PSA

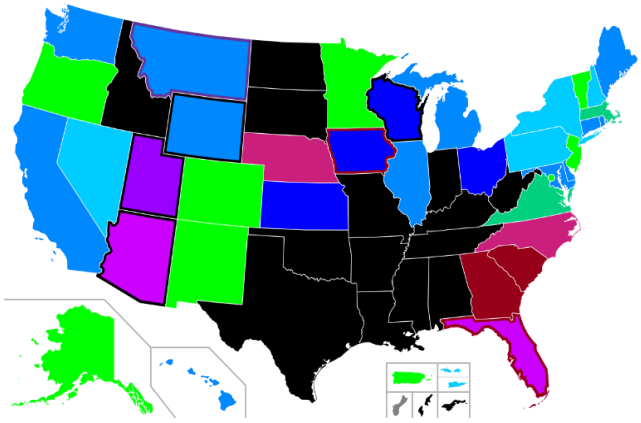
Patient Safety America Newsletter

April 2024 http://PatientSafetyAmerica.com John T. James, Ph.D.

Question: In a new study in BMJ, how many health conditions were associated with ultra processed food? A) 10 B) 15 C) 20 D) 25 E) 30

Rape Related Pregnancy in Abortion-Ban States

Victims of rape often do not report their rape or suffer because their sexual assault goes uninvestigated, at least in Houston.[1] A team of six experts investigated the impact of the laws banning abortion in the 14 states (see black states in figure, Wikipedia) that have done so from July 2022 up to January 2024.[2] They estimated rates of vaginal rape from the CDC database that tracks such things, and then estimated the frequency of ensuing pregnancies by a complex method beyond the scope of this summary (and my understanding). During the study period, an estimated 520,000 rapes occurred in nine abortion-banned states where abortion is not allowed even for rape, of which 59,000 were estimated to cause pregnancy.



I cannot imagine any crueler response to a rape victim than legally refusing her the right to have an abortion in her home state. The rape itself is traumatic enough, but for legislators to ban abortion after a rape seems unconscionable to me. In the 5 states where there is a rape-exception to the abortion ban, it is unlikely that rape victims will seek an abortion because they must report the rape to police to have it legally performed. Historically, only 1 in 5 rapes are reported to police. In an editors' note to this finding they opined that 'The best solution to this problem is a national law protecting the right of all people to choose to terminate pregnancy.' I think that limiting abortions to the first 15 weeks of gestation makes sense. What do you think?

If Medical Debt Were a Disease

I suspect that my readers may have experienced serious medical debt or at least know someone who is struggling with the burden of medical debt. This is a uniquely American phenomenon among developed countries. Two MDs commented on a study recently published in *JAMA Open*.[3] That study revealed that there was a 'dose response' curve between the level of medical debt and the following outcomes: physically unhealthy days, mentally unhealthy days, and mortality. Obviously, these harmful outcomes are more common in those with fewer financial resources. The claim is that a new underclass of people has been created: the medical debtor.

The editorialists offer several ways to mitigate this iatrogenic effect: abolish aggressive debt collection, force non-profit hospitals to reinvest in community health, and enhance the chances for charity care. Somehow, the administrative burden of

[1] HPD says more than 4,000 sexual assault cases were suspended | khou.com

[2] https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2814274

[3] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2815532

healthcare, which consumes about one third of healthcare dollars, must be reduced. I was surprised that the authors did not advocate for the remaining eleven holdout states to expand Medicaid coverage. In general, such a kindness would reduce the fears the working poor have over incurring medical debt. I have personally witnessed a woman brought to tears after removal of a kidney tumor because the debt she incurred was the total sum of all the money she and her husband earned in a year. Obviously, private equity enterprises are not going to help Americans with reduced medical debt.

