Welcome to IECG Session 2 Elder Mistreatment, Cognition, Medication

THIS PROJECT IS/WAS SUPPORTED BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA) OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) UNDER GRANT NUMBER U1QHP28740, GERIATRICS WORKFORCE ENHANCEMENT PROGRAM FOR $3.5 MILLION. THIS INFORMATION OR CONTENT AND CONCLUSIONS ARE THOSE OF THE AUTHOR AND SHOULD NOT BE CONSTRUED AS THE OFFICIAL POSITION OR POLICY OR, NOR SHOULD ANY ENDORSEMENTS BE INFERRED BY, HRSA, HHS OR THE U.S. GOVERNMENT.

USC University of Southern California

Keck School of Medicine of USC

Geriatric Healthcare Collective

IECG AGENDA

November 4, 2022

Time	Agenda Session 2	Presenter
2:05 PM- 2:20 PM	Refresh & Reflect • Large group discussion on connecting	*Freddi Segal-Gidan*
2:20 PM- 2:30 PM	IECG Urgent Issues	*Freddi Segal-Gidan*
2:30 PM-2:40 PM	Elder Mistreatment Overview	*Ricky Esquivel*
2:40 PM-3:00 PM	Cognition	*Chris Beam*
3:00 PM- 3:30 PM	Medication	*Tanya Gurvich*
3:30 PM-3:45 PM	Break Into Teams	
3:45 PM-4:30 PM	Team Building	*All Teams break out Online students connect with team via Facetime/ Phone*

Share out questions

- How did you connect with your partner? Facetime, phone, in-person
- How did you describe the IECG program to your older adult partner? Any helpful tips?
- How did the conversation go about wellness? Mental health? And Nutrition?

IECG 2022-2023

What to do in case of an urgent issue with your senior partner

Freddi Segal-Gidan, PA, PhD
Physician Associate &
Gerontologist
Associate Professor Clinical
Neurology,
Family Medicine & Gerontology,
USC

IECG Supporting your older adult partner if they are in emotional pain

- Please remember that these calls are meant to be social in nature, you are not operating in a clinical capacity, however, if your older adult does talk about thoughts of death, wanting to die, euphemisms (“sad,” “feeling blue,” “lonely,” “I’m ready to go”) or anything that is concerning to you

Here is a guide to help you with an appropriate response.

Ask them more about it. Depending on what they are saying, you can or should ask them more about it. Follow your gut instinct, if it sounds off track then follow up.

1. Assess for risk of suicide or harm
2. Listen without judgment
3. Give reassurance and information- link
4. Encourage appropriate professional help
5. Encourage self-help and other support strategies

If you suspect suicidality or elder abuse

If you detect suicidal ideations or feel your older adult is experiencing a form of abuse. Let them know you are concerned and would like to ask some additional questions. Let them know you are a mandated reporter and are required to follow up accordingly:

Report suspicions of abuse as soon as possible.

Adult Protective Services
https://www.napsa-now.org/

IECG Risk Assessment and Response

Low risk, after your phone call ends call or email your team faculty team lead.

- Use resources to engage older adult in coping skills, increasing support

Medium risk call your team faculty lead while you're still on the phone with your partner, if faculty is not available try your faculty discipline lead.

- Safety plan:
  1. Ask questions to find out if they are seeing a mental health provider and encourage them to call them.
  2. Ask them if they are willing to provide the mental health provider's phone number to you so you can call on their behalf
  3. Ask if there is anyone around (at home, nearby) ensure they are not alone
  4. Use resources to engage older adult in coping skills, increasing support, and reasons to live
  5. Review protective factors

High Risk (danger to self or others)

1. Ask if someone is with them, a family member, friend or caregiver, etc. and ask to talk to them.
2. Let them know they should call 911 because the older adult is in immediate danger to self
3. If the older adult is alone and high risk, has ideations, intent, plan and means an urgent intervention is required, call 911 then also let them know that you care about their well-being and will be sending someone to look in on them, and that "they are coming to help you".
4. Obtain their address, use your conference calling option on your phone, keep your older adult on the phone when you call 911.
5. After the situation has resolved immediately contact your faculty team lead

IECG Team Member	Name	Email	Discipline	COLOR	Cell Phone
Faculty Planning Team Leads	Ashley Halle	Ashley.Halle@med.usc.edu	Occupational Therapy	Blue	Ask your team
Faculty Planning Team Leads	Chris Beam	beamc@usc.edu	Psychology	Green	Ask your team
Faculty Team Lead	Bruna Martins-Klein	brunamar@usc.edu	Psychology	Fuschia	Ask your team
Faculty Team Lead	Carolyn Kaloostian	Carolyn.Kaloostian@med.usc.edu	Medicine	Pink	Ask your team
Faculty Planning Team Leads	Mitzi D'Aquila	daquila@med.usc.edu	Physician Assistant Studies	Silver	Ask your team
Faculty Planning Team Leads	Tanya Gurvich	gurvich@usc.edu	Pharmacy	Black	Ask your team
Faculty Team Lead	Isabel Edge	Isabel.Edge@med.usc.edu	Medicine	Orange	Ask your team
Faculty Team Lead	Jennifer Okuno	jennifer.okuno@med.usc.edu	Physical Therapy	White	Ask your team
Faculty Planning Team Leads	Jo Marie Reilly	jmreilly@med.usc.edu	Medicine	Yellow	Ask your team
Faculty Planning Team Leads	Dawn Joosten-Hagye	joosten@usc.edu	Social Work	Teal	310-991-1831
Faculty Team Lead	Janice Tramel	jtramel@med.usc.edu	Physician Assistant Studies	Purple	Ask your team
Faculty Team Lead	Kelsey Peterson	kelsey.peterson@med.usc.edu	Occupational Therapy	Gold	Ask your team
Faculty Team Lead	Patrick Tabon	Patrick.Tabon@med.usc.edu	Pharmacy	Lime	Ask your team
Faculty Planning Team Leads	Cheryl Resnik	resnik@pt.usc.edu	Physical Therapy	Red	Ask your team
Faculty Team Lead	Suh Chen Hsiao	shuhsiao@usc.edu	Social Work	Brown	Ask your team
Lead Project Coordinator	Sandra Vasquez	Svasquez2@usc.edu	IECG Admin		626-637-7107
Faculty Planning Team Leads	Freddi Segal-Gidan	segalgi@usc.edu	Physician Assistant Studies		310-989-8697

Contact Information for IECG Faculty and Staff

NATIONAL CENTER ON ELDER ABUSE (NCEA)

NCEA National Center on Elder Abuse
Keck School of Medicine of USC

Richard Esquivel
Research Assistant
Richard.Esquivel@med.usc.edu
National Center on Elder Abuse

Reaching our goals:

Why this work is important.

NCEA
National Center on Elder Abuse

Keck School of Medicine of USC

Education

Through our local, national, and even global outreach efforts we continue to facilitate and promote discussions on elder abuse and how it can be prevented.

Research

More research can introduce additional methods and quality of formal aid and prevention of elder abuse.

Collaboration

Working with like-minded agencies to amplify the voices of older adults.

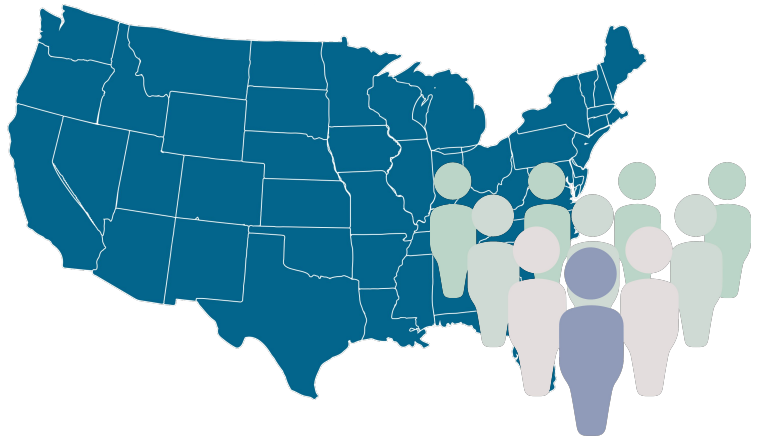
What is Elder Abuse?

Elder Abuse, the mistreatment or harming of an older person, is an injustice that we all need to prevent and address.

