Low-value health care reflects activities by patients and physicians that add little quantifiable differences to care, e.g., going to the emergency department instead of a physician for a sore throat. The poster child for low-value care may be screening programs aimed at populations with a low incidence of the problem being targeted, for example, PSA, prostate-specific antigen measurements in younger men. The problem is that while the test itself may be of low value and low cost, the subsequent reactions by physicians and patients may entail much more testing, false positives, and various harms including increased costs. Care cascades, while it may channel thoughts of the outdoors, fast running streams and nature's bounty, in actuality refers to the health system's response to those low-value activities. A new study tries to quantify what is happening downstream.

Despite the swagger of cardiologists and yes, vascular surgeons, cataract surgery is probably the most performed procedure for Medicare beneficiaries; it has a 90-day mortality rate of about 0.7% on a bad day, and this is in an elderly population with multiple medical problems. For patients undergoing cataract surgery who have no symptoms of coronary disease, a pre-operative electrocardiogram (EKG), is often used, out of "an abundance of caution," as a screening tool and is acknowledged to be of low value and little yield for the effort and cost.

The Study

The researchers focused on Medicare beneficiaries who were scheduled for cataract surgery, 160,000, and were asymptomatic for coronary artery disease (now reduced to 110,000), and who had that screening EKG, a total of 12,500 patients. The remaining 97,000 patients served as the control.
Those patients being screened were older, with more co-morbidities, so from the perspective of common sense, they might have been at higher risk. Additionally, they more often lived in urban centers, with a higher density of cardiologists, than the control group. Of the screened group, the majority required no further intervention, 16%, on the other hand, had one or more additional “cascade events” – an evaluation by a cardiologist or further cardiac testing [1]. And while the initial screening was relatively inexpensive, at roughly $50, the downstream costs were magnified, to approximately $500 per beneficiary. The economic term for the care cascade is a “multiplier;” in this instance, increasing costs 7 to 10 fold without adding additional safety.

Now the testing did provide additional comfort to physicians and perhaps to patients in the face of uncertain outcomes. But it serves to redemonstrate several essential concepts.

- Increasing specialists result in increasing testing, care, and costs.
- Screening populations not at-risk is expensive, and consumes resources best utilized elsewhere.

It is difficult for physicians to rely solely on their judgment in determining risk; everyone wants some objective measure. And that want may be more for a piece of mind re-assurance, than as a pre-emptive malpractice defense.

The authors provide the usual litany of reforms to reduce this waste, educating physicians, directing care to specific facilities and providers, bundling care to include preoperative evaluation, and malpractice reform. None of them have worked so far. It is a wicked problem. What do you want your doctor to do for you? One patient’s “unnecessary screening,” is another’s “skimping on care,” and the plaintiff’s lawyer “substandard care.”

[1] Most of the additional testing included a stress test, echocardiogram or myocardial perfusion study; different means of imaging and measurement looking for structural, ischemic, or functional cardiac problems.

Source: Prevalence and Cost of Care Cascades After Low-value Preoperative EKG for Cataract Surgery in Fee-for-Service Medicare Beneficiaries JAMA Internal Medicine DOI: 10.1001/jamainternmed.2019.1739