Medicare's Nonpayment for Hospital-Acquired Conditions

In 2008, Medicare implemented the Hospital-Acquired Conditions (HACs) Initiative, a policy denying incremental payment for 8 complications of hospital care, also known as “never events.” Using National Database of Nursing Quality Indicators data from 1381 US hospitals, Waters and colleagues examined changes in unit-level rates of hospital-acquired pressure ulcers (HAPUs), injurious falls, central line–associated blood stream infections (CLABSI), and catheter-associated urinary tract infections (CAUTI) before and after initiation of the policy. They found that the HACs Initiative was associated with improved trends in CLABSI and CAUTI but was not associated with improvements in HAPUs or falls. Umscheid and Brennan provide an Invited Commentary.

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Author Audio Interview  jamainternalmedicine.com CME  jamanetworkcme.com

Withholding & Withdrawing Life-Sustaining Treatments in Asia

Little data exist on end-of-life care practices in Asian intensive care units (ICUs). Phua and colleagues conducted a questionnaire survey on 1465 physicians who cared for patients in 466 ICUs in 16 Asian countries and regions. For patients with no real chance of recovering a meaningful life, 70.2% of respondents reported almost always or often withholding life-sustaining treatments, whereas 20.7% reported almost always or often withdrawing life-sustaining treatments; 74.5% deemed withholding and withdrawal ethically different. Attitudes and practice varied widely across countries and regions. Multiple factors related to country and region, including economic, cultural, religious, and legal differences, as well as personal attitudes, were associated with these variations. Koh and Hwee provide an Invited Commentary.

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Association Between Whole Grain Intake and Mortality Risk

Whole grains have been consistently recommended in dietary guidelines to facilitate the prevention of chronic diseases, such as type 2 diabetes mellitus and cardiovascular disease (CVD), although evidence is sparse and inconsistent regarding whether whole grains may also exert beneficial effects on mortality. Using data prospectively collected among more than 110 000 US men and women who participated in the Nurses’ Health Study and the Health Professionals Follow-up Study, Wu and colleagues found that higher consumption of whole grains was significantly associated with a lower total mortality, especially premature deaths due to CVD. Intake of bran, including bran added to diet, but not germ intake, was significantly associated with lower total and CVD morality in these 2 study cohorts. These findings further support increasing whole grain consumption to help achieve better health.

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**HEALTH CARE REFORM**

**ED Copayments Following the Deficit Reduction Act of 2005** 393

To provide states flexibility in administering Medicaid programs while containing costs, the Deficit Reduction Act of 2005 (DRA) gave states the authority to impose cost-sharing strategies including emergency department (ED) copayments for nonurgent visits. Siddiqui and colleagues used a difference-in-difference quasiexperimental approach to compare trends in ED use and use of primary care physicians (PCPs) among Medicaid beneficiaries from 2001 to 2010 using the Medical Expenditure Panel Survey. Despite the provisions of the DRA, ED copayments for nonurgent visits neither decreased ED use nor increased use of PCPs among Medicaid beneficiaries. Baicker and Levy provide an Invited Commentary.

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**Cumulative Use of Anticholinergics and Incident Dementia** 401

Many medications have anticholinergic effects. Although the general view is that anticholinergic-induced cognitive impairment is reversible, evidence suggests that these medications may be associated with increased dementia risk. Gray and colleagues conducted a prospective population-based cohort study in 3434 older adults to examine whether cumulative anticholinergic medication use is associated with increased risk of incident dementia. Using automated pharmacy data, they found that higher 10-year cumulative dose was associated with increased dementia and Alzheimer disease. In particular, people with the highest use were at greatest risk. Campbell and Boustani provide an Invited Commentary.

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**Sodium, Mortality, and Cardiovascular Events in Older Adults** 410

The role of dietary sodium intake on health outcomes in older adults is unclear. Kalogeropoulos and colleagues examined the association between baseline sodium intake and 10-year risk for death, cardiovascular disease, and heart failure in 2642 adults aged 71 to 80 years participating in the community-based Health, Aging, and Body Composition Study. Sodium intake was assessed by a food frequency questionnaire. In adjusted models, sodium intake was not associated with mortality, although 10-year mortality was nonsignificantly lower in the 1500- to 2300-mg group. In models accounting for competing mortality, sodium intake was not associated with risk for cardiovascular disease or heart failure.

**Diagnostic Testing Strategies in ED Patients With Chest Pain** 428

Patients presenting to the emergency department (ED) with chest pain whose evaluation for ischemia demonstrates no abnormalities commonly receive further functional or anatomic studies to detect coronary artery disease. Using logistic regression to conduct a retrospective analysis of 2011 Marketscan claims data, Foy and colleagues found that noninvasive cardiac testing was not associated with reduced odds of future myocardial infarction (MI) compared with no testing. Noninvasive cardiac testing, however, was associated with higher odds of cardiac catheterization and revascularization procedures. These findings suggest that noninvasive cardiac testing may lead to overuse of downstream testing and possibly to overdiagnosis of coronary disease in this patient population. Redberg provides an Editor’s Note.

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**Author Interview**

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