Mrs. K. is a 76-year-old widowed, White frail woman with a history of primary thrombocytosis, hypertension, normopressive hydrocephalus, osteoporosis, depression, hypertension, mild emphysema, anemia, and a parietal stroke. Her stroke has left her with mild expressive aphasia and Gerstmann’s syndrome, which is a cluster of neurological symptoms that include difficulty writing (dysgraphia), difficulty copying simple drawings (apraxia), difficulty with arithmetic (dyscalculia), an inability to distinguish left from right, and difficulty identifying fingers (finger agnosia). For more than 8 years she has been seeing a hematologist/oncologist who has managed her anemia of chronic disease with erythropoietin.

Several years ago she had been quite active, capable of dressing and fixing small meals. However, this quickly changed once her dosage of epoetin alfa (Procrit®) was reduced due to the Medicare policy on monitoring of erythropoietin-stimulating agents. Mrs. K.’s hemoglobin target dropped below 12 g/dL and typically ranged from 9 g/dL to 11 g/dL, leaving Mrs. K. and her family with little choice but to hire assistance in the home 12 to 14 hours per day. The management of her chronic anemia continued to affect Mrs. K. until the family realized that their mother’s hemoglobin was being allowed to drop to much lower levels due to governmental policy limiting reimbursement to physician practices.

Anemia is defined by the World Health Organization (1968) as hemoglobin of less than 13 g/dL in men and less than 12 g/dL in women. However, recent studies have found that the risk of death for older adults was highest for hemoglobin levels of less than 13.7 g/dL for men and less than 12.6 g/dL for women (Zakai et al., 2005). Lower limits of hemoglobin according to gender, age, and race have been proposed as 12.7 g/dL for Black men older than 60 and 11.5 g/dL for Black women older than 20, according to data from National Health and Nutrition Examination Survey-III and Scripps-Kaiser studies (Beutler & Waalen, 2006). An estimated one fourth of community-based octogenarians and one half of chronically ill older adults have hemoglobin levels that would meet the definition of anemia (Eisenstaedt, Penninx, & Woodman, 2006).

Anemia of chronic disease is not limited to those adults with chronic kidney disease. Conditions such as infections, inflammation, and cancer can suppress production of red blood cells in the bone marrow, resulting in a slowly developing anemia over time. When symptoms do occur, they usually result from the disease, causing the anemia rather than occurring from the anemia itself. The diagnosis is typically made by excluding other causes, as no specific laboratory tests exist.

Because no specific treatment exists for this kind of anemia, physicians treat the disorder causing it. Taking additional iron or vitamins does not help. On the rare occasion...
that the anemia becomes severe, transfusions may help. Alternatively, erythropoietin or drugs that stimulate the bone marrow to produce red blood cells may be given. However, the Centers for Medicare & Medicaid Services (CMS; 2007) have a policy that limits the amount (i.e., number of units) that can be prescribed for reimbursement. Why would limits be delineated by CMS? Given that hemoglobin progressively declines with age, the increase in the aging population, and the costs of drugs that stimulate bone marrow to produce red blood cells, CMS will save billions of dollars by limiting usage.

Research has shown that anemia is associated with functional disability; decreased muscle strength; fall injury; increased frailty; increased risk of physical decline; and decline in cognitive function, mood, and quality of life (Lucca et al., 2008). Longer hospitalizations for elective procedures, increased risk for mortality, as well as reduced bone density have been associated with anemia in older adults (Eisenstaedt et al., 2006). Studies have shown that an increase in hemoglobin in women was associated with improved mobility (Chaves, Ashar, Guralnik, & Fried, 2002).

Although many studies were in place prior to the Medicare policy, CMS continued to refuse revision of anemia reimbursement guidelines. Most recently, 91% of oncologists and hematologists reported adverse patient events in the 12 weeks after the July 30, 2007 implementation of the national coverage determination on erythropoietin-stimulating agents. A survey of 307 physicians from November to December 2007 noted an increase in symptomatic patients from anemia (Hansen, 2008).

Most recently, CMS will again influence outcomes of patients through reimbursement policy. The proposed change to reimbursing dialysis and injectable medications bundled as one fee could result in health disparity (Ishani et al., 2009).

Black Americans with kidney disease may be disadvantaged, as Black dialysis patients have more problems with anemia than White patients and typically require higher dosages of erythropoietin-stimulating agents to raise hemoglobin levels (O’Meara et al., 2006). Higher dosages equate to higher costs for the dialysis centers. The stance of CMS in their policy making should lead Americans to believe that health care is not a right, but a commodity that is yours if you do not need expensive medications. Americans should brace themselves for further rationing of health care in the next decade as a mechanism to control health care dollars will encircle all of us. Regardless of whether such policies are right or wrong, these kinds of decisions challenge morality. Will you be one of the many Americans in the future who watches a parent lose functional or cognitive status due to anemia target levels? Or might such a policy affect yourself? While public comment has done little to pressure CMS to change its policy (“Public Comments,” 2007), it is one mechanism that is available for all health care providers and Americans. I challenge each of you to stay abreast of CMS policy when the approach is one of rationing to save dollars in the short term with the potential of long-term consequences when individuals such as Mrs. K. and her family are left with little choice but to hire assistance in the home and experience the decline that is associated with hemoglobin levels below 11 g/DL. As health care providers, nurses must continue to advocate for patients’ rights to maintain a quality of life that allows maintenance of one’s functional status.

REFERENCES


Sonia R. Hardin, PhD, RN, CCRN, NP-C
Associate Professor
School of Nursing
University of North Carolina at Charlotte
Charlotte, North Carolina

The author discloses that she has no significant financial interests in any product or class of products discussed directly or indirectly in this activity, including research support.
doi:10.3928/00989134-2010100831-04