October 23, 2013 DURB Meeting Summary

Issue	Page; Tab	Action	Notes
Roll Call			Present: Dr. Swee, Dr. Zanna, Dr. Gochfeld, Ms. Olson, Dr. Barberio, Dr. Marcus, Dr. Gooen, Mr. Schafer, Dr. Lind (ex officio). Unable to attend: Dr. Moynihan, Dr. Moore
Review of Minutes	Pages 3-10; Tab 1	Approved	Minutes from June 26, 2013 meeting was reviewed and approved. The approved meeting summary will also be posted on the DURB website at: http://nj.gov/humanservices/dmahs/boards/durb/meeting/index.html
Secretary's Report	Page 11; Tab 2		• Educational newsletter on Type 2 diabetes treatment options is awaiting the Medicaid Director's signature. Dr. Swee requested that a copy should be mailed to each Board member prior to distribution. • The draft of the DURB Annual Report for State Fiscal Year 2013 was emailed to Board members prior to the meeting. The State is requesting comments or feedback by November 30, 2013. • Some of the HMOs provided responses to the Board's questions during protocols review. • HealthFirst, one of the NJ HMOs was acquired by WellCare. Transaction will be completed in January 1st 2014. • No update on replacement for three positions in the DURB membership.
Old Business			
1. HMO Response to Protocols Review Questions	Page 13-15; Tab 3		- The Board reviewed responses to some of their questions in the June meeting. Board members still expressed concern about some of the indications that were not covered by the HMOs due to lack of FDA's explicit "support" for these indications but are covered in the fee for service protocols. To alleviate the burden on the provider of providing literature support, Dr. Swee suggested that the State should develop a library of literature to help support the prescribers' decisions. Dr. Lind, Medicaid's Medical Director will be in charge of developing the library. The Board requested a report/update on the process at the next meeting. - The Board also expressed concern about restricting the use of some medications by specialty of the prescriber.

October 23, 2013 DURB Meeting Summary

Issue	Page; Tab	Action	Notes
New Business			
A. Long-Acting Beta-agonists Newsletter	Page 17-19; Tab 4	Approved	The Board reviewed and approved an educational newsletter on long-acting beta-agonists, medications used for the treatment of asthma and chronic obstructive pulmonary disease or COPD. As requested by members, formatting to two pages instead of current three will be done prior to distribution.
B. Protocols Review	Biologic Response Modifiers: Pages 21-27; Tab 5		The Board reviewed the protocols for biologic response modifiers (BRMs). Dr. Swee referenced an email from Dr. Moynihan, a rheumatologist, who requested that all the plans should include ankylosing spondylitis as one of their covered indications. Most did. She also requested that BRMs should be considered for uveitis not responding to conventional treatment. Members thought that this should be an exception and not part of the list of indications. Other concerns expressed by board members: - Specialty prescribers required by HMO plans: The State will work with the HMOs to provide more access for patients. - Step therapy: The Board had no objection to step therapy but requested that there should be a report to monitor how often patients had to use stepped therapy to obtain needed treatment.
	Dronedarone (Multaq®): Pages 28-30; Tab 5		Fee for service (FFS) does not have a protocol for this product. A report for General Assistance (GA) population confirmed low utilization - 127 claims in the first half of 2011 and 35 claims in the first half of 2012.
	Human Growth Hormones: Pages 31-45; Tab 5		No specific changes or requests were made.
	Palivizumab (Synagis®): Pages 46-49; Tab 5		Chris Dube, a medical representative with Medimmune pointed out that Plan (A) did not incorporate a 2012 guideline that recommended treatment for children with congenital or neuromuscular disease regardless of prematurity. The State will follow up with the HMO.
	Protease Inhibitors for Hepatitis C: Pages 50-53; Tab 5		Dr. Swee again expressed his concern about HMO plans restriction of use of these products to specialists.