- Community & institutional settings
- Multiple forms can occur at once
- Under-detected, under-reported

Statistics

- 80 million Americans will be aged 65 or older by the year 2040, nearly **21% of the population**
- **1 in 10** Americans age 60+ experience a form of elder abuse every year
- **1 in 24** cases are reported



Types of Elder Abuse

Physical

Emotional/ Psychological

Sexual

Neglect

Financial

Multiple forms of abuse can occur at once.

Signs of Abuse

Physical Signs

- Broken bones, bruises, and welts
- Cuts, sores, or burns
- Torn, stained or bloody clothes
- Unexplained sexually transmitted diseases
- Dirtiness, poor nutrition or dehydration
- Poor living conditions
- Missing daily living aids (glasses, walker, medications)

Signs of Abuse

Emotional & Behavioral Signs

- Unusual changes in behavior or sleep
- Fear or anxiety
- Isolated or not responsive
- Sadness

Signs of Abuse

Financial Signs

- Unusual changes in bank account or money management
- Unusual or quick changes in a will or other financial documents
- Fake signatures on financial documents
- Unpaid bills

Mandated Reporting

Certain professionals are legally required to report suspected abuse, neglect, or exploitation. Mandatory Reporters may vary by state.

- Health Practitioners
- Employees of a County Adult Protective Services Agency
- Employees of a Local Law Enforcement Agency
- Clergy
- Elder/Dependent Adult Care Custodians
- Officers and Employees of Financial Institute

Reporting Abuse

Report suspicions of abuse as soon as possible.

Adult Protective Services

Long-Term Care Ombudsman

Local Law Enforcement

To connect to a local or state reporting number, contact the Eldercare Locator at eldercare.acl.gov or at 1-800-677-1116 M-F 9AM – 8PM ET.

Talking with Older Adult

If your older adult partner discloses an issue that raises concerns about elder mistreatment:

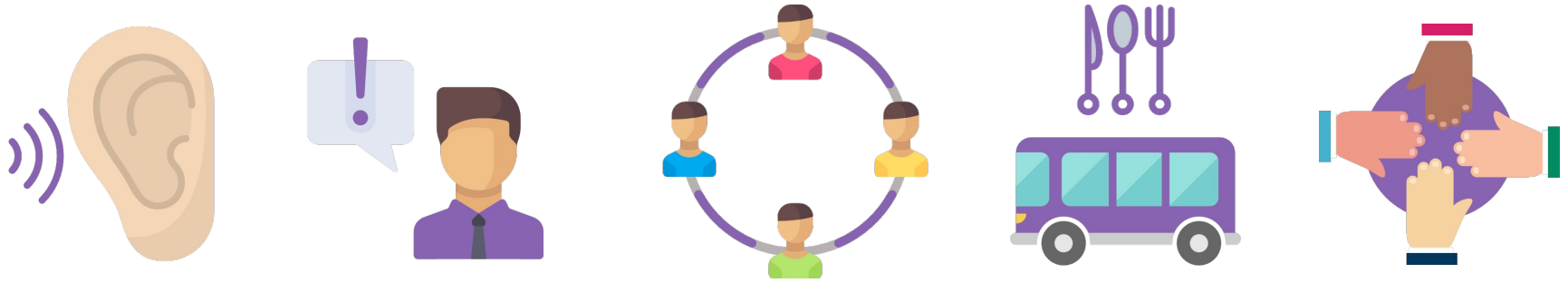
- ❑ Thank them for sharing the information
- ❑ Reassure them that you will address the concern with faculty
- ❑ If the older adult is distressed, ask them if they would like to speak directly with your faculty lead

Resources

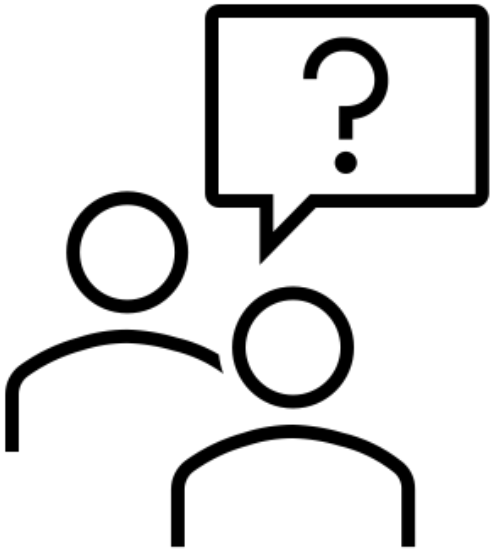
NCEA National Center on Elder Abuse	National Center on Elder Abuse	https://ncea.acl.gov
EAGLE Elder Abuse Guide for Law Enforcement	Elder Abuse Guide for Law Enforcement (EAGLE)	https://eagle.usc.edu
STEAP INITIATIVE Supports + Tools for Elder Abuse Prevention	Supports and Tools for Elder Abuse Prevention (STEAP)	https://ncea.acl.gov/Resources/STEAP.aspx
Training Resources on Elder Abuse	Training Resources on Elder Abuse	https://trea.usc.edu
USC Center for Elder Justice	USC Center for Elder Justice	https://eldermistreatment.usc.edu

Preventing Elder Abuse in Our Community

Elder abuse can be **prevented** – and everyone has a role to play. It is up to all of us to build strong supports for one another and prevent abuse before it happens.



Elder Abuse Curriculum for Medical Residents and Geriatric Fellows



If you are interested in learning more about Elder Abuse and obtaining a certification. Please go to:

https://keckschool.aomlms.com/

For more information on the curriculum, please contact Carmen.vandenheever@med.usc.edu

Thank You!

NCEA
National Center on Elder Abuse

Keck School of Medicine of USC

National Center on Elder Abuse (NCEA)

- 1-855-500-3537 (ELDR)
- ncea-info@aoa.hhs.gov
- https://ncea.acl.gov/

@NationalCenteronElderAbuse

@NCEAatUSC

IECG 2022-2023

Cognition, Dementia, & Delirium

Christopher R. Beam, Ph.D.

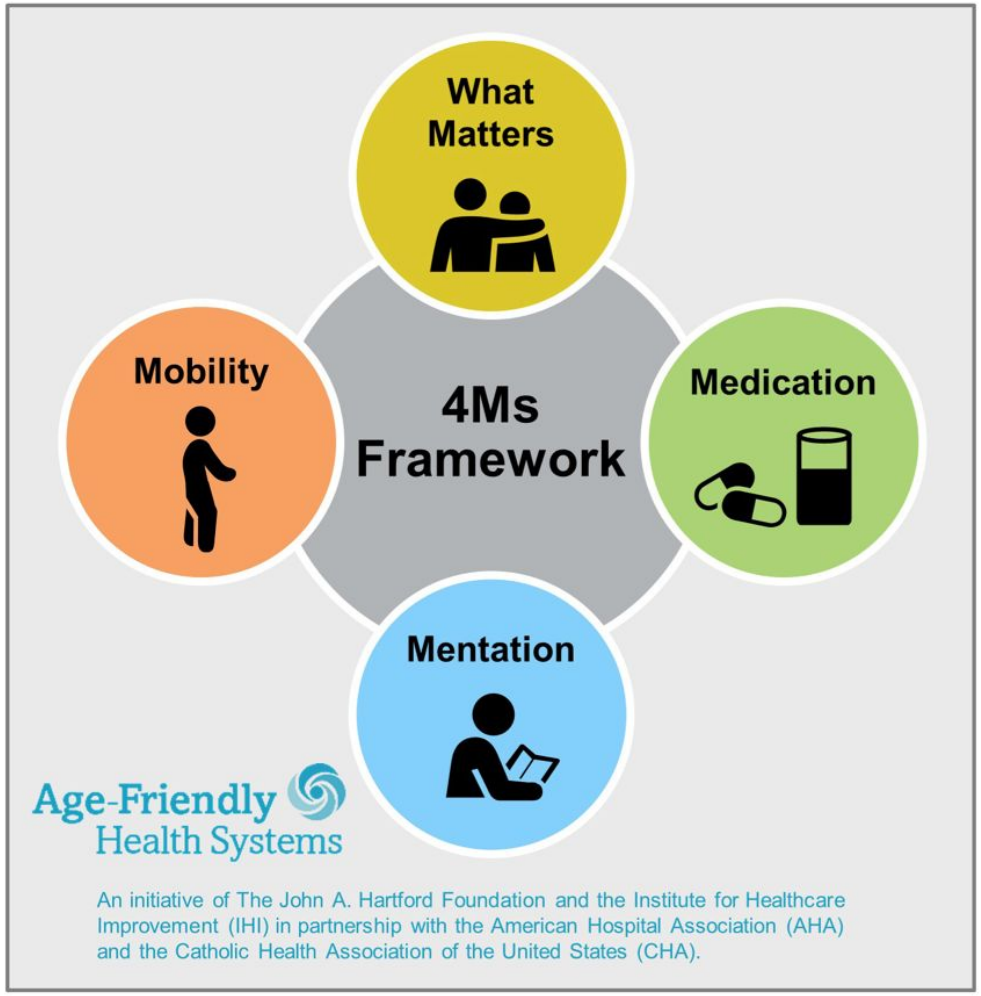
Assistant Professor of Psychology and Gerontology

