Caring for the Vulnerable Elderly: Are Available Quality Indicators Appropriate?

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In October 2007, an update of the quality measures for “The Assessing Care of Vulnerable Elders-3 (ACOVE-3)” was published.1 Clearly patients receiving long-term care represent a vulnerable group and so it is reasonable to inquire whether these indicators are appropriate for our populations. It should be noted that of the 392 quality indicators, 36% were excluded from patients with advanced dementia (one that interferes with basic activities of daily living) and 34% were excluded from patients with a poor prognosis (expected to live less than 6 months). While many of these recommendations are the bread and butter of basic care for older persons, others appear to be based on care for relatively healthy younger persons and lack evidence for their use in vulnerable elders. As there is a high likelihood that these quality indicators will be used to measure physician performance by government and managed care organizations, it is essential that they are carefully scrutinized.

The exclusion of quality indicators in advanced dementia and the last 6 months of life is important. A similar approach was taken with the Glidepaths,2 but in that case the population of older persons was divided into healthy, frail (approximately 5-year survival), end of life (2-year survival), and dementia. The realization that many treatments are inappropriate as one nears the end of life represents an important component of any guidelines. In some cases ACOVE-3 has failed to modify guidelines for the vulnerable elderly or even followed the evidence that exists for healthy elderly.

Not surprisingly, given that ACOVE-3 was sponsored by a pharmaceutical company, aggressive treatment of hypertension is recommended.3 The blood pressure goals stated are 130 mm Hg systolic for diabetes and chronic renal failure and 140 mm Hg for all others. This is despite, as recently documented, as recently documented, MM Hg systolic for diabetes and chronic renal failure and 140 mm Hg. The United Kingdom Prospective Diabetes Study (UKPDS) trial in middle-aged persons lowered blood pressure to below 145 mm Hg. Problematically in the hypertension guidelines is the recommendation of a beta-blocker in persons with hypertension plus ischemic heart disease without the mention of the need for a diuretic together with the beta-blocker.6,7 While the guidelines recommend evaluating orthostatic hypotension, this is only when a new medicine is started and the patient has dizziness, syncope or near syncope, or near-fall or fall. We would strongly recommend that orthostasis is measured in all older persons. In addition, there is no mention of postprandial hypotension.8 Previous studies have not supported the use of antihypertensives in those over 80 years of age.9,10 However, the premature stopping of the Hypertension in Very Elderly Trial (HYVET) because of increased mortality in the control group may suggest that treatment in this group to a systolic blood pressure of 160 mm Hg is appropriate, although a number of questions exist regarding this study and a full recommendation cannot be made until the study details are published in March.

Treatment of cholesterol to 100 mg/dL is most probably too low in vulnerable elderly persons with ischemic heart disease. As found in the Prospective Study of Pravastatin in the Elderly at Risk (PROSPER) study, this did not improve mortality, although in 70- to 80-year-olds a recent meta-analysis and the Heart Protection Study have supported some level of treatment.11–13

The recommendation for calcium and vitamin D for osteoporosis14 should be enlarged to include at least those with osteopenia, and a measured 25(OH) vitamin D level should be obtained.15–17 The inclusion of raloxifene, calcitonin, and hormone replacement therapy alongside bisphosphonates and teripatride for osteoporosis in vulnerable older women would appear to be preposterous.18,19 While I believe testosterone may have a place in the treatment of some vulnerable elderly men,20,21 their recommendations for testosterone for male osteoporosis would seem to be inappropriate.

The failure to recognize the role of ear wax in hearing loss while strongly suggesting referral for hearing aides and cochlear implant seemed somewhat inappropriate.22 To set the HbA1C at a treatment threshold level of 9% seems excessively high and a level of around 7% with minimal side effects is usually easily obtainable in vulnerable elders.23–25 On the whole, the weight loss quality indicators by Reuben26 were excellent, although I would quibble with a threshold of 10% weight loss as most guidelines would consider 5% a more

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DOI: 10.1016/j.jamda.2007.11.002
The use of a low-salt diet for hypertension is questionable in view of the role of therapeutic diets in the production of weight loss and the negative effect of weight loss in vulnerable elderly. The depression section pointed out the minimal differences between selective serotonin receptor inhibitors and disipramine and nortryptilnine. It was nice to see that there was only a recommendation of medication discussion, rather than insisting on its use for dementia, but was disappointed to see that physical restraints were not prohibited in dementia patients in hospitals. Use of delirium intensive care units should have made physical restraints obsolete in most hospitalized patients. The recommendation of stool softeners in the palliative care section diminishes an important area.

My 5 favorite quality indicators from ACOVE-3 are:
- If a vulnerable elderly (VE) is discharged from a hospital to home or nursing home THEN there should be a discharge summary in the outpatient or nursing home chart.
- If a VE has a history of 2 or more falls (or 1 fall with injury) in the previous year, THEN there should be documentation of orthostatic vital signs.
- If a VE is prescribed a drug THEN the prescribed drug should have a clearly defined indication.
- If a VE has iron deficiency anemia THEN no more than 1 tablet daily of low-dose oral iron should be prescribed.
- All VE should have documentation of the presence or absence of urinary incontinence during the initial evaluation.

Overall, these quality indicators should be of use in the care of the vulnerable elderly. They should not be looked at alone but seen in conjunction with other approaches such as the American Medical Directors Association (AMDA) clinical guidelines. The chapter on falls is excellent and worth reading by all physicians caring for the vulnerable elderly. It is time to start to measure the physician process in the nursing home, to the same extent that other processes are measured. An excellent project for the AMDA Foundation would be to choose from among the ACOVE-3 guidelines and then measure physician adherence and whether or not higher adherence leads to better outcomes. Using the original ACOVE Quality Indicators it was found that 55% of the guidelines were provided to 372 patients, and patients who had quality scores above the median had a 10% higher survival over 3 years. It would appear that we can do better, and ACOVE-3 represents a reasonable starting place for those of us who care about long-term care.

REFERENCES


