

## BEST PRACTICES: PART I

# INCORPORATING THE GERIATRIC 5Ms INTO GENERAL INTERNAL MEDICINE

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## Introduction

**W**ith our aging population, general internists play crucial roles caring for older adults in various settings. The Geriatric 5Ms (Mobility, Mind, Medications, Matters Most, and Multicomplexity) were launched in 2017<sup>1</sup> and are now a ubiquitous framework highlighting the core components of geriatric care. The Age-Friendly Health System initiative promotes a similar 4Ms framework (Mobility, Mentation, Medication, and What Matters) to incorporate evidence-based geriatric principles on a systems level.<sup>2</sup>

The 5Ms map onto elements of the comprehensive geriatric assessment (CGA), in which an interdisciplinary team assesses and develops a holistic plan for an older adult. CGA leads to improved outcomes, including increased likelihood to be alive and at home following hospitalization, and reduced risk of unplanned hospital admission.<sup>3,4</sup> This evidence provides additional impetus to incorporate the 4/5Ms framework into the general internist's clinical practice.

The following is an overview of each M focused on relevance to general internists, along with practical tools.

## Mobility

Mobility encompasses gait, balance, fall prevention, and function, which greatly impact quality of life and prognosis. While falls are common and can lead to significant morbidity and mortality, patients may hesitate to mention them. Screening is therefore critical. One can ask about a history of falls or feeling unsteady and incorporate the Timed Up and Go, 30-Second Chair Stand, or 4-Stage Balance Test; these and other resources are available on

the CDC's STEADI website. In all clinical settings, we recommend systematically evaluating patients with falls or risk for falls, considering both intrinsic factors (e.g., sensory impairment, pain, incontinence, musculoskeletal conditions, neurological disease, cardiopulmonary conditions) and extrinsic factors (e.g., medications, footwear, home safety). Care plans can then incorporate targeted interventions. Physical and occupational therapists can further enhance evaluation and management.

## Mind

Mind/Mentation encompasses cognition and mood. Older adults may experience cognitive decline ranging from age-related cognitive changes to dementia and may have more risk factors for developing delirium. Internists are often the first to notice, evaluate, and manage cognitive changes, whether chronic (e.g., dementia) or acute (e.g., delirium). Cognitive concerns often span care transitions and thus deserve special attention from internists, such as dementia suspected during hospitalization requiring full outpatient evaluation, or subtle delirium lingering after hospital discharge. Internists can use screening tools such as the Mini-Cog for dementia and Confusion Assessment Method for delirium and can refer based on local resources. After a diagnosis, internists are critical in ongoing counseling, caregiver engagement, and future planning.

Older adults often face grief, significant adjustments in function and living situations, and mood disorders. Given the strong relationships PCPs have with their patients, their role in recognition and management is indispensable.

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# GERIATRICS: AGE-FRIENDLY HEALTH SYSTEMS AS A FOUNDATION FOR MEDICAL CARE

Michael Landry, MD, MSc, FACP, Editor in Chief *SGIM Forum* with Special Guest Editors, Seki Balogun, MD, FACP, AGSF; Patricia Harris, MD, MS, FACP; Katie Drago, MD, FACP

“Caring for our seniors is possibly the greatest responsibility we have. Those who have walked before us have given so much and made possible the life we all enjoy.”<sup>1</sup> The *SGIM Forum* editorial team in conjunction with our Special Guest Editors bring this theme issue on geriatric care to SGIM members to improve the care of our older patients, a task that includes initiative and advocacy. Eventually, most of us will need a caring and empathetic healthcare provider to negotiate the healthcare system and promote our health and well-being as we age. The articles within this theme issue will assist us in becoming more aware of current healthcare topics.

Worldwide, there is a growing movement to foster healthy aging across nations. The World Health Organization (WHO) introduced a global action plan for health care in older adults in 2016<sup>2</sup> through the adoption of the following five age friendly strategies:

1. Creating national frameworks for health aging in every nation with collaboration between all sectors of health care including national, state, and private institutions, as well as scientists, clinicians, hospital administrators and political players.
2. Development of appropriate and friendly health environments for older adults with adequate coordination between different health sectors, making it easier for patients to seek and navigate health care, while also promoting optimal health.
3. Better alignment of health systems to cater to the needs of older adults. This is to ensure that older persons have access to basic and advanced medical services for their complex medical needs and preferences.
4. Developing appropriate health systems for geriatric long term care including home care, community services such as adult day care centers, program of all-inclusive care of the elderly (PACE), and institu-

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# OVERCOMING BARRIERS TO DEPRESCRIBING: AN IMPORTANT ROLE FOR GENERAL INTERNISTS

Martha S. Gerrity, MD, MPH, PhD, FACP, President, SGIM

"We are fortunate to offer a pre-course at the 2024 SGIM annual meeting that will address deprescribing and the latest research from the US Deprescribing Research Network."



The projected number of geriatricians in 2030 is woefully inadequate to meet the needs of frail older patients due to the rapid growth in the over-65 population and the low numbers of trainees entering geriatrics.<sup>1</sup> As general internists, we must assume a greater role in the care of our older patients by focusing on their quality of life, helping them remain functional and socially connected, and avoiding polypharmacy (taking five or more medications daily) with its potential adverse drug reactions (e.g., cognitive decline, falls, and depression).

General internists are well suited to assist geriatricians in caring for elderly patients by identifying polypharmacy and, when appropriate, deprescribing medications. We routinely manage complex medical conditions and medications and frequently work in teams that help

us coordinate patient care and engage with subspecialists. We have a comprehensive whole person approach and long-term relationships with patients, which facilitates our ability to educate our patients and participate in shared decision-making. These characteristics are important in taking on the challenge of polypharmacy and deprescribing.