October 23, 2013 DURB Meeting Summary

Issue	Page; Tab	Action	Notes
Informational Highlights/Reports			
1. Molina Medicaid Solutions (Fee-for-Service) Prior Authorization Report	Pages 55-61; Tab 6		The Board reviewed a new prior authorization report comparing all HMO plans including FFS for the 2nd quarter of 2013. There were discrepancies on the number of prior authorized claims and percentages of denials. Sam Currie, director of pharmacy at Horizon NJ Health explained that these differences will persist due to divergent parameters, denominators, and operational differences among the plans. For Molina's Medical Exceptions Program (MEP) during this period there were 2,805,747 pharmacy claims processed; 73,616 (2.6%) prior authorization requests and 9,762 (13.3%) denials. The top four categories of denials were: (1) Clinical Criteria Not Met, (2) Incorrect Day Supply, (3) Therapeutic Duplication, and (4) MNF Not Returned by Prescriber (MNFNR).
2. HMO 2nd Quarter Reports			For the HMOs, denial percentages ranged from 0.6% to 40%. This discrepancy in range was addressed above.
3. Summary of DURB Action Items	Page 63; Tab 7		
October 2012: Protocol for HIV PrEP		Update	In this meeting, Dr. Marcus questioned the low utilization of the product approved for HIV prophylaxis. Mr. Vaccaro explained that there is no identifier for patients that fall into this category on the FFS population. The HMOs also have diagnosis-capturing issues too. Dr. Zanna will request Dr. Paul's presence in the next meeting to address this question.
June 2013: Educational newsletter			The T2DM educational newsletter is now awaiting Medicaid Director's signature.

October 23, 2013 DURB Meeting Summary

Issue	Page; Tab	Action	Notes
4. DHS and DHSS Programs' Top Drugs Report	Pages 65-77; Tab 8		August 2013 report of the top drugs, by dollar amount, claims count and service units were presented. HIV medications represented the top ten drugs in the list for "ALL population" (92%). Abilify, an atypical antipsychotic made up 8% in this category. Dr. Marcus requested an additional column in the report that will show changes in the ranking of the drugs from month to month (or meeting to meeting). Dr. Swee made a request to Dr. Marcus to provide a report that showed the top drugs (ingested) from the Poison Control Center database.
5. Medication Information	Pages 79-84; Tab 9		The following information were included in the Board's meeting package: (a) NJ Prescription Monitoring Program The Board discussed the benefits and limitations of the NJ Prescription Monitoring Program. The program, a new tool established in 2010 helps in the effort to halt the abuse and diversion of prescription drugs. The limitations however include physicians and pharmacists that cannot access the system because they are not involved in "direct patient care"; healthcare payors that are not authorized to use the system; and eligible pharmacy providers that opt out of the system. Dr. Paul will also address this issue at the next meeting. (b) New APA guidelines on cutting antipsychotic overuse Dr. Gochfeld distributed a more detailed handout from the American Psychiatric Association which discussed "five things physicians should question" prior to prescribing antipsychotic medications. (c) FDA approves new DPP-4 Inhibitor Alogliptin (Nesina®) for T2DM (d) FDA approves dolutegravir (Tivicay®) for HIV infection

October 23, 2013 DURB Meeting Summary

Issue	Page; Tab	Action	Notes
Follow up items: (a)Develop a literature of library			- Dr. Lind will lead the process of developing a library of literature to help providers with information that support off-label prescribing when necessary.
(b) Update Synagis® protocol			- HMO plan "A" to update Synagis® protocol with 2012 information
(c) Provide denials information in Excel format			- Dr. Marcus requested that the denials report should be presented in Excel format for comparison
(d)Add NJ Prescription Monitoring Program to next meeting agenda			- Continue discussion about the NJ Prescription Monitoring Program (PMP) at the next Board meeting
(e)Compare ranking of the top 25 drugs			- Provide previous meeting's ranking of the Top 25 drugs to be compared with current meeting's ranking
(f)Add pre-exposure prophylaxis to next meeting agenda			- Continue discussion about use of drug(s) for pre-exposure prophylaxis (PrEP) at the next Board meeting (Dr. Paul)

Choosing Wisely®

An initiative of the ABIM Foundation

American Geriatrics Society

AGS Geriatrics Healthcare Professionals

Leading Change. Improving Care for Older Adults.

Five Things Physicians and Patients Should Question

1 Don't recommend percutaneous feeding tubes in patients with advanced dementia; instead offer oral assisted feeding.

Careful hand-feeding for patients with severe dementia is at least as good as tube-feeding for the outcomes of death, aspiration pneumonia, functional status and patient comfort. Food is the preferred nutrient. Tube-feeding is associated with agitation, increased use of physical and chemical restraints and worsening pressure ulcers.

