De-Prescribing: Applying Person Centered Approach

Harry Krulewitch MD ,MPH
Family Medicine, OHSU
Portland Oregon

Program outline:

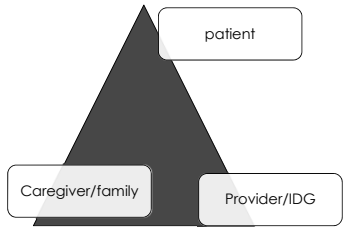
- Chronic Disease Management and Polypharmacy: Where are we Now? Problems and Barriers
- Where are we Going? New Solutions; New Guidelines; New Models
- Application and Implications for the Future

- What it isn't:
  - A comprehensive review of existing resources available to help work with polypharmacy
  - A review of the communication skills and tools cited in the literature to identify goals of care or conduct care conferences

Case:

- Ms.B 74 yr. old new patient, family moved from rural home to local ALF
- Husband died, she is matriarch of large family, religious affiliation supports Full code POLST
- After moving in family notes increased weakness and depression. She is independent in all ADL, admits she is withdrawn, tired, confused, shuffling, eating less without dysphagia or indigestion
- HTN, AF, GERD, gout, CHF, DJD, neuropathy, old lumbar comp fx, osteoporosis, NIDDM
- SLUMS 28/30 exam WNL b/p 108/55 drops to 101/50 No POLST
- Daughter POA convinced she is depressed. "Wants this treated, don't change her specialists' meds." Duplicate bottles in her pharmacy bag. Medi-set is not filled properly. Has meds from five MD, three pharmacies and local naturopath
- Her goals are to live closer to her family, enjoy her grand-daughters, and remain independent avoid nursing home placement
- Furosemide, fluoxetine, gabapentin, Naprosyn, colchicine, allopurinol, gingko, garlic tabs, warfarin, aspirin, lovastatin, amlodipine, vit D, Ca, lisinopril, lorazepam, metoprolol, zolpidem, amiodarone, omeprazole, metformin, glyburide, alendronate

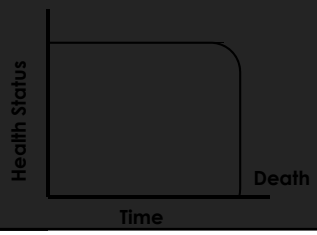
Disease Oriented Outcomes for older patient with multiple chronic conditions



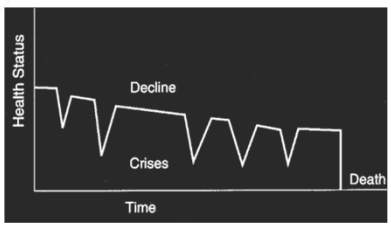
-frailty, comorbidity and functional decline
-loss of mastery, interdependency, resilience
-loss of meaning, dignity, quality of life; hopelessness, helplessness, suffering

Sudden death, unexpected cause

- What we all want



The Reality



CDM, multiple chronic conditions in the elderly and prognosis: the origins of palliative care

- Failure to thrive
- End stage Dementia Fast level 7
- Delirium
- Drugs- three or more
- De-conditioning
- Depression
- Falling, poor balance or gait
- Immobility
- Abuse, isolation, poverty
- Malnutrition, anorexia, dysphagia
- Weight loss

One year mortality rises with the number of syndromes

CH Winograd JAGS 39; August 1991; 778-84

- CVA or sensory impairment
- Chronic illness/weakness
- Dehydration
- Pain
- Incontinence
- Pressure sores

Age is not risk factor

Greater variation within cohorts than between them

Every geriatric case has palliative and ethical dimensions

Autonomy and Function are major contributors to Quality of Life

Chronic Disease has a Trajectory

- Gradual decline over time- CHF, COPD, CAD
- Periods of relative stability
- Periods of real improvement
- A fluctuating downward trend with multiple transitions of care
- Neither Co-morbidity or single disease acuity predicts highest risk group for adverse outcomes
- **Symptom burden and frailty predict highest adverse outcomes**
- AH Salanitro et al; JAGS 60: 1632-7:September 2012