Deprescribing is the process of recognizing, and then tapering or stopping unnecessary or potentially harmful medications.<sup>2</sup> It is easy to recognize the need to deprescribe in some patients. These are patients who dislike taking medications and ask about stopping them, patients who walk into clinic with a large suitcase when asked to bring in their medications, and patients on known high-risk medications (e.g., opioids, benzodiazepines). For other patients and medications, it's complicated. We first need to recognize that the benefits of a medication,

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The SGIM Forum, the official newsletter of the Society of General Internal Medicine, is a monthly publication that offers articles, essays, thought-pieces, and editorials that reflect on healthcare trends, report on Society activities, and air important issues in general internal medicine and the healthcare system at large. The mission of the Forum is to inspire, inform, and connect—both SGIM members and those interested in general internal medicine (clinical care, medical education, research, and health policy). Unless specifically noted, the views expressed in the Forum do not represent the official position of SGIM. Articles are selected or solicited based on topical interest, clarity of writing, and potential to engage the readership. The Editorial staff welcomes suggestions from the readership. Readers may contact the Editor, Managing Editor, or Associate Editors with comments, ideas, controversies, or potential articles. This news magazine is published by Springer. The SGIM Forum template was created by Howard Petlack.

# Q & A WITH SGIM'S CEO AND THE CHAIRS OF SGIM'S GERIATRICS COMMISSION

Eric B. Bass, MD, MPH; Patricia Harris, MD, MS; Kathleen Drago, MD, FACP

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**EB: What are the goals of the Geriatrics Commission?**

PH: The goals of the Geriatrics Commission, formerly known as the Geriatrics Task Force, are to: 1) facilitate implementation of activities within SGIM related to geriatrics; 2) coordinate activities between SGIM and other organizations active in geriatrics clinical care, education, and research; 3) design and implement new projects that focus on improving clinical care and education related to geriatrics; and 4) facilitate career development of SGIM members interested in geriatrics.

**EB: What is the best example of how the Geriatrics Commission has incorporated education and research in geriatrics into SGIM meetings?**

PH: One of the most successful activities of the commission has been the sponsorship of the Distinguished Professor of Geriatrics Program at SGIM's annual national meeting. Every year since 2004 the commission has selected a professor in general internal medicine or geriatrics who has nationally recognized expertise in education, research, and/or clinical care related to the care of older adults. The table of Distinguished Professors includes an amazing group of leaders who have advanced the fields of geriatrics and general internal medicine.\*

The commission invites the selected Distinguished Professor of Geriatrics to give a special presentation at the national meeting and to participate in reviewing and discussing posters and oral presentations at the meeting on topics in geriatrics. The presentations by the Distinguished Professors have been superb and inspiring, and recordings of recent presentations are available on GIMLearn.<sup>1</sup> In 2023, the Distinguished Professor of Geriatrics Best Poster Presentation Award went to Rashmi Sharma,

MD, MHSc, from the University of Washington Medical Center, for a poster titled "Challenges Experienced by Family Members of Hospitalized Older Adults with Dementia When Making 'In-the-Moment' Decisions Regarding Intensity of Care." The Distinguished Professor of Geriatrics Best Oral Abstract Presentation Award went to Halima Amjad, MD, PhD, MPH, from the Johns Hopkins University, for an abstract titled "Overwhelmed: Dementia Care in Primary Care."

**EB: What has the Geriatrics Commission done to foster collaboration with other organizations on issues related to geriatrics?**

KD: One of the most important accomplishments was the seminal work over a decade ago when the Geriatrics Task Force collaborated with the American Geriatrics Society (AGS), American Board of Family Medicine Foundation, and American Medical Association to define minimum competencies in geriatrics for internal medicine and family medicine residents. That project produced a report with a comprehensive set of 26 competencies in seven domains, including: transitions of care; hospital patient safety; cognitive, affective, and behavioral health; complex or chronic illnesses; medication management; ambulatory care; and palliative and end-of-life care.<sup>2</sup> Since that report was published in 2010, it has provided a strong basis for continuing efforts to strengthen internal medicine and family medicine training in geriatrics.

In recent years, the Geriatrics Commission has continued to support collaborative

efforts to strengthen education and research in geriatrics. For example, in 2022, the commission supported a grant proposal by the AGS to create a resource for new and emerging investigators interested in including  
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2023, Alison Huang, MD, MS	2012, Roseanne Leipzig, MD
2022, Eliseo Perez-Stable, MD	2011, C. Seth Landefeld, MD
2021, Mara Schonberg, MD	2010, Marie A. Bernard, MD
2019, Peter Boiling, MD	2009, Albert L. Siu, MD, MPH
2018, Christopher M. Callahan, MD	2008, Neil M. Resnick, MD
2017, Richard Hodes, MD	2007, Mary Tinetti, MD
2016, Elizabeth Eckstrom, MD	2006, David Reuben, MD
2015, Gail Sullivan, MD, MPH	2005, Christine Cassel, MD
2014, Catherine Sarkisian, MD, MSPH	2004, Eric B. Larson, MD, MPH
2013, Jean Kutner, MD, MSPH	

\* We did not have a Distinguished Professor in 2020 because there was no national meeting that year due to the pandemic.

# IS THIS OLDER ADULT SAFE TO LIVE INDEPENDENTLY?

Elise Binder, MD, MEd; Nam-Ha Brown, MD; Shivani Jindal, MD, MPH

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A 79-year-old man with disabling dysarthria and hemiparesis from past strokes comes to the hospital with his family because they are concerned about his ability to live independently. He is admitted for safe disposition planning. He has lived in different settings over the last 10 years, including apartments and in long-term care, most recently leaving to reside in a hotel. He desires to return to his childhood home, uninhabited and reportedly in disrepair. His family is concerned because they believe he needs additional functional support. The patient insists he can care for himself. We were tasked with determining his capacity to make decisions about disposition planning and a return to independent living.

