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Turner, Robin M.; Cardona, Magnolia

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Monitoring and addressing overdiagnosis and overtreatment to reduce low-value care across all healthcare settings

Associate Professor Robin Turner, University of Otago, New Zealand
&
Associate Professor Magnolia Cardona, Gold Coast University Hospital and Bond University, Australia
Introduction

• Two themes to this talk
  – What we have learnt from our body of research into the last year of life
  – With a focus on study designs incorporating choice
Overtreatment in the last year of life

- Research lead by A/Prof Cardona
- Identifiable and potentially preventable
2017: Aus 3.7 million aged 65+ years; QLD 720,000

2050: Double

1 in 5 emergency presentations

1 in 7 could have been managed by a GP

AUS 85+y.o. Resuscitation: 2,650

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What is overtreatment near the end of life?

- Any medical, surgical treatments or additional testing or hospitalisations that will not change management or prognosis and can potentially cause harm.
- This overuse of treatments inflicts unnecessary patient suffering, creates false hope of patient survival and frustration among clinical staff, and generates unsustainable costs.
What can we do to reduce it?

Tools for predicting people at risk of death within the year are available for free.

1. Tools for predicting people at risk of death within the year are available for free.
2. Timely honest conversations on non-aggressive options using decision aids and advance health directives.
Te whakamahere tiaki i mua i te wā taumaha  Advance Care Planning

What is advance care planning?
Do your advance care plan
Advance care planning in 5 steps
What tools can help me?
Kia kōrero | Let’s talk advance care planning campaign
Some ACP stories
About us
Questions and answers
News & events
Publications & resources

Advance care planning (ACP) is the process of thinking about, talking about and planning for future health care and end-of-life care. It is about identifying what matters to you.

Health care staff
Is choice beneficial?

• Shared decision making & decision aids increasingly important
• Patients weigh up the harms and benefits and make a decision for treatment in line with their values and beliefs
• Important to have evidence of when treatment choice is beneficial and when it may be harmful
  — Does patient choice of treatment change outcomes?
• How do we measure the effect of choice?
Randomised trials incorporating patient choice

• Standard RCTs do not allow for the investigation of participant preferences for treatment
• 2-stage design with participants randomised to choice or no choice
• Analysis method developed by Rucker (1989) allows estimation of:

  Treatment effect: standard randomised comparison of the A vs B

  Selection effect: the comparison of people who prefer treatment A with those who prefer B

  Preference effect: the comparison of people who receive their preferred treatment with those who do not (i.e. the effect of choice)
Design incorporating treatment choice

- Consent eligible patients

  - No choice
    - Randomize
      - A
      - B

  - Choice
    - Choose B
    - Choose A
Analysis

• Uses information in the choice arm to estimate the mean outcomes for people who did or did not receive their preferred treatment

• Previous use of this design has shown large effects of preference that were not seen in the traditional analysis

When should I use this design?

• Addition of a choice arm (to estimate preference & selection effects) reduces power to detect the treatment effect (if the total sample size is not increased)

• The design appeals when:
  – preference is important
  – treatment effect is known to be small

• Treatments should be (nearly) equally preferred
  – This preference rate very important in determining sample size
Conclusions

• Need to identify older people at increased risk of dying sooner (e.g. CriSTAL tool)
• Informed decision making
• Evidence from two-stage RCT design that choice is beneficial
• More conversations earlier