What Matters to Veterans?

Staff Member Guide to Veteran-Centric Age-Friendly Care

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May 15, 2024

Abstract

Delivering compassionate care to our aging Veterans requires a comprehensive approach to manage their unique health care needs throughout the lifespan. Veteran-centric care involves aligning care with values, preferences, and health care goals unique to each Veteran. The VA's Office of Geriatrics and Extended Care joined the Age-Friendly Health Systems movement developed by the John A. Hartford Foundation and the Institute for Healthcare Improvement to improve health care for aging Veterans. An Age Friendly Health System for Veterans aims to deliver safe, reliable, high-quality health care based on what matters most to Veterans using the VA Whole Health holistic approach. Although some health care providers have their own experiences of military service, no two experiences are the same. Providing support, empathy, and acceptance to each Veteran and approaching Veteran health care with genuine curiosity and concern regarding their lived-in experience is imperative to increasing trust and providing Veteran-centric care. The Age-Friendly Health Systems framework offers a set of evidence-based practices known as the 4Ms: What Matters, Medication, Mentation, and Mobility. Understanding "What Matters" to our unique and vulnerable population of Veterans who dedicated their life to our freedom requires awareness, knowledge, and compassion from all members of the care team.

VA Mission Statement

“To fulfill President Lincoln’s promise to care for those who have served in our nation’s military and for their families, caregivers, and survivors.”

Objectives

- Understand Age-Friendly Systems & Whole Health
- Review Veteran Identity
  - Military Culture
  - Core Values
  - Era of Service
  - Service-Related Experiences and Exposures
- Provider Educational Resources
- Veteran Resources

Introduction: Discover What Matters

Introduction: Age Friendly Health Systems

- Age Friendly Health Systems Initiative
  - The John A. Hartford Foundation
  - Institute for Healthcare Improvement
  - 8.1 million of 16.5 million living Veterans in the U.S. are 65 years and over[33]
  - In partnership with:
    - American Hospital Association
    - Catholic Health Association of the United States.
- Increased understanding and appreciation of the aging Veteran's identity based on awareness of their military service, experiences, and related health issues can help contextualize symptoms, guide treatment planning, and improve Veteran health outcomes[22]
- Applying the 4Ms to Veteran-centric care practices can
  - Help build trust
  - Increase engagement
  - Improves the management of complex medical and mental health conditions that impact Veterans[19]

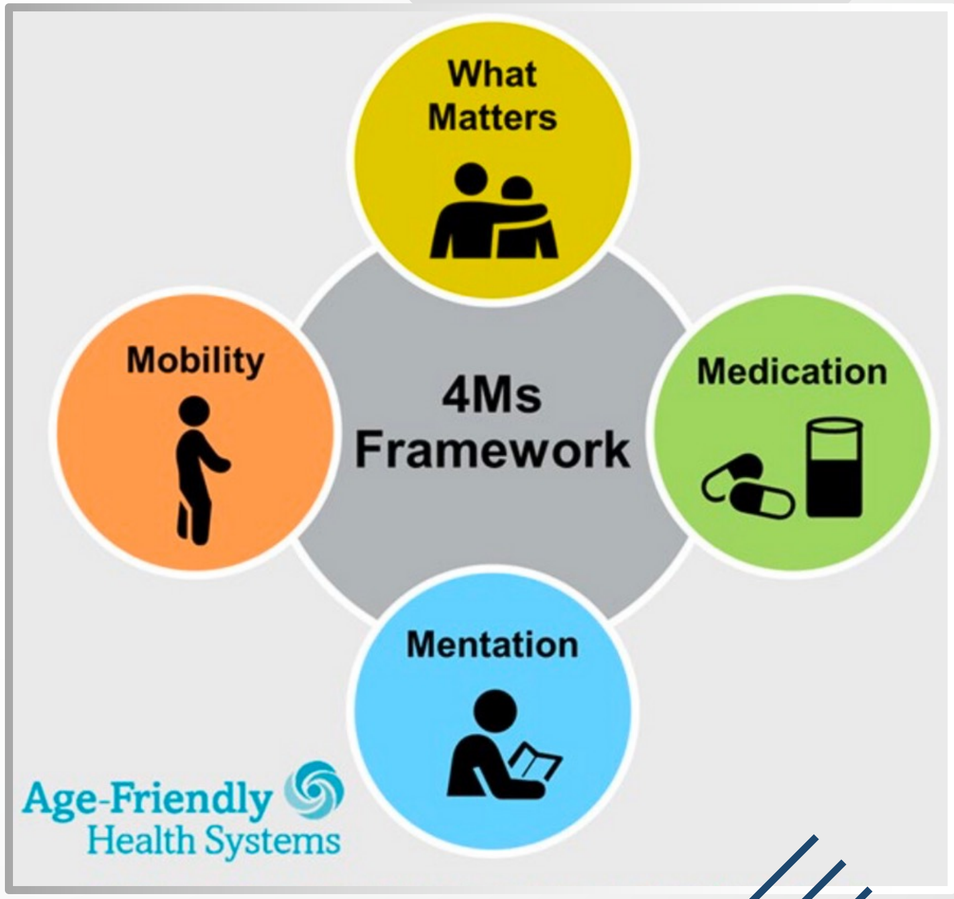
Age-Friendly Health Systems

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

Medication
If medication is necessary, use Age-Friendly medications that do not interfere with What Matters to the older Veteran, Mobility, or Mentation across settings of care