*Capacity assessment can be challenging. Physicians are often asked to determine a patient's ability to make medical decisions, but they are also asked to determine capacity for independent living when planning for discharge. Many clinicians lack formal training in capacity evaluation and clinicians may not recognize patients who are incapable.<sup>1</sup> Capacity is decision- and task-specific—a patient may have capacity to make lower risk choices, but have difficulty making decisions with higher risks.<sup>2</sup> Capacity to live independently includes components like those for medical decision-making capacity, however judgement and function (application of relevant basic Activities of Daily Living [ADLs] and Instrumental Activities of Daily Living [IADLs]) are key to independent living.<sup>2</sup> Social history, functional and cognitive assessments, and patient values about what makes a home a home are important parts of the evaluation. Understandably, older adults with frailty and functional and/or cognitive decline grieve their former independent selves and find it difficult to accept help.*

The patient is an Army Veteran and worked in a factory for 30 years after military service. He does not smoke, drink alcohol, or use recreational substances. He is divorced, with two adult children, and his sister and brother live in different states; they, with the patient, co-own their childhood home. His sister and brother wish to sell the home because it is “uninhabitable.” The patient’s daughter is his Power of Attorney and his nieces and nephews live nearby. The patient says returning to

this home is the most important thing to him. He became tearful when speaking fondly about his experiences growing up there and how the home represents independence.

*To support an older person's goal to age in place, it is important to understand their functional status and if needs can be met with home and community services. Functional assessment requires collaboration with interprofessional team members such as occupational and physical therapists and social workers. Cognitive assessment is a meaningful part of the evaluation of a person's capacity to live independently.*

From 2013-20, the family observed the patient was requiring more support with ADLs, becoming more forgetful, and spending large sums of money for items he could not recall. He expressed delusions about his daughter stealing money (money used for home health services and caregivers). Neuropsychology assessments performed over this time revealed executive dysfunction and memory deficits. In 2020, the patient scored 3/5 on Mini-Cog ( $\geq 3$  normal) and 6 on Short-Blessed Test (0-4 normal, 5-9 possible impairment,  $\geq 10$  impairment consistent with dementia). During the current hospitalization he scored 26/30 on the MoCA (Montreal Cognitive Assessment) ( $\geq 26$  normal). Physical and occupational therapists report the patient requires assistance for several basic ADLs and all IADLs. The patient did not recognize his functional limitations and could not outline a plan for “24/7” home health services to meet his needs. His family could not provide additional support in the home.

Ultimately, we determined the patient lacked capacity to return to independent living. Nearly normal performance on cognitive testing made this determination challenging.

## Discussion

In this case, aligning the patient’s care plan with What Matters (as part of Age-Friendly 4Ms care) was complicated because the patient desired to reside in a home where he could not receive the functional supports necessary to meet his goal to age in place.

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# DEPRESCRIBING IN HOSPITALIZED OLDER ADULTS

Katie Drago, MD, FACP; Seki Balogun, MD, FACP, AGSF

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For many older adults, health care is a mobius strip. They move from setting to setting, specialty to primary care, home to hospital to post-acute rehab, and bring with them polypharmacy, the suitcase that older adults carry with them from place to place. As they move through the mobius strip, their suitcase gets packed with new or adjusted medications until it is too heavy to carry and the patient falters in their move along the mobius strip. We see this clinically as the consequences of polypharmacy, such as falls, injuries, adverse drug events (ADEs), delirium, cognitive impairment, and poor compliance with medication regimens, but the relationship is rarely called out. While treating polypharmacy has been mostly siloed in the ambulatory space and at times in post-acute care, hospitalization can be a key step to address crippling polypharmacy. In treating acute medical conditions in older adults, a common occurrence in hospital care is the addition of multiple new agents and adjustment of existing medications. Often, hospitalization is not seen as an opportunity to deprescribe.

Older patients are often admitted to the hospital with long-established medication regimens and there is a common assumption that “they must be on all these for a good reason.” Sometimes these situations may be looked at as being “not my circus, not my monkeys.” Hospital providers are an important check in the mobius strip to ensure that everything in the polypharmacy suitcase really should be there at that time in the patient’s journey. Physiology changes with age, and chronic medical conditions change with time and pharmacology advances. Medications that were reasonable 5 or 10 years ago, may no longer be appropriate for a patient’s current condition.

Age-related pharmacokinetic and pharmacodynamic changes make certain medications potentially inappropriate for older adults, such as those identified in the American Geriatrics Society Beers Criteria.<sup>1</sup> Common examples include medications with anticholinergic activity (first generation antihistamines, muscle relaxants, antispasmodics, tricyclic antidepressants), cardiovascular

“Hospitalization is a powerful opportunity along the mobius strip of health care to be a check on medication safety and intervene early in cases of polypharmacy.”

medications (alpha 1 blockers, central alpha agonists), benzodiazepines, and non-steroidal inflammatory agents. Published tools, such as the STOPP/START

criteria, are also very useful in identifying medications that may no longer be suitable or contraindicated, as well as potential prescribing omissions.<sup>2</sup> For example, a frail patient with hypertension and recurrent falls may have more risks for adverse effects than benefits if they take an alpha blocker or thiazide diuretic.

Recent deprescribing protocols developed specifically in acute care settings use various tools, including an electronic decision support tool for deprescribing, and an interdisciplinary approach comprised of clinical pharmacists, nurse practitioners, and physicians. These protocols incorporate drug specific factors, such as a drug safety profile, as well as drug-drug and drug-disease interactions. These frameworks result in significantly reduced pill burden and improved cost effectiveness of medications.<sup>3-5</sup> Elimination of potentially inappropriate medications for older adults and utilizing this interdisciplinary approach are important in helping to prevent future ADEs.