Common chronic conditions

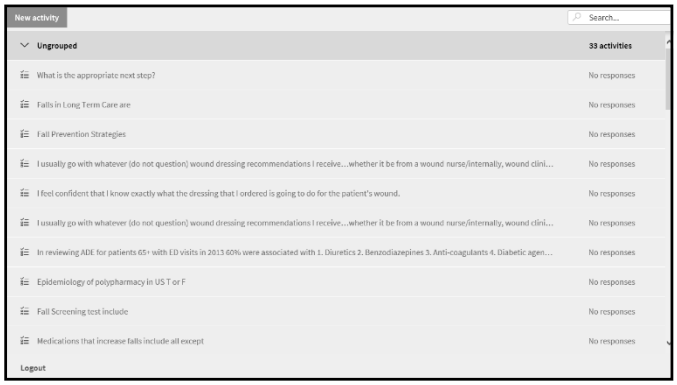
- **Hypertension**
- **COPD**
- **CHF**
- **DM**
- **AF**
- **Osteoporosis**
- **Dementia**
- **CKD**
- **PD,CVA**
- **Cirrhosis**

- **50% older adults have 3+**
- **40% dementia cases have 5+**
- **50% CHF have 5+**

- Tinetti ME,et al; JAMA 2012; 307: 2493-4
- Glynn LG et al. Fam Pr 2011; 28: 516-23

Every Condition has a Guideline
Every guideline has one or more meds

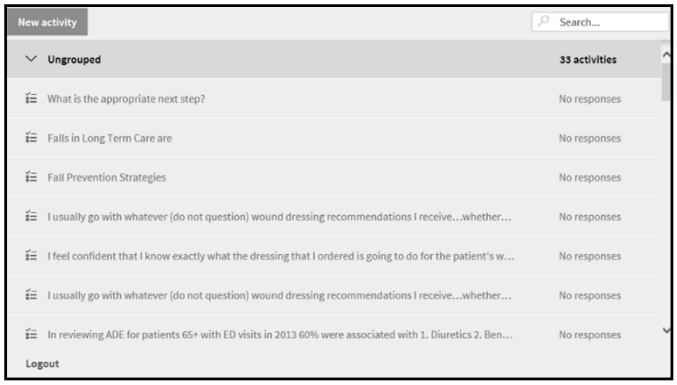
- Diabetes
  - 2-3 hypoglycemic agents
  - Statin, ACE, ASA
  - HTN control
- Osteoporosis
  - Ca,VitD
  - Bisphosphonates
- Dementia with agitation
  - SSRI, Mirtazapine
  - Anti-psychotic neuroleptics
  - Depakote, Tegretol, Trazadone
  - benzodiazepines
- AF
  - B blocker, digoxin, Ca channel, amiodarone
  - Anti-coagulants: warfarin, DOAC
- CAD
  - B blocker, statin
  - ACE,ASA
  - Plavix if stent
- CHF
  - B blocker, ASA, ACE/ARB,
  - Aldactone
  - Furosemide, Thiazides



Emergency Department Polypharmacy
2013-2014 adults 65 and over

- Emergency room visits for ADE on the rise
- 43% of those 65 and older with ADE were hospitalized
- 60% of ED visits for ADE in those 65 and older were associated with: **anticoagulants**
  diabetic agents
  opioid analgesics replacing digoxin

MJ Koronkowski et al JAGS 65: 1401-5,July 2017



Polypharmacy
2005-2011

- The number of older adults using **five or more** prescription drugs on a regular basis increased from 31% to 36%.
- When adding non prescription drugs use went from 53% to 67%
- Rates of potential ADE adverse drug events rose from 8% to 15%
- Most significant outpatient increases:
  - Statins 34-46%
  - Anti-platelet therapy 34-44%
  - Omega 3 fish oils 5-19%
    - MJ Koronkowski et al; JAGS 65:1401-5,July 2017

Psychosocial aspects: Patients Protest de-prescribing

- "my specialist said never stop this drug";
- "thanks but I want to talk to a specialist first"
- Medication is perceived as beneficial
- Lack of physician guidance to taper or stop
- Influence of friends and family
- Fears about withdrawal or relapse

Barriers-medicalization of death creates cultural barriers for doctor and patient

- Training
- Fears
- Need to Make Diagnosis
- Technological Imperative
- Death as the Enemy
- We reward fixing things
- Predicting course of chronic illness is difficult

Evidence Based guidelines : a growing crisis
disease oriented outcomes are flawed

