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Assisted Living Column

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Is that really worth it – assuring value

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Increasingly providers are being required to focus on total cost of care as a result of the increase in provider payment being based on total cost of care and patients experiencing greater out of pocket expenses. As a result providers must take into account the total cost of care which requires assessing the cost and value of individual components of care. Providers, through their orders, control up to 80 percent of all healthcare costs.[1] But all too often these providers are unaware of the costs of the services that they have ordered. As primary care providers have responsibility for the total cost of care through at risk programs such as accountable care organizations, bundle payments, episodes of care (hospitalizations & skilled nursing facility) managed care organization, and program for all-inclusive care for the elderly. The other reason for providers caring more about cost is the fact that patients, because of the shift in making them more responsible for out-of-pocket expenses, have a direct reason to question providers to be sure they are receiving the value they are paying for.

To assure getting this value requires providers knowing the cost to assess in comparison to the expected outcomes so they can appreciate the value of services and compare alternatives. This ranges from screening, preventive care, site of care and expense to them. For example, some certain screenings may be inappropriate both in terms of clinical and financial outcomes. This can also be said of diagnostic or laboratory testing that providers order without consideration of the cost but whose needed information could be obtained in a much more cost effective manner.

Preventive screening

There are clear recommendations and guidelines regarding screening; however, these need to be applied to individual conditions and goals. The principle condition is life expectancy, Understanding so that a provider can apply a patient's goals and desires to screenings and other services. This of course is part of the whole appreciation of what one will do with results before ordering the service. If a patient states at this point in their life they do not want to pursue any treatment for cancer should that be identified in a mammogram than why put that patient through that study.

Screening tests like mammograms are of less value in patients with life expectancy of just a few years. In fact all screening test and much preventive care has significantly less impact in patients with very limited life expectancy.

Statins

Many conditions such as coronary and cerebrovascular atherosclerosis are clinical problems of growing concern because we have an aging population. Cardiovascular risk in the elderly has been found to be under managed in several epidemiological studies. Increasingly, there was mounting evidence that cholesterol is an important modifiable risk factor in patients who were more than 65 years of age and this became a driving force in practitioners increased aggression in monitoring lipid levels and prescribing statins. While

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it is important to recognize the benefit of treating high-risk older patients, one cannot forget that conclusions regarding the importance of treating the elderly with cardiovascular risk was made after the adjustment for the presence of comorbid conditions. Much of the evidence that we rely on in making cardiovascular treatment decisions for the elderly comes from the Study for Assessing Goals in the Elderly (SAGE).[2]

This study compared the effects of cholesterol lowering therapy for elderly patients. The comparison was made between intensive and moderate cholesterol-lowering efforts in a cohort of 893 men and women who ranged in age from 65 to 85 with all participants having coronary artery disease. The results showed that the intensive strategy, where patients were given 80 mg of atorvastatin daily, showed no superiority to a moderate approach of providing patients with 40 mg of pravastatin per day. We can also look back on data that was gathered from the Prospective Evaluation of Pravastatin in the Elderly (PROSPER) trial.

This trial included elderly patients who ranged in age from 70 to 82 years of age who had vascular disease or who had high risk four vascular diseases. These patients were followed for an average period of 3.2 years and eventually it was determined that pravastatin treatment reduced the relative risk a coronary death, nonfatal myocardial infarction, and fatal or nonfatal stroke significantly by 15% and CHD death by 24%. A third large clinical trial, the Medical Research Council/British Heart Foundation Heart Protection Study, compared simvastatin 40 mg daily to placebo in over 20,000 patients with more than 1200 of those patients between the age of 75 and 80 years. For elderly patients that received a statin had a 13% lower all cause mortality rate and a 17% lower death rate from vascular causes.