Many of these interventions, however, have not consistently shown a reduction in adverse drug events. This may be because of the relatively small sample sizes of high-risk patients included in studies, as well as the short duration of studies focusing mainly on short-term adverse drug events. Fortunately, many hospitals already routinely involve clinical pharmacists in the care of all patients, so the potential for ADEs may be mitigated in certain instances. Other beneficial effects of deprescribing, such as improved nutritional intake, may also be more evident several weeks to months after hospitalization.

In considering deprescribing in hospitalized older adults, practical steps would include identifying all high-risk patients with polypharmacy (typically defined as taking five or more medications), with particular atten-

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# WHAT MATTERS MOST: CONNECTING VALUES WITH CARE PREFERENCES FOR OLDER ADULTS

Mary L. Thomas, MD, MPH; Laura J. Morrison, MD

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“**W**hat if I want to turn it off?” she asked. Jen (name changed) has had her left-ventricular assist device (LVAD) for many years. This admission was similar to the other handful this year which were also for gastrointestinal bleeding. She is no stranger to hospitalization. She has, however, become a stranger to the quality of life (QOL) she once enjoyed. As the palliative medicine team, we were consulted to help facilitate discussions about Jen’s desire to deactivate her LVAD. In other words, we needed to figure out what matters most to Jen.

What “Matters Most” is one of the Geriatric 5Ms and involves determining individualized meaningful healthcare outcomes, goals, and care preferences for older adults based on their stated values.<sup>1</sup> Connecting a patient’s values with their care preferences, especially when there is discordance between the two, can be challenging. Multiple strategies from serious illness communication science provide tools in this realm. This article highlights communication techniques, including Vitaltalk’s REMAP (reframe, expect emotion, map, align, plan),<sup>2</sup> a framework to transition with a patient from a shared understanding of difficult news to identify and translate their values into treatment recommendations.

## Establishing a Frame of Reference (Reframe, Expect Emotion)

Often when a conversation is needed to clarify next steps, it is because what we have been doing is not working as we hoped, or something has changed in a significant way. With Jen, we were drawn to reframe around the possibility that what we were doing was not aligning with her goals. We need to remember that emotion is likely to surface in some form (sadness, anger, fear) and be ready to identify and support it.

## Connecting Values with Care Preferences (Map, Align, and Plan)

Once Jen’s understanding of the medical facts and her prognosis is clarified, we map her values. Within the 5M framework, this is determining what matters most and

it is mapping within REMAP. We ask multiple questions like what activities bring joy or what would make life not worth living? We then align expressed values into care preferences. Values and preferences are not the same, so values must be prioritized and not overlooked.<sup>1</sup> We aim to make a recommendation and see if this resonates with Jen. During this process we cannot forget other important considerations.

## Intersectionality

We cannot elicit what matters most to our patients without acknowledging and exploring all of their facets (with permission). *Intersectionality* is defined as “the interconnected nature of social categorizations, such as race, class, and gender, as they apply to a given individual or group, regarded as creating overlapping and interdependent systems of discrimination or disadvantage.”<sup>3</sup> Jen is a 65-year-old, English-speaking, African-American, cis-gendered, heterosexual woman with multiple comorbidities limiting her daily functioning. She is a great-grandmother and a devout Christian. Each of these identities and characteristics plays a role in her decision making and influences her ultimate response to what matters most to her in her care planning.

Our identities are not the same as our patients’, which can create discomfort while exploring their impact on patient decision making. To help mitigate this discomfort, separate your beliefs and experiences from your patients’ and transform that feeling into curiosity through your questions. Jen found support through her faith. Ultimately, God told her not to discontinue her LVAD.

## Trauma-Informed Care

When caring for people from marginalized populations, it is critical to be mindful of possible distrust of the medical system as a result of our patients’ lived experiences with systemic racism, discrimination, and other biases. That distrust may extend to us. It is our responsibility as clinicians to identify it and respond with trauma-in-

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# SCREENING AND DIAGNOSIS OF DEMENTIA IN PRIMARY CARE

Stephanie Nothelle, MD

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Primary care physicians (PCPs) provide the majority of dementia care. However, many PCPs feel insufficiently trained to diagnose dementia, lack time to incorporate dementia screening, and are concerned about sensitively sharing a diagnosis of dementia.<sup>1</sup> Timely diagnosis of dementia is important. Benefits of timely diagnosis include decreased caregiver stress and delayed transition to long-term care. This article reviews the definitions and diagnostic criteria of mild cognitive impairment (MCI) and dementia, describes available screening tests for MCI and dementia, and discusses how to sensitively share a diagnosis of dementia.

## Definitions and Diagnostic Criteria

MCI and dementia exist on a spectrum where MCI is an intermediary condition between normal cognition and dementia. Estimates suggest that each year 8-13% of persons with MCI will progress to dementia, while up to 16% will revert to normal cognition and others will remain with MCI.<sup>2,3</sup>

*The Diagnostic and Statistical Manual 5<sup>th</sup> edition (DSM-5)* refers to dementia as a major neurocognitive disorder and MCI as a minor neurocognitive disorder and provides diagnostic criteria for dementia and MCI.<sup>3</sup> Per the DSM-5, to make a diagnosis of MCI, the patient must have a decline in cognitive functioning that does not interfere with function in daily activities and is not explained by delirium or a psychiatric disorder. MCI should be detected by a history gathering from the patient and a second informant (e.g., a caregiver) and by cognitive testing. A patient needs to have deficits in only one of the six following cognitive domains to meet criteria for MCI: complex attention (e.g., ability to tap each time letter “A” is said), executive function (e.g., planning, organization), learning and memory (e.g., short-term recall), language (e.g., aphasia), perceptual-motor (e.g., visuospatial or navigation skills), or social cognition (e.g., identification of emotions in others).

To make a diagnosis of dementia, there needs to be a decline from previous level of cognitive functioning not explained by delirium or a psychiatric condition detected by a combination of history taking from the patient and an informant and objective cognitive tests. However, in dementia, the cognitive impairment must be severe

enough to impair function and it must include one or more cognitive domains. Of note, memory does *not* need to be one of the cognitive domains that is impaired.

