Goals:

A PGY-3 resident will be able to develop strategies for managing complex elderly patients, using the principles of the Patient-Centered Clinical Method.

Objectives:

Patient Care

- Develop a differential diagnosis for a patient’s problem(s)
- Develop a plan for management that incorporates an understanding of the patient’s feelings and ideas about their illness, functional state and expectation as well as an understanding of the whole person
- Identify gaps in knowledge of these areas (patient’s feelings and ideas, etc. and their proximal and distal context)

Medical Knowledge

- Describe which functional assessment tools would be appropriate in management of the patient
- Demonstrate a knowledge of the patient’s disease process
- Describe the patient-centered clinical method

Interpersonal Communication

- Demonstrate an ability to contribute positively to group discussion

Systems-Based Practice

- Describe the potential roles of other health professionals in the care of the patient
- Identify community resources that would be appropriate for care of the patient

Professionalism

- Demonstrate a sensitivity to the needs of the older patient
• Recognize ethical issues encountered in these scenarios

• Demonstrate respect of the older patient in discussion of these scenarios

**Practice-based learning and improvement**

• Provide a scenario based on a patient you have seen, as well as several questions that have arisen for you in the care of this patient
Session Guide

Time needed: 2 to 3 hours, depending on the how many scenarios are discussed

Equipment needed:

- Tables and chairs for small group discussion
- Flip charts and markers
- LCD projector and computer is optional
- White board with markers is optional.

Suggested Readings:

This reading discusses principles that may be helpful in caring for older patient with multiple co-morbidities:


More resources available at:

3 or more: Managing multiple health problems in older adults. Available at: [http://www.americangeriatrics.org/health_care_professionals/clinical_practice/multimorbidity](http://www.americangeriatrics.org/health_care_professionals/clinical_practice/multimorbidity)

Recommend readings that address the conditions in the case scenarios. Sample readings below (taken from the JAMA series *Care of the Aging Patient: From Evidence to Action*)

Reuben, DB. Medical Care for the Final Years of Life: “When You’re 83, It’s Not Going to Be 20 Years.” *JAMA*. 2009;302(24):2686-2694

Carr, DB, Ott, BR. The Older Adult Driver with Cognitive Impairment: “It’s a Very Frustrating Life.” *JAMA*. 2010;303(16):1632-1641


Goode, PS, Burgio KL et al. Incontinence in Older Women *JAMA*. 2010;303(21):2172-2181

Arroyo, JG. A 76-Year-Old Man with Macular Degeneration. *JAMA*, May 24/31, 2006; Vol 295, No. 20:2394-2406
Instructor script and notes:

NB: 1 to 2 weeks prior to session, ask residents to identify an older patient they have cared for that has posed a difficult management issue for them. Ask them to draft a brief scenario describing the case, and two identify at least 2 questions they have regarding management of the patient. As instructor, you will need to collect these responses, edit them and collate them for the session.

I. Briefly review the goal for the session. You will review the objectives in more detail before beginning the discussion. For example, “Today we are going to apply the principles of the patient-centered clinical method to some difficulty patient situations that you have encountered.”

II. Review the patient-centered clinical method – 20 minutes
   A. Recommend drawing the outline of the method on a white board, and “filling it in” – ask the residents to describe the various components. Or, you can project a slide with an outline of the method on a smart-board, ask the residents to describe the various components and “fill it in.” Or you can project a slide with the method fully diagrammed and discuss the various components. Or you can handout a sheet with a diagram and discuss.

