# Patient Safety Blueprints Before Builds: Patient Assessment in Clinical Decision-Making

Devra Dang, PharmD, CDCES, FNAP
Clinical Professor
UConn School of Pharmacy
Schwarting Symposium April 2026

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## Learning Objectives

At the conclusion of this presentation, pharmacists should be able to:

- Explain the Pharmacists' Patient Care Process and strategies to optimize the "Collect" and "Assess" steps to improve assessment and clinical decision-making.
- Identify common pitfalls that affect optimal patient assessment across healthcare settings.
- List strategies to incorporate patient-centered approaches into patient assessment and clinical decision-making.

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## Disclosures

- Devra Dang has no actual or potential conflict of interest with the content of this presentation.
- Please refer to the official prescribing information for each product for discussion of approved indications, contraindications, precautions, and warnings.

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## AUDIENCE POLL #1

Which of the following most accurately reflects your familiarity with the Pharmacists' Patient Care Process?

- A. I utilize it on a daily basis/whenever I engage in patient care activities.
- B. I utilize portions of it on a daily basis/whenever I engage in patient care activities.
- C. I'm not familiar with it yet.
- D. N/A – I'm not engaged in patient care activities.

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## Pharmacists' Patient Care Process (PPCP)

- Developed by Joint Commission of Pharmacy Practitioners via consensus process in 2014, updated in 2025
- Incorporated as required element
  - Accreditation Council for Pharmacy Education (ACPE)'s Accreditation Standards and Key Elements for the Professional Program in Pharmacy Leading to the Doctor of Pharmacy Degree
  - American Society of Health-System Pharmacists' Accreditation Standard for Postgraduate Residency Programs,
  - ACPE's Accreditation Standards for Continuing Pharmacy Education

*Joint Commission of Pharmacy Practitioners. Pharmacists' Patient Care Process. May 20, 2025. Available at: https://jcpp.net/wp-content/uploads/2018/10/Pharmacists-Patient-Care-Process-Document-2025.pdf*

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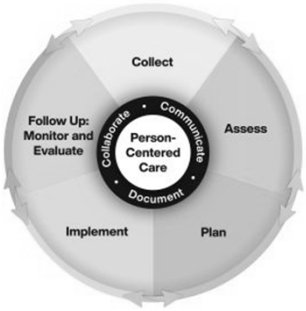
## Pharmacists' Patient Care Process




*Joint Commission of Pharmacy Practitioners. Pharmacists' Patient Care Process. May 20, 2025. Available at: https://jcpp.net/wp-content/uploads/2018/10/Pharmacists-Patient-Care-Process-Document-2025.pdf.*

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## Pharmacists' Patient Care Process

**Collect:** "The pharmacist ensures the collection of necessary subjective and objective information about the patient to understand the relevant medication and medical history, overall health status, and other pertinent factors. Information may be gathered and verified from multiple sources (e.g., the patient, caregiver, observations, existing patient records, other health care professionals)."

**Assess**: "The pharmacist assesses the collected information to identify and prioritize patient needs to inform the establishment of a care plan."

*Joint Commission of Pharmacy Practitioners. Pharmacists' Patient Care Process. May 20, 2025. Available at: https://jcpp.net/wp-content/uploads/2018/10/Pharmacists-Patient-Care-Process-Document-2025.pdf.*

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## Pharmacists' Patient Care Process

**Plan**: "The pharmacist develops a person-centered, evidence-based, cost-conscious care plan in partnership with the patient and/or caregiver and in coordination with other care team members."

**Implement**: "In providing person-centered care, the pharmacist implements a prioritized care plan in partnership with the patient and/or caregiver and in coordination with other care team members."

**Follow-up – Monitor and Evaluate**: "The pharmacist follows up to monitor and evaluate the implementation of the care plan and the patient's overall health in collaboration with the patient, caregiver, and other care team members, as needed."