Department of Psychology

Dornsife College of Letters, Arts and Sciences

Objectives

- Review “Mentation” in Age Friendly Health Systems
- Describe what happens to cognition over the lifespan and how to communicate it to older adults
- Differentiate dementia, delirium, and depression
- Identify how to locate and use evaluations for assessing cognition in a virtual format, including the MoCA Blind, TICS and Mini-Cog



What Matters

Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication

If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility

Ensure that older adults move safely every day in order to maintain function and do What Matters.

Cognition Over the Lifespan

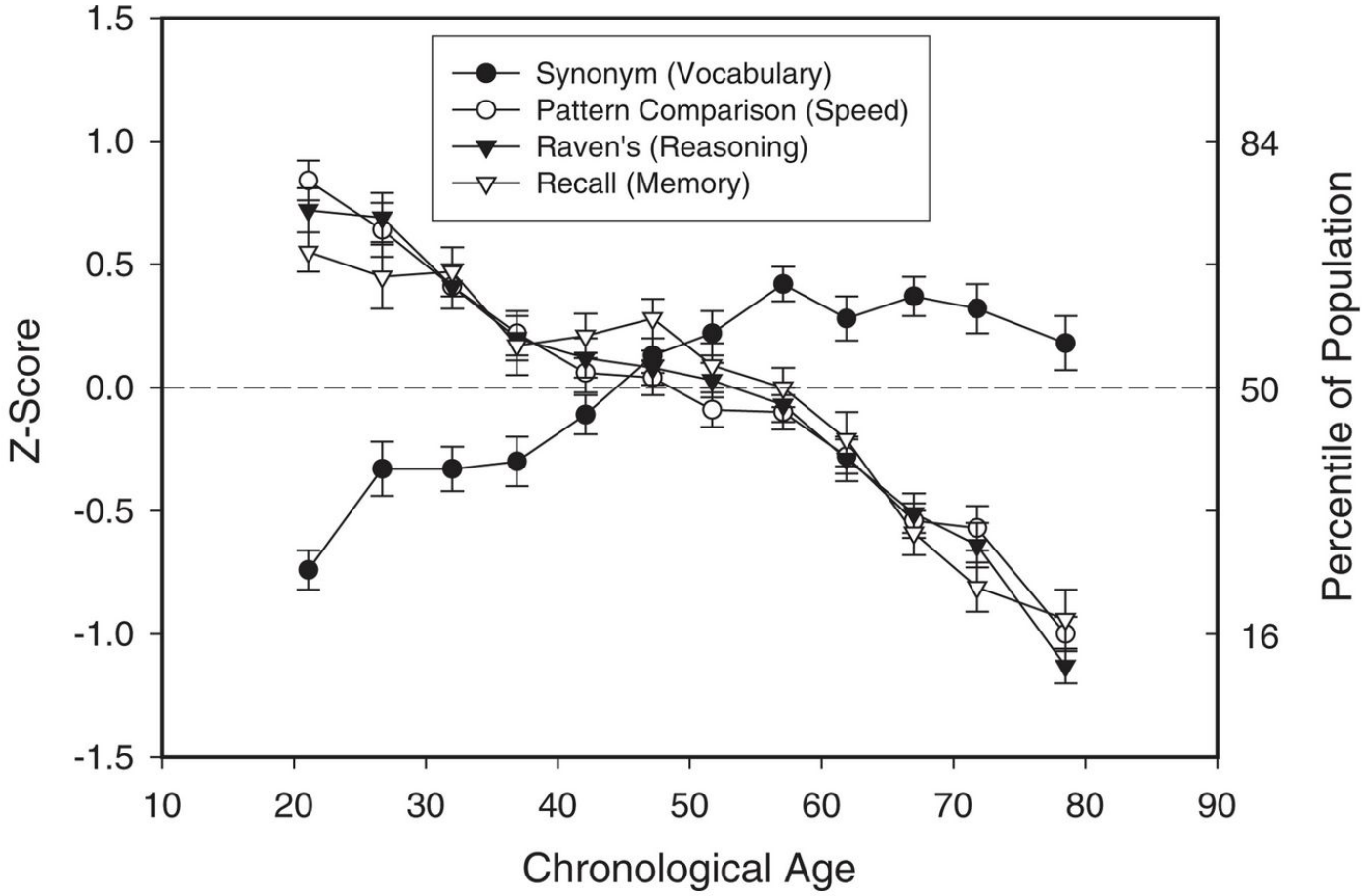


Fig. 1. Means (and standard errors) of performance in four cognitive tests as a function of age. Each data point is based on between 52 and 156 adults.

Salthouse (2004)

Different Intelligences

Multidimensionality
Multidirectionality

Different Forms of Intelligence

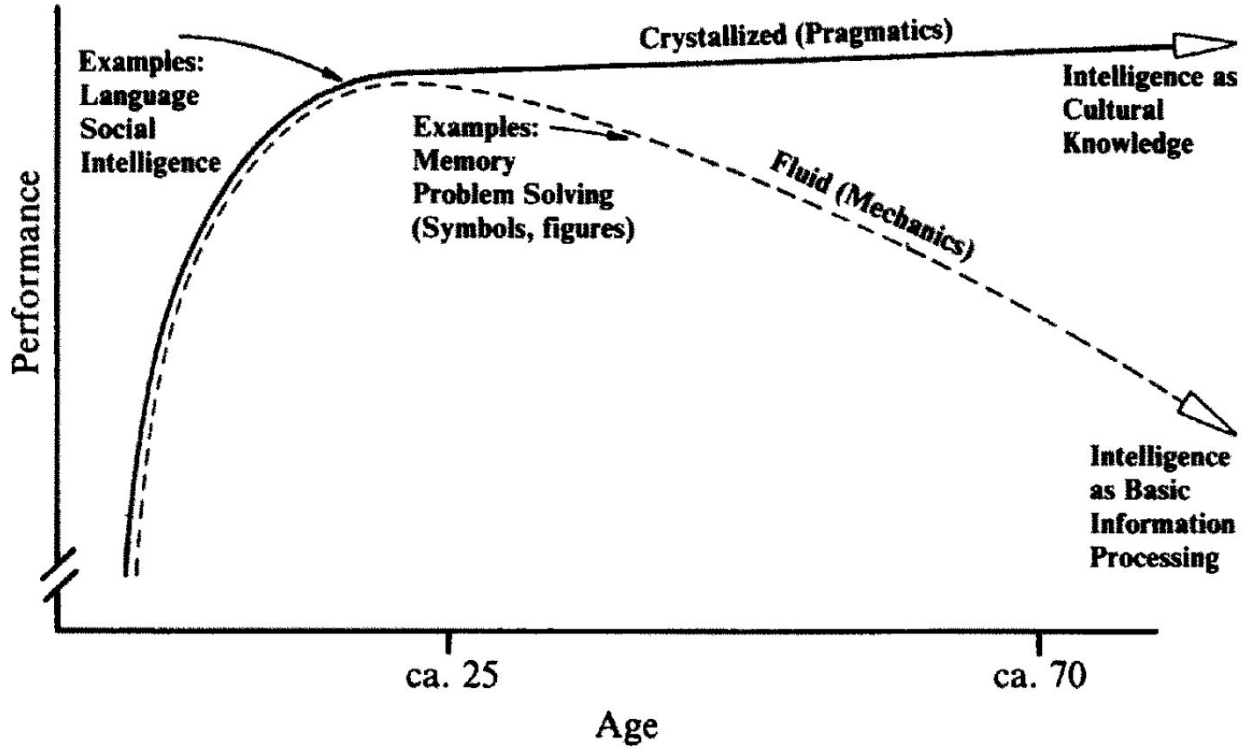


Figure 1. One of the best known psychometric structural theories of intelligence is that of Raymond B. Cattell and John L. Horn. (The two main clusters of that theory, fluid and crystallized intelligence, are postulated to display different life-span developmental trajectories.)