III. Case discussion
   A. Provide an overview of the structure: we will break into X groups (of 3 to 4 residents, depending on the number present). Each group will discuss X number of cases (depending on time and number of residents), and will then present the results of your discussion to the entire group.
   B. Describe the format for group discussion, using the guidance below:
   C. As a group, identify:
      i. Medical conditions involved
      ii. Include differential diagnoses
      iii. Functional domains you need to assess and how you would assess them (which instrument)
      iv. Which medical conditions pose greatest threat to functional status
      v. Other health professionals that might help you gather information, assess function, and help you implement a management plan
      vi. Community agencies that might be helpful in management of the patient
      vii. Review the patient-centered clinical method below, identify potentially useful (needed) information from:
         a. Understanding patient’s feelings and ideas about illness, functional impacts and expectations.
         b. Understanding the whole person (the person, their proximal context and distal context).
      viii. Envision what common ground would look like for this patient
          a. What are the problems that could be agreed upon?
          b. What would your roles/patient’s roles/family or caregiver roles be?
          c. What are goals that might reasonable be held in common?
      ix. Identify potential resources to help with medical decision making and medical management.
      x. Identify and prioritize unanswered questions/issues.
D. Break the larger group into smaller groups of 3 to 4 residents.
   i. Give each group a flip chart and markers
   ii. Give each group at least once copy of the Discussion Guide and the diagram of the Patient-Centered Clinical Method
   iii. Give each group at least one copy of the cases
   iv. Instruct the group to identify the cases provided by that group’s members. That group will discuss those cases. Have group select a case to discuss.
   v. Ask the group to discuss a case, using the Discussion Guide, and to write their key findings on a flip chart.
   vi. Clarify that everyone understands the instructions.
   vii. Give the groups about 10 to 15 minutes to discuss each case.

E. Monitor groups’ progress, answer questions, and keep them on track.

F. Group presentation: Once done with small group discussion, each group should present their case and their discussion to all of the groups. Give each group 5 to 7 minutes to do this. Keep track of important concepts, and highlight them at the end of each discussion.

G. Repeat steps d through f until all cases are discussed or until group runs out of time. Give feedback to groups, especially after the first set of case discussions, to help them stay on task with use of the Discussion Guide.

IV. Summary and wrap-up
   A. Review some of the important points and questions that arose during the case discussions, with particular emphasis on understanding and assessment of the patient’s function, and on key elements that would facilitate the finding of Common Ground between patients and physicians.

Extra tips: If there are certain conditions that you want to highlight (e.g. driving assessment), include some illustrative cases in the list of cases, in the event that the condition is not included in the cases generated by the residents. Be sure to let residents know that these cases will be included ahead of time. Also be sure to let residents know that there may not be time to discuss all of the cases. Don’t spend too much time at the beginning on discussion of the patient-centered clinical method – this is a “refresher, and the case discussions will help to give residents a better understanding of the method.

Handouts and Teaching Materials:

- Outline of the Patient-Centered Clinical Method (handout and PowerPoint slide)
- Diagram of the Patient-Centered Clinical Method (handout and PowerPoint slide)
- Discussion Guide (handout)
- Cases (sample list of cases provided)

Instructor Reference Materials:

- Be familiar with the diagrammatic representation of the Patient Centered Clinical Method.
Outline of the Patient-Centered Clinical Method

1 – Exploring both disease and illness experience
   Cues and prompts

2 – Understanding the whole person
   Proximal Context
   Distal Context

3 – Finding Common Ground
   Mutual decisions

4 – Incorporating prevention and health promotion

5 – Enhancing the patient-physician relationship

6 – Being realistic
Diagram of the Patient-Centered Clinical Method

1 – Exploring both disease and illness experience
   Cues and prompts

2 – Understanding the whole person

3 – Finding Common Ground
   • Problems
   • Goals
   • Roles

4 – Incorporating prevention and health promotion

5 – Enhancing the patient-physician relationship

6 – Being realistic
Case Discussion Guide

As a group, identify:

