Save Money or Give Better Care? How About Both?

Dear Dr. Jeff:

Everyone seems to be coming up with suggestions to save money by providing less care to our elderly patients. There are new lists of tests not to order, diseases not to treat, cancer screenings to skip, and now an exhaustive new Beers list of medicines not to use—essentially every possible medication for some diagnoses. Prescription drug plans don’t want us to use expensive medications, even if they might be more effective. How our local emergency department calls me, annoyed, when a frail elderly patient is transferred from the nursing home without a do-not-resuscitate order.

Accountable Care Organizations, medical homes, rehospitalization penalties, bundled-payment strategies, and an endless list of new acronyms all seem more concerned with saving money than improving care. In the midst of this barrage, physician incomes are actually declining, hospitals and nursing homes are closing, and our patients are receiving worse care.

What do you think we should do?

Dr. Jeff responds: There is ample reason to believe that neither insurance companies nor legislators necessarily have our patients’ best interests at heart. Increasing corporate profits and cutting taxes are not goals that necessarily mesh with higher-quality health care. On the other hand, you should not surrender to the temptation to despair over the endless changes in long-term care. In the weird mixture of actual change, possible change that may never happen, and apparent change that is really more of the same, there is some danger and a few genuine opportunities to improve care. Appearances to the contrary, the sky is not falling.

Providing top-quality medical care to elderly patients with multiple illnesses is unavoidably expensive. But the United States already spends a higher percentage of its gross national product on health care than any other country in the world, while achieving outcomes that are mediocre at best and truly embarrassing at worst. The potential to save money while improving care is obvious, though how is less clear. It is not surprising that those in the health care industry look to save money on people who consume the greatest share of health dollars: elderly patients with multiple diseases and irreversibly ill patients near the end of life.

Ironically, many of the proposals and guidelines that seem controversial are based on excellent scientific evidence and sound principles of geriatric care. Despite the mantra “evidence-based medicine,” many physicians are reluctant to abandon their ingrained habits and idiosyncrasies or to confront the unrealistic expectations of patients and their families. New guidelines on laboratory testing and cancer screening offer genuine opportunities to provide the individualized, person-centered care that we have long espoused. I am fascinated by the number of practitioners who used to blame all these unnecessary tests on malpractice concerns and survey worries but now, reluctant to change their habits, are “advocating for” their patients’ rights to radiation exposure and phlebotomy.

Mixed Messages

I was recently asked to meet with an angry family. Their mother had been admitted to our affiliated hospital for management of her end-stage lung disease. Her physician there had failed to order her then-due annual mammogram. The family believed that this was negligence, although they wondered if the hospital’s mammography room was possibly too small to accommodate her oxygen tank. They were hardly foolish. They clearly had been convinced that an annual mammogram would prevent their mother from getting breast cancer and were trying to protect her.

Americans have been seriously over-sold on the power of preventive medicine, particularly of cancer screening and cholesterol control. Advocacy groups such as the American Cancer Society and the American Heart Association, generally admirable organizations with significant physician input, have chosen to simplify their messages for vulnerable populations.

It is obviously easier to get out the message “every woman needs an annual mammogram” than the more nuanced and accurate “women over 50 and below 70 with a life expectancy of more than 5 years would benefit statistically from an annual mammogram, as would certain other high-risk groups, while some women over 70 would benefit statistically from a mammogram every 2 years—if they would accept treatment.” I eagerly await the day when the American Heart Association acknowledges that patients over 85 live longer with high cholesterol.

In fact, the overwhelming majority of our long-term care residents fall into groups to which these simple messages don’t apply. New guidelines to that effect will help us promote reality-based medicine. But the revisions to the Beers criteria also offer the potential to improve care, as long as they’re properly understood and applied. The new version is the product of an expert panel of physicians and pharmacists who identified a long list of Food and Drug Administration-approved medications that may carry extra side effects for elderly patients. These medicines are not “forbidden” for use in the elderly, as some physicians and a number of surveyors seem to think. However, the list does highlight certain medications that may have safer alternatives, require extra monitoring, or might best be withheld in favor of nonpharmacologic approaches or no treatment at all.

Therefore, the list is not the same as a clinical practice guideline. For example, many patients have been on a listed medication for years and benefited from its use. Since this amounts to a successful safety trial with n = 1, there is no reason to change such a patient to a “safer” alternative. However, in the current regulatory environment, it might be wise to document that you were aware of the concern but had determined that it did not apply in this particular case.

Many physicians have been shocked by the new Beers listing of every antipsychotic medication and all the benzodiazepine antianxiety medications. Prior lists had emphasized particular risks associated with the long-acting benzodiazepines such as diazepam (Valium) and the so-called typical antipsychotics such as haloperidol (Haldol) and chlorpromazine (Thorazine). However, these drugs’ alternatives, which had been touted as safer (if no more effective), have not proved so.

Furthermore, the new list includes concerns about sedating antidepressants. This leaves many clinicians aghast that they have nothing to prescribe for an elderly person who is severely agitated.

However, the Beers panel’s concerns about prescribing sedating medications for the elderly simply reflect the reality that these medications are neither safe nor particularly effective, especially when prescribed for agitated behaviors in dementia patients. The AMDA House of Delegates recently approved a resolution emphasizing the need for enhanced nonpharmacologic approaches to the management of the behavioral complications of dementia. Nonpharmacologic approaches are generally safer, more effective, and may be quicker than any drug. The Beers list strengthens the hand of those of us who advocate safer and more effective responses to difficult behaviors.

More or Less

I will discuss the issue of reductions in care implied by accountable care organizations, bundled payments, medical homes, managed long-term care plans, and the soon-to-be-seen FIDA (Fully Integrated Dual Advantage) facilities in a later column. Suffice it to say that these approaches do represent a significant threat to long-term care facilities as they are currently constituted. Even if the Supreme Court decides to overturn President Obama’s Affordable Care Act, these proposed money-saving “quality” measures are unlikely to go away.

On a happier note, although the reimbursement of primary care practitioners has continued to be under attack by managed care corporations, and malpractice costs and office expenses have continued to rise, Medicare reimbursements for services to nursing home residents has significantly outpaced inflation in recent years, bringing them in line with comparable office and hospital services. Advocacy by AMDA and others within the American Medical Association’s RUC (the relative-value updating committee) has increased the values associated with nursing home admission and follow-up visits, and the RUC is now reviewing discharge codes for potential increases.

Nursing home physicians can now earn amounts comparable to the incomes of their hospital and office-based peers.Billing and coding seminars, such as the terrific training sessions provided by Dr. Alva “Buz” Baker, CMD, and Dr. Len Gelman, CMD, have helped practitioners achieve appropriate reimbursement for the medically necessary services they perform.

Meanwhile, there is still a need for more primary care services for nursing home residents, who would be better served by more physician attention and fewer medications and diagnostic tests. A prompt evaluation by an experienced physician or nurse practitioner is better care than magnetic resonance imaging (much less the totally inappropriate skull x-ray) for a resident with a headache.

Sometimes, more is less. Sometimes more is more. Fewer tests and drugs would mean better care. More caring doctors and nurse practitioners at the bedside evaluating the frail elderly would mean better care. The combination would be better care at less cost.

Dr. Nichols is the medical director of Our Lady of Consolation and Good Samaritan Nursing Homes in Suffolk County, N.Y., and senior vice president for clinical effectiveness of the Catholic Health Care System of Long Island. He invites your questions for possible discussion in this column, to careg@elsevier.com. You can also comment on this and other columns at www.caringfortheages.com, under “Views.”