PSA

Patient Safety America Newsletter

July 2022 http://PatientSafetyAmerica.com John T. James, Ph.D.

Question: From 2000 to 2018 how has the prevalence of prediabetes changed in US youth?
A) unchanged B) 50% up C) 100% up D) 150% up E) 200% up

Repeated Hurricanes and Mental Health

I live in a suburb of Houston that is about 25 miles from the Gulf of Mexico. This time of year – hurricane season – we keep an eye on happenings that could lead to a hurricane or tropical storm coming our way. Thus, an article caught my eye that asked whether repeated hurricanes in Florida impact mental health.[1] Studies have shown that there are mental health effects after a serious hurricane, but the investigators in this study asked about repeated hurricanes as impacting mental health. They used a post-traumatic stress symptoms (PTSS) tool to assess mental health 60-hours before and after hurricane Irma in 2017, and after hurricane Michael in 2018. They used a survey population that was known to be representative of Florida residents. Roughly 1100 to 1600 Floridians responded to each of the three surveys.

The factors most associated with PTSS before and after Irma were as follows: prior mental health, prior hurricane loss or injury, media coverage of the hurricane, being in an evacuation zone and not evacuating, and loss or injury from the hurricane. The same pattern persisted for those surveyed after hurricane Michael. Functional impairment resulted from the 'double dose' of hurricanes. The authors opine that repeated natural disasters may lead to the need for more mental health interventions. My message to readers is to not be hesitant to seek mental health services if you have been painfully affected by a natural disaster.

Increasing Prediabetes in American Youth

One way or the other, most of us have youths in our lives. It may not be our responsibility to help manage their health, but at times this may be needed. A group of Chinese and American investigators published a research letter in *JAMA Pediatrics* in which they asked whether the diagnosis of prediabetes has changed in American youth from 1999-2000 to 2017-2018.[2] They defined prediabetes as an A1c of 5.7 to 6.4 and a fasting plasma glucose of 100 to 125 mg/dL. They used the NHANES database, identifying 6600 youths aged 12-19 for their analyses. They found that the prevalence of prediabetes increased from 12% to 28% over the years covered by their analysis.

Demographically, they found as follows: the increase in males was from 16% to 36%, among females the increase was from 7% to 20%, among those underweight or normal weight the increase was from 9% to 24%, among those youth that were overweight, the prevalence increased from 15% to 28%, and in obese youth from 18 to 40%. The authors note that since they did not have access to glucose tolerance data, they may have underestimated the prevalence of prediabetes. The message is clear. We adults are not encouraging our youth into healthy behaviors that reduce their risk of diabetes.

[1] https://pubmed.ncbi.nlm.nih.gov/35708689/

[2] https://pubmed.ncbi.nlm.nih.gov/35344013/

Are you a Victim of Diagnostic Inequity?

A PhD nurse educator at The Center for Diagnostic Excellence of the Armstrong Institute for Patient Safety and Quality in Baltimore wrote about how to erase diagnostic inequities by making excellence in diagnosis uniform regardless of one's potential for inequitable care.[3] Diagnostic inequities may be present because of many factors to include the following: race, ethnic group, residence location, income (insurance status), age extremes, disabilities, language used, gender, and sexual orientation. The fundamental question is how to iron-out all the inequities. The author rightly argues for a system approach rather than focusing on individual encounters. The National Academy of Medicine has declared that such a system must have three features: the diagnostic framework, the diagnostic process, and feedback on outcomes to facilitate learning. The importance of patient reporting was noted. Moreover, the importance of what happens outside the system must be considered. The call is for better engagement with those who are at risk for diagnostic inequity.

As a reader of this stuff, you may ask, 'So what am I supposed to do?' Your first role is to know how to ask questions and get complete answers when your clinician is pursuing your diagnosis. A good question might be this, 'How many of my symptoms and abnormal clinical measurements are attributable to your proposed diagnosis?' Your second role involves feedback. If your physician got your diagnosis right, then thank him. If he got it wrong or it was delayed, then make sure he is aware of this outcome and how it has affected your health.

Do Armed Guards Deter Mass Shootings in Schools?