Value-Based Dementia Care

Many of us have witnessed the tragedy of dementia as this awful disease steals the very soul of once vigorous and creative friends and family members. It may be said that dementia is to be feared even more than death itself. In the HEALTH CARE REFORM section *of JAMA Internal Medicine*, three experts wrote about the promise and limitations of the GUIDE model of care to simultaneously improve care for those with dementia and reduce the cost of that care.[4] Given Medicare's previous experience with models focused on specific diseases, this model's focus on integrated care may not be that promising. The authors cite four flaws in the current approach to dementia care: care is often not team-based, caregiver burden causes burnout, social needs of dementia patients are not effectively addressed, and dementia care is inequitable. If you think any model that addresses all these factors is going to reduce the cost of dementia care (i.e. be value based) you have been smoking something strong.

Here is where some reality, as I see it, must come into play. Each dementia patient that does not have a compassionate and knowledgeable advocate should be assigned one. Such an advocate must know how to insist on patient centered care appropriate to the specific needs of the patient. This will require shared decision-making. Individuals with this skill could be required to be employees of skilled nursing facilities. Perhaps there would have to be one of these advocates per every 20 to 50 residents in the facility that do not have a personal advocate. The focus would have to be doing all that makes sense *for the patient* and not everything that can be done *to the patient*. End of live directives are a must for those with dementia to avoid revenue-based care over value-based care. The fix will not be easy to implement.

Maltreatment of Children

In an opinion article in *JAMA* entitled 'Struggling to stem the tide of child maltreatment.' three experts characterize this problem in the US and propose ways to 'stem the tide.'[5] The experts apparently are a pediatrician, a hospitalist, and a child-abuse expert. They are unhappy with the recent declaration from the U.S Preventive Services Taskforce, which concluded that there is no evidence of primary care referrals that lead to less maltreatment of children. The experts call upon their colleagues to not abandon their efforts to reduce maltreatment of children, even when there is no solid evidence of any effectiveness. Lack of effectiveness is likely due to absence of comprehensive studies. They mention several societal improvements as follows: Medicaid expansion, paid family leave, earned income tax credit, and shorter waitlists for childcare. They further note that reported serious child abuse drops by half after the child's first birthday. They caution that it will require a multifaceted effort to stem the tide of child maltreatment.

There is a message in all this for non-physicians. Otherwise, I would not have included this summary. Be aware of the maltreatment of children. For example, one thing I see as people drive away from our food distribution location in Houston is that there are children in some vehicles that are not placed in car seats. In fact, there is not a car seat for *any* child in the vehicle. I hope to gently encourage drivers to find a source of free child seats. One widespread maltreatment of children is to allow

[4] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2815532

[5] https://jamanetwork.com/journals/jama/article-abstract/2816235

too much screen time. The Mayo Clinic has a comprehensive summary of the adverse effects of too much screen time.[6] I might add that forcing a rape victim to carry her baby to term may increase the risk of maltreatment of the baby.

Home Healthcare: Medicare Advantage (MA) Plans compared to Traditional Medicare (TM)

A large team of investigators decided to determine if there was a difference in intensity of home-health care and outcomes when MA and TM beneficiaries were compared.[7] They examined the records of 285,000 patients treated from January 2019 through December 2022. The records were from 102 home-health locations in 19 states. The difference findings were as follows: MA patients were kept in home-health 1.6 days less than TM patients and received fewer medical visits. TM patients were 4% more likely to improve in self-care than MA patients. MA patients were 5 % more likely to be discharged into the community than TM patients.

The authors conclude that the cost-limiting within MA plans may produce shorter home-health stays. Earlier discharge into the community and less improvement in self-care of the MA patients may suggest that they are more dependent when discharged than TM patients. To me, these do not seem to me to be large differences between the two types of Medicare; however, taken with other differences in coverage, they might sway some beneficiaries to keep their TM plan.

Decision Aid and Tubal Sterilization of Pregnant Women

In my opinion, decision aids are a critical part of shared decision-making in preparation for the patient to effectively engage with her clinician if an invasive procedure is under consideration. An eclectic team of investigators tested the effectiveness of a decision aid for pregnant women who wish to consider tubal sterilization.[8] In 2020-2023, the investigators gathered 350 women between the ages of 21 and 45. They were randomly assigned to the control group or to the group receiving the decision aid.

