LOUISIANA HOSPITAL ASSOCIATION
MALPRACTICE AND GENERAL LIABILITY TRUST

A CLOSER LOOK AT MEDICINE MARCH | 2017

eNSIGHTS

Colorectal

Cancers decline in older adults

The rate at which people are diagnosed with colon and rectal cancer, and the death rates from these cancers, dropped nearly 33% from 2000 to 2013 for those aged 50 years and older, according to a report from the American Cancer Society.

The report credits the drop in part to screening, and the group says even more deaths could be avoided with widespread and timely screening. Colon and rectal cancer combined is the third most commonly diagnosed cancer in both men and women in the U.S. Estimates indicate this year nearly 135,430 people will be diagnosed with colorectal cancer and 50,260 people will die from the disease.

Rates of colon and rectal cancer vary by age, race, and ethnicity. Rates are highest among older people and in non-Hispanic blacks, and lowest in Asian Americans/Pacific Islanders. The cancer society says higher rates among non-Hispanic blacks are thought to be largely because of low socioeconomic status, which is linked with obesity, unhealthy diet, smoking, and lower rates of screening.

Dr. H. Gilbert Welch, a professor of medicine at Dartmouth and a prominent critic of cancer screening, says while colonoscopies probably helped in reducing cancer deaths the declines are so substantial other forces may be at work. He notes that overall colorectal-cancer incidence has dropped by almost 40% since 1975 and by more than 45% since its peak in the mid-1980s.

"The magnitude of the changes alone suggests that other factors must be involved. None of the trials of colorectal-cancer screening has shown a 50% reduction in mortality – nor have trials of screening for any type of cancer," he wrote last May in the **New England Journal of Medicine**.

Colorectal

Cancers rise in young adults

The incidence of colorectal cancer is increasing among young adults, while declining rapidly overall, according to a recent study in the **Journal of the National Cancer Institute**.

Colon cancer incidence rates have increased by 1.0% to 2.4% annually since the mid-1980s in adults age 20 to 39 years, and by 0.5% to 1.3% since the mid-1990s in adults age 40 to 54 years. Rectal cancer rates rose at about 3% per year for people in their 20s and 30s, and 2% annually for those ages 40 to 54.

As a result, three in ten new cases of rectal cancer now are diagnosed in patients younger than 55 – double the proportion in 1990. American Cancer Society researcher Dr. Rebecca Siegel, who led the study, told the **Washington Post** the magnitude of the increase identified "was just very shocking."

In interviews with other media outlets, she explained the trends indicate people born in 1990 have double the risk of colon cancer and quadruple the risk of rectal cancer compared to the risk someone born in 1950 faced at a comparable age. She suggested one explanation might be a complex interaction involving the same factors that have contributed to the obesity epidemic – changes in diet, a sedentary lifestyle, excess weight, and low fiber consumption.

But the truth is nobody knows for sure why there is an increase, says Dr. Mohamed Salem, an assistant professor at Lombardi Comprehensive Cancer Center at Georgetown University. "It's hard to blame it on obesity alone. We suspect there is also something else going on," he commented to the **New York Times**.

In any event, the recent findings are ominous, notes Dr. Siegel, strategic director of surveillance information service at the American Cancer Society. "Trends in young people are a bellwether for the future disease burden. Our finding that colorectal cancer risk for millennials has escalated back to the level of those born in the late 1880s is very sobering," she says.

"Educational campaigns are needed to alert clinicians and the general public about this increase to help reduce delays in diagnosis, which are so prevalent in young people, but also to encourage healthier eating and more active lifestyles to try to reverse this trend," she added.

Some observers emphasize that although the incidence of colorectal cancer in young people is on the rise it remains very low. The disease will be diagnosed in just one in 100,000 people in their 20s compared with about 50 in 100,000 people in their early 60s.

inside

2 Retail clinics draw more patients
3 Designed for comfort?
4 Do patient-advocacy groups speak for patients?

LOUISIANA HOSPITAL ASSOCIATION
MALPRACTICE AND GENERAL LIABILITY TRUST
eNSIGHTS
A CLOSER LOOK AT MEDICINE
MARCH | 2017

A view from afar

Retail clinics draw more patients

Visits to retail health clinics nearly doubled over the past five years among commercially insured Blue Cross and Blue Shield members, increasing from 12.2 visits per 1,000 members to 24 per 1,000 members.