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

People with dementia often exhibit aggression, resistance to care and other challenging or disruptive behaviors. In such instances, antipsychotic medicines are often prescribed, but they provide limited benefit and can cause serious harm, including stroke and premature death. Use of these drugs should be limited to cases where non-pharmacologic measures have failed and patients pose an imminent threat to themselves or others. Identifying and addressing causes of behavior change can make drug treatment unnecessary.

3 Avoid using medications to achieve hemoglobin A1c <7.5% in most adults age 65 and older; moderate control is generally better.

There is no evidence that using medications to achieve tight glycemic control in older adults with type 2 diabetes is beneficial. Among non-older adults, except for long-term reductions in myocardial infarction and mortality with metformin, using medications to achieve glycated hemoglobin levels less than 7% is associated with harms, including higher mortality rates. Tight control has been consistently shown to produce higher rates of hypoglycemia in older adults. Given the long timeframe to achieve theorized microvascular benefits of tight control, glycemic targets should reflect patient goals, health status, and life expectancy. Reasonable glycemic targets would be 7.0 – 7.5% in healthy older adults with long life expectancy, 7.5 – 8.0% in those with moderate comorbidity and a life expectancy < 10 years, and 8.0 – 9.0% in those with multiple morbidities and shorter life expectancy.

4 Don't use benzodiazepines or other sedative-hypnotics in older adults as first choice for insomnia, agitation or delirium.

Large scale studies consistently show that the risk of motor vehicle accidents, falls and hip fractures leading to hospitalization and death can more than double in older adults taking benzodiazepines and other sedative-hypnotics. Older patients, their caregivers and their providers should recognize these potential harms when considering treatment strategies for insomnia, agitation or delirium. Use of benzodiazepines should be reserved for alcohol withdrawal symptoms/delirium tremens or severe generalized anxiety disorder unresponsive to other therapies.

5 Don't use antimicrobials to treat bacteriuria in older adults unless specific urinary tract symptoms are present.

Cohort studies have found no adverse outcomes for older men or women associated with asymptomatic bacteriuria. Antimicrobial treatment studies for asymptomatic bacteriuria in older adults demonstrate no benefits and show increased adverse antimicrobial effects. Consensus criteria has been developed to characterize the specific clinical symptoms that, when associated with bacteriuria, define urinary tract infection. Screening for and treatment of asymptomatic bacteriuria is recommended before urologic procedures for which mucosal bleeding is anticipated.

Choosing Wisely®

An initiative of the ABIM Foundation

American Geriatrics Society

AGS Geriatrics Healthcare Professionals

Leading Change. Improving Care for Older Adults.

Five More Things Physicians and Patients Should Question

6 Don't prescribe cholinesterase inhibitors for dementia without periodic assessment for perceived cognitive benefits and adverse gastrointestinal effects.

In randomized controlled trials, some patients with mild-to-moderate and moderate-to-severe Alzheimer's disease (AD) achieve modest benefits in delaying cognitive and functional decline and decreasing neuropsychiatric symptoms. The impact of cholinesterase inhibitors on institutionalization, quality of life and caregiver burden are less well established. 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, and should be included in the treatment plan in addition to any consideration of a trial of cholinesterase inhibitors. If goals of treatment are not attained after a reasonable trial (e.g., 12 weeks), then consider discontinuing the medication. Benefits beyond a year have not been investigated and the risks and benefits of long-term therapy have not been well-established.

7 Don't recommend screening for breast or colorectal cancer, nor prostate cancer (with the PSA test) without considering life expectancy and the risks of testing, overdiagnosis and overtreatment.

Cancer screening is associated with short-term risks, including complications from testing, overdiagnosis and treatment of tumors that would not have led to symptoms. For prostate cancer, 1,055 men would need to be screened and 37 would need to be treated to avoid one death in 11 years. For breast and colorectal cancer, 1,000 patients would need to be screened to prevent one death in 10 years. For patients with a life expectancy under 10 years, screening for these three cancers exposes them to immediate harms with little chance of benefit.

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. In patients who take megestrol acetate, one in 12 will have an increase in weight and one in 23 will die. The 2012 AGS 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.

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, increasing the 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. Additionally, 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.

