Quality Measures, Clinical Practice, NCCN, and McAllen, Texas

The most important recent publication on health care in the United States can be found in the June 1 The New Yorker magazine, in an article by Dr. Atul Gawande of Brigham & Women's Hospital (available at: http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande?yrail). Dr. Gawande spoke with locals about health care in McAllen, Texas—a town notable for spending more per capita on health care than the average resident earns in a year. He made a quick diagnosis: health care costs are high in McAllen because of the most expensive piece of medical equipment—the doctor’s pen!

That is, expenses are high because clinicians order and deliver a lot of health care services, many of which may not be needed. The result is not necessarily better health but simply higher costs. The White House is reportedly paying close attention to Dr. Gawande's article as the administration embarks on health care reform.

Doctors may have several reasons for over-ordering medical services, including insecurity in medical judgment, misunderstanding proper care algorithms, patient demand, the desire to “do right” by patients, excess supply of available medical services, and personal financial gain.

In light of this article, data in the paper by Foster et al. in this issue of JNCCN (page 712) are illuminating. The authors created a series of hypothetical case management questions and asked oncologists to state the next treatment or evaluation. The study reports that oncologists often made guideline-consistent choices but also suggests that these same oncologists frequently order unnecessary tests (such as staging PET, chest imaging, and laboratory tests to determine menopausal status or measure tumor markers) that the guidelines make straightforward statements against ordering. Conversely, some procedures endorsed by NCCN guidelines—placement of a clip in the breast before neoadjuvant chemotherapy, for example—were too often neglected.

The point is not that guideline–based care should be driven by cost, but that guidelines can create the opportunity for better care and that “better care” can include doing less, not more, toward “medicalizing” patients. Well-crafted guidelines that delineate what should not be done are every bit as valuable to clinicians and patients as those that note what should be. By providing clear justification—“cover”—for not ordering unnecessary tests, guidelines can be a fortifying tonic to clinicians, payors, and regulators seeking to set reasonable limits on health services. Someone must draw the line, and for the highest quality care, the best people to do that are the kinds of clinical experts that comprise the NCCN panels.

At the same time, the article by Foster et al. highlights the fact that clinicians don’t always follow recommendations. Adherence to the guidelines requires 2 key actions from clinicians: knowing the guidelines and then practicing in accord with them. Effectively disseminating the guidelines and encouraging concordance is a huge challenge. Clinicians are creatures of habit, and changing habits to provide more or less treatment or evaluation is daunting. Further, practice-changing behavior cannot happen if the clinical team is not familiar with the guideline at baseline.

We need registry-type data to chart the actual practices of clinicians and patients, to see whether and how much their real-world behaviors are concordant with guidelines. Insurance companies, Medicare, and organizations such as NCCN are tracking those data in many clinical instances. The hypothetical situations crafted by Foster et al. are valuable for divining the other gap in compliance—familiarity. By understanding where clinical teams are aligned with guidelines and where they are not, we can begin to raise the bar. We can focus education, outreach, and awareness efforts on the most profound deficiencies and those likely to have the greatest impact on clinical outcomes and cost.

Readers of the article by Foster et al. will quickly appreciate several “dos and don’ts” of managing early-stage breast cancer. That awareness could save costs from coast to coast; maybe even in McAllen, Texas.