Choosing Wisely

Clinical integration is changing healthcare

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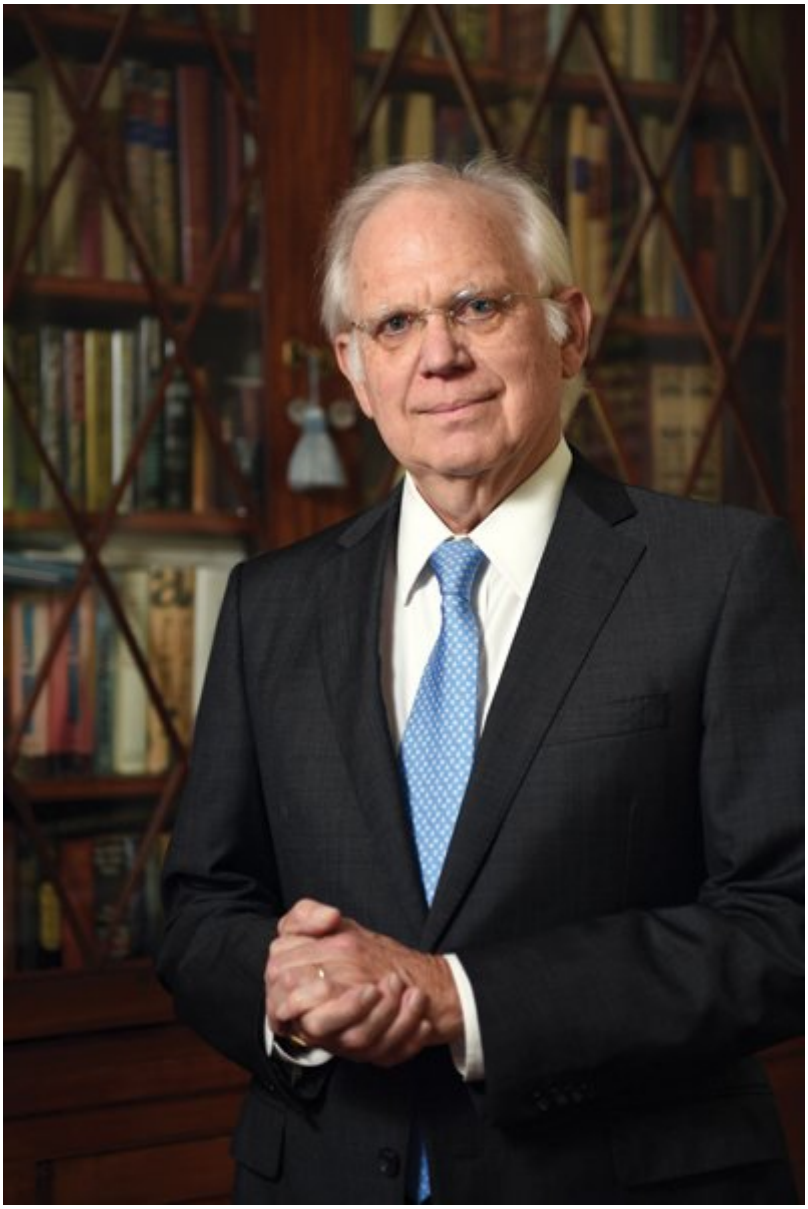

CHERYL GERBER PHOTOGRAPH

Quality of care, coordination of care and cost of care are center stage in medicine these days. Dr. Jeffrey Griffin stepped up to help New Orleans and Louisiana gain status for quality and affordable healthcare.

“We started this thing as an East Jefferson effort in 2007. After visiting a program in Texas, we got local doctors engaged, an essential mandate,” says Griffin, a local colon and rectal surgeon who doesn’t just keep his eye on rear ends.

Dr. Griffin was a founding father and currently heads the regional board of managers for “this thing,” which is the Gulf South Quality Network. It is all about bringing private practice and employed physicians together with hospitals to improve the quality of cost effective healthcare.

Griffin hit a homerun. The Gulf South Quality Network has grown from 370 physicians in 2010 to some 3,000 Louisiana physicians today. It has become the largest clinically integrated network in Louisiana. It blankets the state from Lake Charles to New Orleans and north to Alexandria. Locally the network includes the East and West Jefferson hospitals, Touro, Tulane, Children's, Lakeview and the Louisiana Heart Institute.

The other major network in the state is run by Ochsner, the largest employer of physicians in Louisiana. Its clinically integrated network allows them to bring non-Ochsner employed physicians into their fold. Adding private practice physicians in its network increases its scope and range of services, a situation important to insurance companies with members all over the state.