10 Avoid physical restraints to manage behavioral symptoms of hospitalized older adults with delirium.

Persons with delirium may display behaviors that risk injury or interference with treatment. There is little evidence to support the effectiveness of physical restraints in these situations. Physical restraints can lead to serious injury or death and may worsen agitation and delirium. Effective alternatives include strategies to prevent and treat delirium, identification and management of conditions causing patient discomfort, environmental modifications to promote orientation and effective sleep-wake cycles, frequent family contact and supportive interaction with staff. Nursing educational initiatives and innovative models of practice have been shown to be effective in implementing a restraint-free approach to patients with delirium. This approach includes continuous observation; trying re-orientation once, and if not effective, not continuing; observing behavior to obtain clues about patients' needs; discontinuing and/or hiding unnecessary medical monitoring devices or IVs; and avoiding short-term memory questions to limit patient agitation. Pharmacological interventions are occasionally utilized after evaluation by a medical provider at the bedside, if a patient presents harm to him or herself or others. Physical restraints should only be used as a very last resort and should be discontinued at the earliest possible time.

How This List Was Created (1-5)

The American Geriatrics Society (AGS) established a work group chaired by the Vice Chair of Clinical Practice and Models of Care Committee (CPMC). Work group members were drawn from that committee, as well as the Ethics, Ethnogeriatrics and Quality and Performance Measurement (QPMC) committees. AGS members were invited to submit feedback and recommendations as to what they thought should be included in the list via an electronic survey. The workgroup first narrowed the list down to the top 10 potential tests or procedures. The workgroup then reviewed the evidence and sought expert advice to further refine the list to five recommendations, which were then reviewed and approved by the AGS Executive Committee and the Chairs/Vice Chairs of CPMC, Ethics and QPMC.

How This List Was Created (6-10)

The American Geriatrics Society (AGS) used the same work group from its first list to develop its second list. The group was chaired by the Chair of Clinical Practice and Models of Care Committee (CPMC). Work group members were drawn from that committee, as well as the Ethics, Ethnogeriatrics and Quality and Performance Measurement (QPMC) committees. AGS members were invited to submit feedback and recommendations as to what they thought should be included in a *Choosing Wisely*® list via an electronic survey. The workgroup then narrowed the list down and reviewed the evidence, seeking expert advice to further refine the list to five recommendations, which were then reviewed and approved by the AGS Executive Committee and the Chairs/Vice Chairs of CPMC, Ethics and QPMC.

AGS' disclosure and conflict of interest policy can be found at www.americangeriatrics.org.

Sources

1

Finucane TE, Christmas C, Travis K. Tube feeding in patients with advanced dementia: A review of the evidence. JAMA. 1999;282(14):1365-1370.

Gabriel SE, Normand ST. Getting the methods right – The foundation of patient-centered outcomes research. N Engl J Med [Internet]. 2012 Aug 30;367(9):787-90.

Teno JM, Feng Z, Mitchell SL, Kuo S, Intrator O, Mor V. Do financial incentives of introducing case mix reimbursement increase feeding tube use in nursing home residents? J Am Geriatr Soc. [Internet]. 2008 May;56(5):887–890.

Teno JM, Mitchell SL, Kuo SK, Gozalo PL, Rhodes RL, Lima JC, Mor V. Decision-making and outcomes of feeding tube insertion: A five-state study. J Am Geriatr Soc.[Internet]. 2011 May;59(5):881–886.

Palecek EJ, Teno JM, Casarett DJ, Hanson LC, Rhodes RL, Mitchell SL. Comfort feeding only: A proposal to bring clarity to decision-making regarding difficulty with eating for persons with advanced dementia. J Am Geriatr Soc. [Internet]. 2010 Mar;58(3):580–584.

Hanson LC, Carey TS, Caprio AJ, Lee TJ, Ersek M, Garrett J, Jackman A, Gilliam R, Wessell K, Mitchell SL. Improving decision-making for feeding options in advanced dementia: A randomized, controlled trial. J Am Geriatr Soc. [Internet]. 2011 Nov;59(11):2009–2016.

2

The American Geriatrics Society 2012 Beers Criteria Update Expert Panel. American Geriatrics Society Updated Beers Criteria for potentially inappropriate medication use in older adults. J Am Geriatr Soc. 2012 Apr;60(4):616-31.

National Institute for Health and Clinical Excellence and Social Care Institute for Excellence NICE-SCIE. National Collaborating Centre for Mental Health. Clinical guidelines #42: Dementia: Supporting people with dementia and their careers in health and social care [Internet]London. 2006 Nov. Amended 2011 Mar [cited 2012 Oct 16]. Available from: www.nice.org.uk/CG042

Maher A, Maglione M, Bagley S, Suttorp M, Hu JH, Ewing B, Wang Z, Timmer M, Sultzer D, Shekelle PG. Efficacy and comparative effectiveness of atypical antipsychotic medications for off-label uses in adults: A systematic review and meta-analysis. JAMA [Internet]. 2011 Sep 28;306(12):1359-69.

