you using antibiotics wisely?

Up to **50%** of older adults in long-term care (LTC) have bacteria in their urine but do not have a urinary tract infection (UTI). Unnecessary antibiotic use in older adults with asymptomatic bacteriuria can be harmful and lead to serious complications.

Health professionals working in LTC are key partners in the battle against antimicrobial resistance—an emerging public health threat. The below practice change statements will help you optimize your antibiotic prescribing.

The following key practice changes have been identified and are intended to reduce unnecessary antibiotic use for asymptomatic bacteriuria in LTC. They are not a substitute for timely individual clinical assessment and management and do not apply to the acutely unwell resident with suspected sepsis.

	PROCESS OF CARE	PRACTICE CHANGE RECOMMENDATIONS
1.	NEW ADMISSION/ PERIODIC HEALTH EXAMINATIONS/NEW REFERRALS IN LTC	Don't perform screening urinalysis/urine dipstick and/or urine culture and sensitivity for residents on admission, during periodic health examinations, or prior to new specialist referrals.
2.	USE OF URINE DIPSTICK OR URINALYSIS	Don't perform urine dipstick/urinalysis to diagnose a UTI.
3.	ASSESSMENT OF RESIDENT WITH CHANGE IN HEALTH STATUS (E.G. CHANGE IN URINE ODOUR OR COLOUR, CHANGE IN BEHAVIOUR, FEVER, ETC.)	Don't assume a UTI is the cause of any change in health status, including behaviours, until alternate explanations are excluded, such as volume depletion, constipation, skin breakdown, medication side effects, and other sources of infection. Don't send a urine culture unless the change noted is accompanied by minimum criteria for a UTI (specific for residents with and without catheters). Do perform a clinical assessment to identify alternate causes for change in health status including examination of the perineal skin. Do complete a comprehensive delirium workup, if clinically indicated, which may include a urine culture (See Practice Change Recommendation #5). Do encourage increased fluid intake if urine is concentrated or malodorous. Do document and reassess.
4.	SUBSTITUTE DECISION MAKER/FAMILY REQUEST TO SUBMIT A URINE CULTURE OR TREAT A UTI	Don't collect a urine culture upon request without first seeking to understand and address resident/substitute decision maker/family concerns. Provide a differential diagnosis and a rationale for the investigations that will help identify the etiology of the symptoms.
5.	MANAGEMENT OF RESIDENT WITH CLINICAL CRITERIA FOR A UTI	Don't order a urine culture unless minimum criteria for a UTI are present.

Minimum criteria are found in the box on the next page.

prescribe antibiotics unless minimum criteria for a UTI

treat a UTI for excessive durations.

DURATION OF THERAPY DEPENDS ON UTI SYNDROME	
UTI Syndrome	Duration of Therapy
mplicated cystitis	3–5 days depending on antibiotic chosen
licated cystitis (male resident, terized resident, urological abnormalities)	7 days
pyelonephritis	7 days

forget to reassess the need for antimicrobial therapy 3 days of starting antibiotics to check antibiotic tivity results and that the resident is improving. Antibiotic py should be stopped if result of the urine culture cted before antibiotics is negative.

routinely screen residents from LTC homes with a ysis/urine dipstick unless minimum criteria for a UTI are nt. Look for alternate explanations for change in clinical s. Refer to Practice Change Recommendation #3.

LOEB CRITERIA[1,2])

In a catheterized resident:

- Any one of the following after alternate explanations have been excluded:
  - fever [> 37.9°C (100°F) or a 1.5° C (2.4°F) increase above baseline on at least two occasions over the last 12 hours]
  - flank pain
  - shaking chills
  - new onset delirium

and differ from criteria that are used for surveillance. d resident.

lease visit: www.choosingwiselycanada.org/antibiotics-LTC.

ada.org | @ChooseWiselyCA | /ChoosingWiselyCanada

Urine Cultures in LTC

- 50% of those tested showing bacteria present in the absence of symptoms
- Premature Diagnostic Closure
  - Over-testing and treating asymptomatic bacteriuria with antibiotics can increase the risk of failure to consider other causes of changes in condition including COVID
- Over-testing and over-treatment can lead to:
  - Diarrhea
  - C. difficile
- Overuse of antibiotics contributes to increasing antibiotic-resistant organisms.

