PUTTING THE 4 M's TO PRACTICE

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Ascension

Short Biography

Education includes Wabash College, IU School of Medicine, Internal Medicine Residency at St Vincent Hospital and Geriatric Fellowship in Geriatric Medicine at Queen's Medical Center, University of Nottingham, UK.

Professional interests include: care of the frail elderly, comprehensive dementia care and teaching.

Extracurricular activities include exercise, food and wine, golf and often acting like a psychiatrist which I am not.

NO DISCLOSURES

Care of the Aged: Age-Friendly and the 4Ms

Major advances in medicine(resulting in lots of older people!) have left our health systems behind as we struggle to reliably provide evidence-based practice to every older adult at every care interaction

- Follow evidence-based practice where possible
- Cause no harm…"primum non nocere."
- Align medical care with What Matters to the older adult and their family caregivers

84yo female questions regarding chronic pain and polypharmacy.

On gabapentin 600mg 3X daily for chronic foot pain, no known SE's. Has had full w/u by ortho. Could not identify diagnosis as a peripheral neuropathy. Also on duloxetine for foot pain

Back fracture of T8 4 yrs ago and says it still hurts her. On tramadol twice daily and Prolia/Ca/D...previously on teriparatide

Rt eye is significantly impaired, had laser surgery for Macular Degeneration

Widowed, was caregiver for her first husband who had early onset Alzheimer's, now re-married

Chronically taking alprazolam 0.25mg 2X daily for nerves

Takes meclizine occasionally for vertigo, hates dry mouth

PMH: Meniere's, benign positional vertigo, hypertension, osteoporosis, gastroesophageal reflux, chronic renal disease, chronic pain right foot, overactive bladder, anxiety, hypothyroid

ADL/IADL intact except no longer driving due to vision

Power of Attorney/Healthcare Representative and LW in place

EXAM:

WDWN, alert, clean and neat, fully engaged

Clearly has visual impairment esp on rt, hearing is nl

GUAG: completely nl, Romberg normal

Kyphotic spine with diffuse tenderness esp T8

Recall 3/3   inverted hands on clock face so Mini-Cog 4/5

UTD on current events

Not anxious, not depressed

FINDINGS AND RECOMMENDATIONS:

MULTIMORBIDITY...many chronic illnesses

POLYPHARMACY...many, many medications

CHRONIC PAIN ISSUES

MOBILITY:

gait is steady, keep up regular physical activity

MEDICATION: medication changes suggested.

Wean off alprazolam very gradually. It can increase your risk for falling and not certain you still need it.

Need to see if tramadol still needed for back pain. this is a complicated pain medication that may not be needed any longer

High dose gabapentin can have some side effects on the brain in the future we may find a lower dose is sufficient

Later, will consider trial off duloxetine for chronic pain, no affective illnesses

Consider vestibular rehabilitation in place of meclizine

MENTATION: no concern. Continue to be socially active and engaged

WHAT MATTERS: "I love life." Wants to be active and free of pain

Suggested consulting with a low vision specialist

Has Health care proxy appointed and all advance directives done

EVENTUAL RESULTS:

- Took herself off alprazolam altogether, slow wean
- Remains on duloxetine for chronic foot pain, now anxious to try off
- Reduced gabapentin to 600mg 2X daily for foot pain, eventually down to 300mg nightly
- Off scheduled tramadol , takes an occasional AM dose when she is busy out of the house for chronic back pain
- Prolia continued indefinitely/CA/D, previously on teriparatide
- No longer requires meclizine following vestibular rehab
- Very happy on fewer medications, mentally a lot less “foggy”

86 yof brought to our attention by her PCP for evaluation of gait, balance, memory and safety.
She lives alone in a 2 story home, has little custodial assistance, has a history of multiple falls and believes she has likely been swindled on more than one occasion. She is aware of mild memory issues, but no cognitive diagnosis has been established.
Very little family involvement, has no Power of Attorney, daughter out of town and has own health issues.
No acute medical issues.

Old records reveal:

Major visual impairment due to macular degeneration.

PMH: 17 listed chronic diseases/issues

Meds: 17 active meds, doubt full compliance

WHERE TO START??

MENTATION/MOOD:

Mini-cog 2/5 (Recall 1 out of possible 3)

St Louis University Mental Status (SLUMS)   21/30

Geriatric Depression Scale(GDS) 13/15, blunted affect

MOBILITY:

Get Up and Go: up with difficulty using Rolling Walker, very kyphotic, slow careful gait, held walker way ahead of herself, o/w pretty safe

Romberg was positive, balance was terrible

MEDICATIONS:

Could not accurately list her medications or their intended usage

WHAT MATTERS:

Steadfastly did not want daughter notified, believes she would want daughter as POA. Wants to stay at home but not be a burden.

MENTATION:
Struggling cognitively, cannot make any kind of a diagnosis, suspect high baseline
Very likely has MDD, no medications until social/compliance issues resolved
Drastically needs more help in home! Questionable decision making ability.

MOBILITY:
Very high risk for falls…...she agreed to have Home Care PT/OT/RN
Arrangements made for significantly more in-home custodial care thru care management intervention(eventually!)