Schneider LS, Tariot PN, Dagerman KS, Davis SM, Hsiao JK, Ismail MS, Lebowitz BD, Lyketsos CG, Ryan JM, Stroup TS, Sultzer DL, Weintraub D, Lieberman JA; CATIE-AD Study Group. Effectiveness of atypical antipsychotic drugs in patients with Alzheimer's disease. N Engl J Med [Internet]. 2006 Oct 12;355(15):1525-38.

3

The Action to Control Cardiovascular Risk in Diabetes Study Group. Effects of intensive glucose lowering in Type 2 Diabetes. N Eng J Med [Internet]. 2008 Jun 12;258(24):2545–2559.

The Action to Control Cardiovascular Risk in Diabetes Study Group. Long-term effects of intensive glucose lowering on cardiovascular outcomes. N Eng J Med [Internet]. 2011Mar 3;364(9):818–828.

Duckworth W, Abraira C, Moritz T, Reda D, Emanuele N, Reaven P, Zeive FJ, Marks J, David SN, Hayward R, Warren SR, Goldman S, McCarren M, Vitek ME, Henderson WG, Huang GD. Glucose control and vascular complications in veterans with type 2 diabetes. N Eng J Med[Internet]. 2009. 360(2):129–139.

ADVANCE Collaborative Group. Intensive blood glucose control and vascular outcomes in patients with type 2 diabetes. N Engl J Med[Internet]. 2008 Jun 12;358:2560-72.

UK Prospective Diabetes Study (UKPDS) Group. Effect of intensive blood-glucose control with metformin on complications in overweight patients with type 2 diabetes (UKPDS 34). Lancet [Internet]. 1998;352:854-65.

Montori VM, Fernández-Balsells M. Glycemic control in type 2 diabetes: Time for an evidence-based about-face? Ann Intern Med[Internet]. 2009 Jun 2;150(11):803-8. Erratum in: Ann Intern Med. 2009 Jul 21;151(2):144. PMID: 19380837

Finucane TE. "Tight Control" in geriatrics: The emperor wears a thong. J Am Geriatr Soc [Internet]. 2012 Aug 6;60:1571–1575.

Kirkman MS, Briscoe VJ, Clark N, Florez H, Haas LB, Halter JB, Huang ES, Korytkowski MT, Munshi MN, Odegard PS, Pratley RE, Swift CS. Diabetes in older adults: A consensus report. J Am Geriatr Soc. 2012 Oct;60(12):2342-2356.

4

Finkle WD, Der JS, Greenland S, Adams JL, Ridgeway G, Blaschke T, Wang Z, Dell RM, VanRiper KB. Risk of fractures requiring hospitalization after an initial prescription of zolpidem, alprazolam, lorazepam or diazepam in older adults. J Am Geriatr Soc. [Internet]. 2011 Oct;59(10):1883–1890.

Allain H, Bentue-Ferrer D, Polard E, Akwa Y, Patat A. Postural instability and consequent falls and hip fractures associated with use of hypnotics in the elderly: a comparative review. Drugs Aging [Internet]. 2005;22(9):749–765.

The American Geriatrics Society 2012 Beers Criteria Update Expert Panel. American Geriatrics Society Updated Beers Criteria for potentially inappropriate medication use in older adults. J Am Geriatr Soc. 2012 Apr;60(4):616-31.

5

Nordenstam GR, Brandberg CA, Odén AS, Svanborg Edén CM, Svanborg A. Bacteriuria and mortality in an elderly population. N Engl J Med. 1986 May 1;314(18):1152–1156.

Nicolle LE, Mayhew WJ, Bryan L. Prospective randomized comparison of therapy and no therapy for asymptomatic bacteriuria in institutionalized elderly women. Am J Med. 1987Jul;83(1):27–33.

Juthani-Mehta M. Asymptomatic bacteriuria and urinary tract infection in older adults. Clin Geriatr Med [Internet]. 2007 Aug;23(3):585–594.

