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Dartmouth Atlas Project Issues Report Card on Health Care for the Aging Population
Adherence to Evidence-Based Practices Varies Widely Across the Country

Lebanon, N.H. (February 17, 2016) – Some aging patients spend nearly a month of the year in contact with the health care system, whether in the hospital, at a doctor’s office or at a lab visit, yet depending on where they live, they still might not be receiving medical care that reflects evidence-based practices, according to a new report from the Dartmouth Atlas Project.

The report, “Our Parents, Ourselves: Health Care for an Aging Population,” is a report card that shows where the United States is making progress in patient-centered care and where improvements need to be made for older adults, a population predicted to surge from 43.1 million in 2012 to 83.7 million by 2050. Bodies change with age, as do people’s priorities. Therefore, older adults require care that meets these changing needs. This report highlights areas of health care that present distinctive challenges faced by older adults, including those of us with multiple chronic conditions or dementia.

“It is striking how much of an older adult’s life is occupied by health care, especially those with multiple chronic conditions or dementia,” said Julie P.W. Bynum, MD, MPH, associate professor of The Dartmouth Institute for Health Policy & Clinical Practice and the report’s lead author. “In 2012, the average Medicare beneficiary was in contact with the health care system on 17 days – meaning in an inpatient setting or having a clinician visit, procedure, imaging study, or lab tests in an outpatient setting – and 33 days if they had two or more chronic conditions.”

Medicare beneficiaries in East Long Island and Manhattan, N.Y., spent 24.9 and 24.6 days, respectively, in contact with the health care system, while patients in Marquette, Mich., and Lebanon, N.H., only spent 10.3 and 10.2 days, respectively. For patients with multiple chronic conditions and dementia, the amount of time spent in contact with the health care system was even higher. Across the 306 hospital referral regions the report looked at, patients in Manhattan and East Long Island, N.Y., tied for the highest rate of contact days among patients with two or more chronic conditions, at 46.2 days, and patients in East Long Island also had the highest rate of contact days among patients with dementia, at 44.9 days.

“The findings from this report will generate meaningful conversation about the care for our aging population and identify areas of action for health systems, advocates, and policy makers,” said Terry Fulmer, PhD, RN, FAAN, president of The John A. Hartford Foundation, which sponsored the report. “This action is especially needed for older adults with multiple chronic conditions or dementia who often face complex challenges when navigating the health care system and advocating for the best care possible.”

The report also sheds light on the fact that, on average, just more than half (56.9 percent) of Medicare beneficiaries in 2012 had a primary care physician as their predominant provider of care – the doctor with whom the person has the most outpatient visits – despite evidence suggesting that greater reliance on primary care physicians can lower costs and reduce avoidable hospitalizations.

Are Older Adults Receiving Evidence-Based Care?

In addition to these broad measurements based on 2012 Medicare data, the report looks at whether patients are receiving medical treatments in accordance with evidenced-based practices.

Among the starkest findings is the lack of adherence to guidelines for prostate cancer screening with a blood test, called a prostate-specific antigen (PSA) test. Although once debated, the US Preventive Services Task Force (USPSTF) in 2012 recommended against all PSA screening regardless of age. The American Cancer Society and the American Urological Association recommend against PSA testing in older men, but recommend that younger men (beginning in their 50s to as old as 69) should practice shared-decision making with their doctors to discuss the pros and cons. Despite these recommendations, the national average rate of PSA screening among older men, ages 75 and older, was 19.5 percent, and regional discrepancies were significant, from 9.9 percent in Casper, Wyo., to 30 percent in Miami, Fla.

Similarly, regular breast cancer screening with mammography has long been promoted in the medical community, but recent research suggests that screening has a minimal effect, if any, on breast cancer-related mortality. The USPSTF recommends biennial screening mammography for women ages 50-74, but notes that there is insufficient evidence to assess the benefits of screening in women 75 years and older, and evidence has shown the potential harmful effects of false positive results. Despite these findings, the report unveils that the national average rate of screening mammography for women age 75 and older was 24.2 percent, but rates varied more than twofold across hospital referral regions, from 15.3 percent in Miami, Fla., to 37.2 percent in Sun City, Ariz.