*Joint Commission of Pharmacy Practitioners. Pharmacists' Patient Care Process. May 20, 2025. Available at: https://jcpp.net/wp-content/uploads/2018/10/Pharmacists-Patient-Care-Process-Document-2025.pdf.*

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## PPCP: Collect

- Subjective data
  - From
    - patient, caregiver
    - visiting nurse, health aide, other healthcare professionals
  - Prescription medications, OTCs, herbals, CAM, others
  - Past prescription/nonprescription medication history and experiences
- Potential pitfalls
  - Not collecting data from multiple sources
  - Not collecting information on herbals, CAM, or other products that may affect the treatment plan
  - Confusing subjective data with objective data

*Joint Commission of Pharmacy Practitioners. Pharmacists' Patient Care Process. May 20, 2025. Available at: https://jcpp.net/wp-content/uploads/2018/10/Pharmacists-Patient-Care-Process-Document-2025.pdf.*

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## PPCP: Collect

- All diagnoses
- Allergies/intolerances to medications, foods, other relevant substances
- "…patient health concerns, priorities, goals, lifestyle factors, beliefs, preferences, social determinants of health that affect medication outcomes and overall health"
- Potential pitfalls
  - Not collecting data from multiple sources
  - Confusing subjective data with objective data
  - Not understanding diagnoses and other objective data

*Joint Commission of Pharmacy Practitioners. Pharmacists' Patient Care Process. May 20, 2025. Available at: https://jcpp.net/wp-content/uploads/2018/10/Pharmacists-Patient-Care-Process-Document-2025.pdf.*

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## PPCP: Collect

- Objective data
  - Physical assessments
  - Labs
  - Imaging
  - Genomics
  - Cognitive and functional status
  - Data from medical devices and digital health tools
  - Medications, immunization history
- Potential pitfalls
  - Not collecting data from multiple sources
  - Confusing subjective data with objective data
  - Not verifying objective data
- Gather, and verify, information from multiple sources

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## PPCP: Assess

- "…assesses the collected information to identify and prioritize patient needs to inform the establishment of a care plan:
  - Evaluate medication's indication, appropriateness, effectiveness, safety, adherence
  - Identify medication-related problems
  - Assess existing and any new medical problems
  - Evaluate social determinants of health, cultural considerations, and health literacy
  - Determine preventive care and wellness needs (e.g., medications, immunizations, education, screenings)

*Joint Commission of Pharmacy Practitioners. Pharmacists' Patient Care Process. May 20, 2025. Available at: https://jcpp.net/wp-content/uploads/2018/10/Pharmacists-Patient-Care-Process-Document-2025.pdf.*

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## PPCP: Assess

- Potential pitfalls
  - Not asking the "why" question
  - What is the patient's problem #1 compared to what is the HCP's problem #1?
  - Assumption regarding patient's understanding of their condition
  - Assumption of adherence and continued adherence
  - Cognitive/implicit bias
  - Not evaluating social determinants of health (SODH)

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## PPCP: Plan

- "The pharmacist develops a person-centered, evidence-based, cost-conscious care plan in partnership with the patient and/or caregiver and in coordination with other care team members
  - Addressing prioritized medication therapy problems and other medication-related needs
  - Incorporating prioritized medical problems, lifestyle modifications, preventive care needs, and social determinants of health
  - Integrating continuity of care, safe and timely transitions of care, referrals, follow-up, and appropriate monitoring parameters
  - Confirming patient and/or caregiver understanding and agreement with the goals and plan"

*Joint Commission of Pharmacy Practitioners. Pharmacists' Patient Care Process. May 20, 2025. Available at: https://jcpp.net/wp-content/uploads/2018/10/Pharmacists-Patient-Care-Process-Document-2025.pdf.*

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## PPCP: Assess, Plan


**Medication-Related Problems**

| | | | |
|---|---|---|---|
| Untreated indication<br>Drug use without indication | Ineffective medication<br>Dosage too low | Adverse drug reaction<br>Drug interaction<br>Dosage too high | Non-adherene (multiple reasons) |

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## PPCP: Plan

- Potential pitfalls
  - What is the patient's problem #1 compared to what is the HCP's problem #1?
  - Not clearly developing/identifying the therapeutic goals for each medical condition being treated
    - ***"We don't chase numbers. We chase outcomes."***
    - Health status
    - Vary depending on setting
    - Patient-centered goals
  - Consulting only 1 guideline
  - Not including patient-centered goals and shared decision-making

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## Shared-Decision Making

National Academy of Medicine (NAM)'s Healthy Providers, Healthy Patients project https://www.youtube.com/watch?v=5AqNGmyfR7I&t=4s

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## AUDIENCE POLL #2

Example scenarios:

A. A patient comes to the prescription drop off window of the community pharmacy and asks to speak to the pharmacist. He asks for an OTC product to treat the "rash" on his left arm.