1. Medical conditions involved
   a. Include differential diagnoses
2. Functional domains you need to assess and how you would assess them (which instrument)
3. Which medical conditions pose greatest threat to functional status
4. Other health professionals that might help you gather information, assess function, and help you implement a management plan
5. Community agencies that might be helpful in management of the patient
6. Review the patient-centered clinical method below, identify potentially useful (needed) information from:
   a. Understanding patient’s feelings and ideas about illness, functional impacts and expectations.
   b. Understanding the whole person (the person, their proximal context and distal context).
7. Envision what common ground would look like for this patient
   a. What are the problems that could be agreed upon?
   b. What would your roles/patient’s roles/family or caregiver roles be?
   c. What are goals that might reasonable be held in common?
8. Identify potential resources to help with medical decision making and medical management.
9. Identify and prioritize unanswered questions/issues.
1 - Exploring both disease and illness experience
   Cues and prompts

   History
   Physical Lab

   Feelings
   Ideas
   Function
   Expectations

2 - Understanding the whole person

   Disease
   Person

   Illness

   Proximal Context

   Distal Context

3 - Finding Common Ground
   • Problems
   • Goals
   • Roles

4 - Incorporating prevention and health promotion

5 - Enhancing the patient-physician relationship

6 - Being realistic
Sample Case Scenarios

Scenario 1

P.W. is a 77-year-old female with a history of upper GI bleed, indeterminate pulmonary nodules, and more recently decreasing functionality at home involving muscle weakness and hand swelling, who presents today for follow-up of her hand swelling and urinary incontinence. She was living in downtown cville and was interested in going to an assisted living facility, but her sons refused to support her in that decision due to poor outcome with another family member. She can no longer comb her hair, and refuses any blood draws and most medication, though is otherwise cognitively intact.

She has, instead, moved out into the country to live with her sons, where she may have less access to med facilities/nursing care. APS have already been involved.

How do I handle her refusing to work things up but presenting over and over with new problems? I'm so frustrated at her sons for not supporting her assisted living facility goals (there may be financial issues here I'm not fully aware of).

Scenario 2

Mr. A is a 78 year old retired Anglican Priest with mild Alzheimer’s dementia. He lives with his wife, who still works. He drives to Barracks Road for lunch every day, and has never had an accident. He has a h/o HTN and Hyperlipidemia, and he is on galantamine for his dementia. He also takes lisinopril and hctz. He has had some trouble with depression, which has responded well to celexa.

When should he stop driving? How do I evaluate him for this?

Scenario 3

Mr. Y is an 84 y/o man whom lives with his wife and daughter. He has issues of stability and falls frequently. He refuses to go to a nursing home - he also refuses home health physical therapy. He also refuses to go to an senior community center with his wife for daytime activities. The last time he did go - he cursed at people and was told he is not welcome anymore if he continues to exhibit this behavior. His family no longer goes out anymore to stay at home to take care of him.

Scenario 4

Mr. C.A. is a 75 y.o. male with a hx of pulm htn, CHF, lymphedema with chronic wounds, HTN, and CKD presenting in WI clinic for follow up on his multiple medical issues.

Items I found challenging:

1. Sorting through the concerns that were voiced- daughter, wife and patient all seemed to have differing opinions. hard to tell who was most important to listen to.
2. Prioritizing his medical issues in the context of his complaint (he was worried about his legs, so was I but I was also worried about his shortness of breath and CKD!)
3. Digging through his notes to figure out what would be the appropriate next step in his management.

**Scenario 5**

79 y/o African American lady with long standing, well controlled HTN and questionable pulmonary disease.

She does have a h/o asthma but this has not been active for 30+ years. When I inherited her she had a diagnosis of COPD but given her disposition/age, she has been unable to perform PFTs. Her cxr's look fine. ECHO shows some diastolic dysfunction with this she persistently c/o subjective shortness of breath and nocturnal cough. She is on optimal COPD meds, intermittent lasix, albuterol all offering some relief.