Reflect Before you Collect:
Practice Change Recommendations for management of UTI in Long-Term Care

Using Antibiotics Wisely

Many older adults receive antibiotics for urinary tract infections (UTIs) even though they do not have UTI symptoms. Help reduce unnecessary antibiotic prescribing for asymptomatic bacteria with our Using Antibiotics Wisely recommendations, tools, and resources.

Practice Change Recommendations

	PROCESS OF CARE	PRACTICE CHANGE RECOMMENDATIONS
1.	NEW ADMISSION/ PERIODIC HEALTH EXAMINATIONS/NEW REFERRALS IN LTC	Don't perform screening urinalysis/urine dipstick and/or urine culture and sensitivity for residents on admission, during periodic health examinations, or prior to new specialist referrals.
2.	USE OF URINE DIPSTICK OR URINALYSIS	Don't perform urine dipstick/urinalysis to diagnose a UTI.

Practice Change Recommendations

3. **ASSESSMENT OF RESIDENT WITH CHANGE IN HEALTH STATUS (E.G. CHANGE IN URINE ODOUR OR COLOUR, CHANGE IN BEHAVIOUR, FEVER, ETC.)**

MINIMUM CRITERIA FOR UTI (MODIFIED LOEB CRITERIA[1,2])

In a non-catheterized resident:	In a catheterized resident:

• Acute dysuria or 2 or more of the following:
  • fever [> 37.9°C (100°F) or a 1.5° C (2.4°F) increase above baseline on at least two occasions over the last 12 hours]
  • new or worsening urgency
  • frequency
  • suprapubic pain
  • gross hematuria
  • flank pain
  • urinary incontinence
	• Any one of the following after alternate explanations have been excluded:
	  • fever [> 37.9°C (100°F) or a 1.5° C (2.4°F) increase above baseline on at least two occasions over the last 12 hours]
	  • flank pain
	  • shaking chills
	  • new onset delirium

[1] Note that these are clinical criteria validated for diagnosis for a UTI and differ from criteria that are used for surveillance.
[2] Note that confusion alone is not symptom of UTI in non-catheterized resident.

Practice Change Recommendations

4. SUBSTITUTE DECISION MAKER/FAMILY REQUEST TO SUBMIT A URINE CULTURE OR TREAT A UTI

Don't collect a urine culture upon request without first seeking to understand and address resident/substitute decision maker/family concerns. Provide a differential diagnosis and a rationale for the investigations that will help identify the etiology of the symptoms.

5. MANAGEMENT OF RESIDENT WITH CLINICAL CRITERIA FOR A UTI

Don't order a urine culture unless minimum criteria for a UTI are present.

6. MANAGEMENT OF RESIDENT WITH POSITIVE URINE CULTURE

Don't prescribe antibiotics unless minimum criteria for a UTI are met.

Practice Change Recommendations

7.

SELECTING ANTIBIOTIC AND DURATION FOR A RESIDENT WITH CLINICAL CRITERIA FOR A UTI

Don't treat a UTI for excessive durations.

DURATION OF THERAPY DEPENDS ON UTI SYNDROME	
UTI Syndrome	**Duration of Therapy**
Uncomplicated cystitis	3–5 days depending on antibiotic chosen
Complicated cystitis (male resident, catheterized resident, urological abnormalities)	7 days
Acute pyelonephritis	7 days

Practice Change Recommendations

8. FOLLOW-UP ASSESSMENT OF RESIDENT WITH CLINICAL CRITERIA FOR A UTI	Don't forget to reassess the need for antimicrobial therapy within 3 days of starting antibiotics to check antibiotic sensitivity results and that the resident is improving. Antibiotic therapy should be stopped if result of the urine culture collected before antibiotics is negative.
9. RESIDENT TRANSFERRED TO THE EMERGENCY DEPARTMENT	Don't routinely screen residents from LTC homes with a urinalysis/urine dipstick unless **minimum criteria** for a UTI are present. Look for alternate explanations for change in clinical status. Refer to Practice Change Recommendation #3.

