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

- 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 investigator-generated 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...
'It is difficult to get a man to understand something when his salary depends on his not understanding it.

Upton Sinclair
Final thoughts...

- 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