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

Mobility
Ensure that older Veterans are able to move safely every day to maintain function and do What Matters



Components of Whole Health & Well-Being

Live Whole Health

RESOURCE DIRECTORY Click Here

4Ms: What Matters

- Veteran-centric care acknowledges the significance of lifetime experience of the **<u>Whole Veteran</u>**
- Effective strategies to better engage Veterans crucial to improving care[19]
- High reliability approach to improve care and achieve zero harm[5]
- Requires Veteran Cultural Competence[16]
  - Provides context to “What Matters”
  - Basis for the relationships between the Veteran and care team
  - Integrates care and decision making across care settings
- Military experience unique for each Veteran
  - Key component of social history and impacts every aspect of a Veterans life[16]
  - Lasts beyond time in service
  - Conditions emerge & change with aging process

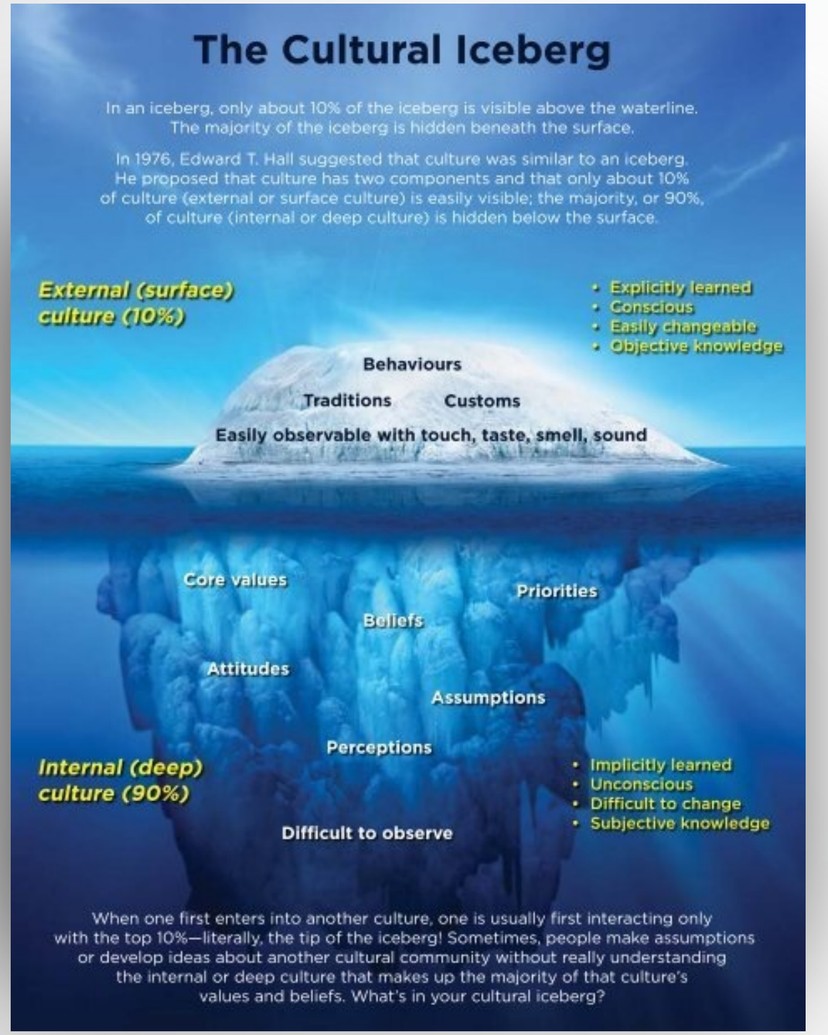
When to Discuss “What Matters?”

- Connect conversations to something the Veteran cares about
- Any member of care team can initiate these conversations
- Inpatient Conversation Opportunities:
  - Upon Admission
  - New diagnosis or change in health status
  - Goals of Care
  - Ongoing Chronic Disease Management[14]
- “What Matters” conversations must take cognition, health status, and identity into consideration[13]

4Ms: Veteran-Centric

- Understanding the context of lived-in experience is especially important in those with multiple chronic conditions at risk for fragmented or unwanted care[18]
- Core Values are fundamentals in which beliefs are rooted, including ideas of fulfillment and happiness[18]
- Cognition[13]
  - Maximize autonomy for Veterans
  - Consider best time of day for conversation
- Health Status[13]
  - Goals and preferences may change over time and with aging
  - Particularly important during acute inpatient episode of care
- Identity[13]
  - Veteran Culture
  - Core Values
  - Era of Service
  - Common Health Concerns

Identity: Veteran Culture



[Cultural Vital Signs Checklist]
Suggested ways to obtain data from Veterans to better inform care in a skilled and sensitive way.