Three PhD's sought an answer to the question above to improve insight into how to deal with mass shootings in schools.[4] They identified 133 such shootings in the years from 1980 through 2019. Some of the ancillary findings were interesting to me. The age range of shooters was 10 to 53 years old, but only 11% were older than 22 years. Seventy percent were students and 15% were former students. Seventy six percent were white and 98% were male. The average number of people killed by weapon type (where known) was as follows: assault rifle or submachine gun – 5.36, handgun – 1.45, shotgun – 1.79, and rifle – 0.87. The average number of people killed if an armed officer was present in the school was 2.83 times the average number when an armed guard was not present.

These data strike me as the basis for a reasonable discussion about the value of miliary style weapons vs. their value in any situation other that where the user intends to kill people. Thinking that an armed guard is a deterrent may be wrong.

Suicide and Medicaid Expansion

Under the Affordable Care Act, states had the option of expanding Medicaid coverage to people that traditionally have not qualified because their income is just over the cutoff. Most states have expanded Medicaid coverage. Texas is one that has not expanded it. A team of investigators asked if there was an association between the suicide rate and whether a state had expanded Medicaid. An association was expected because expansion states would have more mental health coverage available to those struggling to stay out of poverty.

The investigators followed suicide rates from 2000 through 2018, noting the rate changes when states expanded Medicaid coverage.[5] More than 550,000 deaths by suicide were noted in the National Center for Health Statistics databased for people aged 20 to 64. Ninety percent were in whites and 78% were males. Comparing the suicide rates for expansion states (2.56/100,000) to non-expansion states (3.10/100,000), the authors deduced that from 2015 through 2018 about 1818 deaths by suicide were prevented by states expanding Medicaid. The authors observe that suicide prevention is a benefit of mental health expansion.

End-of-Life Racial Disparities in Dementia Care

In general, the US is doing some long-overdue soul searching to identify racial disparities across the spectrum of life. Healthcare researchers have targeted many studies toward discovering and rectifying racial disparities in healthcare. An invited

[3] https://pubmed.ncbi.nlm.nih.gov/35522307/

[5] https://pubmed.ncbi.nlm.nih.gov/35704315/

commentary in *JAMA Open* described background data and then commented on recent findings about end-of-life care for those with dementia.[6] For example, black and Hispanic patients more often lack advanced care planning. Unfortunately, Blacks and Hispanics seem to have a higher rate of dementia than whites and are less likely to engage hospice care.

There are many possible explanations for this apparent disparity; however, the authors point out that equitable care does not necessarily mean identical care utilization. In my opinion, making important decisions about end-of-life care must be done at the individual level. Regardless of one's racial and ethnic background, the 'system' should make shared decision-making the hub of where decisions are made. Opportunities for that should be equitable.

Mitigating Diagnostic Errors

A study from a few years ago found that roughly 12 million Americans are misdiagnosed each year as outpatients. We patients have a role in helping to fix this problem. First, allow me to summarize a commentary on ways to improve the efficiency of medical diagnosis.[7] By 'efficiency' it is meant that clinicians find the most direct route of testing and evaluation that leads to a sufficiently accurate diagnosis. Diagnostic errors involve diagnosing a patient with something they do not have or missing a diagnosis of an illness they have. The process of diagnosing a patient may require invasive tests that involve risk. The key question is, 'What is the chance the patient has a specific disease and what are the consequences if it is not diagnosed in a timely fashion?'

Clinicians must be able to access appropriate information and integrate complex data to make an accurate diagnosis. The authors call for better tracking of missed or delayed diagnosis. In my opinion, this is where the patient enters the picture. If you discover that you were misdiagnosed or a diagnosis was not made in a timely way, then persuade the physician that revealed that to you to communicate with his colleague who misdiagnosed you. Follow up to ensure that this was done. Missed diagnosis is often the cause of malpractice suits, so reporting to a physician that he misdiagnosed a patient may be awkward. There are already electronic assist devices to help physicians get it right the first time.