The challenge with her is:

1. I can't get PFTs on her: she cannot do them
2. She is not interested in many interventions/changes
3. She gets confused easily with medications, changes etc
4. She lives by herself and comes in by herself so I don’t have a friend or family member to help with her management/insights (though i have been in contact with her daughter who live in Maryland)
5. She does not want to schedule visits often (2 months is the quickest f/u she wishes to do)
6. She told me "she's used to having a male doctor" but is willing to "stick with" me
7. I am not sure what else to offer her and it seems we are just status quo but she does state that she is doing ok and her SOB is not worse nor much better on meds

**Scenario 6**

75 y/o female initial visit who has not seen a physician for over 20 years, presenting for progressively increasing confusion and hallucinations. Patient claims to occasionally see small gnomes on the front lawn for which she has called the police. She has full ADLs and is not seem altered or confused during the clinic session. Subsequent consults to neuro feel that patient may have Lewy body dementia but they are not certain. Psychiatry feels that patient should see them regularly and start Seroquel. Patient lives at home alone but close to daughter's house. Caretaker occasionally visits but patient is predominantly alone. Patient has no significant PMH, no medications, does not smoke, drink alcohol or use any other drugs. The patient does not wish to see any other doctors other than myself and does not want to take medications. The daughter is not sure what to do.
Guiding Principles for the Care of Older Adults with Multimorbidity

This Clinical Tool, based on the 2012 Patient-Centered Care for Older Adults with Multiple Chronic Conditions: A Stepwise Approach from the American Geriatrics Society, has been developed to assist healthcare providers implement the 5 Guiding Principles in taking care of an Older Adult with Multimorbidity.

"More than 50% of older adults have three or more chronic diseases." By definition, older adults with multimorbidity are heterogeneous in terms of severity of illness, functional status, prognosis, and risk of adverse events even when diagnosed with the same pattern of conditions. Priorities for outcomes and health care also vary. Thus, not only the individuals themselves, but also the treatments that clinicians consider for them will differ.

The adoption of these guiding principles may improve healthcare and outcomes for older adults with multiple conditions. Patients should be evaluated, and care plans should be designed and implemented according to the individual needs of each patient, with the recognition that few studies are currently available that have rigorously evaluated the effectiveness of approaches related to these guiding principles.

The full document, together with accompanying resources, can be viewed online at americangeriatrics.org.
### Guiding Principle I: Patient Preferences Domain

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<tr>
<th>Goal</th>
<th>Implementation Strategies &amp; Resources</th>
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<td>Elicit and incorporate patient preferences into medical decision-making for older adults with multimorbidity.</td>
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</table>

- Know which factors are most important to each patient:
  - Preferences may change over time, and should be re-assessed, especially with a change in health status.
  - Patients can demand any and all treatments if these options do not have a reasonable expectation of some benefit.

- Resources:
  - Decision aids that facilitate decision-making by identifying and quantifying all potential treatment outcomes.
  - Decision analysis tools to optimize choices.
  - Patient preferences:
    - Keep in mind:
      - Preferences may change over time, and should be re-assessed, especially with a change in health status.
      - Patients can demand any and all treatments if these options do not have a reasonable expectation of some benefit.

- Considerations:
  - Key questions:
    - Does the intervention apply to older adults with multimorbidity? Do the potential benefits exceed the potential harm?
    - Does the intervention have a better health-related quality of life benefit compared to the standard of care?
    - Are the potential benefits and harms balanced?

- Key considerations:
  - Safety and efficacy:
    - Safety and efficacy are important considerations in decision-making.
    - Safety and efficacy are important considerations in decision-making.
  - Patient preferences:
    - Preferences may change over time, and should be re-assessed, especially with a change in health status.
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### Guiding Principle II: Interpreting the Evidence Domain

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### Guiding Principle III: Prognosis Domain

**Goal**: Frame clinical management decisions within the context of risk, burdens, benefits, and prognosis (e.g., remaining life expectancy, functional status, quality of life) for older adults with multir morbidity.