Baltes (1987)

Cognitive Domains

- Not just one score
- Crystallized and fluid intelligence
- Verbal versus nonverbal
  - Verbal Comprehension
  - Nonverbal Reasoning
  - Processing Speed
  - Working Memory
- Memory versus nonmemory

Cognitive Aging Tenets

Tenet 1

Cognitive aging is best understood using a developmental life span approach that considers cognitive development as a lifelong process that begins with conception and ends with death.

(Judge & Dawson, 2018, p. 94)

Cognitive Aging Tenets

Tenet 2

Cognitive aging occurs within a framework of gains, declines and stability.

(Judge & Dawson, 2018, p. 94)

Cognitive Aging Tenets

Tenet 3

Cognitive aging is influenced by and incorporates a wide range of inter- and intraindividual differences, including but not limited to lifestyle factors such as diet, exercise, health habits and education.

(Judge & Dawson, 2018, p. 94)

Considerations

Understand the intricate relationship between cognition and everyday function

Functional impairment is an important outcome

Be able translate basic research findings into real-world situations and clinical practice

(Judge & Dawson, 2018, p. 105)

Dementia, Delirium, and Depression

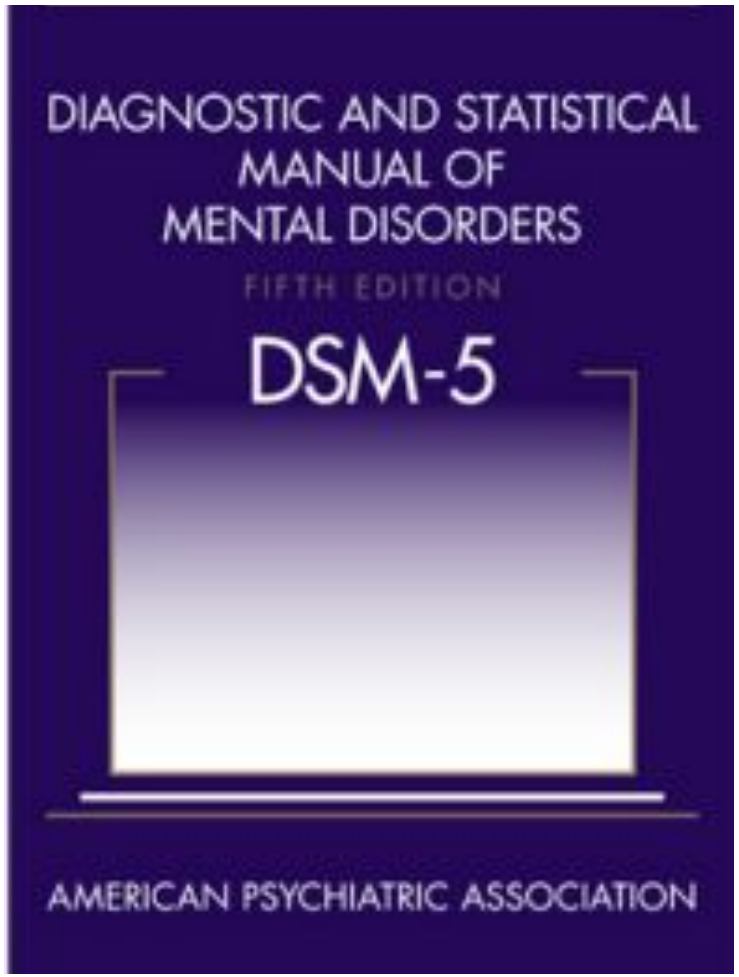
Geriatric Syndromes

Defined: multifactorial health conditions that occur when accumulated effects of impairments in multiple systems render an older person vulnerable to situational challenges

Giants of Geriatrics (1975)
- Immobility
- Incontinence
- Instability
- Intellectual incapacity

Geriatric Syndromes (2007)
- Functional decline
- Pressure ulcers
- Incontinence
- Falls
- Delirium/dementia

Emerging syndromes
- Sarcopenia, polyprovider, polypharmacy, pain, frailty



Neurocognitive Disorder (NCD)

NCD is an acquired deficit in 1+ areas of cognitive function

- Complex attention
- Learning and memory
- Language
- Executive function
- Perceptual-motor skill
- Social cognition

Severity

- NCD can be *mild* or *major*
- *Major NCD* can be *mild, moderate, severe* too
- APA (2013) replaced *dementia* with major *NCD*

Mild Cognitive Impairment (MCI; Mild NCD)

Syndrome characterized by impairment in a single cognitive domain

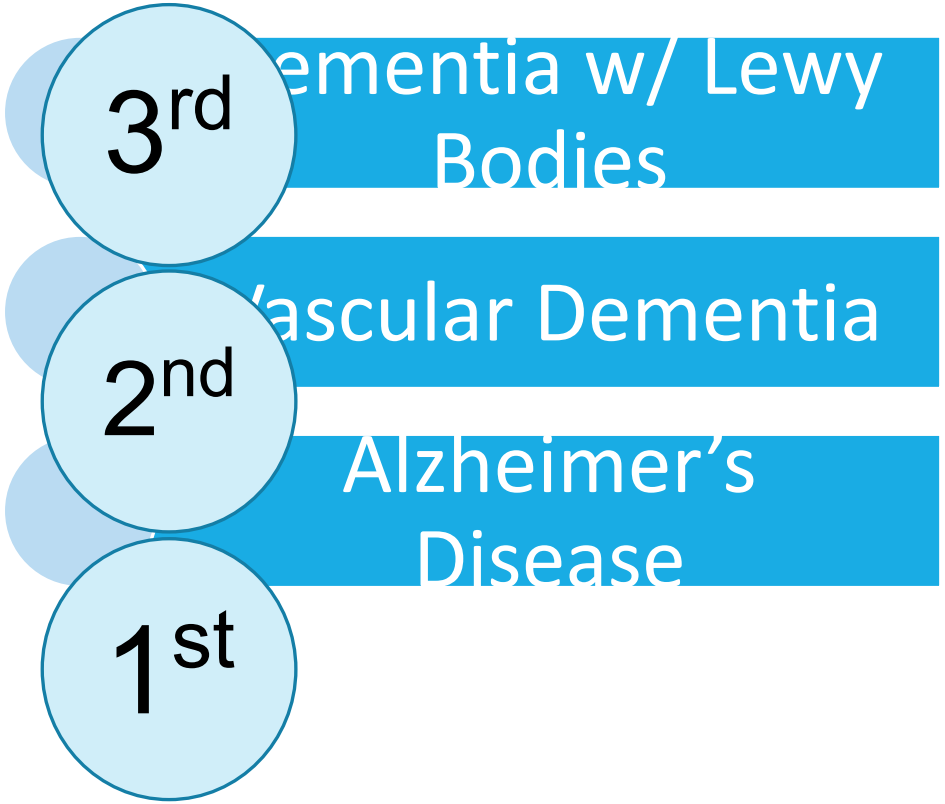
Usually memory (amnestic MCI)

People w/ MCI do not meet criteria for dementia

Dementia (Major NCD)

- Global term; not a specific disease
- Describes atypical or pathological changes in cognitive functioning
- Classifications: reversible or irreversible
- Delirium ≠ dementia ≠ depression

Three Most Common Types of Dementia



Delirium

- Has an acute, dateable onset
- Treatable or reversible
- Possible symptoms:
  - Difficulties with attention and concentration
  - Change in alertness
  - Agitation or psychotic symptoms
- Symptoms can fluctuate dramatically
- Considered a medical emergency

Depression (MDD)

Chronic or acute

Evident for ≥ 2 weeks on more days than not

Five of 9 symptoms endorsed

- One of 2 cardinal symptoms (sadness or anhedonia)

Weight change, sleep change, agitation, fatigue, diminished ability to concentrate, feelings of worthlessness, thoughts of death

Dementia, Delirium, & Depression

Table 2. Differential Diagnoses for Delirium

Clinical Features	Delirium	Dementia	Depression
Onset	Acute	Insidious	Acute or insidious
Duration	Hours to weeks	Months to years	Weeks to months
Course	Fluctuating	Chronic and progressive	May be chronic
Progress	Usually reversible	Irreversible	Usually reversible
Level of consciousness	Altered	Usually clear	Clear
Orientation	Variable	Disoriented	Oriented
Attention and concentration	Poor	Normal except in late stage	May be impaired
Speech	Incoherent	Coherent until the late stage	Usually normal
Thought process	Disorganized	Limited	Usually organized
Perception	Hallucinations are frequent especially visual	May have hallucinations especially visual	May have hallucinations especially auditory
Psychomotor activity	Variable	Normal	May be slow

(Mittal et al., 2011)

Assessments

Considerations

- Avoid making your older adult feeling ”tested”
- Can complete in multiple visits
- Do not force older adult to complete if they are uncomfortable or becoming upset
- Do not diagnose your older adult
- Make sure you’re not capturing ”something else” (hearing, vision, etc.)