Assessing Visual Acuity in Older Adults

Anyone of Medicare age or older knows well that their eyesight is not as good as it once was. The US Preventive Services Task Force (USPSTF) has just 'ruled' on the suitability of screening older adults for loss of visual acuity, finding a recommendation of 'I,' which means that the evidence for doing this is inconclusive. An ophthalmologist (presumably) wrote her views on the USPSTF conclusion in *JAMA Ophthalmology*, noting that there was no ophthalmologist among the 16 experts making the recommendation.[8] She notes that when the USPSTF renders a rating of A or B, the Affordable Care Act requires that the service be covered by insurance without any out-of-pocket cost. She discusses several points made in the evidence document for the rating of I, noting that it lists three causes of loss of visual acuity – macular degeneration, cataracts, and refractive error. She writes that evidence in all three cases clearly points to the value of treating each of these vs. no treatment. Simple screening may miss glaucoma and diabetic retinopathy.

Although the author never explicitly states her view that the I recommendation is wrong, my sense is that this is what she believes. She favors a complete eye examination over a visual acuity screen, but the latter has some value if performed by a well-trained person.

Adenoma Detection During Colonoscopy

Adenomas are considered a precursor lesion to colon cancer, so their detection and removal during a colonoscopy is important. An expert wrote that many clinicians, and therefore many patients, are not aware that the quality of colonoscopy is highly operator dependent.[9] The worst performing operators miss 90% of adenomas. The measure is

[6] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2793180

[7] https://jamanetwork.com/journals/jama/article-abstract/2792808

[8] https://jamanetwork.com/journals/jama/fullarticle/2792705

[9] https://pubmed.ncbi.nlm.nih.gov/35670806/

called the adenoma detection rate (ADR). Physicians with a higher ADR have been shown to produce a lower risk of post-colonoscopy colon cancer. Noting that less skilled operators continue to miss too many adenomas, the author calls for public transparency into the ADR of each operator so that low-performing physicians can be identified and trained. The USPSTF now recommends screening for colon cancer at the age of 45 years.

If I were a person that had decided I needed a colonoscopy, I would declare to my potential physician operator that I have read about adenomas being a precursor to colon cancer. Therefore, I wonder how often you have been able to detect adenomas when you perform a colonoscopy. My point here is to place the concern on your worrisome nature and not on the fact that you have no idea how capable the operator may be at finding adenomas.

Links of Interest

How to reform the Centers for Disease Control and Prevention:
https://www.healthaffairs.org/do/10.1377/forefront.20220608.696952

Feds want to hide hospital safety during COVID:
https://www.inquirer.com/health/medicare-surgery-complications-philly-hospital-safety-20220615.html

Physician sexual misconduct (PSAN):
https://www.patientsafetyaction.org/

Looking for doctor information online:
https://www.patientsafetyaction.org/wp-content/uploads/2022/03/Looking-for-Doctor-Information-Online-1-7-22.pdf

Summary of OIG findings on harm of Medicare patients in hospitals:
https://www.statnews.com/2022/06/16/patient-safety-gains-stalled-over-past-decade/?utm_source=STAT+Newsletters&utm_campaign=12058f3096-Daily_Recap&utm_medium=email&utm_term=0_8cab1d7961-12058f3096-150553369

Overhaul US public health system:
https://news.yahoo.com/citing-disastrous-pandemic-response-expert-120718886.html?guccounter=1&guce_referrer=aHR0cHM6Ly93ZWJtYWlsMS5lYXJ0aGxpbmsubmV0Lw&guce_referrer_sig=AQAAAIxXLknYTzCxKDe6L3cJ-z5RetIImcXg-HNiwSXzAUqdpzQ4epVqqNrGLv4g2xOJElzgampmrXF4JLGJiNdlvNmskg2Q83AJ0TBnuphOptVYUrdAG8y86bxARwclC0Y34yiICblJqninSGqi0r5Kl2jZVCBw8KxOakJJy4tcBkdy

Excellent video on medical boards failing to inform patients about sanctioned doctors:
https://www.youtube.com/watch?v=2Axtr17lRyg

Feds plan to keep secret the hospitals that gave COVID to their patients:
https://www.politico.com/news/2022/06/25/biden-officials-to-keep-private-the-names-of-hospitals-where-patients-contracted-covid-00042378
Pharma's marketing of diabetes drugs:
https://www.reuters.com/investigates/special-report/usa-diabetes-overtreatment/

Are drug regulators for hire in the USA?
https://www.bmj.com/content/377/bmj.o1538.full?ijkey=jPIowyCkUJwciSR&keytype=ref

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http://patientsafetyamerica.com/e-newsletter/

Answer to question: best answer is 'E.' The true increase is 230%, reference #2.