Summary of the addendum for the creation of senior-proof guidelines

nederlandse internisten vereniging

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SUMMARY OF THE ADDENDUM FOR THE CREATION OF SENIOR-PROOF GUIDELINES

1 Objective of this addendum

This addendum aims to increase the focus on elderly people in the development of guidelines in the broadest sense of the word (see 2.). Up to now, too little attention has been paid to this (clinically heterogeneous) group in guidelines, and certainly not systematically, i.e. in all stages of the development process. One of the consequences of this is that it is often not clear whether the recommendations apply in turn to elderly people, or only to relatively healthy middle-aged adults. Whether the subject of the guideline concerns a disease (for example COPD), a problem or a complaint (for example chronic pain in elderly people), or a specific intervention (for example combined endoscopic and laparoscopic removal of colonic polyps), this addendum aims to provide support in all cases.

The use of this addendum does not presuppose that one or more clinical geriatricians/geriatric medicine internists are members of the guideline working group by default. Phrased differently: a guideline working group without these specialists may also use this addendum. This addendum is intended both for general guidelines and for guidelines that are specifically aimed at elderly people as a target group.

This addendum was developed as an appendix to Medical Specialist Guidelines 2.0 (version October 2011), and follows the organisation of the development process presented herein as much as possible. Three stages are distinguished in Medical Specialist Guidelines 2.0: the preparation stage, the development stage and the completion stage (Medical Specialist Guidelines 2.0, p.p. 17-19). The preparation stage runs from the moment the development of guidelines is discussed. This includes the choice of a subject and establishing which organisations are involved. The preparation stage lasts up to and including the assembly of a working group. The development stage starts when the working group is complete. The development stage also includes a comprehensive analysis of problem areas, where a variety of stakeholders is heard. The development stage ends when the working group has a draft guideline ready. Each of these stages features a number of main points that are adopted from the Guideline for Guidelines (version 2010) of the former Management Council for the Quality of Care.

2 Categories of elderly people

This addendum distinguishes four groups of elderly people:

1. Relatively healthy elderly people;
2. Elderly people with one additional specific (interfering) comorbid condition (disease, disorder). Interfering comorbidity refers to co-existing conditions that have an impact on the disease or disorder that is the subject of the guideline, namely via ‘drug-condition, drug-drug, and food-drug interactions’. An example of interfering comorbidity is osteoporosis in elderly people with COPD. Medication with corticosteroids in connection with COPD negatively impacts bone density and increases the risk of fractures.
3. Elderly people with multimorbidity (several co-existing chronic conditions), where it does not involve one specific comorbid condition;
4. Vulnerable elderly people. Vulnerability in elderly people is understood to mean: ‘the decrease of reserves and capacity through an accumulation of deficiencies in several domains’. Vulnerable elderly people have an increased risk of negative health outcomes, such as fall incidents, delirium or functional limitations, non-specific symptoms, such as extreme fatigue or unexplained weight loss, frequently occurring infections, post-operative complications and mortality.

3.1 Subject and objective

The extent to which a specific focus on elderly people is required or desirable within a guideline may be determined by *applying* the criteria, as established by the Management Council for the Quality of Care for the choice of a subject, *to the target group of elderly people*. These criteria are:

- the prevalence of the disease or condition;
- the level of suffering;
- the social relevance; and
- the expectation that a guideline may improve the quality of care.[1]

Whether there should be a focus on a *specific group of elderly people* as defined above depends on whether or not *prevalent* interfering comorbidity or multimorbidity occurs in the target population of the guideline. For vulnerable elderly people, what will mainly be important is whether prognosis, care organisation or outcome measures justify attention for this specific target group. The lack of scientific literature is, in itself, no reason not to pay attention to one of the groups of elderly people mentioned in the guideline.

In order to verify whether one of the groups of elderly people requires more or less focus than another, a 'quick search' of the literature may be performed where *elderly-specific evidence in the form of systematic reviews of landmark studies* may be examined. It is also possible to look at the availability of adjacent guidelines (that are currently being developed), and at the expertise of subject-matter specialists, in particular that of a clinical geriatrician/geriatric medicine internist, and whether this is used.

- Should the initiator of the guidelines decide *not* to focus specifically on *elderly people*, then they state this in the introduction to the guideline, where other considerations for the demarcation of the subject of the guideline are usually mentioned as well.
- If the initiator – if necessary, after consultation with the primarily professional organisations involved, and possibly (umbrella) organisations for elderly people and informal carers – decides to focus specifically on *elderly people*, then the following is stated in the introduction to the guideline:
  - the specific target group it involves: elderly people, elderly people with one specific (interfering) comorbid condition, elderly people with multimorbidity or vulnerable elderly people; and
  - the starting questions that take this into account.

3.2. Considerations for participation by a clinical geriatrician/geriatric medicine internist and organisations for elderly people in guideline working groups

The composition of a working group for a guideline is initially determined by the subject. Based on the subject, the professional groups primarily involved are approached by the initiator. When the decision has been made to focus on elderly people, then this is not to say that a clinical geriatrician/ geriatric medicine internist should sit in the working group.

There are various ways in which a clinical geriatrician/ geriatric medicine internist may be involved in a working group:

- participation (where the NVKG/ NIV authorises this as well);
- provision of feedback on draft documents during the development stage or on a consultation basis for a single module;
- involvement in the analysis of problem areas and peer review.

[1] The Guideline for Guidelines of the Management Council for the Quality of Care (2012; p. 7) states: 'The selection of the subject is determined, among others, by the prevalence of the disease or condition, the level of suffering, the social relevance and the expectation that a guideline may improve the quality of care'.