Assessment Options

Numerous!

- Mini-Mental Status Exam (costs)
- Telephone Interview for Cognitive Status (TICS) (costs)
- Mini-Cog (free)

Be aware of restrictions for future use

- Training required?
- Fees?
- Permission? (education, clinical or research)

Mini-Cog

Two-item test

- Word list recall (3 words, 3 points)
- Clock Drawing (in person, 2 points)
- Serial subtraction (telephone) or multi-step performance task (in person)

Scoring: 5 possible points, with < 3 validated for dementia screening

No medical or clinical background required

Available in many languages

Adhikari et al. (2021)

Adhikari, S. P., Dev, R., & Borson, S. (2021). Modifying the Mini-Cog to Screen for Cognitive Impairment in Nonliterate Individuals. *International Journal of Alzheimer's Disease*.

Baltes, P. B. (1987). Theoretical propositions of life-span developmental psychology: On the dynamics between growth and decline. *Developmental psychology, 23*(5), 611.

Judge, K. S. & Dawson, N. T. (2018). Cognitive function. In B. R. Bonder & V. Dal Bello-Haas (Eds.), *Functional performance in older adults: Fourth edition* (pp. 93-108). F. A. Davis Company.

Judge, K. S. & Dawson, N. T. (2018). Cognitive and emotional function: Health conditions. In B. R. Bonder & V. Dal Bello-Haas (Eds.), *Functional performance in older adults: Fourth edition* (pp. 181-200). F. A. Davis Company.

Mittal, V., Muralee, S., Williamson, D., McEnerney, N., Thomas, J., Cash, M., & Tampi, R. R. (2011). Delirium in the elderly: a comprehensive review. *American Journal of Alzheimer's Disease & Other Dementias, 26*(2), 97-109.

Salthouse, T. A. (2004). What and when of cognitive aging. *Current directions in psychological science, 13*(4), 140-144.

References

IECG 2022-2023

The role of a clinical pharmacist in the interdisciplinary care of an older adult

Tatyana Gurvich, Pharm.D., BCGP, APh
Assistant Professor of Clinical Pharmacy
USC School of Pharmacy
UCI Dept of Geriatrics: Senior Health Center
UCI Medical Center

USC School of Pharmacy

Learning Objectives

Identify

- Identify problems that lead to medication related adverse events in geriatric patients

Define

- Define the term poly-pharmacy

Define

- Define the term medication cascade

Describe

- Describe the 4 pillars of the Age Friendly Health Systems approach to taking care of a geriatric patient

Identify

- Identify “high risk” medications on the Beers Criteria

Develop

- A model of interdisciplinary care for a geriatric patient with clinical pharmacy interventions

"One of the first duties of the physician is to educate the masses not to take medicine."
Sir William Osler (1849-1919)

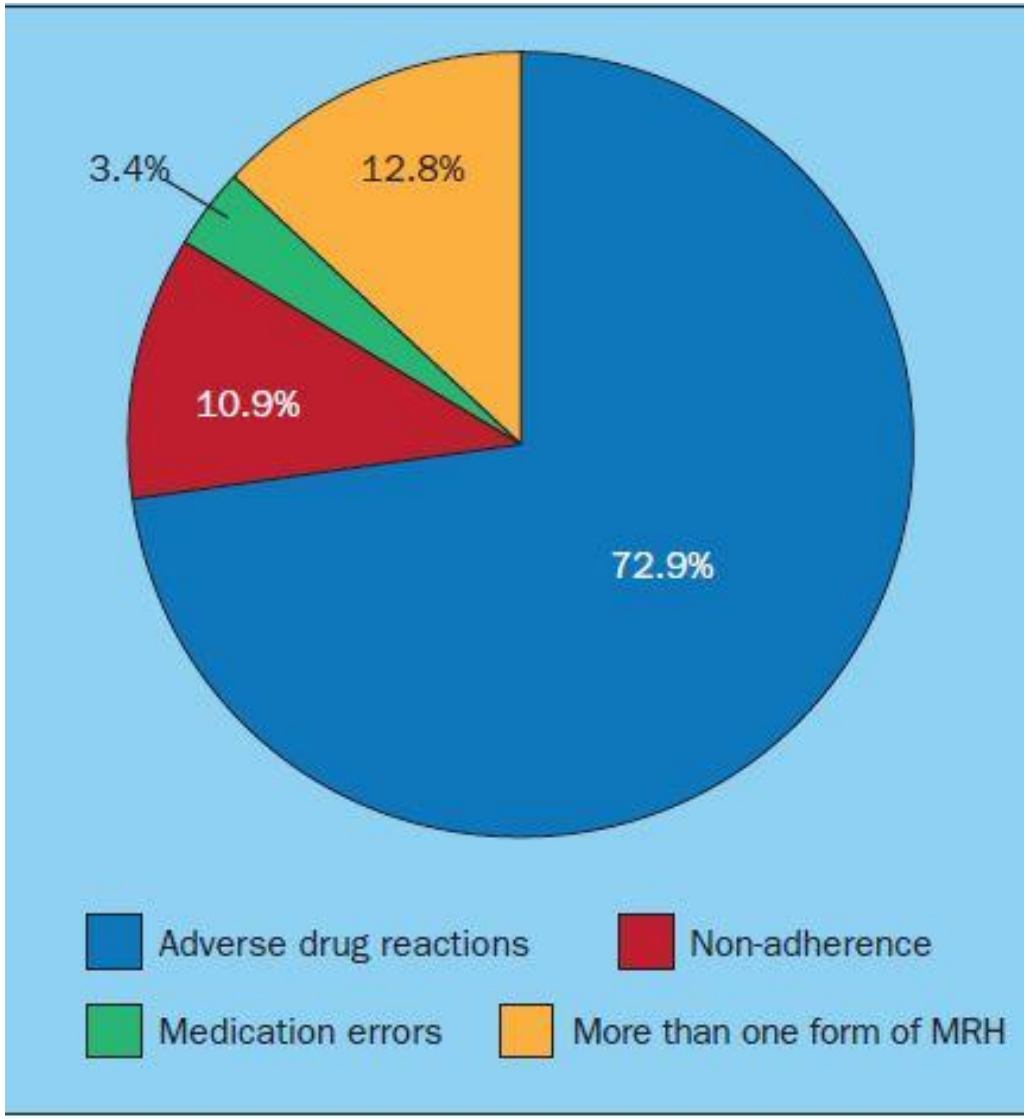
"This is the rub. There are many older adults who would be healthier if they threw away half of their medications."

Michael A. Steinman, MD. "Polypharmacy: Time to Get Beyond Numbers." JAMA Intern Med. 2016 April;176(4): 482–483.

Typical Chronic Conditions in Older Adults

Medication Problems: Common, Costly, Preventable

- Total estimated healthcare expenditure related to potentially inappropriate medications is $7.2 billion
- 27% of adverse events in primary care offices
- 37% of adverse events in nursing homes
- 380,000-450,000 adverse drug events occur annually in hospitals
- JAGS 2012 *Arch Int Med* 2009
- https://www.beckershospitalreview.com/quality/8-statistics-on-adverse-events-at-skilled-nursing-homes.html



Hospitalization-Related Mistakes

- Forms of medicines-related harm (MRH) in older people following hospital discharge, as reported by Parekh *et al*, 2018

Promoting Appropriate Prescribing

Herbal Usage in Older Adults

Rx:

- Wellbutrin 150mg bid
- Clonazepam 0.5mg q day
- Flomax 0.4mg q day
- Proscar 5mg q day

Over the Counter Medications

	Common Sleep Aids	Allergy Medicines	Motion Sickness Medicines
Ingredients to Avoid	diphenhydramine or doxylamine	chlorpheniramine	dimenhyrinate or meclazine
Example Drugs			

Belladonna	Valerian Root	Marijuana	Alcohol
			

OTC Medications contribute to Polypharmacy

- Duplication
- Adverse side effects and interactions

High-Risk OTC medications

25% of patients don't tell their doctors about OTC use

- Doctors don't ask
- Pts think they don't need to know

Michael A. Steinman, MD, Polypharmacy: time to get beyond numbers, JAMA Intern Med. 2016 April ; 176(4): 482–483.