To determine which cognitive domains are involved, a clinician can review the pattern of errors on an in-office cognitive assessment (e.g., spelling “world” backwards is a test of attention while recalling words is a test of learning and memory). Further, in talking with patients and families, a clinician can categorize the described impairments within domains. For example, getting lost while driving represents a deficit in the perceptual-motor domain, while inability to organize a family dinner likely represents a deficit in executive functioning.

## Tools for Screening

Clinicians should consider screening for dementia or MCI in any patient where the patient or caregiver reports trouble with the patient’s thinking or memory. Further, new functional impairment in any of the instrumental activities of daily living may represent new cognitive decline. Instrumental activities of daily living include arranging transportation, managing medications, managing finances, cooking, shopping, communicating on the phone, using the bathroom, laundry, and housework.

Several in-office or bedside screening tools exist for screening of dementia or MCI.<sup>4</sup> Perhaps one of the quickest basic screening tests for cognitive impairment is the 3-minute “Mini-Cog.” With this assessment, a clinician lists three words for the patient to remember, asks the patient to draw a clock and set the time as instructed, and then asks the patient to recall the three words. One point is given for each word correctly recalled and two points are given if the clock draw is correct. A score of 2 or less is associated with a high likelihood of significant cognitive impairment. Other commonly used tests include the Mini-Mental State Exam, the Montreal Cognitive Assessment, and the St. Louis Mental Status Exam.

## Sharing the Diagnosis

Prior to cognitive testing, it can be helpful to ask the patient and family what they would want to know about the results.<sup>1</sup> Some patients and families will want to have

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# IS THE JUICE WORTH THE SQUEEZE? RISKS AND BENEFITS OF NEW DEMENTIA TREATMENTS

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In July 2023, the FDA gave full approval for lecanemab to treat Alzheimer's dementia. Lecanemab is a monoclonal antibody that targets a step in the amyloid plaque formation pathway in the brain.<sup>1</sup> The story of the approval of this and similar medications is rife with controversy that internists should understand to allow a balanced conversation with patients regarding these treatments.

A major part of the controversy surrounding these drugs is that the earlier FDA approval of a slightly different amyloid antibody, aducanumab, resulted in the resignation of several key members of the advisory committee to the FDA.<sup>2</sup> The FDA approved the medication despite the committee unanimously voting not to approve the medication. The two trials of adacanumab were stopped early due to futility and only published after lecanemab demonstrated better results. A newer amyloid antibody, donanemab, had trial results published recently. The information shared here should help readers considering referral for lecanemab treatment and donanemab (should it receive future FDA approval).

## Treatment Burden

Lecanemab requires an infusion every other week. To qualify for treatment, the patient must be diagnosed with either mild cognitive impairment or early stage Alzheimer's dementia. Other types of dementia or more severe cognitive impairment exclude patients from eligibility.

To receive Medicare reimbursement, prescribers of lecanemab must participate in monitoring via a registry to track outcomes.<sup>3</sup> The FDA put no similar safety measure in place. The CMS registry asks about cognitive testing results, either the Montreal Cognitive Assessment Test (MoCA) or another type of cognitive test, and asks for verification of amyloid testing via an amyloid PET scan, lumbar puncture or other test that detects amyloid levels. Additionally, the prescriber must report functional testing results.

Finally, information is required on whether the patient is taking an antiplatelet or is on anticoagulation,

presumably because of the potential adverse effects of this medication. The number needed to harm for potential cerebral hemorrhage (ARIA-H) is 12.1 people, which is alarmingly low.<sup>1</sup> In addition to biweekly infusion center visits, patients are monitored for potential adverse reactions via brain imaging and other close monitoring while under treatment.

## Treatment Efficacy

The Clinical Dementia Rating Sum of Boxes (CDR-SB) is a standard tool used in dementia research to evaluate the effectiveness of a treatment. It is evaluated on an 18 point scale. For clinical trials purposes, a difference of 0.3 is considered significant. In the lecanumab trial, the difference between the treatment group and placebo on the CDR-SB at 18 months was 0.45. The trial also demonstrated a significant decrease in amyloid volume in the lecanemab group compared to the placebo group at 18 months.

## Health Equity

Let's consider this: The drug currently carries a hefty price tag exceeding \$25,000 per year. Now, add context to the equation. The Alzheimer's Association reports that Black individuals are twice as likely as their Caucasian counterparts to receive a dementia diagnosis while Latinx individuals face a risk 1.5 times higher. However, the clinical trial enrollment figures reveal an alarming disparity. Black participants accounted for a mere 2.5%, Latinx individuals comprised just 12.4%, and Caucasians dominated at 77%. This glaring incongruity not only raises concern but also begs a crucial question: Shouldn't those most impacted by the disease enjoy more equitable access to potential treatments, including the opportunity to participate in clinical trials? It's time we confront these disparities and ensure that cost and systemic exclusion no longer act as a barrier to those most in need.<sup>4</sup>

In summary, when considering whether to refer patients to receive lecanemab treatment there are four key

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# EVALUATING OLDER ADULTS WITH DECLINING eGFR

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The number of older adults with chronic kidney disease (CKD) across the country is rapidly growing, driven by increased lifespans as well as higher incidences of diabetes and vascular disease. In the world of geriatric nephrology, more physicians are questioning the assumption that all older adults with low estimated glomerular filtration rate (eGFR) have renal pathology. Because of the way we estimate and classify renal function, some older patients labeled as having “CKD” may have relatively normal renal function for their age.