Nicolle LE, Bradley S, Colgan R, Rice JC, Schaeffer A, Hooton TM; Infectious Diseases Society of America; American Society of Nephrology; American Geriatric Society. Infectious Diseases Society of America Guidelines for the diagnosis and treatment of asymptomatic bacteriuria in adults. Clin Infect Dis. [Internet]. 2005 Mar 1;40(5):643-65.

6

Courtney C, Farrell D, Gray R, Hills R, Lynch L, Sellwood E, Edwards S, Hardyman W, Raftery J, Crome P, Lendon C, Shaw H, Bentham P; AD2000 Collaborative Group. Long-term donepezil treatment in 565 patients with Alzheimer's disease (AD2000): randomized double-blind trial. Lancet. 2004 Jun 26;363(9427):2105–15.

American Geriatrics Society 2012 Beers Criteria Update Expert Panel. American Geriatrics Society updated Beers Criteria for potentially inappropriate medication use in older adults. J Am Geriatr Soc. 2012 Apr;60(4):616–31.

Kaduszkiewicz H, Zimmermann T, Beck-Bornholdt HP, van den Bussche H. Cholinesterase inhibitors for patients with Alzheimer's disease: systematic review of randomized clinical trials. BMJ. 2005 Aug 6;331(7512):321–7.

Birks J. Cholinesterase inhibitors for Alzheimer's disease. Cochrane Database Syst Rev. 2006 Jan 25;(1):CD005593.

7

Schröder FH, Hugosson J, Roobol MJ, Tammela TL, Ciatto S, Nelen V, Kwiatkowski M, Lujan M, Lilja H, Zappa M, Denis LJ, Recker F, Páez A, Määttänen L, Bangma CH, Aus G, Carlsson S, Villers A, Rebillard X, van der Kwast T, Kujala PM, Blijenberg BG, Stenman UH, Huber A, Taari K, Hakama M, Moss SM, de Koning HJ, Auvinen A; ERSPC Investigators. Prostate-cancer mortality at 11 years of follow-up. N Engl J Med. 2012 Mar 15;366(11):981–90.

Moyer VA; U.S. Preventive Services Task Force. Screening for prostate cancer: U.S. Preventive Services Task Force recommendation statement. Ann Intern Med. 2012 July 17;157(2):120–34.

Walter LC, Covinsky KE. Cancer screening in elderly patients: a framework for individualized decision making. JAMA. 2001 Jun 6;285(21):2750–6.

Lee SJ, Boscardin WJ, Stijacic-Cenzer I, Conell-Price J, O'Brien S, Walter LC. Time lag to benefit after screening for breast and colorectal cancer: meta-analysis of survival data from the United States, Sweden, United Kingdom, and Denmark. BMJ. 2012 Jan 8;346:e8441.

8

Hanson LC, Ersek M, Gilliam R, Carey TS. Oral feeding options for people with dementia: a systematic review. J Am Geriatr Soc. 2011;59:463–72.

Milne AC, Potter J, Vivanti A, Avenell A. Protein and energy supplementation in elderly people at risk from malnutrition. Cochrane Database Syst Rev. 2009Apr 15;2:CD003288. DOI: 10.1002/14651858.CD003288.pub3.

Ruiz Garcia V, López-Briz E, Carbonell Sanchis R, Gonzalvez Perales JL, Bort-Marti S. Megestrol acetate for treatment of anorexia-cachexia syndrome. Cochrane Database Syst Rev. 2013 Mar 28;3:CD004310.

American Geriatrics Society 2012 Beers Criteria Update Expert Panel. American Geriatrics Society updated Beers Criteria for potentially inappropriate medication use in older adults. J Am Geriatr Soc. 2012 Apr;60(4):616–31.

Mazotta P, Jeney CM. Anorexia-cachexia syndrome: a systematic review of the role of dietary polyunsaturated fatty acids in the management of symptoms, survival, and quality of life. J Pain Symptom Manage. 2009;37:1069–77.

Dewey A, Baughan C, Dean TP, Higgins B, Johnson I. Eicosapentaenoic acid (EPA, an omega-3 fatty acid from fish oils) for the treatment of cancer cachexia. Cochrane Database Syst Rev. 2007 Jan 24;1:CD004597.

Reid J, Mills M, Cantwell M, Cardwell CR, Murray LJ, Donnelly M. Thalidomide for managing cancer cachexia. Cochrane Database of Systematic Reviews 2012 Apr 18;4:CD008664.

Yavuzsen T, Davis MP, Walsh D, LeGrand S, Lagman R. Systematic review of the treatment of cancer-associated anorexia and weight loss. J Clin Oncol. 2005;23:8500–11.