Heterogeneity of Older Adults

The most heterogenous population of all age groups

Age 91

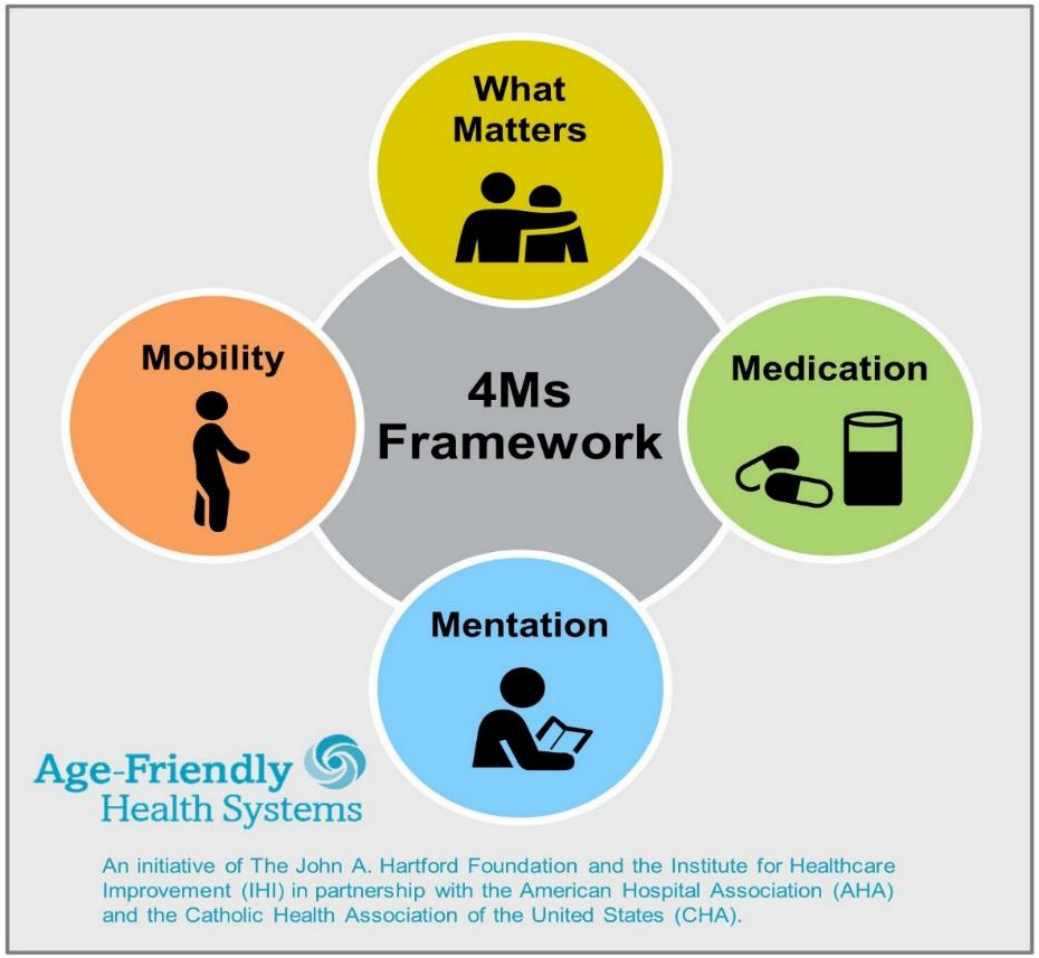
Goals of care vary

- Level of function
- Life expectancy

Treatment goals are more individualized

- Not always based on Clinical Practice Guidelines
- What the patient wants is of paramount importance

Age-Friendly Health Systems



What Matters

Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication

If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility

Ensure that older adults move safely every day in order to maintain function and do What Matters.

How Medications Impact Each Pillar

What Matters most	Medications	Mentation	Mobility
• Polypharmacy impact on quality of life • Caregiver training in monitoring for medication-related adverse outcomes	• High-risk medications • De-prescribing	• Managing depression effectively • Managing cognitive decline • Medication related cognitive decline and depressive symptoms	• Medication related muscle pain, fatigue • Dizziness and fall risk as a medication side effect

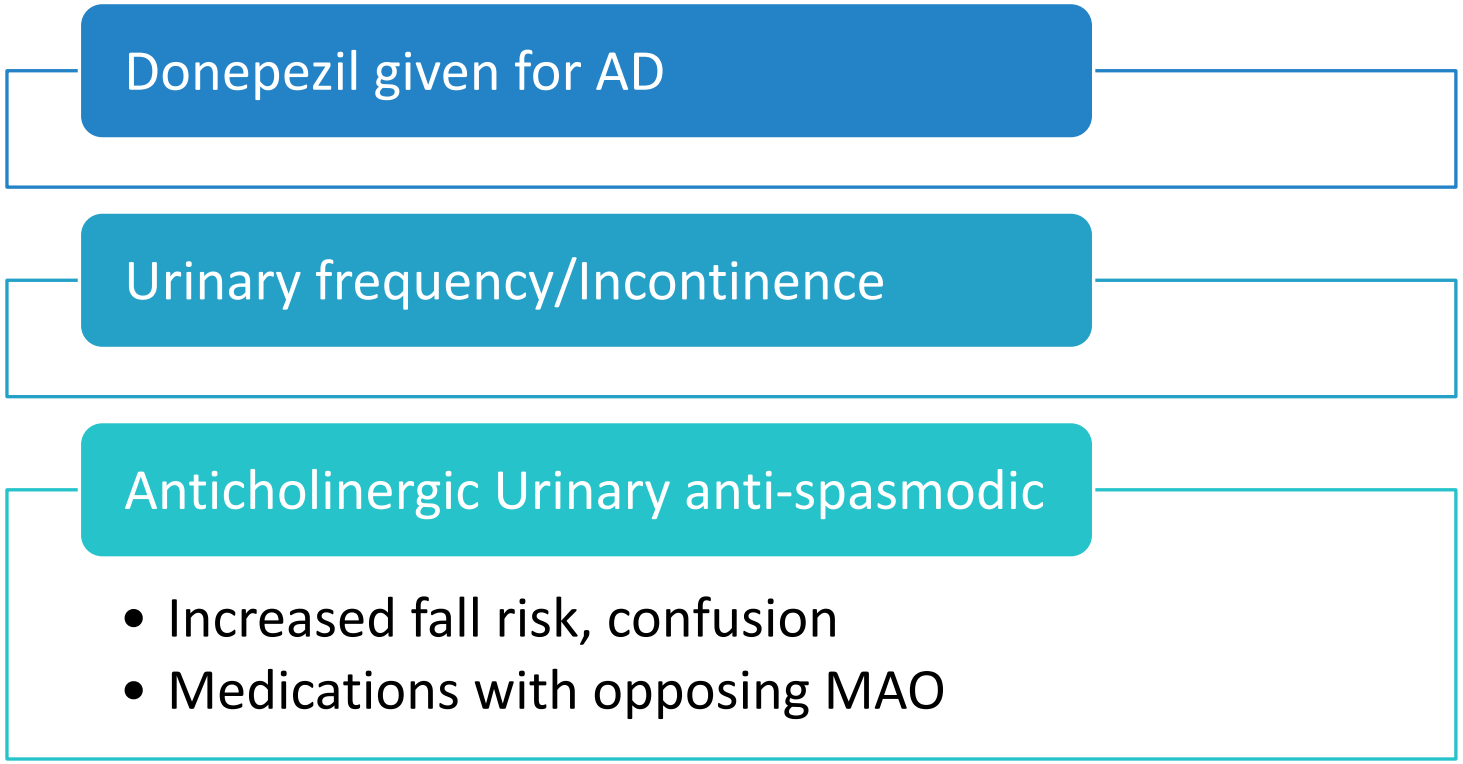
What is Polypharmacy and who is at risk?