**How to Use in Clinical Practice**

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<td><strong>Incorporate progress into clinical decision-making.</strong></td>
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<tr>
<td>• Frame a focused clinical question.</td>
</tr>
<tr>
<td>• Determine the outcomes being predicted (e.g., remaining life expectancy, functional ability, quality of life, or a condition-specific risk such as stroke).</td>
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<tr>
<td>• Select a prognosis measure, while recognizing its strengths and limitations.</td>
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<td>• Discuss prognosis.</td>
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<td>• Integrate this information into the decision-making process.</td>
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<td><strong>Prioritize decisions based on the geriatrician’s ability to provide benefit and or other relevant outcomes.</strong></td>
</tr>
<tr>
<td>• Prioritize treatments or interventions unlikely to provide benefit and/or harm without benefit or minimal benefit.</td>
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<tr>
<td>• Consider the role of prognosis in decision-making (e.g., short-term goals vs. long-term goals).</td>
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<tr>
<td>• Address issues such as advance directives, need for aggressive glucose control, physical therapy.</td>
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<td>• Identify situations in which a determination of prognosis may help inform clinical decision-making.</td>
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<td>• When making decisions about treatment or prevention (e.g., whether to continue a medication or discontinue a dose).</td>
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<td>• Change in clinical status (e.g., weight loss, functional decline, after a fall).</td>
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<td>• The PEDE Scale (for elderly patients).</td>
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<td>• STOPP/START (Screening Tool to Alert to Right Treatment and Screening Tool of Older Persons’ potentially inappropriate Prescriptions).</td>
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<tr>
<td>• Cancer screening.</td>
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<tr>
<td>• Use tables:</td>
</tr>
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<td>• Prognostic index based on risk factors for the year following acute hospitalization.</td>
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### Guiding Principle IV: Clinical Feasibility Domain

**Goal**: Consider treatment complexity and feasibility when making clinical management decisions for older adults with multimorbidity.

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<tr>
<td><strong>Assess ability of the older patient with multimorbidity to adhere to the treatment plan on an ongoing basis.</strong></td>
</tr>
<tr>
<td>• Treatment complexity increases with multimorbidity.</td>
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<tr>
<td>• Researchers and clinicians must work together to ensure continuity of care.</td>
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<tr>
<td>• Patient-centered discussions must occur in collaboration with the support system (family caregivers).</td>
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<tr>
<td>• Tools available to measure medication management capacity.</td>
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<tr>
<td>• Medication Management Ability Assessment (MMAA).</td>
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<tr>
<td>• Drug Regimens Unassessed-Grading Scale (DRUGS).</td>
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<tr>
<td>• Resolution Prediction Schedule (RPS).</td>
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<tr>
<td>• Resolution Management Treatment for Delirium in the Elderly (MOTDE).</td>
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<tr>
<td><strong>Clinical feasibility and individual preferences should inform treatment choices.</strong></td>
</tr>
<tr>
<td>• Key considerations:</td>
</tr>
<tr>
<td>• Evidence-based medicine alone is not an adequate guide.</td>
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<tr>
<td>• Balancing the benefits of providing interventions that reduce adherence.</td>
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<tr>
<td><strong>Identify treatment complexity with patient participation.</strong></td>
</tr>
<tr>
<td>• Discuss adherence and individual preferences with the older adult with multimorbidity.</td>
</tr>
<tr>
<td>• Suggest education programs that teach patients self-management skills.</td>
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<td><strong>Address barriers between wishes of prescribers versus those of the older adult with multimorbidity.</strong></td>
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<tr>
<td>• Discuss and re-evaluation must be ongoing.</td>
</tr>
<tr>
<td>• Patient education should be provided.</td>
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<tr>
<td>• Care should be offered for optimal adherence and treatment complexity.</td>
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### Guiding Principle V: Prognosis Domain

Frame clinical management decisions within the context of risks, burdens, benefits, and prognosis (e.g., remaining life expectancy, functional status, quality of life) for older adults with multimorbidity.

