



Exciting News in the Area of Prevention and Screening

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Mrs. G, a 72-year-old woman with a history of hypertension, presents to your office for her annual physical. She comes with several questions related to prevention and screening after doing some on-line reading and hearing about the recent controversy over mammography. She wants to know how much longer she should continue to have mammograms, colonoscopies and other such screening testing. She is a vibrant woman who works two days a week as a volunteer at a local school and travels every few months to Florida, where she has a second home. She golfs and plays tennis regularly and has had no major medical illnesses or hospitalizations.

Mrs. B, a 72-year-old woman with a history of stroke, moderate dementia, hypertension, high cholesterol, osteoporosis and arthritis comes with her husband for her annual physical. Her husband is her primary caregiver, and Mrs. B requires assistance with dressing, eating and ambulating. She has recently developed incontinence, and her husband lets you know he recently hired a part-time nursing assistant to help him at home because it is difficult to leave her alone for any prolonged period of time. She is mostly homebound, though she still enjoys going out to church and lunch with her children on Sundays.

These two very different women come in for an annual physical examination. Most of the care they receive will be similar; e.g., physical exam, flu shots, laboratory evaluation, and medication reconciliation. However, when the question of prevention and screening is raised, the conversations will diverge and become more complex despite the patients being of the same age. Screening recommendations can be followed in most patients in cookbook fashion; however, as a patient ages, and especially if functional losses accumulate, the decisions become more complex and require individualized discussions of risks and benefits, treatment preferences, quality of life and life expectancy.

The topic of prevention has come into sharper focus recently with two major developments. The first, the passing of the Patient Protection and Affordable Care Act (ACA) will eliminate cost-sharing for Medicare beneficiaries for preventive health services, presumably allowing older adults to more often take advantage of preventive testing by removing financial barriers.¹ Second, the U.S. Preventive Services Task Force (USPSTF) in 2005 convened a geriatrics subgroup of its Methods Workgroup to redefine their methodology to better address the preventive needs of the older adult.² The first review to apply this new approach has just been published on the topic of fall prevention.³

Prevention has been murky for older and frail adults. For years, there has been a smaller evidence base to guide deci-

sion making because older adults are often excluded from the randomized trials used to formulate screening guidelines.² Additionally, the decision to screen or not is complicated by comorbid illnesses, functional status, patient preferences and life expectancy. The outcomes that studies use to inform guidelines do not always apply to the older adult, who may not be looking to extend life or to prevent disease, but to maximize function and quality of life.² In addition, the outcomes that we sometimes strive for in older adults, such as improved function and quality of life, are difficult to measure as discrete outcomes in reviews and trials. The overarching questions that guide decisions can be summarized: Will the screening test diagnose the disease? Can the older adult tolerate the treatments that will be required? Will the person live long enough to benefit from the treatments, or will time-to-benefit exceed life expectancy?

The ACA will improve access for older adults to preventive services, but it will also open the proverbial “can of worms” for some patients who can now more easily get preventive services but for reasons of co-morbidities, life expectancy and others, might not benefit from them. The new methodology the USPSTF is using will help better equip both patients and providers to make these difficult decisions. Updated guidelines will now be more applicable to the older adult population and will provide more guidance on outcomes, including the nontraditional outcomes that are more applicable to the older adult population.

Specifically, the new methodology aims to address aging-specific issues for diseases prevalent in older adults. The USPSTF will aim to update recommendations with evidence that includes adults 65 years or older.² The Task Force is also proposing to better accommodate the multi-factorial nature of geriatric syndromes and the interventions used to treat them.²

The USPSTF changes and proposals are exciting ones that will benefit older adults. The two women above will profit from greater clarity in the future. For now, the recommendations made to each should take into account baseline health, life expectancy and patient preferences. Sadly, Mrs. B’s functional status portends a poor prognosis, and her likelihood of benefiting from screening measures is small. If she is diagnosed with colon or breast cancer, treatment would be unlikely to extend her life and would substantially impair her quality of life and current level of functioning. She is able to stay at home with help, and still able to enjoy some activities with her family. Much luckier, Mrs. G has a considerably longer life expectancy, and with her high functional status, can still be expected to benefit from preventive services.

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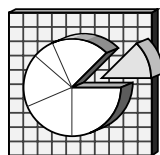
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Health By Numbers

RHODE ISLAND DEPARTMENT OF HEALTH • DAVID GIFFORD, MD, MPH, DIRECTOR OF HEALTH

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Treatment for Asthma Symptoms and Prevalence of Persistent Asthma among Children Enrolled in Rhode Island's Managed Care Medicaid Program

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Asthma is a leading chronic illness among children in the United States, and is disproportionately distributed in both prevalence and severity among low income and minority populations.^{1,2,3,4,5} The National Committee on Quality Assurance (NCQA) has established a standardized definition for *persistent asthma* as one of the HEDIS (Health Plan Employer Data and Information Set) measures.⁶ This measure is based on a patient's use of outpatient, Emergency Department (ED) and inpatient services, as well as the number of medication dispensing events over time.⁷ The HEDIS measure for asthma is reported annually for both commercial and government-sponsored health plans,⁸ and therefore this measure is well understood within the public health community. In addition, this measure can be easily calculated using most routine claims systems.

In this brief, we examine the prevalence of asthma symptoms treated in children aged 5-17 enrolled in Rhode Island's managed care Medicaid Program (RIte Care), as well as the prevalence of children who met HEDIS criteria for *persistent asthma*. We also describe the pharmacotherapy of NCQA identified medications used to treat asthma.

METHODS

Data for this brief are based on the Medicaid Managed Care Utilization Data Set (i.e., Encounter Data) from the RI Department of Human Services. Participating health plans are required to submit claims level data for all professional and institutional services as well as all outpatient prescriptions provided to Medicaid enrollees. The focus of this report is on services incurred during calendar year 2009 to children who were between 5 and 17 (inclusive) as of December 31, 2009.

The NCQA defines *persistent asthma* as any patient who is continuously enrolled for two years who met at least one of the following criteria during the measurement year and the year prior to the measurement year: 1) at least four outpatient visits with asthma listed as any of the diagnoses treated *and* at least two outpatient prescriptions for an asthma defined medication, 2) any ED visit with asthma listed as the primary diagnosis, 3) any inpatient admission with asthma listed as the primary diagnosis, or 4) four or more outpatient prescriptions for an asthma-related medication. Since the requirement for two years of continuous enrollment would exclude many RIte Care children with asthmatic conditions, we used a variation of the HEDIS measure