The decision aid consisted of details (written, oral, and video) about the procedure of tubal sterilization, birth control options, and a checklist on values of the patient. The outcome measures were (1) *knowledge* measured by 10 true/false questions, and (2) *decisional conflict* using a standard scale. The decision-aid group scored an average of 76% on the *knowledge* test and the control group scored 56%. On the *decisional conflict* scale of 100 points the decision-aid group scored 13 points and the control group scored 19 points. Fewer points indicate less decisional conflict.

The purpose of my summary goes well beyond any intention to have anyone think about tubal sterilization options. The purpose is to illustrate how useful a thoroughly vetted decision aid can be in situations where a well-informed decision must be made by the patient.

Financial Toxicity Impacts Heart Failure Patients

An MD commented on a recent study of the relationship between the outcomes of heart failure and the financial burden placed on the person with heart failure.[9] In their primary analysis, of the hundreds of patients they studied, the mortality after 1 year was as follows: little economic burden, 13%; moderate economic 19%; and severe economic burden, 28%. The view that there was a cause-and-effect relationship was reinforced by the finding that 65% of those with severe economic burden avoided healthcare, whereas only 5% of those with little economic burden reported avoiding healthcare. The commenter noted that the findings suggest a feedback loop in which worsening heart failure and worsening economic burden work progressively together to produce more hospitalizations and an earlier death. It is as if financial toxicity suppresses

[6] https://www.mayoclinichealthsystem.org/hometown-health/speaking-of-health/children-and-screen-time

[7] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2815745

[8] https://pubmed.ncbi.nlm.nih.gov/38502127/

[9] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2816602

the positive effects of medications, especially if their cost contributes to financial toxicity. The expert suggests that we have a lot more to learn about the adverse effects of financial toxicity on health.

Ultra-processed Foods and Health

From *JAMA Medical News in Brief*: A massive analysis (9.9 million participants) of the relationship between consumption of ultra-processed foods, such as ready-to-eat meals, snacks, and sugary drinks, found an association with an enhanced risk of 30 different adverse health outcomes.[10] Not only was an earlier death associated with junk-food consumption, it was also associated with a higher risk of cardiovascular disease, type II diabetes, and mental health problems. The cause of the association may be failure to eat foods that contribute to better health outcomes or because ultra-processed foods contain lots of additives whose aggregate adverse effect may be unknown. The writer suggests that such foods should contain a warning label.

Interesting Links

Fake cancer research: https://www.vox.com/future-perfect/24086809/fake-cancer-research-data-scientific-fraud

The plundering of America's hospitals: https://www.businessinsider.com

Doctor hopping from one state to another after giving up license: https://www.kcra.com/article/former-vacaville-oral-surgeon-gets-license-in-idaho-less-than-year-after-surrendering-california-license/60128706

United Health Care is buying up physician practices to make $$$$: https://www.statnews.com/2024/03/11/

How government pays for Medicare Advantage Plans: https://www.commonwealthfund.org/publications/explainer/2024/

Common sense oncology in last weeks of life: https://www.cbc.ca/news/health/cancer-kingston-common-sense-oncology-1.7136127

Boarding in ERs is deadly (Forbes): https://www.forbes.com/sites/jessepines/2024/03/13/er-waits-for-hospital-beds-are-deadly-many-hospitals-arent-fixing-it/?sh=607e5af95a32

*John Oliver on Medical Boards (22-minute video): https://www.youtube.com/watch?v=jVIYbgVks7E

How to make medical devices safer: https://www.medtechdive.com/news/fda-medical-device-recall-improvements/710567/

Best and worst states for doctors: https://wallethub.com/edu/best-and-worst-states-for-doctors/11376

Steward's ownership team pays itself a $100 million dividend, and the CEO Ralph de la Torre buys a $40 million yacht: https://lowninstitute.org/steward-implosion-provides-cautionary-tale-on-private-equity-in-health-care/

Biden on women's health initiative: https://abcnews.go.com/Health/president-bidens-executive-order-womens-health-research/story?id=108239760

NATIONAL QUALITY FORUM MEMBER

Answer to the Question: (E) more than 30 health conditions. Reference #10

Find past newsletters: **http://patientsafetyamerica.com/e-newsletter/**

[10] https://jamanetwork.com/journals/jama/fullarticle/2816703