Post hoc secondary analysis of older adults in the randomized clinical trial Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial-Lipid-Lowering Trial (ALLHAT-LLT) showed no significant differences in all-cause mortality between pravastatin and usual care for primary cardiovascular prevention in older adults. Even though statin therapy for primary cardiovascular prevention has been associated with reductions in cardiovascular morbidity, there is no significant evidence to promote the use of statins for primary prevention in adults who are 75 years of age or older.

Hemoglobin A1c

Type II diabetes mellitus is a common condition in elderly patients. Despite its common occurrence, there is little availability of clinical evidence to guide glycemic treatment in older adults. In particular, there is lack of data that compares intensive glycemic control against standard glycemic control in diabetics who are older than 80 years of age. Conclusions that we can draw from available evidence indicate that intensive glycemic control does not reduce major macro vascular events in older adults for at least ten years. In addition, intensive glycemic control does not result in improved microvascular outcomes for at least eight years. Equally as important is the suggestion that intensive glycemic control in the elderly substantially increases the risk of severe hypoglycemia. The general conclusion is that the potential harm that results from hypoglycemia that has been caused by trying to achieve intensive glycemic control outweighs the benefit associated with maintaining a hemoglobin A1c below 7.5%.

For elderly patients with type II diabetes, patient centered care driven optimal targets for hemoglobin A1c should be influenced by several factors that include life expectancy, patient choices for medication delivery such as injections, and patient care goals. If the patient has a shorter life expectancy and is showing strong desire to avoid injections of insulin or avoid frequent fingerstick monitoring we should consider those goals of care in setting a higher target for our hemoglobin A1c that may include having a target as high as 8.5% to 9%.

Blood pressure

It is estimated that up to 80% of the population that is over 60 years of age have hypertension. New guidelines were recently announced for monitoring blood pressure and defining hypertension that will undoubtedly increase the number of people that will be defined is having hypertension. This is important for the general population because hypertension is a silent disease that generally doesn't cause symptoms until organ damage has occurred. Current evidence now tells us that maintaining blood pressure within the 130/80 range is going to promote more health benefits.

The contributors that we have identified as elevating blood pressure have not changed and continue to include stress, poor diet, excessive alcohol intake, tobacco use, and insufficient sleep. It is not yet clear what impact's recommendations will have on the management of hypertension and the elderly. The Eight Joint National Committee guidelines (JNC 8), published in 2014, recommended that we use the best available evidence when treating patients with hypertension what does this mean for elderly patients? Elderly patients have developed higher cardiac risk profiles over time and seemed to benefit from even modest reductions in blood pressure. The American Geriatrics Society speaks of taking frailty into account when designing plans of care for patients and describes ways to screen for frailty. Level of frailty is determined by poor grip strength, unexplained weight loss, slow gait speed, and fatigue levels.[3]

Mammograms

National guidelines recommend that doctors work with female patients who are 75 years of age or older to make reasonable decisions about whether or not to pursue screening mammograms as it is thought that there is limited benefit for this group unless the patient in question is expected to live at least another decade. There is potential harm that is pointed out for performing screening mammograms for women in this age group. That is that a patient may be misdiagnosed as having a harmful breast lesion and undergo aggressive treatment with side effects when that lesion is actually benign. The risk for increased harms with testing and subsequent interventions should be the focus for decision making when discussing mammogram screening in woman over age 75 who have life expectancy less than 5–10 years. For woman over 75 with life expectancy that exceeds 5–10 years there should be realist discussion about what may follow if the tests is positive for any suspicious findings before deciding to proceed with the screen.[4]

Colonoscopy

Many patients who are elderly (defined as 65 years of age and older) and very elderly (defined as 80 years of age or older) undergo colonoscopy screening procedures because elderly patients have a higher prevalence of colorectal cancer in addition to having diverticulosis and hemorrhoids. The elderly have high yields for both screening and diagnostic colonoscopy procedures, however, they also have increased risk for adverse events and complications though many of these are minor. Currently, the United States Preventive Services Task Force recommends discontinuation of screenings in average risk individuals when they reach age 75. In addition, the American College of Physicians "Choosing Wisely" campaign to