Identity: Core Values

What Matters

- DoD: Duty, Integrity, Ethics, Honor, Courage, and Loyalty
- Army: Loyalty, Duty, Respect, Selfless Service, Honor, Integrity, and Personal Courage
- Marine Corps: Honor, Courage, and Committment
- Navy: Honor, Courage, and Committment
- Air Force: Integrity First, Service Before Self, Excellence in all We Do
- Space Force: Character, Connection, Courage, and Commitment
- Coast Guard: Honor, Respect, and Devotion to Duty


Your core values are the deeply held beliefs that authentically describe your soul.
John C. Maxwell

Identity: Era of Service

World War II
1941-1945

War Exposures

- Over 100 million served;16 million were Americans[29]
- Around 119,000 still alive as of 2023[34]
- Deadliest & most destructive war in history
  - 291,557 American battle deaths[29]
  - 670,846 Non-mortal woundings[29]
  - Ionizing radiation[30]
  - Mustard Gas[30]
  - Cold injuries[30]

Korean War
1950-1953

War Exposures

- Around 5.7 million served[29]
- 33,739 battle deaths[29]
- 103,284 non-mortal woundings[29]
- ”Forgotten War” overshadowed by WWII
- Never officially declared war “conflict”
- First Desegregated War
- Cold injuries[30]
- Neuropathy[30]
- Frostbite[30]
- Toxic Exposures[30]

Vietnam War
1964-1975

War Exposures

- Around 8.7 served[29]
- 47,434 battle deaths[29]
- 153,303 non-mortal woundings[29]
- Public frustration and government mistrust[20]
- First widely-televised war[20]
- Shame & Stigma-unpopular war; Vets treated with public hostility[20]
- Agent orange exposure
- Hepatitis C[30]
- Liver Fluke infection[30]
- PTSD-~30% suffer[20]
- War has debilitating effect on their lives[20]

Gulf War
1990-2001

War Exposures

- 700,000 troops: 7% women, 17% National Guard and Reserve[12]
- Gulf War Illness: myriad of symptoms: including fatigue, muscle aches, memory lapse, rashes affecting ~250,000 Veterans[20]
- PTSD ~12% suffer[20]
- Toxic Exposures: sarin, environmental toxins, pesticides[30]

OEF/OIF/OND
2001-Ongoing

War Exposures

- Combined penetrating blunt trauma, blast injuries[31]
- Traumatic amputation[31]
- Spinal Cord Injury[31]
- TBI ~22% of casualties
  - long term devastating consequences[31]
- PTSD 11-22% suffer[20]
- Mental health issues[31]
- Military Sexual Trauma[31]
- Toxic exposures: burn pits, sewage, agricultural contamination, sand/dust[30]
- Infectious diseases[31]
- Acinetobacter[31]
- Depleted Uranium[31]
- Difficulty re-adjusting[20]
- Feelings of isolation[20]

4Ms: Medication

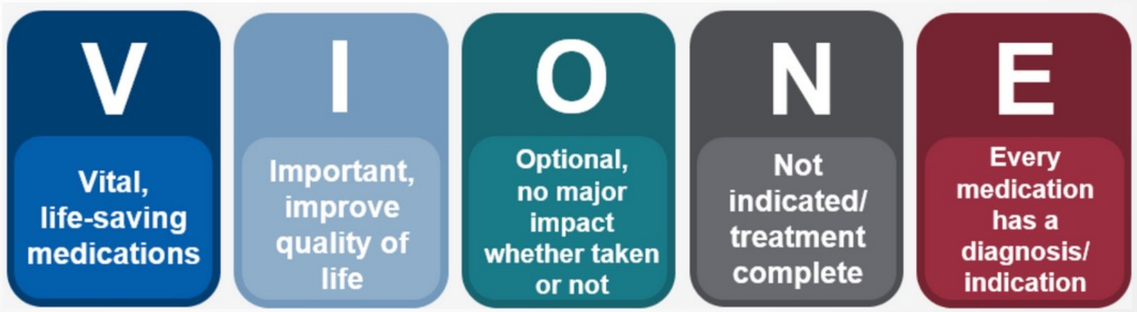
- Veterans have complex medical conditions that may be related to their service- connected disabilities requiring lifelong medical management
- More than 40% of people in U.S. ≥65 years take five or more prescriptions[27]
- Polypharmacy is associated with increased risks of falls, cognitive impairment, and negative outcomes and ranks among top 10 common causes of death in the U.S.[8 16 27]

Best Practices

- Deprescribing is the clinically supervised process of stopping or reducing medications that cause harm or are no longer beneficial[18 27]
- Comprehensive medication review may reduce all-cause mortality [18 27]
- VIONE[28]
  - VA medication methodology to reduce polypharmacy, improve safety, comfort and medication compliance.
  - Clinicians and pharmacists use VIONE acronym to determine if medication supports health goals

Medication

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



4Ms: Mobility

Best Practices

- Avoid restraints[18]
- Remove catheters & tethering devices[18]
- Avoid high risk medications[18]
- Assess & manage orthostatic hypotension and dizziness[18]
- American Geriatrics Society- Beers Criteria to reduce harmful or potentially inappropriate medication[16]
- Set daily mobility goals that support what matters[18]
  - Review & support progress toward a mobility goal
- Manage impairments that reduce mobility[18]
  - Pain
  - Balance
  - Gait
  - Strength
  - Vision impairment
- PT referral[18]
- Address home safety; educate caregivers[18]
  - Home assessment checklist before discharge[18]
- CDC STEADI[4]
- Prevent adult falls in hospital-based settings
  - Decreased LOS
  - Reduce hospital re-admission
  - Increase mobility for fall prevention