Resident and Caregiver resource

choosingwiselycanada.org/wp-content/uploads/2017/06/UTIs-EN.pdf

Antibiotics for Urinary Tract Infections in Older People: When you need them - and when you don't

Choosing Wisely Canada™

Antibiotics are medicines that can kill bacteria. Health care providers often use antibiotics to treat urinary tract infections (UTIs).

The main symptom of a UTI is a burning feeling when you urinate.

However, many older people get UTI treatment even though they do not have symptoms. This can do more harm than good. Here's why:

Antibiotics usually don't help when there are no UTI symptoms.

Feeding Tubes

4. Don’t insert a feeding tube in individuals with advanced dementia. Instead, assist the resident to eat.

Feeding tubes outcomes in advanced dementia

Lee et al. / JAMDA 22 (2021) 357-363
J.K. Yuen et al. / JAMDA 23 (2022) 1541-1547

- **Meta-analysis in 2020 (Lee et al. / JAMDA 22 (2021) 357-363)**
  - 12 trials, 1805 persons with feeding tubes, 3800 without
- Outcomes with feeding tubes
  - Increased mortality (OR 1.7, p=0.03)
  - Increased pneumonia (OR 3.56, P<0.001)
  - Increased pressure injuries (OR 2.55, p<0.001)
  - No significant difference in nutritional markers (HgB, Albumin, cholesterol)
- **Careful Hand Feeding and pneumonia risk (J.K. Yuen et al. / JAMDA 23 (2022) 1541-1547)**
  - 764 inpatients with advanced dementia (464 feeding tube, 300 hand feeding)
  - Increased pneumonia in those with feeding tube (60% vs 48%, p<0.001)
  - No difference in survival at 1 year

Feeding Tubes in advanced dementia

- Feeding tubes do not prolong or improve quality of life in advanced dementia
- Studies show that tube feeding does not make the patient more comfortable or reduce suffering
- Tube Feeding causes:
  - Fluid overload
  - Diarrhea
  - Abdominal pain
  - Discomfort, agitation
  - Aspiration pneumonia, pressure ulcers

Caring for Persons with Advanced Dementia

choosingwiselycanada.org/wp-content/uploads/2017/05/Feeding-tubes-EN.pdf

- Review goals of care
- Address other issues impacting loss of appetite
  - Constipation
  - Delirium
  - Depression
  - Medication side effects – sedation, dry mouth
- Support feeding by hand
  - Finger foods, favorite foods
- Dental care
  - Oral pain, dentures, daily oral care

Long-Term Medications

5. Don’t continue or add long-term medications unless there is an appropriate indication and a reasonable expectation of benefit in the individual patient.

Long-Term Medications

- Consider an individualized approach:
  - Goals of Care
  - Life Expectancy – ex. ePrognosis
  - Time to benefit
  - Frailty
  - Balance of harms and benefits

Long-Term Medications

- Examples of medications that can be potentially deprescribed depending on health status and goals of care:
  - PPIs
  - Anti-hypertensives
  - Statins
  - Bisphosphonates – use FRS to determine whether or not to continue
  - Acetylcholinesterase inhibitors
  - Antidiabetic medications – can consider target of A1C of 8.5% depending on frailty (Canadian Diabetes Association, 2018)
- Keeping these medications can cause issues with mobility, function, quality of life, and mortality

Choosing Wisely (AMDA, CGS)

Don’t continue cholinesterase inhibitors or memantine for dementia without periodic reassessment for perceived benefits (cognitive, functional, behavioural) and adverse effects, (CGS)

Don’t routinely prescribe or continue sedative hypnotics (BDZ,trazodone) for sleep disorders in geriatric populations (AMDA, CGS)

Don’t use Sliding Scale Insulin (AMDA)

Don’t use hypoglycemic agents to achieve A1C targets < 7.5%, moderate control is generally better (CGS)

Don’t prescribe a medication without conducting a medication reconciliation review, and consider opportunities for deprescribing