When (overall) starting questions in relation to *relatively healthy* elderly people or *elderly people with an interfering comorbid condition* that is (medically) treated are included in the guideline project, deployment may be limited to the provision of feedback within the framework of **peer review**. In the event of an *interfering comorbid condition* it is also possible to consider a medical specialist in the field of this specific comorbid condition.

When it concerns (overall) starting questions *in relation to elderly people with multimorbidity*, a choice between participation during the development stage and providing feedback during the development stage depends on the nature of the multimorbidity.

When (overall) starting questions with regard to *vulnerable elderly people* are included in the guideline project, then participation or the provision of feedback during the **development stage** by a clinical geriatrician/ geriatric medicine internist is an obvious choice.

The beliefs, values or preferences of elderly patients are of importance for the preparation of the appropriate recommendations, in particular during the weighing of the pros and cons of treatment options. Involvement of an organisation for elderly people is therefore desirable (see also 4.4.2).

4.1 Inventory and analysis of problem areas

When attention is paid to elderly people, then the suggested guideline with regard to the *patient perspective* is to involve organisations for elderly people and organisations of informal carers in the inventory of problem areas, and additionally to perform literature research, preferably in MEDLINE and the Cochrane Library. 'Patient preferences', 'patient satisfaction', 'patient experiences', 'patient participation', 'physician-patient relations' and 'shared decision-making' may be used as (controlled) keywords, in combination with the subject, and possibly limited to systematic reviews and/or elderly[tiab] or AGED[Mesh].

4.2 Starting questions and outcome measures

- Besides outcome measures such as mortality and morbidity, it is possible to consider outcome measures such as quality of life, hospitalisation, cognitive functioning, functional status or treatment burden in relation to elderly people;
- In addition, the required follow-up duration with regard to the outcome measures is considered because this may be of importance in connection with the prognosis (think of the time-to-benefit);
- It is recommended to also determine the relative importance of the outcome measures with the guideline working group.

If the guideline focuses on elderly people, then the relative importance of the various outcome measures for this target group needs to be explicitly stated.

4.3 Systematic review of the evidence

4.3.1 Searching for studies

With respect to "general" guidelines

For all the search strategies listed below, the search results may be narrowed down in a later stage to articles with a high average age, or studies in which meta-analyses (of individual patient data), subgroup analyses or results of meta-regression are reported in relation to treatment effect and interactions between treatment effect and comorbidity and/or age categories of elderly people.

For elderly people of category 1: as a general rule, the same search strategy will suffice as that for younger adults.

For elderly people of category 2: For this category of elderly people, keywords for the relevant comorbid condition need to be included in the search query.

For elderly people of category 3: For this category of elderly people, the following keywords are recommended (in PubMed):

Chronic disease [MeSH Major Topic] OR Comorbidity [MeSH Major Topic] OR "Multiple chronic conditions" OR "Multiple chronic illnesses" OR "Multiple chronic diseases" OR "Multiple morbidity" OR "Multiple comorbidity" OR "Chronic condition" OR "Chronic illness" OR "Multiple conditions" OR "Multiple illnesses" OR "Multiple diseases" OR "Multimorbidity" OR "Multi morbidity" OR "Multi-morbidity" OR "Comorbid disease") AND Aged: 65+ years

For elderly people of category 4: For this category of elderly people, the following keywords are recommended (in PubMed):

"Frail Elderly"[Mesh] OR frail*[tiab] OR "short physical performance battery"[tiab] OR "Sarcopenia"[Mesh])

With respect to geriatric guidelines

The search strategies of Van de Glind et al (2014) are recommended for this; see the appendix: geriatrics search filter in the addendum.

4.3.2 Study subjects

Studies on interventions

With a view to internal validity and the applicability of studies with regard to various categories of elderly people, combining well-performed (systematic reviews of) RCTs and observational studies, preferably prospective cohort research, may have added value, and this depends on the importance of the starting question as established by the working group in the preparation stage.

Diagnostic accuracy of studies

Preferably focus on systematic reviews on diagnostic test accuracy, or on studies with subgroup analyses and "age factors".

4.3.3 Summarising study characteristics

For clinical studies that focus on the treatment of diseases that frequently occur in elderly people, a check should be made regarding whether these studies produce the required evidence for elderly people by verifying:

- whether elderly people are well represented in the studies,
- whether it concerns a representative population of elderly people,
- whether the results (effectiveness and toxicity) of interventions in elderly people are specified separately.

4.3.4 and 4.3.5 Determining the quality of evidence for every outcome measure as well as the overall quality of evidence

The overall quality of evidence may vary for the different categories of elderly people because:

- various outcome measures may be used;

- the relative importance of an outcome measure may differ; and
- the quality of evidence may differ for each outcome measure, among others, due to indirect evidence.

In the event of a lack of sub-group analyses or results of meta-regressions that give information on the effects of (diagnostic or therapeutic) interventions in elderly people, it may be checked whether effects for a specific outcome measure in studies that present overall results, vary according to the average age of the study population or the percentage of patients with, for example, the relevant comorbidity in each study.

4.4 and 4.5 Formulating and implementing recommendations

When examining the balance of desired and undesired effects for (the various categories of) elderly people, consider:

- absolute benefits and absolute risks of interventions;
- medicine interactions;
- drug-disease interactions;
- treatment burden;
- capacity of a patient;
- prognosis (remaining life expectancy, functional status, years spent with limitations, quality of life) and
- the values and preferences of patients.

When implementing recommendations for elderly people, consider what specific impeding factors (at the level of individual care providers, at the level of the organisation, and at the level of the system) exist for their application, and in particular how they may be addressed.

5 Identifying possible knowledge gaps

The advice regarding knowledge gaps in relation to younger adults and (vulnerable) elderly people is to list and prioritise them separately in the guideline.