Achieving prevention and health, rather than more health care

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Rutgers is researching a new health care model that emphasizes primary

care and prevention over emergency care in underserved communities

If more people have access to health insurance, we have to be sure the death rates of those with certain chronic conditions are decreasing.

This is one of the statements Gregory Peck, an acute care surgeon and associate professor at Rutgers Robert Wood Johnson Medical School, will be researching on behalf of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) at the National Institutes of Health.

Peck recently published two studies investigating death rates for gallstone disease, a disease of the abdomen that causes right-sided belly pain after eating, which share risk factors with other deadly diseases. His study, published in *Gastro Hep Advances*, found that between 2009 and 2018 the number of deaths of people in New Jersey with diagnosed gallstone disease (1,580) remained steady and did not improve, and that deaths in Latinos ages 65 and older potentially increased.

His study in the *Journal of Surgical Research* found that after Medicaid expansion in 2014 as compared to before, the amount of emergency surgery to remove the gallbladders for gallstone disease decreased in the state overall, but increased in people with Medicaid. While fatality from gallbladder removal surgery decreased for those 65 or older, there was increased death from surgery in the younger population and a trend of more death in the population with Medicaid. Further, the relatively decreased amount of gallbladder removal surgery occurring in ambulatory outpatient care centers did not necessarily help this.

Peck discusses the implications of the findings on a new shift in health care to prevention model.

Why did you focus on gallstone disease?

As a metabolic disease, gallstone disease is also linked to heart disease, cancer, diabetes, obesity and a sedentary lifestyle. In fact, heart disease, which is the No. 1 killer in America, and gallstone disease, which is the No. 1 digestive disease requiring surgery in America, share the risk factors of high levels of bad cholesterol type and obesity.

How do these studies inform public policy?

The amount of people dying with gallstone disease—most of whom require surgery—over the past decade has not gotten better. That's 160 people a year who still are dying from a preventable death such as gallstone disease. Making progress is what this type of epidemiologic study focuses on, and concerningly, we might not have made good progress.

If Medicaid expansion didn't positively affect the death rate of people with gallstone disease and we see it increase specifically in older Latino populations, we need to be asking if we are helping people of color and those who live in communities with lower socioeconomic status improve health or treating them sooner to prevent emergency surgery and especially decreasing death from emergency surgery. Insurance expansion is certainly needed, but we have to ensure the action specific pieces of policy impact the population requiring surgery in a patient-centered way.

The real goal is preventing the disease from even occurring. When we pass public health policy, we need to advocate for preventive care that reaches people through their community. Right now, the findings show that we might just be providing people with insurance cards who find themselves still needing to use the emergency department. Instead, that insurance should help them visit their primary care doctor, who can help them make changes like decreasing their bad cholesterol levels, which

contribute to gallstone disease, and help them access care in ambulatory surgery centers sooner.

We need to cultivate preventive health care rather than ballooning the investment in emergency health care, which does not solve current inequities.

What other steps to improve access to care should be taken?

We propose a novel population health approach that shifts from the reactive treatments of emergency disease to proactive prevention. One place to start is increasing access to appropriate outpatient elective health care for underrepresented groups with barriers to preventive care, such as by increasing health insurance that incentivizes the behaviors toward improved health. A first step for my research group is to focus on diseases that currently require as much emergency as elective care, such as gallstone disease, and understand this by understanding who presents to the hospital, as to dial this back into the community level, to decrease hospital care.

In addition, in primary care, laboratory, radiology or ambulatory care settings we need to improve communication with people with low English proficiency—especially how well prevention is explained in a patient's primary language. Language barriers might also prevent them from understanding the importance of cholesterol or blood pressure control over the one, two and three decades of life, or how they find access to diagnostic tests or treatment needed earlier.

More information: Gregory L. Peck et al, Ten-Year Trends of Persistent Mortality with Gallstone Disease: A Retrospective Cohort Study in New Jersey, *Gastro Hep Advances* (2023). DOI:

10.1016/j.gastha.2023.03.023

Gregory L. Peck et al, Decreased Emergency Cholecystectomy and Case Fatality Rate, Not Explained by Expansion of Medicaid, *Journal of Surgical Research* (2023). DOI: 10.1016/j.jss.2023.03.006