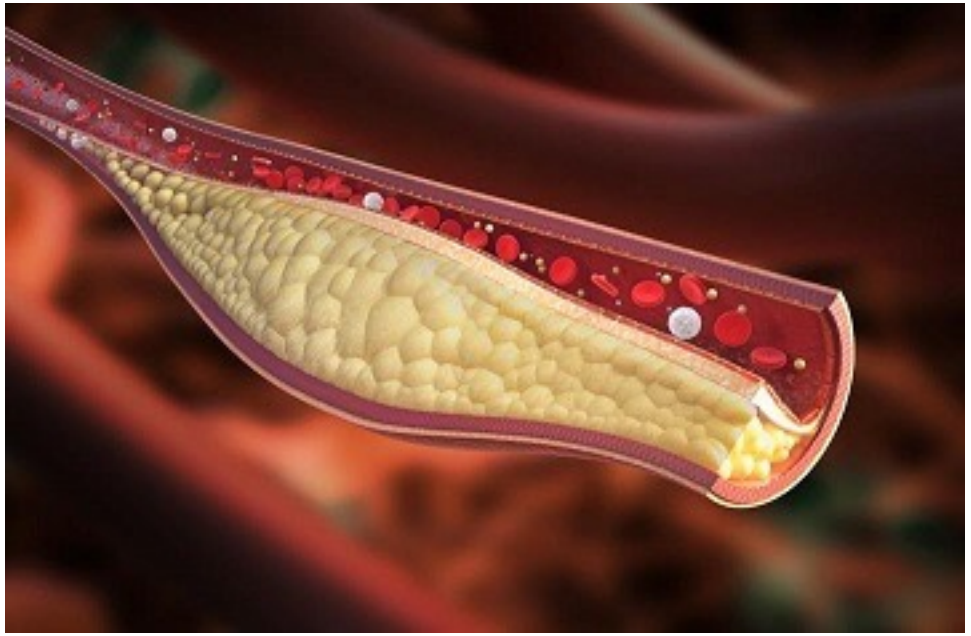
New Diabetes Management in LTC, CSLTCM

- Don't use sliding scale insulin for older adults living with frailty in LTC homes.
- Don't place high importance on achieving A1C target for older adults living with frailty in LTC homes, instead focus on relaxed glycemic goals with the focus on avoidance of hypoglycemic and symptomatic hyperglycemia

- New ADA and CDA guidelines incorporate recommendations for older adults, frailty
- Up to 40% of LTC residents in Canada have diabetes
- Choosing Wisely Canada webinar ‘rethinking glycemic control in LTC’
- https://choosingwiselycanada.org/event/cwtalks-sept2023/

Screening and Routine Testing

6. Don’t order screening or routine chronic disease testing just because a blood draw is being done.



Screening and Routine Testing

- Do not do these tests unless it adds to quality of life
- Screening/routine testing could lead to harmful overtreatment in frail residents nearing end of life and misuse of resources
- Individualized approach to screening based on frailty, goals of care, comorbidities, life expectancy, and patient preference