- Every condition has a guideline
- Every guideline recommends at least one pill
- Evidence based medicine is based on single organ system interventions and disease oriented outcomes not patient oriented outcomes
- "Treatment cascade" increases risk of polypharmacy
- RCT exclude patients with multi-morbidity and use healthy individuals without confounding diseases; not who we see daily
- Heterogeneity of the oldest elderly physiology impacts outcomes
  - Greater variety within cohorts than between them
  - Variation increases with each aging cohort
- Drug –drug interactions impact efficacy studies
- RCT rarely measure negative outcomes or side effects
- Time to treatment benefit reduces effectiveness in the oldest old

before *Being Mortal* By Atul Gawande there was: *How We Die;* Jeff Nuland; first Vintage books 1993

- "Death with dignity is confused with a heroic battle with death."
- "Doctors nurses family and patient are all in a pitched battle cheerleading a fight to the finish."
- "Whoever fights the hardest is the bravest and this defines our dignity and self respect."
- "Offering amazing tantalizing cures in the face of reality is a false hope and a deception and a disservice to our patients. What are the consequences of all this?"

Our aging patients are suffering

- Medical treatment may not alleviate the suffering of our older patients
- Patients with multiple chronic conditions might benefit from interventions like de-prescribing long before they are candidates for end of life care
- Providers may experience moral distress implementing treatments they know are causing more harm and suffering to their patients
- The inability to know how to discuss de-prescribing pervades the entire process and is highlighted in every major publication as the most important but least discussed aspect of care

MORAL DISTRESS: Barriers in the workplace when dealing with suffering due to cultural and organizational issues *that violate personal ethics places ourselves* at risk

- **Pathological altruism** -causing physical or psychological harm to oneself by placing the needs of others above oneself
- **Burnout/vital exhaustion** -cumulative stress and exhaustion
- **Vicarious trauma; numbing out** and disassociating from one's own feelings/ dysfunction from prolonged exposure to intense stress/pain/suffering: **PTSD/ addictions**
- **Organizational hostility/bullying** -behaviors that controls, devalues, objectives, disrespects, diminishes others; peers, colleagues within groups or between- our patients or other disciplines. Overt **abuse.**
- **Structural violence** -direct or indirect policies and cultural/institutional values that undermine the dignity, job security and safety of health care workers: discipline, work expectations, pressure to conform, incentives to practice based on profit, efficiency, production goals etc

Polypharmacy and Evidence Based Guidelines for Medical Treatment **Where we Are**

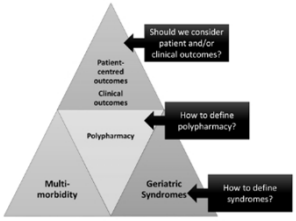
Where Are We?

Our current medical model is not working for older adults with chronic medical conditions

- "To me it seems that our current research is not hampered significantly by the lack of accurate data, but rather by an inability to explain in satisfactory way data that are hardly in question."
  - Noam Chomsky, Language and Mind 1968

Person centered care: Goals of care are the focus

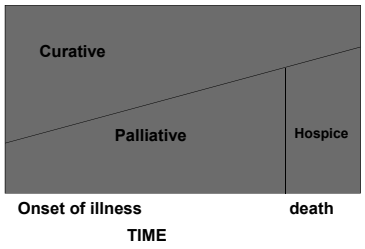
Untangling the evidence: is it possible?



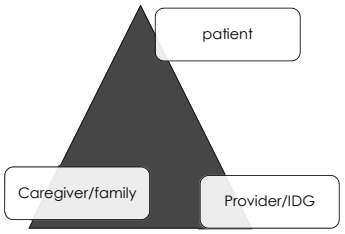
Thinking Outside the Box

- Care must be person centered and reflect individual preferences
- Caregiver interventions must be patient centered rather than condition centered. Behavioral and mental health must be integrated with medical care, and mental health benefits must have parity with medical care.
  - RL Kane et al JAGS 65: 462-5,March 2017
- **Person/patient centered care provides the conceptual basis for implementing palliative care plans by emphasizing *person centered goals* over disease centered outcomes** - Institute of Medicine 2001

Continuum of Care



conceptual model for **person centered outcomes**
focus on 5M: mentation, mobility, medications, what matters, multi-morbidity-AGS,IHI, Hartford



-principles of adult learning-enhance capacity through self learning
-build: mastery, interdependency, resilience
-the provider models the skills for the team; the team models the skills for the patient and family

Action Steps for Decision Making with Multi-morbidity
Executive summary For AGS Guiding Principles
C Boyd et al JAGS April 2019; 67,(4); 665-73

Have any of Us Been Taught How to Do This?