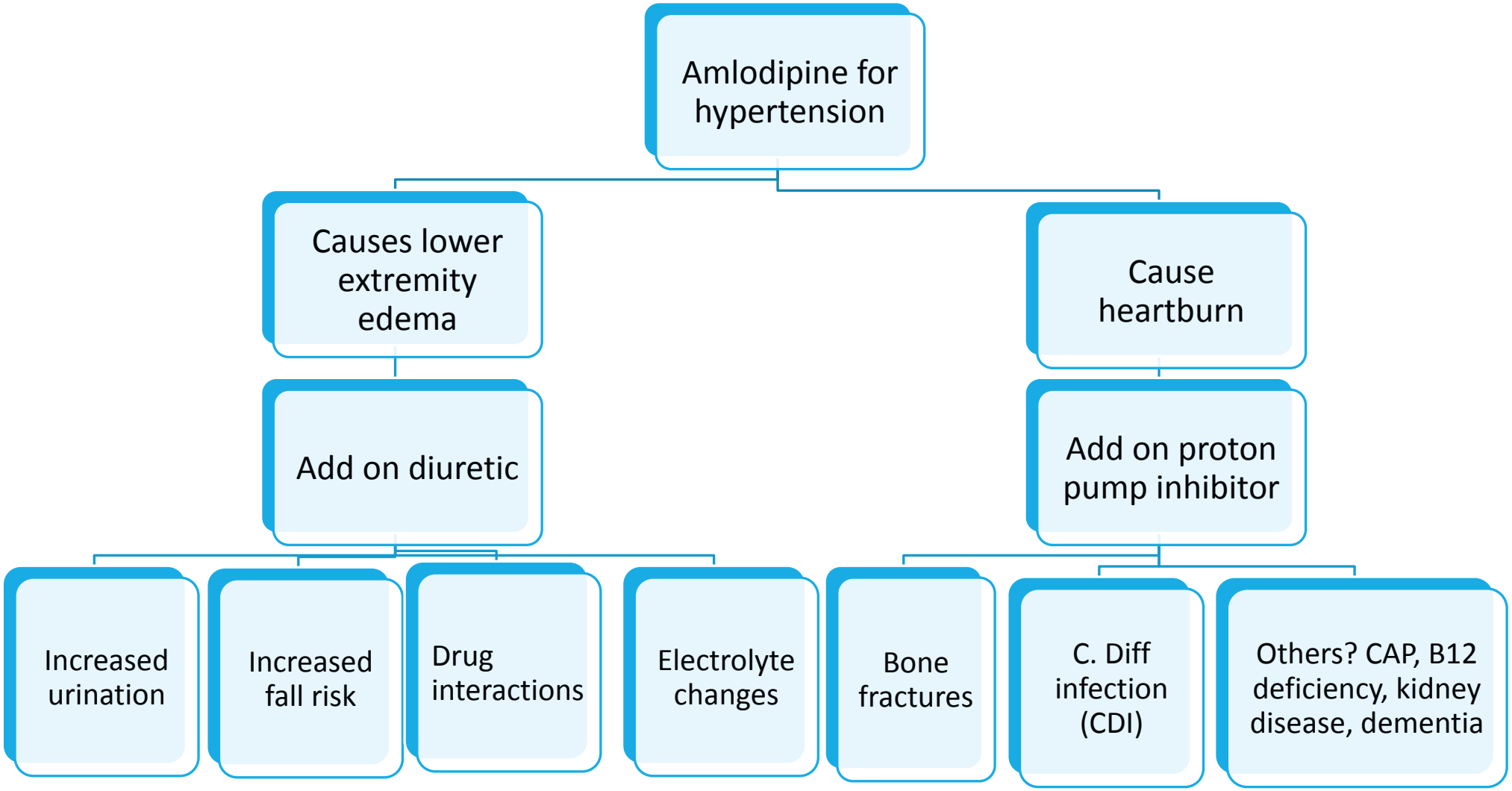
The use of unnecessary medications regardless of the number of medications being taken

Taking more medications than clinically necessary

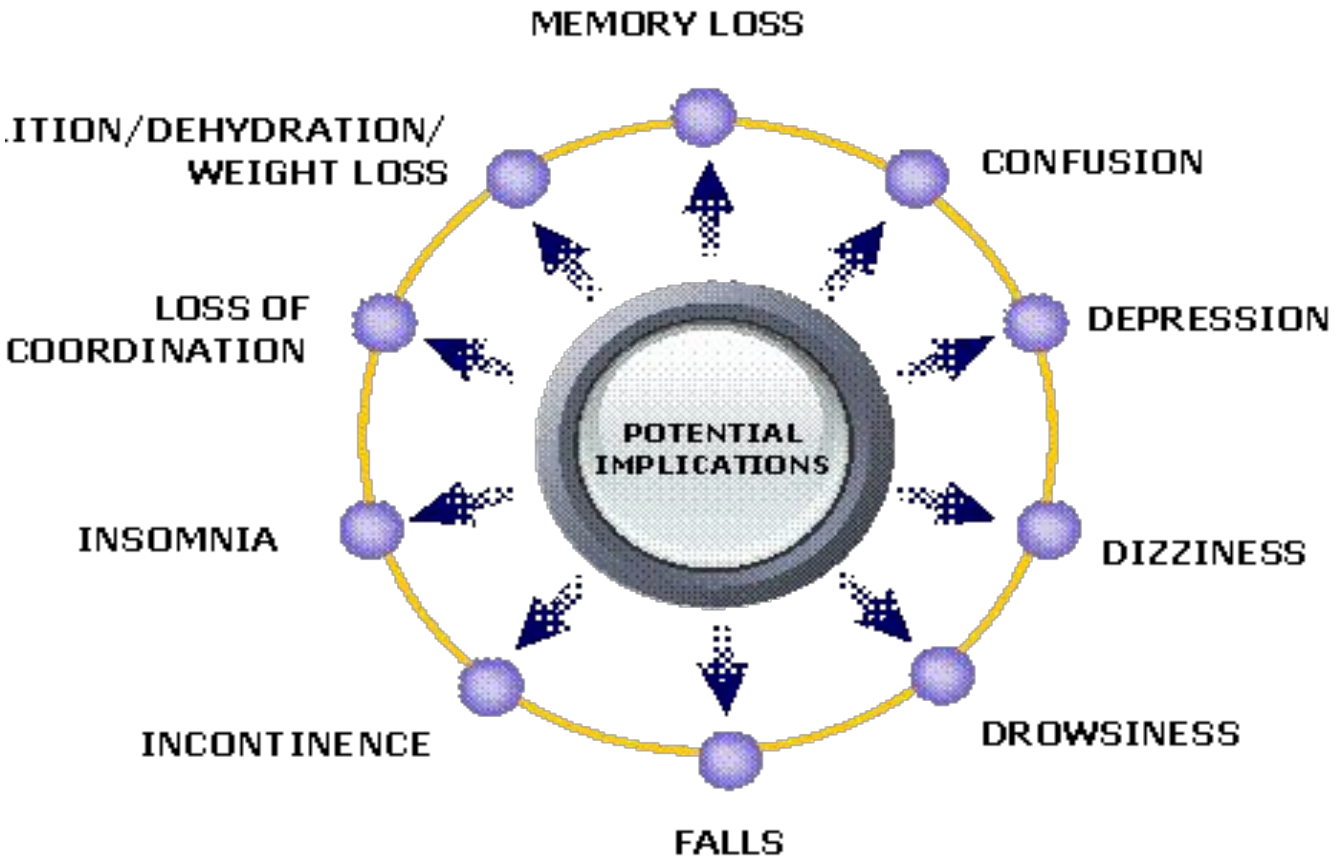
Any Geriatric Patient taking ≥ 5 medications

Prescribing cascade: A drug-induced adverse event which mimics symptoms of another disease which is being treated with more medications




Amlodipine for hypertension
Causes lower extremity edema
Add on diuretic
Increased urination
Increased fall risk
Drug interactions
Electrolyte changes
Cause heartburn
Add on proton pump inhibitor
Bone fractures
C. Diff infection (CDI)
Others? CAP, B12 deficiency, kidney disease, dementia

The Mantra of Geriatric Pharmacology



"Any symptom in an elderly patient should be considered a drug side effect until proven otherwise" ~Jerry Gurwitz MD

How do we know if our older adult patients are on medications that are NOT appropriate?