Part of this discrepancy relates to the tools we use to estimate GFR: the Modification of Diet in Renal Disease (MDRD) and Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) equations. Both rely on serum creatinine, a reasonably accurate but imperfect biomarker, to estimate renal function. However, healthy individuals have more muscle mass than those with CKD, and therefore have a higher GFR at the same creatinine level. As a result, the MDRD and CKD-EPI equations tend to underestimate GFR in healthy adults (in one analysis, by up to 25% and 16%, respectively).<sup>1</sup>

In 2012, the Kidney Disease Improving Global Outcomes (KDIGO) group released their practice guidelines for the evaluation of CKD.<sup>2</sup> By these guidelines, any adult with an eGFR of less than 60 persisting for three months is determined to have CKD, even absent other evidence of kidney damage. These eGFR cutoffs do not vary based on age; thus a 30-year-old and a 90-year-old with the same eGFR’s of 58 are lumped into the same CKD3a bucket.

The KDIGO guidelines hold 90-year-old nephrons to the same standards as their 30-year-old counterparts. Yet nephrons, like all functional units in the body, undergo a predictable process of aging called senescence, even in the absence of true pathology or disease. At the cellular level, glomerular capillary walls deteriorate, podocytes degrade, and tubular function slows, leading to fewer functional glomeruli. Even in the absence of comorbidities, renal function declines an estimated 1 ml/min/1.73 m<sup>2</sup> (unit of GFR) per year starting at age 40.<sup>3</sup> For example, a 30-year-old with a relatively average GFR of 105 may undergo a reduction of nearly 50% to a GFR of 55 by age 90.

When taken together, equations that underestimate eGFR in healthy adults, age-nonspecific CKD diagnostic criteria, and age-related renal senescence mean that CKD is likely over-diagnosed in older adults.

Notably, isolated reduced eGFR in older adults does not always portend a poor prognosis. The CKD Prognosis Consortium, one of the largest studies to examine this, initially used age-nonspecific cutoffs of eGFR to determine a threshold that was independently associated with adverse outcomes, including cardiovascular events and all-cause mortality. The study found that adverse outcomes increased significantly below an eGFR of 60, driving the KDIGO 2012 guidelines’ definition of CKD as an eGFR of <60. Years later, the same data from the Consortium was reanalyzed using age-specific eGFR cutoffs<sup>4</sup> (the normal range of eGFR was >105 for ages 18-54, 90-104 for ages 55-64, and 75-89 for ages 65+). Among older individuals, researchers found that mortality did not significantly increase until an eGFR of <45. Older adults with an eGFR of 45-59 had the same rates of cardiovascular events and all-cause mortality as those with an eGFR of 60 and above. Furthermore, for older patients with an eGFR of 45-59 without albuminuria, the risk of progression to ESRD is rare (<1% risk in 5 years).<sup>5</sup>

Overdiagnosis of CKD in older adults is harmful. It can lead to unnecessary distress for patients and their families, result in subtherapeutic drug dosing, expose older adults to excessive interventions and side effects, overwhelm specialist resources, and elevate the cost of care. We can have more nuanced discussions with patients about management of mild to moderate CKD by recognizing the context around eGFR equations and CKD definitions. This may mean closely monitoring patients with stable CKD3a rather than pursuing more advanced testing or referrals. Providers must interpret eGFR in clinical context. Certain scenarios warrant a nephrology referral and urgent work-up for renal pathology, including rapidly declining renal function, active urine sediment, significant albuminuria, etc. If there are no other signs or sequelae of kidney damage present, a stable eGFR between 45–59 might be considered typical for the patient’s age.

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in reducing the risk of an outcome such as cardiovascular events, no longer outweigh the risks of adverse outcomes, such as falls or increasing cognitive decline.

Although I care for elderly patients with long medication lists, I realize I am not addressing polypharmacy and deprescribing as often as I should. This occurs even though I am required to review medication lists with patients and reconcile the list against what they are taking. For this geriatrics theme issue of *SGIM Forum*, I summarize what we know about the barriers to deprescribing and what might improve our ability to deprescribe. I hope SGIM members in primary care and inpatient settings will join our geriatrics colleagues in addressing polypharmacy and become better role models for trainees in recognizing and tackling this problem.

### Barriers to Deprescribing

Several recent qualitative studies of patients, caregivers, and physicians identify some of the barriers and facilitators to deprescribing.<sup>3-5</sup> These studies echo findings of earlier studies. Barriers to deprescribing fall into three interdependent categories: health system, physician, and patient barriers.

Health system barriers include:

- Time constraints during visits
- Reimbursement for cognitive services
- Inadequate team support for deprescribing
- Physician continuity
- Little focus on polypharmacy in routine screening
- Guidelines and performance metrics that inhibit instead of support deprescribing.

Physician barriers include:

- Clinical inertia—it's easier to continue prescribing
- Inadequate information about the risks and benefits of deprescribing for a patient
- Uncertainty about patients' overall prognosis to determine if it's

the right time to deprescribe for specific patients

- Language and terms used with patients when prescribing (e.g., “you need this medication,” “it will prevent a heart attack”) and discussing deprescribing
- Inadequate skills in shared decision making
- Perceived authority of subspecialists who first prescribed the medication(s).

Patient barriers include:

- Fear of bad outcomes if a medication is stopped
- Habit
- Perceived authority of subspecialists who first prescribed the medication(s)
- Perception that pills are better than lifestyle changes in treating a condition.

### Facilitators of Deprescribing

Many of the identified facilitators for deprescribing focus on physicians and what we can do to address physician and patient barriers. First is recognizing polypharmacy and deciding to deprescribe. Introduce the concept of deprescribing by noting the number of medications patients are taking and asking them if they would like to consider tapering off some of their medications. Add deprescribing to your plan for your next visit with the patient. This allows time for the next step—gathering information about the patient's overall prognosis from prognostic calculators (e.g., ePrognosis) and the benefits and risks of deprescribing specific medications. Consulting with subspecialists who started or assist with monitoring a medication may reassure physicians and patients that deprescribing is the right strategy.