- **Elicit** and incorporate patient and **family/caregiver preferences** into medical decision making
- **Recognize** the limitations of evidence based guidelines and interpret and apply the literature tailored to this population
- **Frame** clinical management decisions within the context of harm, burden, benefits prognosis(remaining life expectancy, function, quality of life)
- **Consider** treatment complexity and feasibility when choosing clinical management decisions
- **Use strategies** *for choosing therapies that optimize benefit and minimize harm, enhancing quality of life and patient preferences*

Structured interview models in literature

- Vitaltalk.org
- Patientprioritiescare.org
- EPEC (educating physician for end of life care NIM)
- PreferenceBasedLiving.com
- Deprescribing.org (CADEN)
- Advancecareplanning.ca
- The conversationproject.org
- Serious Illness Conversation Guide

Preferences for Everyday Living

PELI-NH- KM Abbott et al; JAMDA; December 2018 (pp 1092-8)

Top 20/75 with 90% consistent over 90 days

- Respect
- Care for personal belongings
- Feel cared for (by staff)
- Regular contact with family
- provide relief when upset
- Choose who can participate in your care plan discussions
- Control room temperature
- Choose your medical providers
- Choose your mouth care
- Choose how often to bathe
- Take care of where you live
- Keep up with the news
- Choose your hair care
- Choose what to eat
- Set up bed for comfort
- Do your favorite hobbies
- Learn about topics that interest you
- Do your favorite activities
- Regular contact with friends
- Listen to music you like

Synthesizing Developmental Stages into Goals of Care

Erikson stages of old age

- Identity
- Intimacy
- Generativity
- Engagement
- Integrity

Five core values AD Naik et al JAGS 64: 625-31, 2March 2016

- Self-sufficiency, resiliency
- Life enjoyment and legacy
- Balancing quality and length of life, mastery
- Engagement in care
- Connectedness and legacy; interdependency

Principles of goal centered care: is it all about brushing your teeth and combing your hair?

- Locus of control restores autonomy
- Choice and participation restores hope
- Focus is on capacity building/self efficacy/resilience/interdependency
- Goals of care address meaning and developmental tasks of aging: **Your job is to reframe goals into developmental tasks**
- How you communicate may be more vital than what you communicate : allowing, validating, appreciating, empathizing
- **YES its all about brushing your teeth and combing your hair**

New Models of De-prescribing

TR Fried, MC Mecca; JAGS June 2019; 67(6); 1123-27

Age 65 with 5 or more medications:

Identify patients with multimorbidity and STRATIFY
assess prognosis, frailty, cognitive and physical impairment
Identify PIM with MAI,BEERS,STOPP

Robust vs Vulnerable

Identify Goals of Care using worksheet

Robust: Apply Clinical de-prescribing; apply BEERS, STOPP. START, applications, guidelines, resources; **align goals of care with evidence based risk assessment (traditional model)**

Vulnerable: Boyd suggested applying PCC Guidelines as soon as prognosis is 2-10 years if vulnerable: Distinguish when harm from treatment is more likely than reducing risk of disease

Mecca/Krulewitch/Messenger- **align goals of care with symptom burden and minimize harm**

BEERS Criteria for Potentially Inappropriate Rx in older Adults due to disease-drug or syndrome-drug Interactions

Cardiovascular/ CHF	**NSAIDS, Cox 2 inhib, digoxin over 0.125mg daily**
	diltiazem and verapamil with reduced EF, cilastazol,
	pioglitazone, rosiglitazone, dronedarone (severe CHF)
syncope	**AChEI, alpha 1 blockers-doxazosin, prazosin, terazosin**
	TCA, chlorpromazine, thioridazine, olanzapine
CNS/ seizures	**bupropion, chlorpromazine, clozapine, maprotiline**
	olanzapine, Thorazine, thioridazine, tramadol
Delirium	**anticholinergics, anti-psycholics, benzodiazepines, chlorpromazine, corticosteroids, H2 receptor antagonists**
	meperidine, sedative hypnotics
dementia	**same as above and add non benzodiazepine receptor agonists, hypnotics, eszopiclone, zolpidem, zalepion**
Falls, fractures	**same as above with anticonvulsants, TCAs, SSRIs, opioids**