Mobility

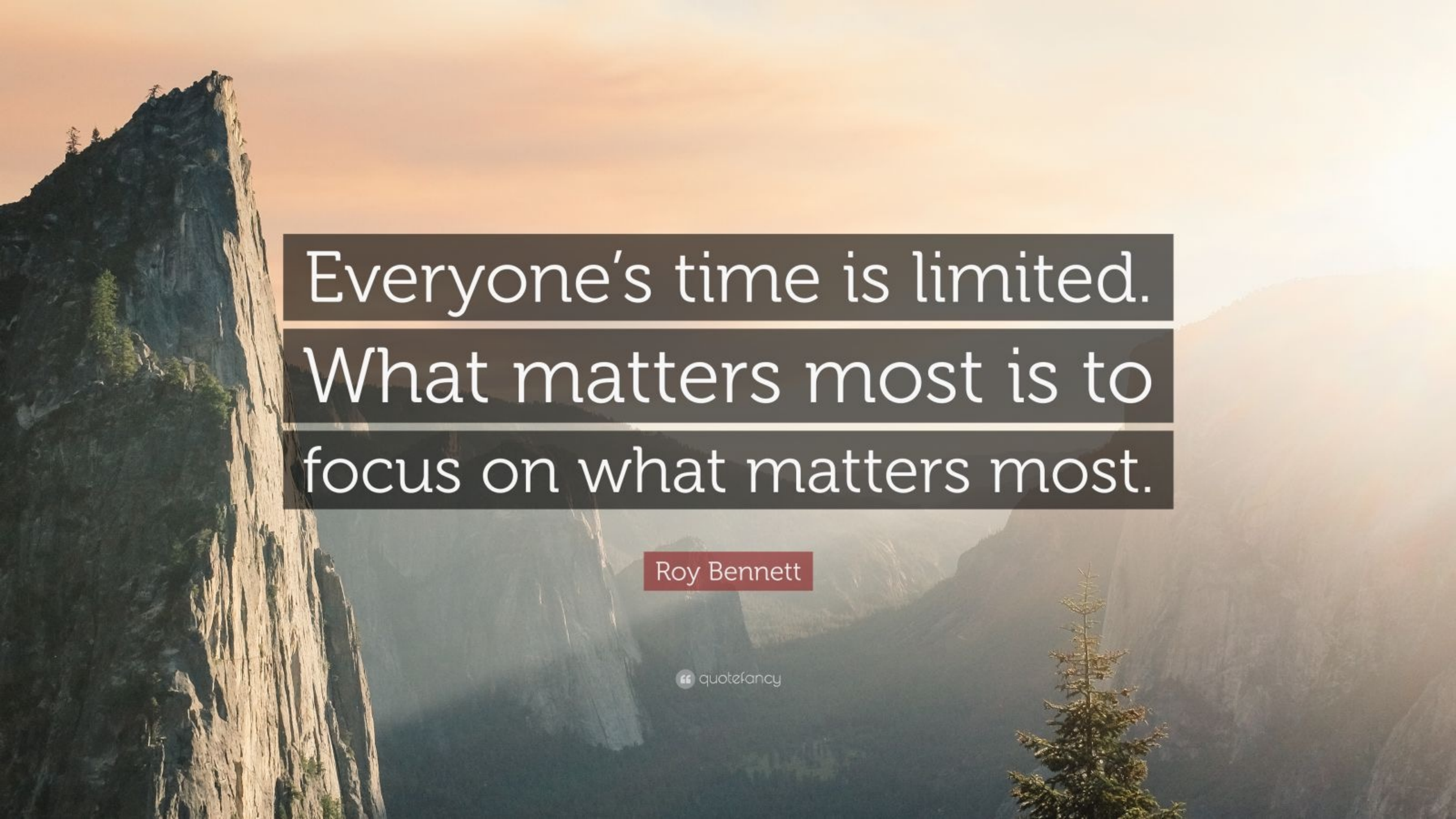
Ensure that older Veterans are able to move safely every day to maintain function and do What Matters

4 Ms: Mentation

- PTSD[35]
  - Studies find doubled risk of developing dementia or Alzheimer's
- Dementia[36]
  - PTSD and History of TBI are strongly connected to behavioral and cognitive functioning
  - Young post 9/11 Veterans may be at elevated risk for early onset dementia because of high TBI rates in early/mid adulthood
- Delirium[10]
  - Most commonly cause by medications and infections
  - Associated with higher morbidity, mortality, increased LOS, & costs
- Depression
  - 30-50% of those who have dementia also suffer from depression[39]
  - Depression and dementia are separate, but share common symptoms: working memory and attention impairment, changes in sleep patterns, and decreased social and occupational function[39]
  - Mobility & physical activity linked to prevention[18]
- Anxiety[1]
  - Up to 40% of people with COPD have anxiety
  - 25% of Veterans have COPD
- Hearing Loss
  - Tinnitus and hearing loss are the top service-connected disabilities affecting American Veterans[40]
  - It is VHA policy that all enrolled veterans and those veterans exempt from enrollment are eligible for medical services that include diagnostic audiology and diagnostic and preventive eye care services, and that the prescription and provision of hearing aids and eyeglasses must be furnished to all eligible
  - Up to 8% of global dementia cases are estimated as being attributable to hearing loss[41]
  - 2015 study in International Journal of Otolaryngology found 79% of veterans with tinnitus also had anxiety, 59% had depression, and 58% had both conditions [38]
  - 2021 Military Medicine study concluded that moderate to very severe tinnitus increased likelihood of positive screening for PTSD, depression, and anxiety[37]

Mentation

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


Everyone's time is limited.
What matters most is to
focus on what matters most.
Roy Bennett
quotefancy

