From "Bench to Bedside"

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DESIGNING COMPARATIVE EFFECTIVENESS RESEARCH THAT IMPACTS CLINICAL PRACTICE

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Designing CER

- Delivering the right care, to the right patient, at the right time, in the most appropriate setting
- Designing research with patients and clinicians that answers questions, and addresses issues, deemed important by them..
- And contributes to decreasing uncertainty, and increasing confidence in evidence that is relevant to clinical practice
- Demonstrating "what works best" for individuals, subgroups, populations among available options

From evidence generation to clinical benefit

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 30% science : finding the "right things to do" (evidence generation) closing the "knowledge gap"

 70% "sociology" : making the right information easy to access (dissemination) closing the "knowing gap"

making the right thing easy to do (uptake)

closing the "knowing-doing gap"

Evidence most likely to impact clinical decision making.....

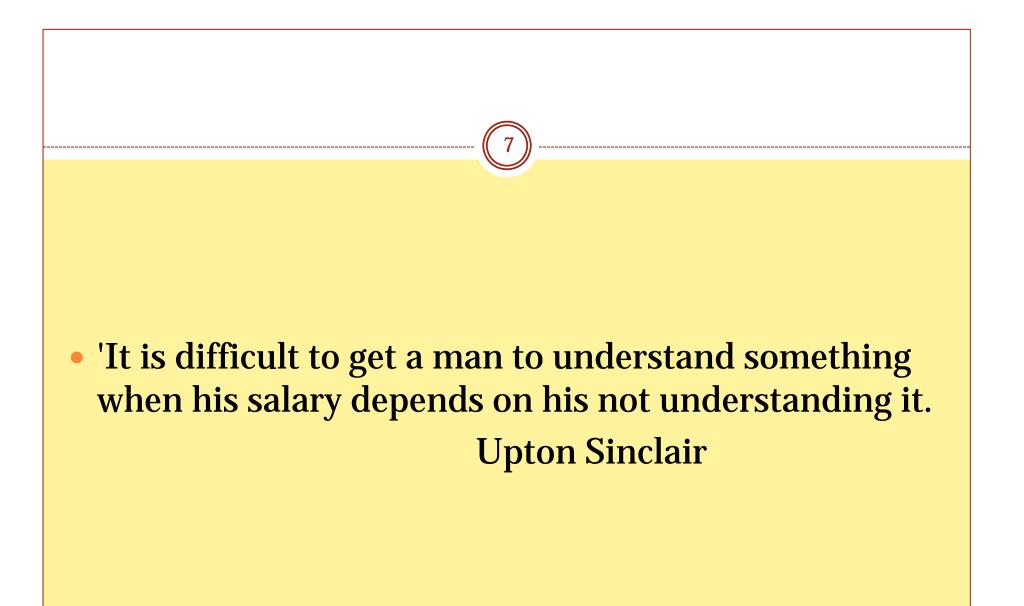
- Research questions move from investigatorgenerated to patient and clinician generated, based on unanswered questions and unmet needs of impacted individuals and communities
- Patients and clinicians involved in all phases of the research enterprise
- Proliferation of therapeutic options, with competing claims of efficacy, driving demand for comparative clinical effectiveness research, comparing interventions (drugs, devices, care pathways, care delivery models, surgical interventions etc.)

Closing the "knowing gap": effective **dissemination**

- Urgent need to decrease noise in the system, increase signal
- Traditional modes of dissemination (peer reviewed journals, conferences, announcements in the lay press) no longer sufficiently robust, reliable or efficient ... "17 years from publication to practice"
- Critical role of "trusted intermediaries", for both patients and clinicians – and, trusted intermediaries without conflicts of interest
- Evolving role for matrixed networks for dissemination

Closing the knowing-doing gap: ensuring uptake

- Infrastructure: EHR's with embedded decision support depends on who is doing the "embedding"
- "Best practice alerts" "who says so?"; risk of "fatigue", leads to "overrides"
- Incentives which facilitate adoption, or obstruct
- Practice context: solo practice or group practice
- Cultural context of the practice: commitment to QI; access to timely feedback, actionable metrics, unblinded sharing of performance data
- Trust a critical element of each of these factors..



Final thoughts...

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• The Kaiser Permanente experience with integrating the results of CER into clinical practice

Optimism about the future

 > strong signals in the environment about the demand from patients and consumers

> emergence and adoption of models of Accountable Care organizations