BEERS criteria drug syndromes; cont/

- GI ASA- over 325mg, non-Cox2 NSAIDs
- Diabetes avoid long acting glyburide, chlorpropamide
- Renal NSAIDS Cox and non-Cox
  - Incontinence in women avoid oral estrogens, alpha-1 blockers
  - BPH avoid anticholinergics except anti-muscarinics
- Parkinson's anti-psychotics *except aripiprazole, quetiapine, clozapine*
- Anti- emetics metoclopramide, prochlorperazine, promethazine
  Anticholinergics leading to bowel dysfunction as well as confusion

BEERS non-infective drug drug strong warnings

ACEI	Amiloride, triamterene +K
Anticholinergics	Anticholinergics
Anti-depressants SSRI,SNRI,TCA	Other CNS drugs
Antipsychotics	Other CNS drugs
Benzodiazepines, non Benz.,	Other CNS drugs
Corticosteroids	NSAIDs
Lithium	ACEI, loop diuretics; lith+
Opioids	Other CNS drugs
Peripheral Alpha 1 blockers	Loop diuretics
Theophylline	Cimetidine
Warfarin	Amiodarone, NSAIDs

Decision making with common diseases-HTN

- Various studies indicate both high and low BP contribute to mortality
- Indications-essential htn, CHF, edema/ascites, Portal HTN, angina, BPH
- Primary, secondary, tertiary prevention
  - CKD, CVD, Cerebrovascular disease
- JNC 8 Guidelines- (non diabetics) evidence is poor
  - < 60 yrs >60 yrs
  - <140/90 <150/90 *I use <160/95 if polypharmacy and frailty
- Treat HTN with SBP >160 and symptoms
- Adverse effects of anti-HTN medications recognized by BEERS and STOPP contributing to orthostatic hypotension, syncope, falls, injury, bradycardia, selective bronchospasm, edema, immobility, electrolyte disorders, dehydration, ARF, dry cough, confusion

Managing diabetes with CDM goals at the end of life

- Prevent hypoglycemia CBG <80; risk encephalopathy and deteriorating cognition. Less stringent hyperglycemia monitoring of CBG and HgA1C
- Minimize adverse side effects with other drugs
- Improve burden of care with less needles, monitoring
- Active dying: no consensus but allow CBG <350, taper or stop diabetic meds

Meta analysis of Interventions to Reduce ADE in Older Adults SL Gray et al JAGS 66:Feb 2018; 282-88

- The most common type of intervention was pharmacist led IDG
- Only one study used clinical decision support software
  - NNH/NNT >1 TIME TO STOP? What if TTB > 2 yr? 5 yr?
- Most communication was in person but a few used written materials
- One study focused mostly on anti-coagulants: start with one class of drug. CADEN encourages physicians to identify three BEERs Rx
- 11 studies used prescribing strategies rather than focusing on one type of ADE
- **Pharmacist led IDG had 35% reduction in ADR**

Goals of Care worksheet-reframing

Preferences Narrative based	Developmental skills/ synthesis Identify Interpret validate	Developmental tasks in old age; Late life/ near death reframe	Prioritize/ rank preferences with realistic goals of care
What are your goals for the next 30 days? 90 days? One year? What would give you the most joy? Meaning?	**Mastery** **Resilience** **Inter-Dependence and legacy**	**Autonomy, self care, function: ADL, IADL, AADL** **Taking hold of the willingness to deal with life completion** **Coming to terms with mortality** **Contemplative practice** **Self-acceptance** **Saying goodbye** **Blessings** **Life repair** **Review, completion** **Forgiveness, harvesting** **Reconciliation, healing** **Reframing meaning and purpose, re-engaging** **Transmission and legacy** **Being with dying transcendence**	

De-prescribing: a modest proposal using AGS and AAFP guidelines; modified Dr. Barbara Messinger -Rapport