MEDICATIONS:
Home Care RN completed medication compliance assistance, unnecessary meds discontinued, became fully compliant with fewer medications and supervision in place

WHAT MATTERS:
Daughter eventually established as POA, pt agreed to assisted living, currently thriving in assisted living facility

Important point:

Sometimes we need to be able to pivot away from the medical model of service to a more effective means of meeting the needs of those who have multimorbidity

Invaluable assistance from our RN Case Manager!!

Comprehensive evaluation at first office visit

Multiple follow up phone calls and proactive intervention

80yof referred by her family with questions regarding her acute decline in functional abilities and her ability to make her own decisions. Family states she is recently become totally dependent on husband for all ADLs

Hospitalized earlier this year with multiple falls, completed subacute rehab and given a new Diagnosis of Mild Cognitive Impairment while in rehab.

Most recently hospitalized for pneumonia with delirium, unclear etiology, completed rehab in subacute unit, returned home and was still having Home PT and nursing care visits at the time of our visit

Barely able to walk now even with an Assistive Device
Can not initiate anything in her care without being cued, o/w husband does everything for her
Family estimates she has had total of 30 falls in the past 6 months and several emergency room visits. Recent labs and Head CT all normal

PMH: macular degeneration with signif visual losses, hypertension, vitamin D deficiency, depressive disorder, hyperlipidemia, fibromyalgia, peripheral neuropathy
Highly educated

Awake but alertness waxes and wanes, quite frail appearing
Eager to cooperate, but prominently slowed processing skills
Very dry mouth with secondarily slurred words
Normal heart rate, systolic BP 120 dropping to 104(very difficult to tell for sure) with standing, no dizziness reported but could not stand unassisted
Neuro: diffusely weak, no specific gross motor deficits
Psych: pretty normal mood, pleasant but did not smile no tears and no serious anxiety. Did not initiate conversation and struggled to answer questions appropriately
Mini-cog: 3/5: not able to do the numbers on the clock, Recall: 2/3(?valid)
No idea of any current events. Completely disoriented
SLUMS 4/28....not a legitimate test, Could not register any of the 5 objects, did have some limited recognition ability

LETHARGIC DELIRIUM, likely related to medication side effects

CURRENTLY UNABLE TO MAKE HER OWN DECISIONS, unable to determine at this time if permanent or not

ABRUPT FUNCTIONAL DECLINES, likely related to above

HIGH CHOLINERGIC BURDEN SCORE OF 7(goal is <2)

ANXIETY AND DEPRESSIVE MOOD DISORDER, suspected

MULTIPLE INJURIOUS FALLS

ORTHOSTATIC BP DROP, how significant?

CAREGIVING CONCERNS, very high current burden of caregiving

MENTATION: lethargic delirium suspected, unknown cognitive baseline, possible Mild Cognitive Impairment. Needs to be reassessed later.

MEDICATIONS: 10 meds, good compliance.

ACETYLCHOLINERGIC BURDEN SCALE: Total = 7.....goal is <2

atenolol = 1

trazodone = 1

cyclobenzaprine =2

paroxetine = 3

MOBILITY: extreme fall risk, multifactorial, possibly orthostatic

WHAT MATTERS: Dau is POA, wants to keep mom home with husband as long as possible. Family worried about her future decision making

92yoF with Alzheimer's dementia admitted to long term care after completing subacute rehab. Hospitalized after she sustained an impacted left femoral neck fracture s/p fall in her assisted living facility.   Was found to have an elevated troponin and new afib with rapid rate while hospitalized and placed on beta blocker and calcium channel blocker. Echocardiogram with normal ejection fraction with left ventricular hypertrophy and severe tricuspid regurgitation

Previously living in assisted living with minimal custodial assistance.
Family notes progressive declines, esp after most recent fracture
Only on 2 meds prior, multiple new meds post hospitalization
Not eating, now quite frail per family

PROBLEM LIST:

- Dementia, moderate to severe
- Hypertension
- Atrial fibrillation
- Recent fragility fracture, likely osteoporotic
- Severe tricuspid regurgitation
- Hyperlipidemia
- Depression, long term
- Weight loss, poor appetite, frailty

COGNITIVE: progressive dementia, FAST LEVEL 6d-e

MEDICATIONS: family requested nothing more than essential meds, taken off atorvastatin, colace, scheduled tylenol, Vit. C calc-vit D.   Currently only on 4 scheduled meds

MOBILITY: unable to ambulate, wheelchair bound, v. high falls risk

WHAT MATTERS: she had been telling daughters for months she was ready to die, daughters clear on her advance wishes.
Power of Attorney in place, Do not resuscitate/Do Not Hospitalize Palliative care predominantly. POST form c/w comfort care

CONCLUSION

http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/default.aspx

Anticholinergic Burden Scale www.ACBcalc.org

FAST SCALE: Functional Assessment Staging Scale.
1984 Barry Reisberg

GDS: Geriatric Depression Score, short form
Yeasavage JA, et al J. Psychiatric Research 1983; 17: 37-49.

SLUMS: St Louis University Mental Status Examination.
SH Tariq., et al. Am J Geriatric Psychiatry 14:900-910, 2006

QUESTION & ANSWER

Dr. C. Andrew Class, Dr. Staci Hollar, Jenny Allbright, Dr. Patrick Healey

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CE Distribution Instructions

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