B. An ambulatory care clinical pharmacist is meeting with a patient with a follow up appointment for HTN management. When the appointment commences, the patient expresses that her chief concern instead is experiencing nausea since the start of this week.

**What information should the pharmacist in either scenario collect from the patient in order to make the most accurate assessment and plan?**

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## PQRSTAU

| | | | |
|---|---|---|---|
| **P**recipitating, **P**alliative, **P**revious | **Q**uality | **R**egion, **R**adiating, **R**eports | **S**everity |
| **T**emporal relationship, **T**ime | **A**ssociated symptoms | U – effect on you | |

Gammaitoni AR et al. *Clin J Pain*. 2003 Sep-Oct;19(5):286-97.

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## Example Scenario

Mrs. Smith is a 77-year-old female (wt: 55 kg) who presents today to the clinic for her annual wellness check. She lives alone in a two-story home and has a daughter that visits her weekly. She reports feeling "more tired lately" and has noticed increased ankle swelling over the past 3 months.

- PMH:
  - Type 2 diabetes mellitus
  - Osteoarthritis
  - Hypertension
  - Hyperlipidemia
  - Depression
  - Chronic kidney disease, stage 3b (most recent eGFR 38, SCr: 1.2 mg/dL)
  - GERD
- Social History:
  - Widowed 3 years ago
  - Former teacher
  - Drives locally during daytime
  - Attends church weekly but stopped attending book club 6 months ago

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## Example Scenario

- Medications (list provided by patient):
  - metformin 1000 mg twice daily
  - glipizide 10 mg twice daily
  - lisinopril 40 mg daily
  - amlodipine 10 mg daily
  - atorvastatin 40 mg daily
  - sertraline 100 mg daily
  - ibuprofen 600 mg three times daily for knee pain
  - omeprazole 40 mg daily
  - gabapentin 600 mg three times daily (started 4 months ago for neuropathy)
  - furosemide 40 mg daily (started 2 months ago for ankle swelling)
  - aspirin 81 mg daily (primary prevention)
  - pantoprazole 40 mg daily
  - diphenhydramine 50 mg at bedtime for sleep
  - multivitamin daily
  - ginkgo biloba supplement (self-prescribed for memory)

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## AUDIENCE POLL #3

**What resources could aid in the patient assessment and decision-making process for Mrs. Smith?**

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**American Geriatrics Society 2023 updated AGS Beers Criteria® for potentially inappropriate medication use in older adults**

By the 2023 American Geriatrics Society Beers Criteria® Update Expert Panel

**STOPP/START criteria for potentially inappropriate prescribing in older people: version 3.**

September 27, 2023

O'Mahony D, Cherubini A, Guiteras AR, et al. STOPP/START criteria for potentially inappropriate prescribing in older people: version 3. Eur Geriatr Med. 2023;14(4):625-632. doi:10.1007/s41999-023-00777-y.

https://psnet.ahrq.gov/issue/stoppstart-criteria-potentially-inappropriate-prescribing-older-people-version-3

STOPP (Screening Tool of Older Persons' Prescriptions) and START (Screening Tool to Alert to Right Treatment) criteria are used to identify potentially inappropriate prescribing in older adults. This article describes the consensus process to update and validate the third version of the STOPP/START criteria using evidence from a systematic review and input from a panel with expertise in geriatric pharmacology. The consensus process resulted in additional STOPP criteria (133 versus 80 in version 2) and START criteria (57 versus 34 in version 2). The additional criteria in version 3 can help clinicians detect and prevent adverse drug-drug and drug-disease interactions.

J Am Geriatr Soc. 2023 Jul;71(7):2052-2081. doi: 10.1111/jgs.18372. Epub 2023 May 4.
https://psnet.ahrq.gov/issue/stoppstart-criteria-potentially-inappropriate-prescribing-older-people-version-3

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*Journal of the American Geriatrics Society*

**Journal** of the **American Geriatrics Society**

SPECIAL ARTICLE

**Alternative Treatments to Selected Medications in the 2023 American Geriatrics Society Beers Criteria®**

American Geriatrics Society Beers Criteria® Alternatives Panel | Michael A. Steinman