Most Louisiana residents have never heard of clinically integrated networks. Electronic medical records made these networks possible. Office medical records in New Orleans moved from index cards to paper files more than 40 years ago. Those files morphed into a billion-dollar industry of information technology for physicians, clinics and hospitals.

Until a few years ago antitrust concerns made it difficult for competing hospitals and physicians to discuss quality and cost around the same table. Legal changes now allow private practice physicians and hospital employed physicians to contract jointly with insurance companies without violating antitrust laws.

"Insurance companies are in the market for better quality care. Often quality and health care savings go hand in hand. The hospitals who join Gulf States remain independent yet can pool various clinical and strategic resources with physicians they employ as well as independent physicians who prefer to be their own bosses," says Griffin. "Getting a group of physicians to agree on best treatment management of expensive chronic disease is a first start."

Bone marrow transplantations for breast cancer are a prime example of how more treatment isn't good treatment. Dozens of women flocked to an Uptown bone marrow transplant center a couple of decades ago. They received high dose chemotherapy that destroyed their bone marrow, which was then reimplanted in a circus of "chemotherapy hell." The hypothesis that higher doses of chemotherapy led to less cancer recurrences was never supported by legitimate medical research, and these rogue treatments went the way of leeches and arsenic.

Physicians relish information sharing over insurance company mandates and gyrations for pre-approval of certain tests and treatments. For example, what percent of my prescriptions are for generic drugs? What are the most common drugs I prescribe and how does this compare to other internists? How does blood pressure and diabetic control in my patents compare to my peers? When weighted for disease severity are my patients hospitalized more or less frequently?

Clinically integrated networks answer these and other questions for physicians in the trenches. Each physician receives a monthly email reminder to access the Gulf South website for a snapshot of current statistics and best practice updates.

Insurance companies also like data sharing. Besides increasing quality, costs generally decrease. This allows the networks to enter into cost savings contracts with the insurance companies. Physicians receiving bonus checks tied to their quality scores quickly become advocates of initiatives such as Choosing Wisely.

When to ask your physician why

Experts say that up to 30 percent of medical testing and care is unnecessary and unlikely to improve an individual person's health. Unnecessary care isn't only expensive; it can be harmful. For example, most internists have patients who had unnecessary prostate biopsies, leading to a lifetime of impotency from unneeded surgery and treatments. All these complications started with a simple PSA, a test still ordered for routine screening, although no longer recommended for such purposes. Primary care physicians see more and more folks with over-treated diabetes and hypertension who pass due to low blood sugars and blood pressures.

Each medical specialty organization has its own "Things to Question," tests, procedures and ways to treat that are best avoided. Consumer Reports joined the leading medical specialty groups to help patients and physicians improve communication and outcomes using evidence based health data. This initiative is called Choosing Wisely (ChoosingWisely.org).

Cardiac stress tests. Up to 45 percent of tests are totally unnecessary. This includes annual testing after cardiac surgery or coronary artery stenting. Such testing in the absence of a change in symptoms doesn't improve any measurable clinical outcome.

EKGs and echocardiograms. In the absence of a change in symptoms, persons with heart disease rarely benefit from routine serial testing. Yet, I've seen instances when cardiologists order such tests routinely with each office visit.

Headaches. CT and MRI scans as part of the initial diagnostic workup for headaches are rarely useful in the absence of specific risk factors. Most headache diagnoses are easily made with a proper history and physical examination to exclude more serious neurologic conditions. Thoughtful clinicians rarely order imaging studies for persons with simple headaches and stable migraines.

Fainting. Persons who have a single fainting episode without a seizure or abnormal neurological signs or symptoms almost never have any structural brain problems. CT and MRI scans for these folks can actually fuel anxiety.

Chest X-rays and EKGs before cataract and other minor surgeries. Such preoperative testing before minor surgeries in the absence of a clinical suspicion of undiagnosed heart or lung disease adds up to millions of dollars yearly in unnecessary medical costs.

Diabetes. Daily home fingerstick testing to follow blood sugar levels in persons with stable Type 2 diabetes not taking insulin is a huge waste of blood, time and money. Many persons with diabetes become addicted to this unnecessary testing. While much medical testing is fueled by financial gains on the provider side, diabetic supply requests are occasionally driven by financial motives on the receiver side. I recently saw signs posted on North Claiborne Avenue offering to buy unused diabetic testing supplies.

Annual Pap smears. Pap smears are needed staring at age 21, as findings in younger women can cause more confusion than benefits. Women with serial negative Pap tests only need one every three years from age 30 to age 65. And women at any age who have had a hysterectomy for non-cancer related reasons never need routine Pap smears.