Barriers

- Lack of recognition of older adults as a priority population[42]
- Provider differences & practice setting challenges[15]
- Lack of awareness or understanding of Veteran Identity[16]
- Veteran mistrust in health care providers due to past experiences[16]
- Lack of awareness of available resources or benefits[43]
- Inadequate home support for implementation[15]
- Insufficient follow-through or engagement[15]
- Medication management/deprescribing barriers due to differences in Veteran and clinician perspectives (e.g. reluctance to give up medication and concerns about efficacy of alternative treatments)[6]

Facilitators

- Earn Veteran trust by knowing them and showing care[24]
- Ensure What Matters conversations are documented and accessible to all members of care team[5]
- Use What Matters Worksheet
- Increase knowledge of Veteran Identity[2 7]
  - Core Values
  - Culture
  - Military Exposures & Health Concerns
- Connect Veterans with existing benefits and services available[24]

Unintended Consequences

- Organizational failure to successfully implement meaningful change[5]
- Unrealistic caregiver and Veteran outcome expectations[5]
  - Requires realistic communication about what is known about disease process progressions and cognitive impairment[5]
- Racial and socioeconomic disparities in rural settings[5]
  - Reliable internet[5]
  - Transportation[5]
  - Meeting complex needs of Veterans with hearing, visual, and cognitive impairment[5]
  - Difficulty with telemedicine[5]

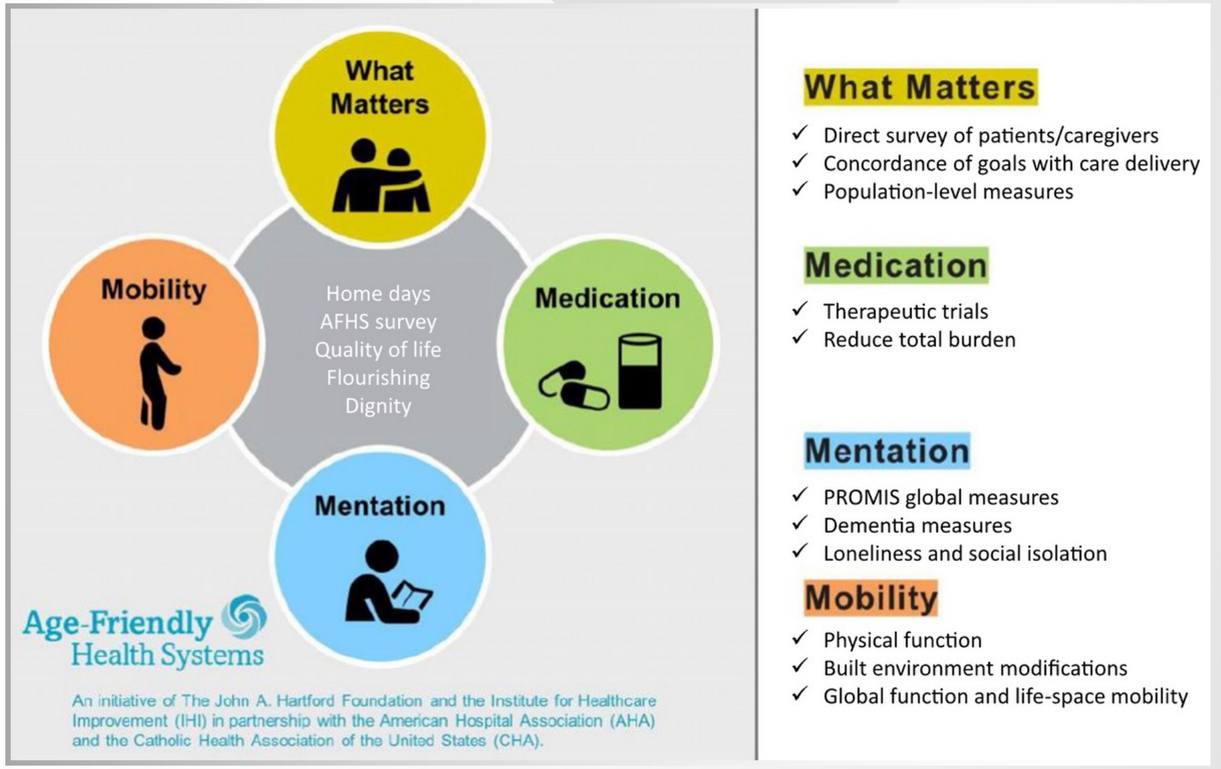
Recommendations

What Matters[3]
- VA Bereaved Family Survey
  - Distributed to NoK of veterans who die in the inpatient setting.
  - Data analyzed in Veteran Experience Center
- Life Sustaining Treatment Initiative
- Whole Health Initiative
  - Personal Health Inventory

Medications[3]
- Updated medication list aligned with the other 3Ms
- Start with what matters to develop trade offs for trials
- Measure number of attempts or referrals for alternative treatment over specific time periods
- VIONE intervention has built in EHR trackable features tied to dashboard that tracks attempts and ID's therapeutic trials
- Consider comprehensive med list instead of individual medications-decrease summed burden over time since some potential high risk may have therapeutic benefit

Mobility[3]
- Interventions to improve physical function (e.g. balance, gait, strength)
- Global measures of function to capture physical function
  - ADLs
  - IADLS require higher level of physical and cognitive ability (e.g. shopping for meals, housekeeping)