**Correspondence:** Michael A. Steinman (mike.steinman@ucsf.edu)

**Received:** 3 April 2025 | **Revised:** 10 April 2025 | **Accepted:** 13 April 2025

**Funding:** The authors received no specific funding for this work.

**Keywords:** AGS Beers Criteria® | pharmacotherapy | quality of care

ABSTRACT

The American Geriatrics Society (AGS) Beers Criteria® serve to identify medications whose potential for harm outweighs their intended benefit in older adults. This highlights the need for guidance not only on what therapies to avoid but also on readily available alternative treatment strategies. AGS thus convened a multidisciplinary, interprofessional panel to develop a list of these alternative treatment strategies for older adults based on guidelines and evidence, updating an earlier effort published in 2015. This report presents these in a manner intended to be easily usable by front-line clinicians facing common clinical scenarios. The list includes pharmacologic alternatives to medications on the AGS Beers Criteria® as well as non-pharmacologic management strategies that are often safer and equally or more effective than the potentially inappropriate medications they are replacing. Clinician, patient, and caregiver resources are also provided to support the implementation of alternative treatment strategies in clinical practice.

J Am Geriatr Soc. 2025 Sep;73(9):2657-2677. doi: 10.1111/jgs.19500. Epub 2025 Jul 23.

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**TABLE 1** | Allergy and pruritus, pain, diabetes mellitus, and weight loss in older adults.

| Condition | Relevant AGS Beers Criteria® medications | Alternatives to consider (recommendations) | Resources |
|---|---|---|---|
| Allergic rhinitis and associated symptoms | First-generation antihistamines<br>*Recommendation: Avoid* | Identify and avoid allergens, where possible.<br>Irrigate nasal passages with purified saline solution (distilled or sterilized water only) with a neti pot or similar system. *Do not use unsterilized tap water.*<br>If using an oral antihistamine, 2nd or 3rd generation agents are preferred, e.g., loratadine, cetirizine, levocetirizine, fexofenadine.[a,b]<br>For nasal symptoms:<br>– Nasal antihistamine sprays (e.g., azelastine or olopatadine, which are absorbed less than oral agents and have fewer adverse effects)<br>– Nasal corticosteroids (e.g., fluticasone, budesonide, triamcinolone)<br>– Nasal mast cell stabilizers (e.g., cromolyn)<br>For ocular symptoms: eye drops (ocular antihistamines or decongestants, artificial tears). | **For patients and caregivers:**<br>Information on allergic rhinitis (UpToDate)<br>https://www.uptodate.com/contents/allergic-rhinitis-beyond-the-basics#H1<br>Self-care for allergic rhinitis (MedlinePlus)<br>https://medlineplus.gov/ency/patientinstructions/000547.htm<br>Instructions on how to self-administer nasal sprays—see Figure 4 (BSACI)<br>https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7162111/figure/fig/<br>Instructions on safe use of Neti pots and nasal irrigation devices (FDA)<br>https://www.fda.gov/consumers/consumer-updates/rinsing-your-sinuses-neti-pots-safe |
| Pruritus | First-generation antihistamines<br>*Recommendation: Avoid* | Generalized pruritus is generally not responsive to antihistamines unless specifically due to a histamine-mediated etiology like urticaria.<br>Tailor treatment of generalized pruritus to the etiology, typically either dry skin, medications (opioids, CNS medications, diuretics, many others), or underlying medical conditions.<br>For dry skin, consider:<br>– Hydrating emollient twice daily<br>– Short showers (<2 min) in lukewarm water<br>– Humidifiers<br>– For other causes of generalized pruritus, address underlying conditions<br>For localized pruritus, consider topical agents such as:<br>– Topical anesthetics (e.g., lidocaine, pramoxine)<br>– Cooling agents (e.g., menthol) | **For patients and caregivers:**<br>Information on causes of itching (AAFP)<br>https://www.aafp.org/pubs/afp/issues/2022/0100/p55-s1.html<br>Information on causes of itching and self-care (MedlinePlus)<br>https://medlineplus.gov/itching.html<br>**For clinicians:**<br>Chronic pruritus review (JAMA 2024)<br>https://jamanetwork.com/journals/jama/fullarticle/2819296 |

J Am Geriatr Soc. 2025 Sep;73(9):2657-2677. doi: 10.1111/jgs.19500. Epub 2025 Jul 23.