Barriers: Symptom burden, syndromes, negative social determinants	Medication/ Evidence based Treatment choices	Disease/Diagnosis	Goals of Care: List worksheet ranked preferences Realistic goals
Assess and prioritize symptom burden, side effects syndromes barriers to GOC	Easy targets Complex targets	prognosis	
	Drug syndromes cascades		clarify with realistic goals
	drug-disease		Validate/empathize
Align barriers with goals of care	Time to benefit Number needed to tx		prioritize
Build consensus	Select and negotiate	Re-assess in timely manner	

Case: revisited

- Ms.B 74 yr. old new patient, family moved from rural home to local ALF
- Husband died, she is matriarch of large family, religious affiliation supports Full code POLST
- After moving in family notes increased weakness and depression. She is independent in all ADL, admits she is withdrawn, tired, confused, shuffling, eating less without dysphagia or indigestion
- HTN, AF, GERD, gout, CHF, DJD, neuropathy, old lumbar comp fx, osteoporosis, NIDDM
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- Labs: Na 126, Cr1.4, BUN 12, K 4.7, Cl 112; HgB 9.7 Plt 214 WBC 6700; ESR,INR, uric acid WNL

Symptom burden	medication	Disease/evidence based Tx	Goals of Care
Assess symptoms Function syndromes	Easy targets Complex targets, Drug syndromes, drug-disease	prognosis	Identify values, meaning, developmental tasks: Improve, maintain autonomy, function, independence, ability to enjoy being close to family
Weakness Depression Fall risk Poor appetite confusion	Lisinopril,amlodipine, ASA furosemide Metoprolol,statin Warfarin,amiodarone Omeprazole Gabapentin Fluoxetine,zolpidem, gingko Colcichine, alendronate Naproxen, allopurinol	HTN CAD, CHF? AF GERD Neuropathy Depression Memory loss? Gout DJD, osteoporosis	promotes legacy, transmission, completion. Validate, prioritize. Build consensus; clarify risks and benefits

Teaching points

- **MULTIPLE PROVIDERS, MULTIPLE DISCIPLINES**
- **19 RX and 5 OTC ; no medi-set or supervision**
- **POOR: ORGANIZATION/COORDINATION/RECONCILIATION**
- **Obtain POLST: what are goals of care? Plan care conference**
- **BLEEDING RISK COUM+ASA+NSAID, GINGKO,GARLIC, fish oil otc/AMIODARONE STOP**
- **NEURONTIN PLUS ZOLPIDEM RISK SEDATION or FALLING STOP**
- **PRESCRIBING CASCADES: Is it gout? Is it CHF? Is it AF?**
- **Alendronate, NSAID > GERD > dysphagia > malnutrition STOP**

Amlodipine>edema> Furosemide> colchicine > CKD STOP

GERD > Omeprazole> allopurinol> CKD/osteoporosis STOP

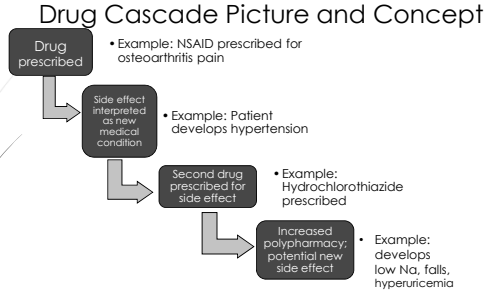
Lovastatin> Amiodarone> colchicine> myalgia> weakness> FALLING STOP

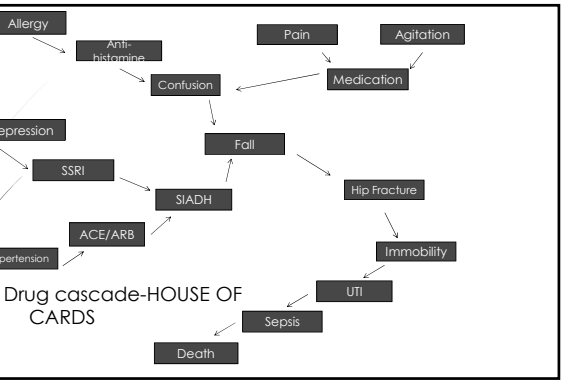
Fluoxetine> Furosemide> Lisinopril> SIADH> CONFUSION and FALLING TAPER

SIADH > Metoprolol + furosemide > orthostatic hypotension> CONFUSION and FALLING TAPER