What is the Beers list?

American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults

A tool for evaluating care

- Across healthcare settings
  - SNF
  - Ambulatory Care
  - Hospitals

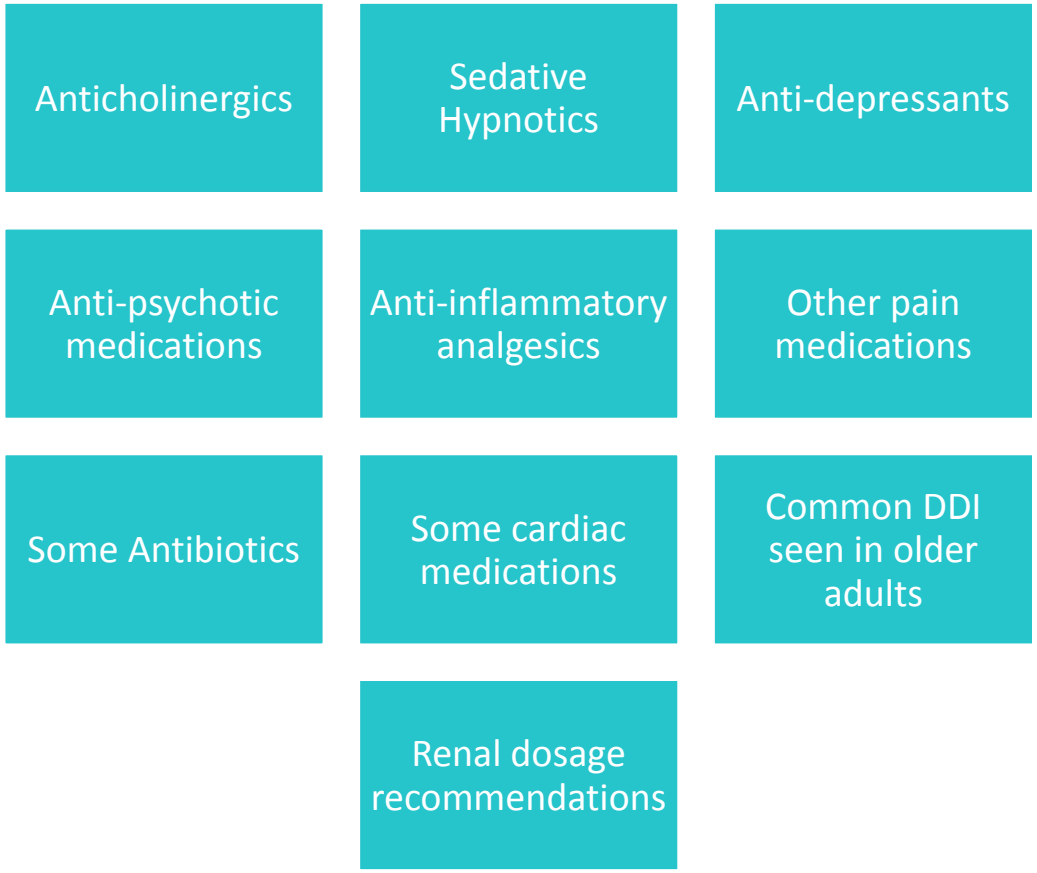
Educate clinicians and patients

- Improve Medication selection
- Reduce the adverse drug events and exposure to PIM's

Risk vs Benefit analysis

- Complexity of prescribing decisions

What is on the Beers criteria?



Drugs which are likely to make the patient more confused

Dugs which increase the risk for falling

Drugs which can cause increased likelihood of side effects or toxicity

It is OK to use medications on this list as long as the patient is adequately monitored, and benefits outweigh risks

Drugs to Avoid: **The Concept of Anticholinergic Load**

Beers Criteria, 2019

Table 7. Drugs With Strong Anticholinergic Properties

Antiarrhythmic	Promethazine
Disopyramide	Pyrilamine
	Triprolidine
Antidepressants	
Amitriptyline	
Amoxapine	
Clomipramine	Antimuscarinics
Desipramine	(urinary incontinence)
Doxepin (>6 mg)	Darifenacin
Imipramine	Fesoterodine
Nortriptyline	Flavoxate
Paroxetine	Oxybutynin
Protriptyline	Solifenacin
Trimipramine	Tolterodine
	Trospium
Antiemetics	
Prochlorperazine	Antiparkinsonian agents
Promethazine	Benztropine
	Trihexyphenidyl
Antihistamines (first generation)	
Brompheniramine	Antipsychotics
Carbinoxamine	Chlorpromazine
Chlorpheniramine	Clozapine
Clemastine	Loxapine
Cyproheptadine	Olanzapine
Dexbrompheniramine	Perphenazine
Dexchlorpheniramine	Thioridazine
Dimenhydrinate	Trifluoperazine
Diphenhydramine (oral)	
Doxylamine	Antispasmodics
Hydroxyzine	Atropine (excludes ophthalmic)
Meclizine	Belladonna alkaloids
Clidinium-chlordiazepoxide	Scopolamine (excludes ophthalmic)
Dicyclomine	
Homatropine (excludes ophthalmic)	Skeletal muscle relaxants
Hyoscyamine	Cyclobenzaprine
Methscopolamine	Orphenadrine
Propantheline	

A systematic approach to dose reduction or discontinuing a medication when existing harm outweighs potential benefit based on:

- Goals of Care
- Current Level of Functioning
- Life Expectancy
- Values
- Preferences

It is a ***patient-centered*** intervention, with inherent uncertainties, and requires shared decision making, informed patient consent, and close monitoring of effects

It is **NOT** about denying effective treatment to eligible patients.

Scott IA, et al. *JAMA Intern Med.* 2015.

Definition: Deprescribing

Five Steps of Deprescribing

Identify potentially inappropriate medications: Rx and OTC

- High risk medication
- Goals of care/comorbidities/cognitive function
- Pill burden/adherence

Dosage reduction vs medication DC

- One drug at a time

Plan for tapering

Monitor (for discontinuation symptoms or the need to restart)

Document outcomes

Scott IA, et al. *JAMA Intern Med.* 2015

AFP Farrel et al Jan 2019

What is Medication Reconciliation?

From the Joint Commission:

- The process of comparing a patient's medication orders to all of the medications that the patient has been taking.
- Done to avoid medication errors such as:
  - omissions
  - duplications
  - dosing errors
  - drug interactions
- Should be done at every transition of care in which new medications are ordered or existing orders are rewritten.
- Transitions in care include changes in setting, service, practitioner or level of care.

General Guidelines

Remind patients to bring all medications and medication lists to **every** visit

Ask about over the counter medications?

- Sleep? Allergies? Pain? Recent illness?
- Ask about packaging/colors when patient can't remember specific

Ask about vitamins and supplements

Ask about Alcohol, Cannabis, and illicit drug use

Ask follow up questions when discrepancies are noted (Who, What, When, Where, Why, How much?)

Allergies vs. intolerances

Document everything

Search for answers

- Look at medication bottles, lists, and pillboxes
  - Last filled
  - Expiration
  - Look inside bottles
- Call pharmacy for last fill information
- Ask your team pharmacist

A Multi-Disciplinary Approach to providing care to an older adult

Pharmacist

-Polypharmacy

- Supplements and OTC
- Medication cascades
- DDI and Adverse Events
- Drug choice
- Dosing and Titration
- General Assessment of Pharmacotherapy
- Patient and caregiver education

QUESTIONS??

Break Out Rooms

***Online students please connect with your teammates via Facetime/ Phone for the breakout discussion**

Location	Team
Auditorium	Jo Marie Reilly
Auditorium	Janice Tramel
Auditorium	Jennifer Okuno
PA 192	Chris Beam
PA 193	Kelsey Peterson
PA 194	Isabel Edge
PA 195	Bruna Martins-Klein
PA 196	Cheryl Resnik
4th floor RM 6404	Patrick Tabon
4th floor RM 6403	Dawn Joosten-Hagye
4th floor RM 6425	Carolyn Kaloostian
4th floor RM 7415	Ashley Halle
4th floor RM 6414	Mitzi D'Aquila
4th floor RM 6413	Suh Chen Hsiao
4th floor RM 6427	Tanya Gurvich