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SGIM Creating Value for Patients: How Can We Prevent the Evaluation Cascade?

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Academic health centers under fee-for-service payment provide little counterbalance to ordering more. As faculty we think, 'Let's just be sure—why not?'

The other day I was in clinic when a second-year resident sat down to check out a 76-year-old woman who was "doing well." The past two years had been very stressful for her. She had been diagnosed with breast cancer, and treatment included surgery, radiation, and chemotherapy. She developed interstitial thickening in the radiation field but was very functional and symptomatic only on prolonged exertion. During an extensive evaluation for pneumonitis and fibrosis, she was found to have a 6 mm pulmonary nodule. With fibrosis and a nodule, an extensive evaluation ensued, including seven CT scans, two echocardiograms, semi-annual pulmonary function testing, a false-positive bone scan precipitated by a complaint of neck pain, and pages of laboratory tests. She saw three different residents in medicine clinic over a two-year period and five specialists with dozens of clinic visits. Although on nocturnal oxygen (which she found difficult to use), her symptoms had not worsened, and her treatment had otherwise not changed. The patient was described as "a little anxious," and to me that was understandable given the events of the past two years. The resident wanted to refer the patient back to pulmonary clinic "so she can be followed once a year," and I sensed that the resident was a bit anxious, fueled by the uncertainty she also felt. Refer? Why not?

I recalled a perspective by Rothberg called "The $50,000 Physical" where he recounted the complication-riddled cascade of evaluation and treatment of his father.[1] Every decision to evaluate a finding was correct, and a string of false-positive findings fueled the cascade. Every imaging study and procedure was evidence-based and every decision justified—except the first one. The evaluation cascade was triggered by an unconfirmed suspicion of aortic enlargement on abdominal palpation—a physical examination finding that has very poor reliability.

We have all seen evaluation cascades, and looking back, we wonder if any could have been avoided. In retrospect, it seems clear that the tests and imaging did not add value to care of the patient and certainly subjected the patient to unnecessary risk. Where did we go wrong? How can we prevent it?

Our practice environment is part of the problem. The increasing pressure to see more patients gives us less time to ponder the evidence and downstream consequences and much less time to explore patient preferences and values around these decisions.[2] Academic health centers under fee-for-service payment provide little counterbalance to ordering more. As faculty we think, "Let's just be sure—why not?"

The pressure to prevent cascades is intensifying. With implementation of the Affordable Care Act and inexorable pressure to reduce cost from payers, the practice environment is transforming rapidly. Patient-centered medical homes (PCMHs) and accountable care organizations (ACOs) are sprouting like weeds, and in some areas of the country, the "business case" is dramatically shifting academic health centers "value proposition."

Citing the "Choosing Wisely" campaign and the American College of Physicians-sponsored high value care initiative,[3] Marcotte et al. recently suggested that professional societies can be effective advocates to convene, develop, resource, and disseminate high-value care and delivery system change within their membership.[4] SGIM committed to high-value care last year announcing the new tag line, "Creating Value for Patients." At the time, Eric Bass reflected on why the tagline and the word "value" are appropriate for SGIM to promote and support.[5]

Well before the tagline was adopted, SGIM members had been at the forefront of advocating for high-value care and were developing resources and educational strategies to support members in that effort.[6-8] As those members have eloquently argued, we need time with patients to elicit their values and preferences and rapid access to reliable evidence about both the disease and the value of testing. We need to advocate for policy change in medical education and primary care reform. We need to teach management strategies, including better patient continuity and frequent follow-up (i.e. in person, by phone or secure e-mail) as a substitute for more images, labs, and doctors. We need to reassure both patients and learners that more testing is not always the answer.

As I looked through the electronic health record tabs at imaging, special studies, lab, and notes, I

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suspected I was looking at an evaluation cascade. Listening to a somewhat anxious resident presenting her plan for an anxious woman with several serious but stable conditions, I needed to formulate a new plan. I needed to prevent a new cascade, and I needed to begin with the patient's values and preferences, good evidence, and an alternative plan that would allay the anxiety. So rather than "Why not?" my new question to ponder and ask the anxious resident was "Tell me why?"

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