Go Low, Go Slow vs Stop Most, Reduce Dose

Drug Cascade Picture and Concept





Drug cascade-HOUSE OF CARDS

Common Symptoms in the Older Adult and Rx

- **Confusion**- anticholinergics, benzos, opioids, sedatives, anti-psychotics, anti-neuropathy
- **Constipation**- TCA, calcium channel bl, anticholinergics
- **Hyponatremia**- thiazides, loop diuretics, anti-epileptics, TCA,SSRI,SNRI, mirtazapine, anti-psychotics
- **Incontinence** / retention-diuretics, anticholinergics, ACEI, caffeine
- **Orthostasis**-antihypertensives esp nitrates, clonidine, alpha blockers, b-blockers,
- **Behavioral Disorder in Dementia-** Anti-psychotics, AChI, antimuscarinics, anti-depressants, seizure meds, anti-anxiety drugs, memantine
- **QT prolongation**- antiarrythymics, antimicrobials, antipsychotics, antidepressants, antiemetics, methadone

Drug Induced Anorexia or Weight Loss

- DM- metformin
- Dementia-Cholinesterase Inhibitors
- Depression-SSRI, Wellbutrin
- Osteoporosis-GERD/bisphosphonates
- Seizures-Topiramate, lacosamide, Dilantin, Depakote
- Parkinson's-carbidopa/levodopa
- AF-digoxin, amiodarone
- COPD-theophylline
- Minor symptoms with anti-histamine- dry mouth from Benadryl, loratadine, Detrol, Ditropan etc
- Analgesics-opioids, NSAIDS: nausea, gastritis, constipation

Easy Targets

- Review and reconciliation of medications at hospital admission, transfer to SNF/PAC, ICF, ALF, and upon entering a hospice program
- Common PIP, ADE-apply BEERS,STOPP, guidelines
- Consider drug-drug interactions: anti-cholinergics, opioids, anti-coagulants
- Common diseases- question tight controls for HTN, Diabetes

Poly-pharmacy complex targets

- Drug-drug interactions
- Disease-drug interactions
- Syndromes-anticholinergic, serotonin, SIADH, opioid
- Dementia with multiple chronic conditions; clusters with poor prognosis
- Relapse is real; monitor and plan for follow up

Reasons for Stopping Rx
helping them make a reasonable choice

- Changing goals of care
- Time to benefit
- Physiological changes
- Lack of efficacy
- Pill burden
- complexity of regime
- Potential for a prescribing cascade
- Dropping risk/benefit
- Drug-drug interactions
- Adverse effects
- Duplication
- Cost
- regulations

The case evolves: a cautionary tale

- Recent hospitalization for CVA/TIA with unwitnessed fall; bruised r hip no Fx
- **UTI, aspiration pneumonia resolved now intake less than 50% on pureed. Crying, agitated, screaming often, confused, disoriented, refusing to do any rehabilitation in SNF. Weight loss 14 pounds to 116. Family notified benefit period for SNF is exhausted.**
- B/P 105/52 HR 84 R 18 T 97.6; dysarthria, right sided bruise, weakness resolving
- Exacerbation old comp fx with fall, pain in lower back and hips and sciatica
- diabetes poor control, CKD worse, confusion, weakness, SLUMs 18/30
- **Severe agitation with movement, no BM in three days, delusional BPSD, depression, anorexia, weight loss, confusion, failure to thrive**
- Rivaroxaban, oxycodone, Vicodin, tramadol, asa, gabapentin, lansoprazole, amlodipine, furosemide, digoxin, carvedilol, ciprofloxacin, lorazepam, trazadone, duloxetine, zolpidem, mirtazapine, quetiapine, losartan ,Hctz, spironolactone, glyburide, metformin, SS
- **Increasing immobility, de-conditioning. Told to place patient on hospice for idiopathic progressive encephalopathy and dementia**
- LABS: HgB 8.4, BUN 72 ,Cr 1.3, Na 130,K 5.7,Cl 106, ESR 48, HgA1c 7.5, Dig 1.8