Watanabe N, Omori IM, Nakagawa A, Cipriani A, Barbui C, Churchill R, Furukawa TA. Mirtazapine versus other antidepressive agents for depression. Cochrane Database Syst Rev. 2011 Dec 7;12:CD006528.

Fox CB, Treadway AK, Blaszczyk, Sleeper RB. Megestrol acetate and mirtazapine for the treatment of unplanned weight loss in the elderly. Pharmacotherapy. 2009;29(4):383–97.

9

National Committee for Quality Assurance. Improving quality and patient experience - the state of health care quality 2013. Washington (DC): National Committee for Quality Assurance; 2013 Oct. 206 p.

Shrank WH, Polinski JM, Avorn J. Quality indicators for medication use in vulnerable elders. J Am Geriatr Soc. 2007;55 (suppl 2):S373–82.

Hajjar ER, Cafiero AC, Hanlon JT. Polypharmacy in elderly patients. Am J Geriatr Pharm. 2007 Dec;5(4):345–51.

Steinman MA, Hanlon JT. Managing medications in clinically complex elders: "There's got to be a happy medium". JAMA. 2010 Oct 13;304(14):1592–1601.

Drenth-van Maanen AC, van Marum RJ, Knol W, van der Linden CM, Jansen PA. Prescribing optimization method for improving prescribing in elderly patients receiving polypharmacy. Drugs Aging. 2009;26(8):687–701.

10

Bray K, Hill K, Robson W, Leaver G, Walker N, O'Leary M, Delaney T, Walsh D, Gager M, Waterhouse C; British Association of Critical Care Nurses. British Association of Critical Care Nurses position statement on the use of restraint in adult critical care units. Nurs Crit Care. 2004 Sep-Oct;9(5):199–212.

Center for Medicare & Medicaid Services. Electronic Code of Federal Regulations. Condition of participation: patient's rights. 42 C.F.R. § 482.13.

Cotter VT, Evans LK. Avoiding restraints in hospitalized older adults with dementia. Best practices in nursing care to older adults with dementia. 2012;01.

Inouye SK. Delirium in older persons. N Engl J Med. 2006;354:1157–65.

Minnick AF, Mion LC, Johnson ME, Catrambone C, Leipzig R. Prevalence and variation of physical restraint use in acute care settings in the U.S. J Nurs Scholarsh. 2007;39(1):30–7.

Maccioli GA, Dorman T, Brown BR, Mazuski JE, McLean BA, Kuszaj JM, Rosenbaum SH, Frankel LR, Devlin JW, Govert JA, Smith B, Peruzzi WT; American College of Critical Care Medicine, Society of Critical Care Medicine. Clinical practice guidelines for the maintenance of patient physical safety in the intensive care unit: use of restraining therapies – American College of Critical Care Medicine Task Force 2001-2002. Crit Care Med. 2003;31(11): 2665–767.

Mott S, Poole J, Kenrick M. Physical and chemical restraints in acute care: their potential impact on rehabilitation of older people. Int J Nurs Pract. 2005 Jun;11(3):95–101.

Flaherty JH, Little MO. Matching the environment to patients with delirium: lessons learned from the delirium room, a restraint-free environment for older hospitalized adults with delirium. J Am Geriatr Soc. 2011 Nov;59Suppl 2:S295–300.

About the ABIM Foundation

The mission of the ABIM Foundation is to advance medical professionalism to improve the health care system. We achieve this by collaborating with physicians and physician leaders, medical trainees, health care delivery systems, payers, policymakers, consumer organizations and patients to foster a shared understanding of professionalism and how they can adopt the tenets of professionalism in practice.

ABIM FOUNDATION

To learn more about the ABIM Foundation, visit www.abimfoundation.org.

About the American Geriatrics Society

The American Geriatrics Society (AGS) works to improve the health, independence and quality of life of all older people. Our geriatrics health professional members work together to provide interdisciplinary, patient- and family-centered team care to older adults. The society also works to bring the knowledge and expertise of geriatrics health professionals to the public via www.healthinaging.org.

AGS Geriatrics Healthcare Professionals
Leading Change, Improving Care for Older Adults.

To learn more about the AGS, please visit www.americangeriatrics.org.

For more information or to see other lists of Five Things Physicians and Patients Should Question, visit www.choosingwisely.org.