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**TABLE 1** | (Continued)

| Condition | Relevant AGS Beers Criteria® medications | Alternatives to consider (recommendations) | Resources |
|---|---|---|---|
| Diabetes | Sliding scale insulin<br>Sulfonylureas<br>*Sliding scale insulin recommendation: Avoid*<br>*Sulfonylureas recommendation: Avoid as first- or second-line choice for monotherapy or as add-on therapy, unless there are substantial barriers to using safer and more effective agents* | **Alternatives to sliding scale insulin:**<br>– "Sliding scale insulin" refers to the use of variable doses of short-acting insulin dependent on glucose values without any basal insulin.<br>– For patients started on sliding scale due to unstable insulin needs, the addition of basal insulin often allows for the safe discontinuation of sliding scale. For patients whose glucose levels remain uncontrolled on basal insulin, the addition of pre-prandial bolus insulin may be required.<br>– If sliding scale measurements do not lead to any insulin for 24–48 h, stop sliding scale insulin. For nearly all older adults with Type 2 diabetes, up-titration of basal insulin and other medications can lead to the safe discontinuation of sliding scale insulin within a few weeks.<br>**Alternatives to sulfonylureas:**<br>– Metformin remains a first-line medication option for most older adults with hyperglycemia. If metformin is chosen, ensure patients are on the maximal tolerated dose (as appropriate given renal function) before increasing other medications.<br>– For many older adults, alternatives to sulfonylureas include SGLT2 inhibitors, GLP1-RAs, and DPP4 inhibitors. Selection among agents should be based in part on comorbid conditions, treatment goals, and preferences. | **For patients and caregivers:**<br>Diabetes guideline summary for patients (VA/DoD):<br>https://www.healthquality.va.gov/guidelines/CD/diabetes/VADoD-Diabetes-CPG-Patient-Summary_final_506.pdf<br>Information and resources on diabetes (CDC):<br>https://www.cdc.gov/diabetes/index.html<br>**For clinicians:**<br>2023 VA/DoD diabetes guideline summary (VA/DoD):<br>https://www.healthquality.va.gov/guidelines/CD/diabetes/VADoD-Diabetes-CPG-Provider-Summary_final_506.pdf<br>2023 VA/DoD diabetes guideline resources, (VA/DoD):<br>https://www.healthquality.va.gov/guidelines/cd/diabetes/index.asp |
| Weight Loss (involuntary or undesired) | Megestrol<br>*Recommendation: Avoid* | Treatment should focus on non-pharmacologic strategies including:<br>– Feeding assistance<br>– Identifying and addressing contributing medications (e.g., medications that affect taste or cause dry mouth, nausea, or anorexia)<br>– Providing appealing foods<br>– Social support<br>– Ensuring adequate access to food (e.g., home meal delivery programs, lifting dietary restrictions where appropriate)<br>Consider calorically dense nutritional supplements and referral to a dietician.<br>Evaluate dentition, chewing, and swallowing and refer for swallow evaluation if appropriate.<br>For patients with depression, consider mirtazapine. | **For patients and caregivers:**<br>Tips on how to gain weight (AAARP)<br>https://www.aarp.org/health/healthy-living/info-2023/how-to-gain-weight-safely.html<br>**For clinicians:**<br>Overview of unintentional weight loss in older adults (Am Fam Phys 2021)<br>https://www.aafp.org/pubs/afp/issues/2021/0700/p34.html<br>Investigation and management of unintentional weight loss in older adults: review (BMJ 2011)<br>https://www.bmj.com/content/342/bmj.d1732 |

J Am Geriatr Soc. 2025 Sep;73(9):2657-2677. doi: 10.1111/jgs.19500. Epub 2025 Jul 23.

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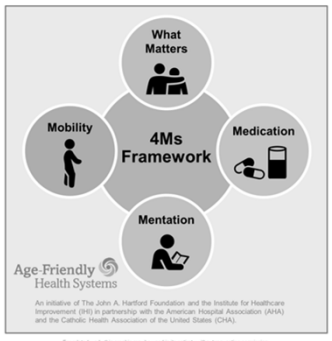
**A**




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

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

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

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

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**13. Older Adults**

Using the 4Ms framework of age-friendly health systems to address person-specific issues that can affect diabetes management

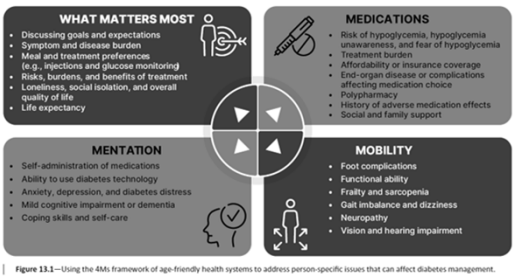


**Figure 13.1**—Using the 4Ms framework of age-friendly health systems to address person-specific issues that can affect diabetes management.