Mentation[3]
- Caregiver access to caregiver support groups
- Education on behavioral management strategies
- Use of respite care



Resources

War-Related Illness and Injury Center

- Free Veteran, Provider, & Clinician Training
- Aims to increase education to improve health outcomes for Veterans with military exposures.
- Live Webinars: sorted by collection for complex post-deployment exposure related health concerns from Vietnam War era to present day.
- Recorded Webinars: extended learning to complete accredited best practice recorded webinars.
- E-Learning: On-demand post deployment health provides critical knowledge.
- ACPM Certification: VA & ACPM partner for introductory and advanced military environmental exposure certifications

War-Related Illness and Injury Center

VA Public Health: Military Exposures

- Search for Military Exposures in four ways:
  - Related health concerns: Agent Orange related diseases, Gulf War Veterans' Illnesses, Radiation Related Diseases, Vaccinations & Medications
  - Wars & Operations: Operation Enduring Freedom, Iraq War, Gulf War, & Vietnam War
  - Exposure Categories: Chemicals, Radiation, Air Pollutants, Occupational Hazards, Warfare Agents
  - Exposure Topics A-Z

VA Public Health: Military Exposures

Provider Resources on Military Exposures

- Provider Education
- Patient Education
- Diagnosis & Treatment
- Research Studies

Provider Resources: Military Exposures

VA Exposure Ed App

- Free Mobile app
- Provides education to health care providers about military-related exposures so they can better serve Veterans.
- Information and resources on a variety of military exposures (e.g., Agent Orange, burn pits, fuels) and related VA policies and programs.

VHA Train

- Veteran-focused, accredited, continuing medical education at no cost to providers.
- Supported by Veterans Health Administration (VHA) Institute for Learning, Education and Development (ILEAD)]
- To learn more, contact the VHA TRAIN help desk at vhatrain@va.gov or visit the VHA TRAIN portal at www.train.org/vha/welcome.

Military Health History Resources

Military Health History Pocket Card for Clinicians

Military History Checklist

Military History Checklist Guide

Resources

VA/DoD Clinical Practice Guidelines

Chronic Disease in Primary Care
- Asthma
- Chronic Kidney Disease (CKD)
- Chronic Obstructive
- Pulmonary Disease (COPD)
- Diabetes Mellitus (DM)
- Non-Surgical Mgmt of Hip & Knee Osteoarthritis
- Dyslipidemia (LIPIDS)
- Hypertension (HTN)
- Chronic Insomnia Disorder and Obstructive Sleep Apnea (Insomnia/OSA)
- Obesity and Overweight (OBE)
- Management of Chronic Multi-symptom Illness

Mental Health
- Bipolar Disorder (BD)
- Management of First-Episode Psychosis and Schizophrenia (SCZ)
- Assessment and Mgmt of Patients at Risk for Suicide
- Major Depressive Disorder (MDD)
- Posttraumatic Stress Disorder (PTSD)
- Substance Use Disorder (SUD)

Pain
- Use of Opioids in the Management of Chronic Pain
- Lower Back Pain (LBP)
- Headache

National Center for PTSD

PTSD Continuing Education: CE/CME

VA Whole Health

- Whole Health goes beyond the illness, injury, or disability
  - Focuses on health & well-being
  - Self-care
  - Encourages complementary therapies (e.g. acupuncture, meditation, and yoga)

Whole Health

- Any Veteran or Service Member enrolled in VA Health Care can participate in one-time virtual session of Introduction to Whole Health

- Getting Started with Whole Health
  - CPRS Whole Health Consult
  - Veteran can call directly: 916-843-9131

Resource Directory

Mind

History: What is patient's baseline cognitive status? Was patient oriented and able to pass brief delirium screen (e.g., reciting months of year backwards) on admission? Recent confusion or memory loss? Anxiety or depression? Change in hearing/vision?

Delirium: CAM (Inouye NEJM 1990, Marcantonio NEJM 2017)
1. **A**cute onset and fluctuating course
2. **I**nattention
3. **D**isorganized thinking
4. **A**ltered level of consciousness

If yes to #1 & 2 AND either 3 or 4, then positive for delirium. Ask about potential contributors (e.g., does patient wear glasses? Hearing aids? Infection? Meds? Pain/Pee/Poop?)

If CAM negative → Mini-Cog evaluation (3 words - banana sunrise chair; clock draw - "draw face of a clock, put in all numbers, set time at ten past 11")

If Mini-Cog abnormal→ MOCA, www.mocatest.org. Use instructions guide.

FAST Scale for staging dementia, stage 1-7.
5 = difficulty dressing = moderate dementia
7c = nonverbal & nonambulatory = advanced dementia, may be eligible for hospice (Mitchell, Advanced Dementia NEJM 2015)

Depression: PHQ-2 screen (Kroenke et al, Med Care 2003)
Over the past two weeks, how often have you been bothered by any of the following problems? (Not at all=0, Several days=1, More than half the days=2, Nearly every day=3)
1. Little interest or pleasure in doing things
2. Feeling down, depressed or hopeless

If PHQ-2 score ≥ 3, do PHQ-9 or Geriatric Depression Scale

Tips for Speaking to Patients with Hearing Impairment:
- Low and slow (high pitched hearing loss), Face the patient
- Rephrase, use pictures or write things down
- Check ears for wax (carbamide drops + ear cleaning)
- Request a Pocket amplification device
- Hearing aid evaluation with audiology

(www.geron.org - Communicating with Older Adults)

Mobility

History: Any recent falls or fear of falling? What is patient's baseline mobility? Does patient live in community or facility? What type?