The next set of facilitators comes into play when discussing tapering or stopping medications with patients. These discussions rely on relationships and the trust patients have in their primary care and inpatient physicians, which are built over time or frequent contact with patients. It

can be enhanced by involving multidisciplinary teams and caregivers who can work with physicians over time to accomplish deprescribing. As general internists, we can learn more about deprescribing and build skills in shared decision making to improve our ability to deprescribe. (We are fortunate to offer a pre-course at the 2024 SGIM annual meeting that will address deprescribing and the latest research from the National Institutes of Health-funded US Deprescribing Research Network.)

Finally, we can advocate for more support from our health systems and payors to address the system barriers to deprescribing and ask guideline groups to consider guidance on when to stop medications, as well as when to start them. Even within our clinics and inpatient settings, we can add polypharmacy to the prevention and health maintenance checklists and electronic health record templates we use. When appropriate, we can add polypharmacy to patients' problem lists to remind us to look for opportunities to deprescribe. Health system facilitators are less well defined yet important to deprescribing. My hope is that those us involved in quality improvement, implementation, and learning health system research will focus some of our work on polypharmacy and deprescribing.

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## FROM THE SOCIETY (continued from page 4)

older adults with multiple chronic conditions in their research. The proposal was funded by the National Institute of Aging and resources are now available on the AGS/AGING LEARNING Collaborative website.<sup>3</sup> We remain eager to explore opportunities for collaboration with any organizations that share an interest in advancing clinical practice, education, and research in geriatrics.

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## MEDICAL EDUCATION (continued from page 7)

formed care. For example, ask your patient if their care plan respects them and what they want to happen moving forward.

While the topic of providing trauma-informed care is outside of the scope of this article, we must acknowledge its necessity in establishing what matters most to our patients. If our patients do not trust us, we are less likely to comprehensively identify what matters most to them. The goal is to avoid retraumatizing interactions and reinforce that they are in control of their care planning.

### Addressing Discordance

Sometimes patients identify health-care preferences that do not seem to align with what matters most to them. In these cases, it is helpful to point out the potential discordance by expressing your concern about how the preference can lead to outcomes that contradict their values. (“*Jen, I’m concerned (or I’m worried) that continuing warfarin*

*will cause more hospitalizations for bleeding which may cause you to miss those important family functions.*”)

### Identifying Trade Offs

There are multiple routes to achieving a medical plan that respects Jen’s values. In her prioritizing preventing a stroke, Jen decided to continue warfarin which may result in a tradeoff between time at home versus another hospitalization. Pointing out these trade-offs helps patients link their values with their preferences, two things patients may not inherently differentiate. Thus, it is our job as physicians to think critically about the various medical plans that both uphold our patients’ values and optimize their QOL.

### Moving Forward

Patients’ preferences, unlike values, may not be static<sup>1</sup> which means treatment plans should frequently be revisited and can be done so across

multiple settings. By mapping our patients’ values through lenses of intersectionality and potential trauma, SGIM members can reevaluate values and ensure they continue to align with their patients’ preferences and care plans.

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### Medications

Biologic changes with aging, medical conditions, and polypharmacy lead to increased risk of medication side effects and adverse events, including falls and delirium. In all settings, internists can avoid potentially inappropriate medications, monitor for adverse effects, deprescribe as appropriate, and simplify regimens. Accurate medication reconciliations are crucial, especially at transitions of care. Clinical pharmacists, if available, can provide recommendations and counseling. Resources include the American Geriatrics Society Beers Criteria, [deprescribing.org](http://deprescribing.org), and [ePrognosis.org](http://ePrognosis.org)'s "time to benefit" decision aid.

### Matters Most

Matters Most focuses on patients' healthcare goals and preferences, no matter their stages of life. Recognizing a patient's likely trajectory is helpful for these conversations, and [ePrognosis.org](http://ePrognosis.org) provides evidence-based calculators to help inform this understanding. Additionally, free, patient-centered tools are available. The Stanford Letter Project and PREPARE for Your Care provide education and tools for advance care planning. Plan Your Lifespan helps patients and families prepare for life-changing events or diagnoses, such as hospitalizations, falls, and dementia. Patient Priorities Care helps emphasize the patient's voice and align care with what is most meaningful and feasible.

### Multicomplexity

Multicomplexity involves the multimorbidity and complex biopsychosocial

situations that older adults frequently experience. Older adults are often excluded from clinical trials, limiting applicability, and having multiple chronic conditions can lead to competing medical recommendations. Principles for managing multimorbidity include understanding the patient's primary concern and preferences, assessing adherence and comfort with the treatment plan, accounting for prognosis, and serially reassessing the plan.<sup>5</sup> Patient Priorities Care, noted earlier, incorporates many of these steps. To help navigate complex biopsychosocial situations, interdisciplinary teamwork with case managers and social workers is key. Clinicians can also refer patients and their loved ones to local area agencies on aging or Eldercare Locator to help navigate resources.

### Conclusion

The Geriatric 4Ms and 5Ms offer clear frameworks to provide comprehensive, person-centered care for older adults in any general internal medicine care setting. Ideally, these principles are integrated into the comprehensive care internists already provide. If needed, domains can be addressed iteratively—for example, understanding what Matters Most during one visit and focusing on Mobility during the next. Furthermore, this framework can be used to improve communication with patients and healthcare team members, educate trainees on geriatric care, and prioritize Age-Friendly Care in our health systems. We encourage SGIM members to familiarize themselves with the 4/5Ms and incorporate them into practice.

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## IMPROVING CARE: PART II

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As with many issues in geriatrics, our collective misunderstanding of what constitutes "normal" kidney function in older adults is rooted in a lack of inclusion of older adults in research, age-insensitive cutoffs in diagnostic criteria and clinical

algorithms, and normative attitudes that the aging process as inherently pathological. SGIM members must understand the limitations of GFR estimation and CKD diagnostic criteria to provide better care for older adults with possible renal dysfunction.