**Figure 13.1**
*Older Adults:*
*Standards of Care in Diabetes - 2026 Diabetes Care* 2026;49(Suppl. 1):S277-S296

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**Table 13.2—Framework for considering treatment goals for glycemia, blood pressure, and dyslipidemia in older adults with diabetes**

| Characteristics and health status of person with diabetes | Rationale | Reasonable A1C goal* | Reasonable CGM goals | Fasting or preprandial glucose | Bedtime glucose | Blood pressure | Lipids |
|---|---|---|---|---|---|---|---|
| Healthy (few coexisting chronic illnesses, intact cognitive and functional status) | Longer remaining life expectancy | <7.0–7.5% (<53–58 mmol/mol) | TIR 70–180 mg/dL (3.9–10.0 mmol) of ≥70%, and TBR ≤70 mg/dL (≤3.9 mmol/L) of ≤4% | 80–130 mg/dL (4.4–7.2 mmol/L) | 80–180 mg/dL (4.4–10.0 mmol/L) | <130/80 mmHg | Statin, unless contraindicated or not tolerated |
| Complex/intermediate (multiple coexisting chronic illnesses† or two or more ADL impairments or mild to moderate cognitive impairment) | Variable life expectancy. Individualize goals, considering:<br>• Severity of comorbidities<br>• Cognitive and functional limitations<br>• Frailty<br>• Risk-to-benefit ratio of diabetes medications<br>• Individual preference | <8.0% (<64 mmol/mol) | TIR 70–180 mg/dL (3.9–10.0 mmol) of ≥50% and TBR <70 mg/dL (<3.9 mmol/L) of <1% | 90–150 mg/dL (5.0–8.3 mmol/L) | 100–180 mg/dL (5.6–10.0 mmol/L) | <130/80 mmHg | Statin, unless contraindicated or not tolerated |
| Very complex/poor health (PALTC or end-stage chronic illnesses‡ or moderate to severe cognitive impairment or two or more ADL impairments) | Limited remaining life expectancy makes benefit minimal | Avoid reliance on A1C; glucose management decisions should be based on avoiding hypoglycemia and symptomatic hyperglycemia | 100–180 mg/dL (5.6–10.0 mmol/L) | 110–200 mg/dL (6.1–11.1 mmol/L) | <140/90 mmHg | Consider likelihood of benefit with statin | |

This table represents a consensus framework for considering treatment goals for glycemia, blood pressure, and dyslipidemia in older adults with diabetes. The characteristic categories are general concepts. Not every individual will clearly fall into a particular category. Consideration of individual and care partner preferences, care partner engagement, abilities, and resources is an important aspect of treatment individualization. Additionally, an individual's health status and preferences may change over time. ADL, activities of daily living; CGM, continuous glucose monitoring; PALTC, post-acute and long-term care; TBR, time below range; TIR, time in range. *A lower A1C goal may be set for an individual if achievable without recurrent or severe hypoglycemia or undue treatment burden. †Coexisting chronic illnesses are conditions serious enough to require medications or lifestyle management and may include arthritis, cancer, heart failure, depression, emphysema, falls, hypertension, incontinence, stage 3 or worse chronic kidney disease, myocardial infarction, and stroke. "Multiple" means at least three, but many individuals may have five or more (193). ‡The presence of a single end-stage chronic illness, such as stage 3–4 heart failure or oxygen-dependent lung disease, chronic kidney disease requiring dialysis, or uncontrolled metastatic cancer, may cause significant symptoms or impairment of functional status and significantly reduce life expectancy. Adapted from Kirkman et al. (5).

**Table 13.2**
Older Adults:
*Standards of Care in Diabetes - 2026 Diabetes Care* 2026;49(Suppl. 1):S277-S296



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**Table 13.2 (continued)**
Older Adults:
*Standards of Care in Diabetes - 2026 Diabetes Care* 2026;49(Suppl. 1):S277-S296



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Session Code

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