	Symptom burden	medication	Disease/evidence based Tx	Goals of Care
	Assess symptoms Function syndromes	Easy targets Complex targets, Drug syndromes, drug-disease	prognosis	Identify values, meaning, developmental tasks
	Weakness, falling Deconditioning Lethargy Near syncope Myalgia, chronic pain New back pain? Hip? Bilat hip and shoulder pain Anorexia, nausea, weight loss Dry? constipated Hx shoulder and back surgery Increased confusion, BPSD agitation, delirium	Rivaraxaban, oxy 10q6, hydrocodone 5q4 prn, 100 tramadol q6 prn Off steroid Asa, insulin, gabapentin glyberide, metformin, SS Lansoprazole Hctz, amlodipine Spironolactone, losartan digoxin, coreg, Lasix Diphenhydramine, Ciprofloxicin, lorazepam Trazedone ,duloxetine, Zolpidem, quetiapine, mirtazapine	Hip fx PMR, DJD CKD IDDM + neuropathy GERD BPH HTN CHF Anxiety, agitation Other (post op UTI) Psychosis, insomnia, depression	Reframe with realistic goals, - Align with goals of care barriers - Validate, prioritize, build consensus GOAL: Unable to do REHAB faces ICF placement and ongoing immobility and decline. Repair, Restore, Purpose, Autonomy

Applying PCC worksheet

- **Agitation, encephalopathy, dry**
- **Opioid use disorder**
- **Serotonin syndrome, BPSD**
- **Anti-cholinergic excess**
- **Neuroleptic use and drug interaction**
- **Proper pain mgnt**
- **Dementia, depression, anorexia**
- **Anemia, PMR, abn BUN,K,Dig**
- **Angry caregiver**
- **Discharged in week to ALF with home care; no hospice needed. Not depressed; eating mech soft easily. No edema, orthopnea, DOE**
- **No lawsuit; no board complaint, no APS investigation at nursing home**
- **Listen, empathize, validate daughter**
- **Negotiate with daughter, specialists, insurance**
- ***STOP* oxycodone, vicodan, tramadol; use 12 mcg Duragesic and 0.5 q6 prn hydromorphone,**
- ***STOP* gabapentin, amlodipine, Hctz, spironolactone and furosemide, *ASA***
- ***LOWER* digoxin losartan and coreg dose**
- ***STOP* mirtazapine, trazadone, zolpidem, lorazepam, duloxetine**
- **TXC**
- **Add steroid, rivastigmine, laxative, fluids**
- **Stop sliding scale, glyburide and metformin; use glargine and glipizide**
- **Re-assess frequently; monitor depression and dysphagia; check for sx, signs CHF, ESR, follow up labs**

Setting Realistic Goals

Dr.K's Geriatric Uncertainty Principle

Risk based decision making

SAFETY CONTROL — **AUTONOMY** INDEPENDENCE

HARM from treatment — **RISK** of Increasing Disease

You cannot maximize both ends of the fulcrum-

What will patient choose to prioritize? goals of care/ consequences/values/ meaning

This is a rewarding process

- Collaboration and shared decision making strengthen relationship to patient and family
- Therapeutic and rewarding for provider and patient
- Encourages discussion upstream before more difficult end of life conversations are necessary
- Families more likely to discuss medication than end of life care planning at first case conference
- Restores our connection to our practice and patients at a deeper level

PCP Physician leadership

"One of the first duties of the physician is to educate the masses not to take medicine."- William Osler

- Palliative care consultations at transitions of life: CBLTC , SNF ICF and NH EOL are missed opportunities to address polypharmacy and goals of care
- The PCP is best provider to have palliative care conference
- What kind of team leader are you? ***Change starts at the top*** in hierarchical organizations
- What management systems reinforce patient centered care? ***Requires ongoing training. Use the IDG morning staff mtg***
- Your team is an ongoing training environment

Wrap up for De-prescribing JUST DO IT!!

- Shift from "start low go slow"
  - To "stop most and reduce dose"
- Patients will consider it if you bring it up
- It is patient specific intervention; stratify early into vulnerable and robust
- Person oriented GOC outcomes over disease oriented outcomes
- It will improve their QOL
- Prioritize-optimizing benefit, minimize harm, maximize QOL and function
- Work with a pharmacist in your team
- Use tools and algorithms
- PRACTICE PRACTICE **PRACTICE**

The Nature of suffering and the Goals of Medicine-Eric J. Cassell

"The relief of suffering and the cure of disease must be seen as twin obligations of a medical profession that is truly dedicated to the care of the sick. Physicians failure to understand the nature of suffering can result in medical interventions that, though technically adequate, not only fail to relieve suffering but becomes a source of suffering itself."