Functional Status: Caregiver assistance prior to admission? Has function changed over the past 6 months?
Independent/ Needs Assistance/ Dependent.

Activities of Daily Living (ADLs or Basic ADLs)	Instrumental Activities of Daily Living (iADLs)
- Feeding - Bathing - Grooming - Dressing - Toilet use, incontinence - Transfers (bed to chair) - Mobility	- Telephone use - Grocery shopping - Food preparation - Housekeeping, laundry - Mode of transportation - Medications - Finances

Fall Risk Factors from Toe to Head:
- Falls in past year? Fear of falling?
- Unsteady when standing/walking?

Intrinsic:
- Foot problems? Who cuts the toenails? Arthritis?
- **Able to stand from a chair without using arms?**
- **Gait Speed - Timed Up and Go test** ≥ 12 secs, 10 ft away
- **Orthostatic hypotension** (decrease in systolic BP ≥ 20 mm Hg or diastolic BP of ≥ 10 mm Hg, or lightheadedness/ dizziness from sitting to standing)
- Incontinence? Other bowel or bladder problems?
- Problems with heart rate and/or arrhythmia?
- Problems with dentition, swallowing or weight loss?
- Hearing impairment?
- Visual acuity <20/40 OR no eye exam in >1 year?
- Cognitive impairment? Depression?

Extrinsic:
- Psychoactive medications? Opioids?
- Medications that can cause sedation or confusion, dizziness, hypotension, hypoglycemia?
- Environment: clutter, rugs, shoes, pets, dim lights, stairs, no shower rails (www.cdc.gov/steadi, Tinetti & Kumar JAMA 2010)

GERIATRICS 5Ms*
Caring for Older Adults

U.S. Department of Veterans Affairs
Veterans Health Administration
Geriatric Research, Education, and Clinical Centers

Alison McGough Holliday, MD, MPH
Chelsea Hawley, PharmD
Andrea Wershof Schwartz, MD MPH

Harvard Medical School
VA Boston HealthCare System
New England Geriatrics Research Education and Clinical Center

*Tinetti, Huang, and Molnar, *The Geriatrics 5M's*, JAGS 2017.

Multicomplexity

History: Ask about day in the life. Assess living conditions, support system. Recent weight loss? Life changes or stressors?

Exam: Examine dentition and toes – who cuts the toenails? What are the comorbidities and which ones affect life the most?

FRAIL Score (Abellan van Kan et al, J Am Med Dir Assoc 2008) **F**atigued? **R**esistance- walk up one flight of stairs? **A**mbulation- walk 1 block? **I**llnesses >5? **L**oss of Weight >5% in past 6 months? ≥3= Frail, at risk of decline in health and mortality

C.A.R.E. for Caregivers (Adelman et al, JAMA 2014)

Caregiver Well-being	**A**dvanced Care Plan	**R**espite	**E**ducation
• *Explore caregiver well-being* • *Identify ADLs and iADLs not being met* • *Social work consult*	• *Start discussion on goals of care & wishes* • *Health Care Proxy, POLST/ MOLST* • *Long-term care?*	*Identify opportunities for respite for the caregiver - others to care for patient, time away, adult day health program*	Resources • *Case manager Counseling & 1:1 CBT* • *Non-medical home services* • *Caregiver support groups* • *Council on Aging* Disease-specific • *Symptom-focused skills*

Best support after discharge? (Kane, JAMA 2011)

Skilled Nursing Facility/SNF	Other settings
• Inpatient rehab: *3h/d of PT/ OT, Medicare pays* • Long term care (LTC)*: inability to perform ADLs or ongoing nursing care, Medicaid pays* • Long-term acute care (LTAC) : *i.e. – recent ventilator or s/p prolonged ICU stay* • Hospice: *≤6 months prognosis, can also be delivered at home*	• Adult day health: *Some have medical/nursing; i.e. - PACE* • Assisted living: *individual units, minimal regulation and hire help prn, meals available* • Independent living facility: *individual units, hire help prn* • Home care: VNA, PT, OT, home health aides for ADLs • Local elder services/Area Agencies on Aging: *i.e. - Meals on Wheels, Homemakers*

Medications

History: Ensure each medication has an indication.
- Who manages the medications? Able to open pill containers? Use pill box? If yes who fills it? Forget doses? Cost concerns?
- How are medications taken (pill, liquid, drops, etc.)?
- Expired or OTC meds?

Physiology of Aging: Remember to Start Low, Go Slow
↓ GFR/Creatinine clearance (with normal creatinine since decreased lean body mass)= ↑ accumulation/risk of toxicity
↓ liver clearance = ↑ in bioavailability, longer half life
↓ baroreceptor responsiveness = ↑ risk of orthostasis/falls
↑ proportion of body fat = lipophilic drugs last longer
↑ permeability of blood brain barrier = ↑ risk of CNS effects