The insurance company notes that while visits to retail clinics grew nearly 20% annually over the past five years, visits to physician offices or hospital emergency rooms increased less than 1% annually over the same period. The group estimates that as many as 30% of ER visits could be treated in retail clinics.

Despite growing use, the level of utilization of retail clinics is still low compared to other acute outpatient care settings, at less than 1%. This is because of the much-smaller number of retail clinics compared to the number of physician offices and other urgent care settings.

Blue Cross and Blue Shield says prices for retail clinic visits are significantly lower than ER charges and slightly less expensive than charges for an office visit. "Despite the price differences, the quality of care for the conditions most commonly treated in retail clinics has been shown to be at least as good as what is provided in traditional settings. As such, most health insurance plans cover retail clinic visits," the company notes.

It adds that while consumers are concerned about the lack of continuity of care at retail clinics they appreciate the prompt care and lower prices. CVS Health, which had only 640 clinics in 2012, now operates more than 1,100 clinics. A company spokesman says CVS hopes to ultimately expand to 1,500 clinics.

eNSIGHTS is produced bi-monthly by
LHA MALPRACTICE & GENERAL LIABILITY TRUST | LHATrustFunds.com

Developed and written by: Mobashir Salahuddin
msalahuddin@sc.rr.com

To be added to our distribution list, please contact
Angela Caston, 225.368.3802
angelacaston@LHATrustFunds.com

On the horizon

Hospital floors pose infection risks

Researchers report floors in patient rooms are often contaminated with methicillin-resistant *Staphylococcus aureus* (MRSA), vancomycin-resistant enterococci (VRE), and *C. difficile* infection (CDI). *C. difficile* was the most frequently recovered pathogen in both CDI isolation rooms and non-CDI rooms.

Infection control professionals warn hospital room floors may be an overlooked source of infection, and caution that because items in the patient's room may touch the floor, pathogens there can rapidly move to the hands and to frequently touched surfaces in the room.

The study was published in the March issue of the **American Journal of Infection Control**, the official journal of the Association for Professionals in Infection Control and Epidemiology (APIC). "Understanding gaps in infection prevention is critically important for institutions seeking to improve the quality of care offered to patients," said 2017 APIC president Linda Greene, RN, MPS, CIC, FAPIC.

"Even though most facilities believe they are taking the proper precautions, this study points out the importance of ensuring cleanliness of the hospital environment and the need for education of both staff and patients on this issue," she said.

Researchers cultured 318 floor sites from 159 patient rooms (two sites per room) in five Cleveland-area hospitals. The hospital rooms included both *C. difficile* infection isolation rooms and non-CDI rooms. Researchers also cultured hands (gloved and bare) as well as other high-touch surfaces such as clothing, call buttons, medical devices, linens, and medical supplies.

Of 100 occupied rooms surveyed, 41% had one or more high-touch objects in contact with the floor. These included personal items, medical devices, and various supplies.

Elderly on more psychotropic drugs

The number of Americans age 65 and older taking at least three psychiatric drugs increased significantly between 2004 and 2013, even though almost half of the patients had no mental health diagnosis, according to a recent analysis in **JAMA Internal Medicine**.

Nearly 46% of the elderly with at least three prescriptions had no diagnosis of a problem with mood, chronic pain, or sleep. Researchers looked at office visits that resulted in the prescribing of at least three psychiatric, sleep, and pain medications (such as Valium, Prozac, OxyContin, and Ambien).

The overall number of such visits increased to 3.68 million in 2013 from 1.5 million in 2004 – nearly a 150% increase, partly because the population is aging but mostly because of polypharmacy.

"I was stunned to see this, that despite all the talk about how polypharmacy is bad for older people, this rate has doubled," commented Dr. Dilip Jeste, a professor of psychiatry and neurosciences at the University of California, to the **New York Times**.

