

***SHARED DECISION MAKING TO IMPROVE CARE:
THE WHY, THE WHAT, AND THE HOW***

***How Changes in Clinical Practice Can Deliver
Better Value***

THE KING'S FUND, LONDON, 22 JUNE 2016

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Dartmouth

SHARED DECISION MAKING TO IMPROVE CARE: THE WHY, THE WHAT, AND THE HOW



- A long history within the NHS
- A major area of interest and research at the King's Fund over 3 decades
- A priority policy plank in 'Liberating the NHS'
- A foundation for the 'House of Care'
- Ample evidence for impact
- Potential not realized

LEARNING FROM VARIATION TO DELIVER WHAT IS VALUED

Challenging Assumptions to Think and Do Things Differently

Prevailing Assumptions

Higher levels of health care produce higher levels of health & wellbeing for people and populations;

Clinical evidence tells us what is the right thing to do for people in need of health care;

Health care is delivery of services by professionals to people unable to understand or do for themselves

Evidence to the Contrary

Health care contributes less to health than social circumstances, including education and behaviour;

Evidence is insufficient; patients' preferences matter in decisions to deliver services that produce value;

Much of health care is exchange of information about achieving what is possible and most valued.

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Resistance to Thinking Differently

Bias toward biomedical vs social science; specialism vs general knowledge; most proximate cause;

Bias toward the objective and generalizable; neglect of context at the level of the individual patient;

Bias toward expertise, capabilities, and agency of professionals with neglect of that of patients / people.

New Models to Do Differently

Integrate services around patients' needs and wants addressing more broadly the determinants of health;

Engage, inform, and support patients in identifying and acting upon their needs and wants;

Leverage joint assets of people and professionals to co-produce better health and wellbeing at lower cost.

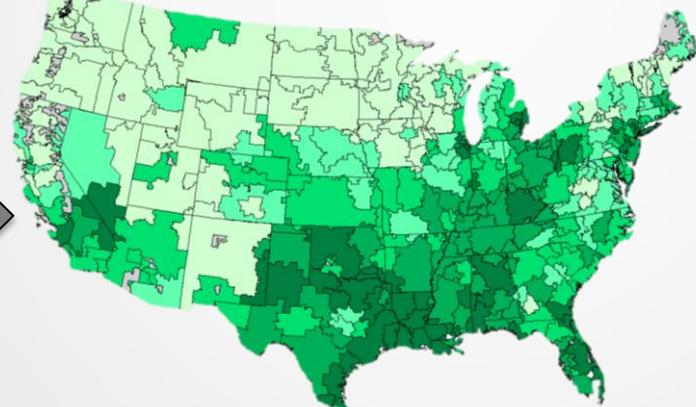
Learning from Variation in the United States to Challenge Assumptions

Increasing Levels of Health Care Increase Health and Wellbeing

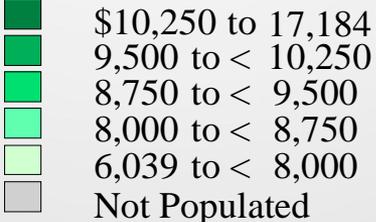


Vermont, 1973

10-fold Variation in Surgery Rates



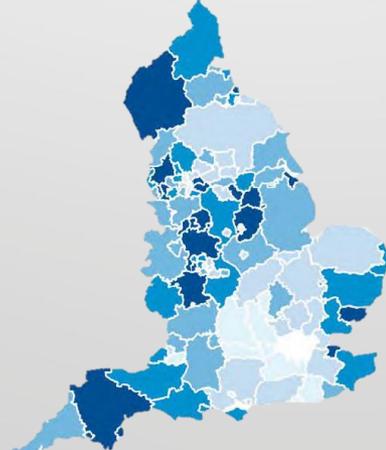
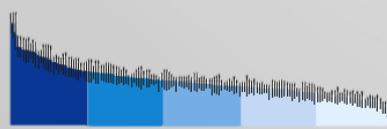
United States, 1996 - 2012



- With higher intensity and cost:**
- No better outcomes in mortality & function
 - More difficulty for patients seeing doctors, longer waits
 - More difficulty for doctors admitting to hospitals and obtaining referrals
 - **Poorer patient relationships**, ability to provide quality care

- 3-fold variation among 152 PCTs in per capita costs for cancer and heart disease care

- 8-fold variation in stents for stable heart disease after NHS Plan capacity building



United Kingdom, 2010

- Sources of waste and harm:**
- Failure to deliver effective health care safely (outcome variation)
 - Overuse and underuse of preference-sensitive care (uninformed clinical decisions)
 - Overuse of supply-sensitive care (uninformed investments in health system capacity)

Learning from Variation in Patients' Preferences to Deliver What is Valued *Evidence is Necessary but Not Sufficient – Patients' Preferences Matter*

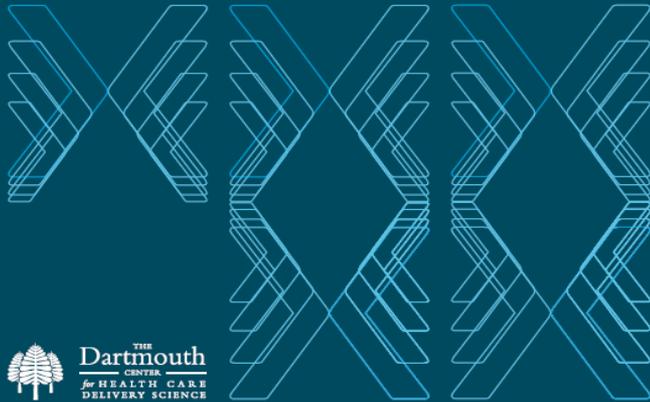
TheKingsFund>

Ideas that change
health care

Authors
Al Mulley
Chris Trimble
Glyn Elwyn

Patients' preferences matter

Stop the silent
misdiagnosis



When Linda was diagnosed with breast cancer, she was devastated. She was 58. She quickly found support from others who had dealt with the disease. Nonetheless, her anxieties as she awaited surgery nearly overwhelmed her. Linda's operation went well. However... .