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<th>Goal</th>
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<tr>
<td>Identify interventions that should not be initiated or should be stopped. Identify interventions that should be started.</td>
<td>• Restore to optimal function.</td>
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<tr>
<td>• Improve quality of life.</td>
<td></td>
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<tr>
<td>• Reduce healthcare costs.</td>
<td></td>
</tr>
<tr>
<td>Identify and reduce potentially inappropriate medications.</td>
<td>• Medications to avoid (consistently across multiple criteria); benzodiazepines and hypnotic antidepressants.</td>
</tr>
<tr>
<td>Resources:</td>
<td>• 2012 AGS Beers Criteria Information on drugs that should be avoided in older adults (<a href="http://www.americangeriatrics.org">http://www.americangeriatrics.org</a>)</td>
</tr>
<tr>
<td>• Screening Tool to Alert Ruling Treatments and Screening Tool of Older Persons: potentially inappropriate Prescriptions (START-POTIP).</td>
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<tr>
<td>Identify medications with a higher risk of adverse events (falls, impaired cognition).</td>
<td>• Medication Appropriateness Index (MAI)</td>
</tr>
<tr>
<td>Resources:</td>
<td>• Sedative and anticholinergic indices</td>
</tr>
<tr>
<td>• Drug Burden Index (DBI)</td>
<td></td>
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<tr>
<td>• Age-Related Risk Score (ARRS).</td>
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<tr>
<td>Carefully consider recommendations for implantable cardiovascular electronic devices.</td>
<td>• HTS Expert Consensus Statement</td>
</tr>
<tr>
<td>Consider non-pharmacologic approaches to limit side effects and address polypharmacy.</td>
<td>• Some examples are physical therapy, assistive devices, and other lifestyle modifications consistent with individual preferences.</td>
</tr>
<tr>
<td>Discontinue medications appropriately.</td>
<td>• Certain drug classes, especially those that act on the cardiovascular or central nervous system, need to be discontinued cautiously as they are most often associated with adverse drug withdrawal events including exacerbations of underlying disease.</td>
</tr>
<tr>
<td>• The reason for discontinuing a medication, a time-limited withdrawal can help clarify whether the medication was needed in the first place.</td>
<td></td>
</tr>
<tr>
<td>• Mostly medications should be stopped one at a time. When further assistance is needed, clinicians should partner with pharmacists and other healthcare providers to optimize medication selection and management.</td>
<td></td>
</tr>
<tr>
<td>Resources:</td>
<td>• The Good Palliative-Deprescribing Practice algorithm</td>
</tr>
</tbody>
</table>

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The **Guiding Principles for the Care of Older Adults with Multimorbidity**, as well as supporting professional and public education tools, can be found at americangeriatrics.org.

These include:

- Guiding Principles for the Care of Older Adults with Multimorbidity: An Approach for Clinicians
- Summary Document: Patient-Centered Care for Older Adults with Multiple Chronic Conditions: A Strategic Approach from the American Geriatrics Society
- Full Practice Core Elements
- 2012 AGS Annual Meeting Presentation on the Guiding Principles
- Relaxed Public Education Materials

**Also available at americangeriatrics.org...**

AGS 2012 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults

The AGS 2012 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults (AGS 2012 Beers Criteria) is the most recent update of the Beers Criteria originally developed in 1991 by the late Mark Beers, MD. The AGS 2012 Beers Criteria categorizes 52 medications or classes of medications that may cause adverse drug events in older adults due to their pharmacologic properties and the physiologic changes of aging.

The AGS 2012 Beers Criteria and the following supporting professional and public education tools and resources can be found at americangeriatrics.org.

**Clinical Tools:**
- Beers Critical Teaching Slides
- Beers Critical Policies, Curriculums
- Beers Critical Mobile App

**Public Education Resources:**
- AGS Beers Criteria Summary - For Patients & Caregivers
- 10 Medications Older Adults Should Avoid
- 10 Medications Older Adults Should Avoid – Explanations
- Avoiding Overmedication and Harmful Drug Repeats
- What to Do and What to Ask Your Healthcare Provider if a Medication You Take Is Listed in the Beers Criteria
- My Medication Diary – Printable Download
- Education at Home Using Medication Safety – Illustrated PowerPoint Presentation

For information on other AGS Publications and Products, please visit americangeriatrics.org.