Researchers reported the biggest jump in prescriptions was in rural areas, and said that might suggest doctors and patients are relying on medications because they don't have access to other options, such as talk therapy and stress management.

The **New York Times** reported that despite recent warnings from federal officials about the risks of combining sedatives with opiates, those prescribed opiates were as likely to be on at least two other drugs than those not taking opiates.

Designed for comfort?

In a celebrated essay titled *Anatomy of an Illness*, the journalist Norman Cousins described his experience in a hospital 50 years ago as he recovered from an illness. Although he was hospitalized in 1964, some of his observations still ring true as became evident recently when almost 200 patients wrote to the **New York Times** about their stay in a hospital.

The readers were responding to a February 22 piece by Harvard physician Dr. Dhruv Khullar on how poorly designed hospitals impede patients' recovery. He noted the spread of infections from one patient to another in semi-private rooms, the lack of privacy as doctors discuss a patient's medical history within earshot of the roommate, and the risk of falls because of poorly lit rooms, slippery floors, or because toilets are too high or too low.

Then there is the matter of noise – the alarms from IV pumps, the beeping of heart monitors, sounds of distress from patients, and the hustle and bustle and conversations of healthcare workers. No wonder patients complain they can't sleep, and little surprise at the near-universal agreement long ago when Cousins wrote "I had a fast-growing conviction that a hospital is no place for a person who is seriously ill."

Even 50 years ago, the multitude of lab tests a patient had to endure was beyond the capacity of some. "I was astounded when four technicians from four different departments took four separate and substantial blood samples on the same day," wrote Cousins. He refused, and insisted they coordinate their activities. Even as an experienced observer, Cousins commented he was surprised at the "regularity with which hospital routine takes precedence over the rest requirements of the patient."

Of course much has changed since then. A number of readers pointed out that Dr. Khullar appears to be working in an antiquated facility as private rooms are now the norm, and acoustics and aesthetics are much better in modern hospitals.

To cite only a few improvements: low-level lighting under the bed and on the wall below the handrail to help improve safety; beds which can be lowered to 16" off the floor to help prevent falls, and which contact the nurse if a high-risk patient gets out of bed. Also, pressure-relieving mattresses, and beds with a built-in weighing scale.

Hospitals have also invested in sound-absorbing materials in corridors and patient rooms. Paging in hospital buildings is limited to emergencies, and in many new facilities the flooring and privacy curtains have antibacterial properties.

What was surprising in the comments in the **New York Times** was how much has not changed. One reader mentioned "the constant procession of hospital workers who come in to wake you up to check your vitals, empty the wastebaskets, install gadgets for your hospital bed, bring trays of food, get you to sign billing forms, offer you marketing surveys, read your chart, and on and on and on. Hospital procedures make it almost impossible to rest in a hospital."

Another reader noted the following annoyances: "I know that a hospital cannot cater to each individual's schedule, but is it really necessary to check my wife's weight at 1:30 a.m. and perform a chest x-ray at 4:30 a.m.? Is it necessary for all of the myriad of machines she was tethered to, to constantly beep, beep, and buzz, buzz, buzz when an electronic signal is going to the nurses' station. The cumulative effect on someone who was critically ill was almost no sleep...and that is not trivial."

Noise in and around patient rooms consistently gets the worst marks on patient surveys conducted by CMS. Nationwide, only 62% of patients report the area around their room was always quiet at night.

It seems unlikely patients' expectations can always be reconciled with the imperatives of medical care. Patients grumble about being woken up for vital signs and lab tests but they are in the hospital because they need to be monitored, and lab tests have to be drawn in the wee hours so the results can be back in time for early morning rounds by physicians.

Even so, hospitals are trying hard. An experienced patient who is also a patient-advocate noted "in my recent hospital experiences, food is much improved and can be ordered as needed, like hotel room service. All rooms are private. Patient rooms are more comfortable. All huge improvements."