Feeding tube placement in people with advanced dementia represents another area of concern. Though once very common, clinical evidence now shows that it does not prolong life or improve outcomes, and instead leads to further complications and adverse effects. Several national organizations, such as the American Geriatrics Society, recommend against this practice. In 2012, 6 percent of beneficiaries with dementia received a feeding tube in the last six months of life, with the widest variations in Portland, Ore., and Salt Lake City, Utah, at 1.3 percent to Lake Charles, La., at 14.2 percent.

Improvements in Evidence-Based Care

The report also offers a historical look at where continued monitoring of key practices and measures has led to improvements in recent years, such as a more than 10 percent increase in adherence to diabetes testing guidelines, when comparing data from 2003-05 and 2012.

Among the most striking improvements, preventable hospital admissions – conditions for which hospitalization may have been preventable with better outpatient care – declined 23 percent, from 5.5 percent of Medicare beneficiaries in 2003 to 4.2 percent in 2012. Rates declined in nearly every hospital referral region, but they varied more than threefold, from 2.2 percent in San Mateo County and San Luis Obispo, Calif., to 7.3 percent in Monroe, La.

The report also reveals a decline in the use of high-risk medications for the aging population. These are medications identified by The National Committee for Quality Assurance (NCQA) to be avoided for use by older patients as they have significant rates of adverse effects. The percentage of Medicare beneficiaries that filled at least one prescription for a high-risk medication decreased nearly 43 percent from 2006 to 2012, from 32.2 percent of beneficiaries to 18.4 percent. However, rates still varied more than threefold across referral regions, from 9.8 percent in Rochester, Minn., to 29.1 percent in Monroe, La.

While improvements are being seen, better medication management is urgently needed for patients with multiple morbidities and dementia who often take multiple medications to manage health challenges. The report uncovers that one in four of these beneficiaries was exposed to at least one high-risk medication. Among the most critical areas for concern is Monroe, La., where 40.3 percent of patients with multiple chronic conditions and 40.1 percent of patients with dementia filled prescriptions for high-risk medications.

The report also looks at 30-day readmission rates, annual wellness visit rates, and the number of unique clinicians that patients see on average, as well as end-of-life treatments, such as late hospice referral and the number of days spent in intensive care, among other findings. The full report can be found at [http://www.dartmouthatlas.org/downloads/reports/Our Parents Ourselves 021716.pdf](http://www.dartmouthatlas.org/downloads/reports/Our_Parents_Ourselves_021716.pdf).

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About the Dartmouth Atlas Project

For more than 20 years, the Dartmouth Atlas Project has documented glaring variations in how medical resources are distributed and used in the United States. The project uses Medicare data to provide information and analysis about national, regional, and local markets, as well as hospitals and their affiliated physicians. This research has helped policymakers, the media, health care analysts and others improve their understanding of our health care system and forms the foundation for many of the ongoing efforts to improve health and health systems across America.

About The John A. Hartford Foundation

Founded in 1929 by John and George Hartford of the Great Atlantic & Pacific Tea Company (A & P), The John A. Hartford Foundation, based in New York City, is a private, nonpartisan philanthropy dedicated to improving the care of older adults. Every eight seconds, someone in America turns 65. The largest-ever generation of older adults is living and working longer, redefining later life, and enriching our communities and society. Comprehensive, coordinated, and continuous care that keeps older adults as healthy as possible is essential to sustaining these valuable contributions. The John A. Hartford Foundation believes that its investments in aging experts and innovations can transform how care is delivered, lowering costs and dramatically improving the health of older adults. The John A. Hartford Foundation was an early funder of the pioneering work of the Dartmouth Atlas on regional variation in health care. Additional information about the Foundation and its programs is available at www.jhartfound.org.

Methodology

The methods used in this report were developed over a number of years and have been described in detail in [peer-reviewed publications](#) and in [previous editions of the Dartmouth Atlas](#). The data are drawn from the enrollment and claims data (100% sample) of the Medicare program. The analyses presented in this report focus on either the entire Medicare population between the ages 65 and 99 (demographic analyses); or a subset of that population, including those receiving fee-for-service care (excluding beneficiaries enrolled in risk-bearing HMOs) (utilization analyses), those with specific disease conditions (cohort-restricted analyses), or those at risk for a specific procedure or service (screening analyses).