The Additional LTC Recommendation #7

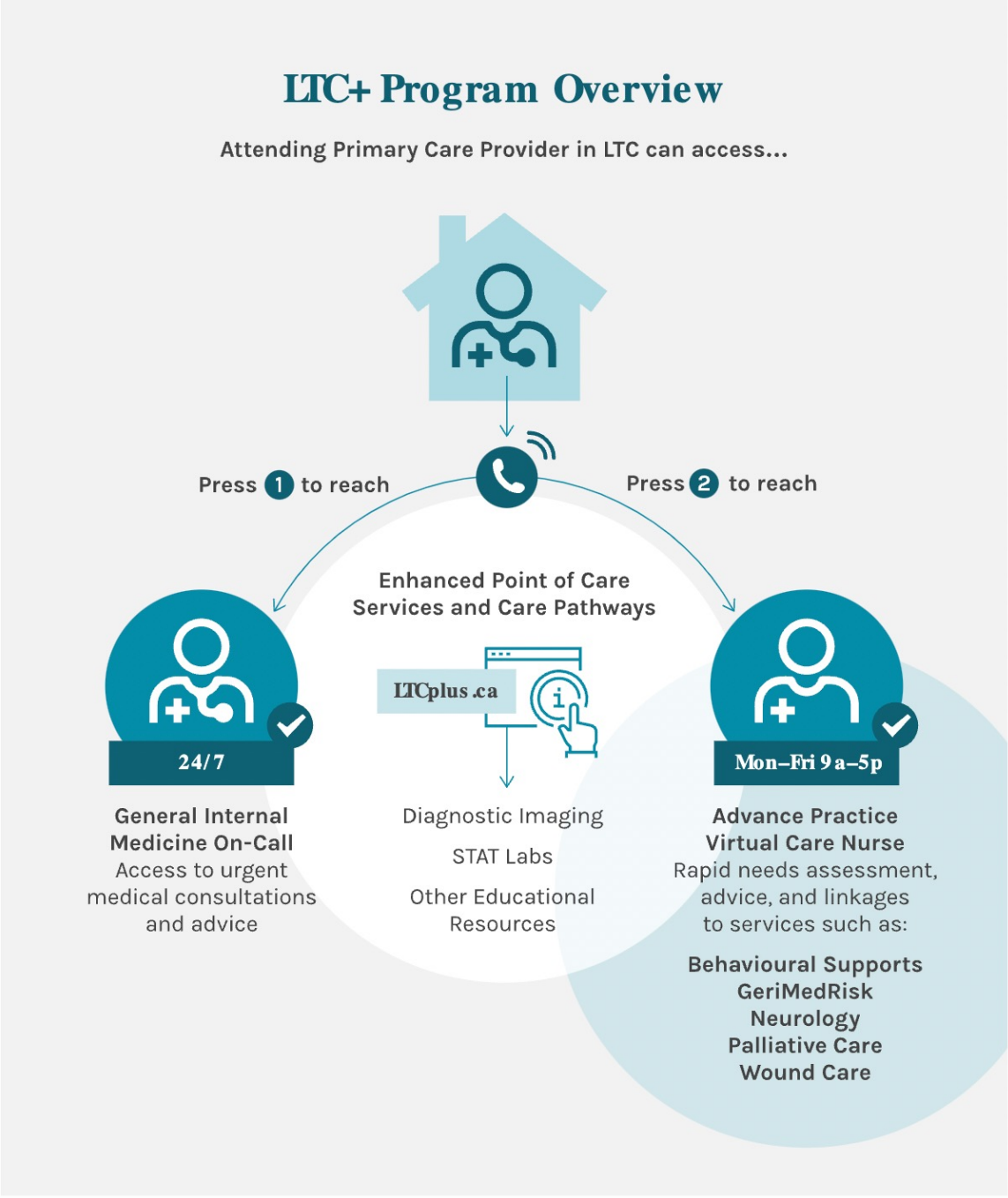
7. Don’t hesitate to use virtual care to complement in-person visits in order to meet the needs of residents in long-term care during the COVID-19 pandemic.

Physical Presence and Virtual Care

- During the pandemic, regulatory boards and CMPA developed tools, temporary remuneration changes, and policies to allow for virtual care to minimize the spread of the virus
- It can be useful for non-urgent and administrative tasks, but in-person assessment should be considered for acute illness or change in condition
- Access is variable at this time depending on the province
- There should be procedures that include the availability and integration of appropriate hardware, software, privacy, and security

A Virtual Care Innovation Example: LTC+

- Virtual care innovation in the Greater Toronto Area
- Linkages between LTC and hospital partners – including specialist consultation and allied health



Behaviour Neurology Virtual Behavioural Medicine

- Team of specialists including: behavioural neurologist, geriatric psychiatrist, neuro-psychologist, nurses, mental health professionals, behavioural support outreach team
- Work in close collaboration with care teams and specialized geriatric services in acute and long-term care homes
- Work with families for caregiver support
- Develop and implement care plans, access behavioural and social supports
- Completely virtual, delivered using Ontario Telemedicine Network (OTN)

Other example of Virtual Innovations in LTC?

- What is being done in your region?
- What is working well?
- Where are the opportunities?

Summary

- Choosing Wisely is difficult in the long-term care setting but critically important
- Helpful resources exist to support Choosing Wisely for advanced care planning in LTC
- Using Antibiotics Wisely - Reflect before you collect
- Virtual care can complement physical care

Thank You!

www.ChoosingWiselyCanada.org / resources

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Advance Care Planning LTC COVID

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