Avoid High Risk Medications:
- Review AGS Beers Criteria (JAGS 2019) for potentially inappropriate medications/ drug-drug interactions, meds affected by renal clearance
- Insomnia: avoid benzodiazepines, zolpidem, antipsychotics (better: melatonin, behavioral interventions like CBT)
- Depression: avoid TCAs, start low go slow with SSRIs
- Pain: avoid high dose/long-term opioids, long-term NSAIDs (better: acetaminophen); see "Pain Medications" section
- Diabetes: avoid sliding scale insulin, sulfonylurea (risk of hypoglycemia). Caution re: overtreatment of diabetes in frail older adults– goal A1c in frail older adults is 8-8.5.*
- Antihypertensives/diuretics: Check orthostatics. Caution re: overtreatment of HTN in frail older adults
- Urinary incontinence: consider mirabegron instead of oxybutynin (anticholinergic). Avoid terazosin (risk of falls).
- Anticholinergics: Diphenhydramine, oxybutynin, scopolamine →confusion, urinary retention, dry eyes/mouth, constipation (Rudolph et al, Anticholinergic Risk Scale, Arch Int Med 2008)
- GI: avoid PPI >8 weeks (nutritional deficiencies, PNA, Cdiff, fractures), avoid metoclopramide (Parkinsonian/EPS)

Deprescribing.org, Medstopper.com, *AGS Choosing Wisely.

Avoid prescribing cascades (drug→adverse effect→new drug). E.g., Iron→constipation→stool softener

Pain Medications:
- Remember non-pharm strategies (Makris, JAMA 2014)
- Acetaminophen 325 – 650 mg q4-6 hours up to 1000 mg q8h (consider trial of scheduled vs prn if normal liver function)
- For severe pain/fractures, considering adding oxycodone 2.5 – 5 mg q4-6h + bowel regimen
- **Caution**: Morphine is renally cleared; tramadol can cause hypoglycemia, avoid meperidine and muscle relaxants

Bowel Regimen: (Mounsey et al, Am Fam Physician 2015)
- STEP 1: Lifestyle modifications (deprescribe anticholinergic agents, ↑ fiber (e.g., fruit, whole grains, lentils, avocado, broccoli), ↑ fluid and exercise, scheduled toileting
- STEP 2: Consider osmotic laxative (polyethylene glycol, lactulose) vs stimulant laxatives (bisacodyl , senna). Lack of evidence for efficacy of stool softener (docusate sodium)

Matters Most

History: How can we help in the most meaningful way for the patient? What does the patient want to do more of? Are there chronic conditions that are more important to the patient that we can address? (see patientprioritiescare.org)

Is **Health Care Proxy** in chart? Confirmed? If not, discuss with pt

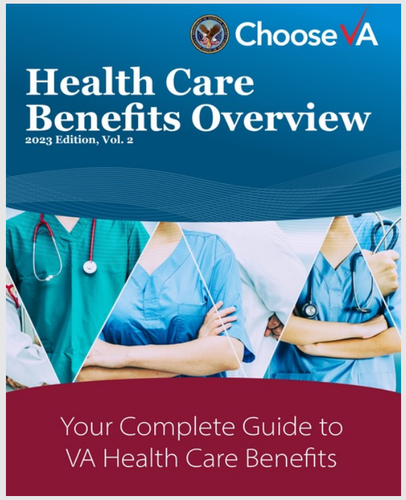
Consider **Prepareforyourcare.org** for advanced care planning for patients with low health literacy (Sudore et al, JAMA IM 2017) or **Theconversationproject.org** for higher health literacy.

Is **POLST** in chart? If yes, does patient confirm POLST? If no, discuss with patient if indicated for older pts or those with serious illness. https://polst.org/

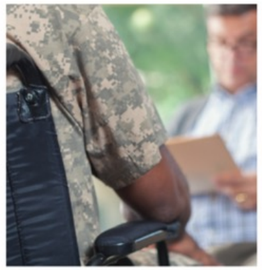
See **eprognosis.org** for communication tips and prognosticating tools & ethics.va.gov/LST/ClinicalStaffResources.asp

Remember **GOOD mnemonic** for goals of care conversations: Goals, Outcomes, Options, Document. (Start with the patient's understanding & the goal - what matters most to them)

Resources



VA Caregiver Support



Veterans Crisis Line
DIAL 988 then PRESS 1

FindTreatment.gov

Find state-licensed treatment near you for addiction and substance use disorder.

FindTreatment.gov

Honor Flight NETWORK®

VA Mobile
Self-Help Apps

App Store

Official websites use .gov A .gov website belongs to an official government organization in the United States.

mobile.va.gov

CANB
CHANGE AND NEW BEGINNINGS

Emergency Shelter

All Solano County clients are to be registered through Resource Connect Solano – RCS. (REGISTER HERE). This ensures that everyone has a fair chance at obtaining...

CANB Solano / Oct 3, 2022

SAMHSA

Homeless and Housing Resource Center

The Homeless and Housing Resource Center (HHRC) was established by the Substance Abuse and Mental Health...

samhsagov

RESOURCE CONNECT SOLANO

Housing and Supportive Services | Resource Connect Solano

Resource Connect Solano streamlines access to life-changing housing and supportive resources for people i...

Resource Connect Sol

VA COMMUNITY CARE

National Resource Directory

National Resource Directory Connects Wounded, Ill & Injured Service Members, Veterans, Their Families, and Caregivers with Those Who Support Them

nrd.gov

Make the Connection | Videos & Info for Military Veterans

Connecting Veterans with information, resources, and solutions to issues affecting their health, well-being, and everyday lives.

maketheconnection.net


IN HONOR OF THOSE
WHO HAVE SERVED
AND THOSE
SERVING NOW
THANK
YOU

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