Indeed, the newer hospitals are marvels all right, with private rooms, art on the walls, music in the lobby, windows with views of nature, and even soothing waterfalls. But there is this too: rooms with a shared toilet, and patient rooms which seem no bigger than 9' x 11' cells because of the partitioning wall which constricts space but does little to afford privacy.

A reader wrote he was in an ICU a few weeks ago and was astounded to discover there was no private toilet. Several readers observed that even now many communities have old, primitive hospitals and there's no escaping the reality that patients' hospital experience depends upon where they live.

Warnings over drugs used for hepatitis C

The U.S. Food and Drug Administration is warning that patients with a past or current hepatitis B virus infection can experience sometimes fatal HBV reactivation if they take any of nine direct-acting antivirals for hepatitis virus C infection.

"As a result, we are requiring a *Boxed Warning*, our most prominent warning, about the risk of HBV reactivation to be added to the drug labels. This warning will also be included in the patient information leaflet or Medication Guides for these medicines," the FDA says.

The agency says healthcare professionals should screen all patients for evidence of current or prior HBV infection before starting treatment with direct-acting antiviral drugs, and monitor

Continued on page 4

Continued from page 3: Warnings over drugs used for hepatitis C

patients using blood tests for HBV flare-ups or reactivation during treatment and post-treatment follow-up.

The FDA added the complications are coming to light now, after widespread use of the drugs, because clinical trials for the hepatitis C drugs excluded patients with HBV co-infection. These patients were excluded in order to specifically evaluate the safety of direct-acting antivirals, including their effects on the liver, in patients infected with only HCV and without the presence of another virus which affects the liver. The FDA warning, issued in October 2016, described 24 cases of hepatitis B reactivation, including three cases of acute liver failure. In January 2017, the Institute for Safe Medication Practices reported that its more-comprehensive research of databases had identified 524 reported cases of liver failure associated with the drugs, and another 1,058 reports of severe liver injury.

Do patient-advocacy groups speak for patients?

Nearly 85% of large patient-advocacy organizations receive financial support from drug companies, medical device manufacturers, and biotechnology firms, and executives from these groups often serve on their governing boards.

"If you're a policymaker and you want to hear from patients, there's a danger if there's an undisclosed or under-disclosed conflict of interest. The 'patient' voice is speaking with a pharma accent," says Dr. Matthew McCoy, primary author of the analysis published in the **New England Journal of Medicine**.

Researchers say it is difficult to get a precise measure of industry support because patient advocacy groups are fuzzy in how they disclose the contributions. "Half of the organizations disclosed their donations in ranges rather than precise amounts, and most of those reported their highest donations with an unbounded upper range," according to **Kaiser Health News**.

Also, pharmaceutical companies might funnel money to patient advocacy groups through other non-profits, which would be harder to trace. "A patient organization may have gotten $1 million from the Making People's Lives Better Fund…That second degree of interrogation is not something we captured," Dr. McCoy said.

On the other hand, since the study focused on patient advocacy groups that receive at least $7.5 million in revenue each year it is likely it overstates support from the industry, as there may be large numbers of small groups that do not receive any support.

Observers note the interests of drug manufacturers and patients are not always the same: patients want cheaper medicine; the pharmaceutical industry wants to maximize revenue. Patients want information about the efficacy of certain drugs; the industry often seeks faster approvals for drugs.

In a separate development, **Kaiser Health News** reports the federal government is scrutinizing financial support provided by drug manufacturers. Pfizer has disclosed it has received a subpoena related to its support of patient advocacy programs that offer financial assistance for Medicare patients' co-pays.

Johnson & Johnson has also said it has received a subpoena seeking information about its support of organizations that pay for patient assistance. Those follow similar subpoenas sent to four drug makers in 2015 and 2016 – Gilead Sciences, Jazz Pharmaceuticals, Valeant Pharmaceuticals, and Biogen.

U.S. officials have not commented about the probe. But they could be trying to assess whether drug makers are covering patients' co-pays for expensive drugs and leaving taxpayers with the bill for the remainder of the cost, said Joel Hay, professor of pharmaceutical economics and policy at the University of Southern California.