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tion to frail older adults. Providers should carefully consider indications for medications and assess if the medication is appropriate for the patient's current clinical condition and consistent with the patient's goals of clinical care. For instance, statin therapy may no longer be indicated in frail older adults with very limited life expectancy and less likelihood of cardiovascular benefit. Hospital medical providers are in the unique position of observing patients consistently over a short period, which can be an opportune setting to deprescribe; however, ambulatory providers need to navigate deprescribing efforts over potentially long periods between visits across a longer interval of time.

Hospitalization is a powerful opportunity along the mobius strip of health care to be a check on medication safety and intervene early in cases of polypharmacy. SGIM

members can lighten the suitcase for these vulnerable patients and make it easier for them to carry as they depart on their next journey.

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items to review with the patient and their loved ones helping them cope with dementia as it progresses:

1. It is only indicated for the very mildest cases of cognitive impairment. Patients must meet treatment criteria through cognitive testing and amyloid testing. Some patients will appear to qualify on the surface, but may not after testing.
2. Lecanemab does not cure Alzheimer's dementia and at best slightly delays disease progression. Dementia will still progress eventually and patients will be forced to stop the treatment in time.
3. The treatment regimen can be burdensome with infusions scheduled every two weeks.
4. With such a low number needed to harm, the potential for serious adverse effects should not be ignored.

The striking lack of diversity in clinical trials assessing the efficacy of lecanemab raises critical questions about our understanding of its benefits and risks. Health equity principles underscore the urgent need for more inclusive research, as the disproportionate impact of Alzheimer's dementia on various racial and ethnic groups demands comprehensive representation in our studies. To comprehend the medication's potential, SGIM members must advocate for trials that reflect the rich diversity of the patients we aim to serve. By doing so, SGIM members can foster a more equitable healthcare landscape and ensure that every individual receives the care they deserve.

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- tional services in skilled nursing and assisted living facilities.
5. Finally, developing effective methods to evaluate different components of health care and health initiatives for older persons to ensure that there is consistent improvement and that their health needs are met.

Many nations have since embraced and adapted these health strategies to enhance the care of their older population.

In 2017, the John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) introduced the Age Friendly Health Systems initiative which, in conjunction with American Hospital Association and the Catholic Health Association of the United States, worked to address the challenges of medical care of our growing older American adult population. Age Friendly Health Care aims to incorporate evidence-based clinical practices aligned with patient preferences and goals of care into every patient interaction. The concept centers around the 4Ms framework—Mobility, Mentation, Medication, What Matters—as well as the subsequent addition of the 5<sup>th</sup> M, Multicomplexity, which are the foundational aspects of geriatric assessments and clinical care.<sup>3</sup>

IHI, in collaboration with many geriatricians and internists, has ad-

vocated and facilitated the adoption of Age Friendly Healthcare in many health systems across the country, spanning all clinical sites of care, including ambulatory, inpatient, post-acute, long term care clinical sites, as well as emergency departments. Through adoption of well-developed interdisciplinary care plans and implementation of the 4Ms principles in clinical care, IHI recognizes and designates health systems as Level 1 (participant teams who have succeeded in incorporating the 4Ms framework in their clinical sites of care) or Level 2 (teams committed to geriatric care excellence and have implemented the 4Ms care model for at least three months). Currently almost 3,000 healthcare institutions in the United States have Level 1 or Level 2 designations.<sup>3</sup> Grants are available for health systems who wish to participate in some or all of the initiatives.<sup>4</sup>

In this theme issue, we explore the concept of Age Friendly Health Care, as well as its application in different clinical care settings and health systems. We also address key geriatric care topics pertinent to all clinicians who provide medical care for older adults including kidney disease in aging, deprescribing, screening and management of dementia with additional focus on new dementia treatments and their associated controversies. These first steps can move us towards what the John A. Hartford Foundation calls “patient

priorities care”—promoting reduction of medications and unnecessary diagnostic testing and improvement of appreciation by patients and clinicians for attention to goals, reduced care burden, and improved quality of life.<sup>4</sup>

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## MORNING REPORT (continued from page 5)

It is undoubtedly disheartening for a patient if they cannot safely live independently. It can be psychologically difficult as well for the physician making this determination. We are guided by medical ethics principles to respect a patient's agency and free will—autonomy, as well as provide compassionate care, acting in a patient's best interest—beneficence. These two principles can clash when a patient wants to live independently but is determined unsafe to do so and the medical team must ensure safe disposition to a location where the patient does not desire to be. Despite this challenge, we can sup-

port patients and their care partners by listening to and acknowledging their feelings and hopes, and aligning a plan that offers as much choice and connection to a patient's goals as possible. Our interprofessional team met with the patient and his daughter to review different facilities close to family with activities the patient enjoys. He and his daughter selected a location where he has been aging well for almost two years.

Capacity assessment can be complex; however, evaluation is robust when we ensure patients and care partners have all the information to make informed decisions, provide

empathic listening, and collaborate with an interprofessional team.

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## BEST PRACTICES: PART III (continued from page 8)

a clear diagnosis, while others may ask for more limited information.

If the patient and family have asked for a diagnosis, it is recommended to specifically use the word dementia instead of a vague phrase such as "memory problems." Pausing after sharing the diagnosis and asking if the patient and family want more information gives them time to process and respond. Many families want to know what to expect in the coming months and what they can do to prepare. Referrals to community-based organizations that offer support and resources for dementia such as the Alzheimer's Association or an Area Agency on Aging can be helpful for additional guidance.

### Conclusion

Primary care SGIM members are on the front line of diagnosing demen-

tia. Monitoring changes in patients' ability to complete instrumental activities of daily living can identify patients who would benefit from cognitive screening. Many screening tools exist to make a diagnosis of MCI or dementia and detection and sensitive disclosure of a diagnosis of dementia can help patients and families prepare for the future.

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