When Susan was diagnosed with breast cancer, she was more stoical than Linda. She was 78, other members of her family had had breast cancer, and she had already been treated for a serious illness – heart failure. She dreaded having surgery, but her surgeon was insistent. Susan's mastectomy was routine....

Learning from Variation in Patients' Preferences to Deliver What is Valued

Evidence is Necessary but Not Sufficient – Patients' Preferences Matter



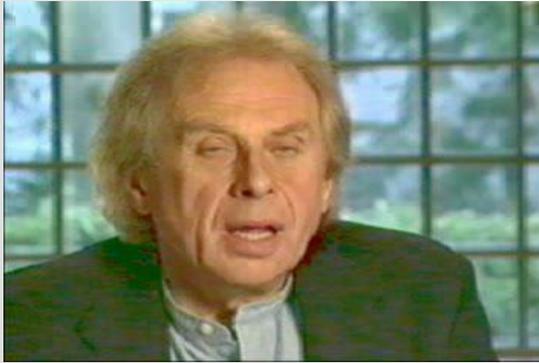
Treatment of early-stage disease



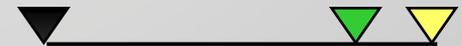
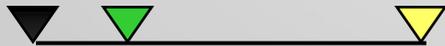
Treatment of metastatic disease

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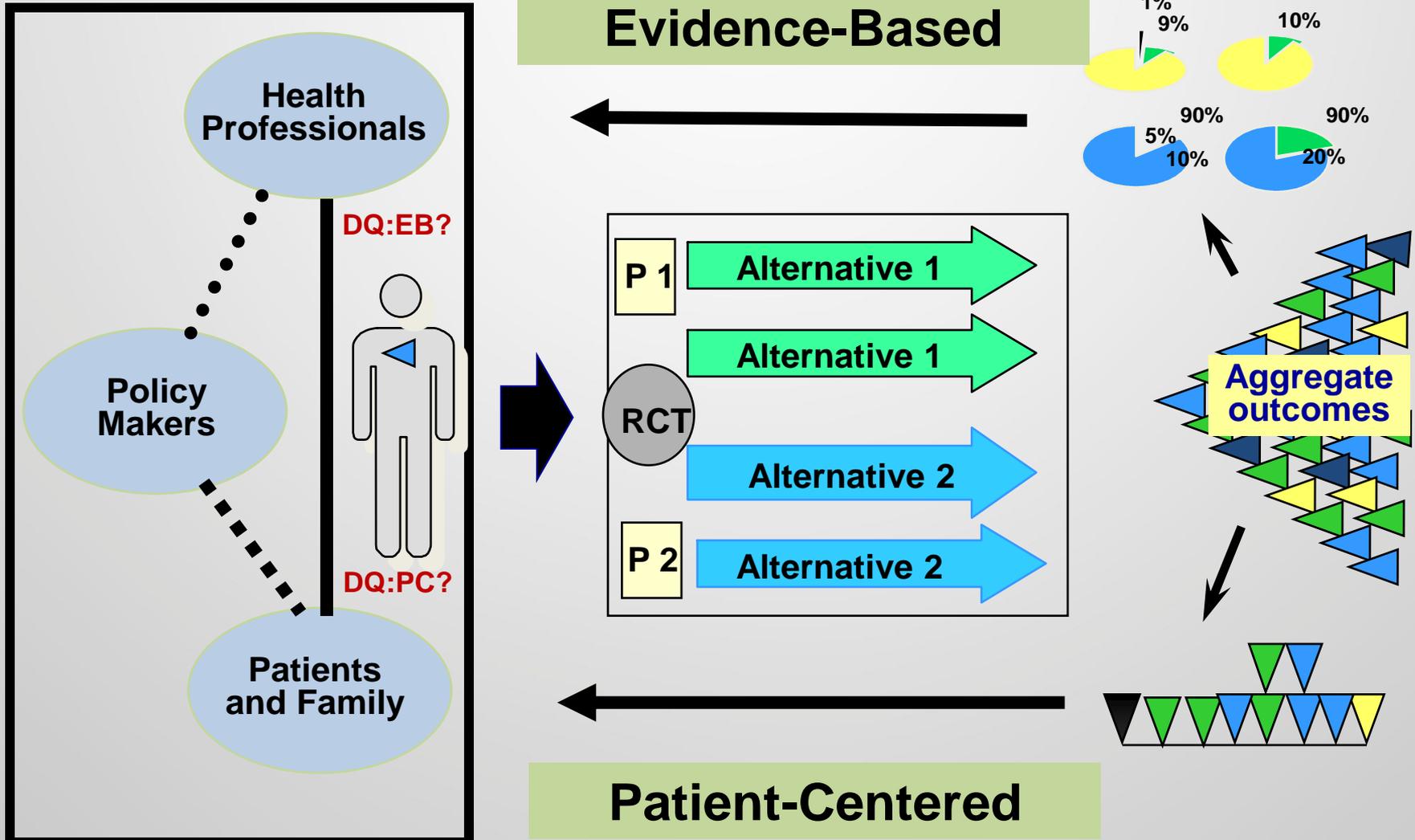
How bothersome is urinary dysfunction?



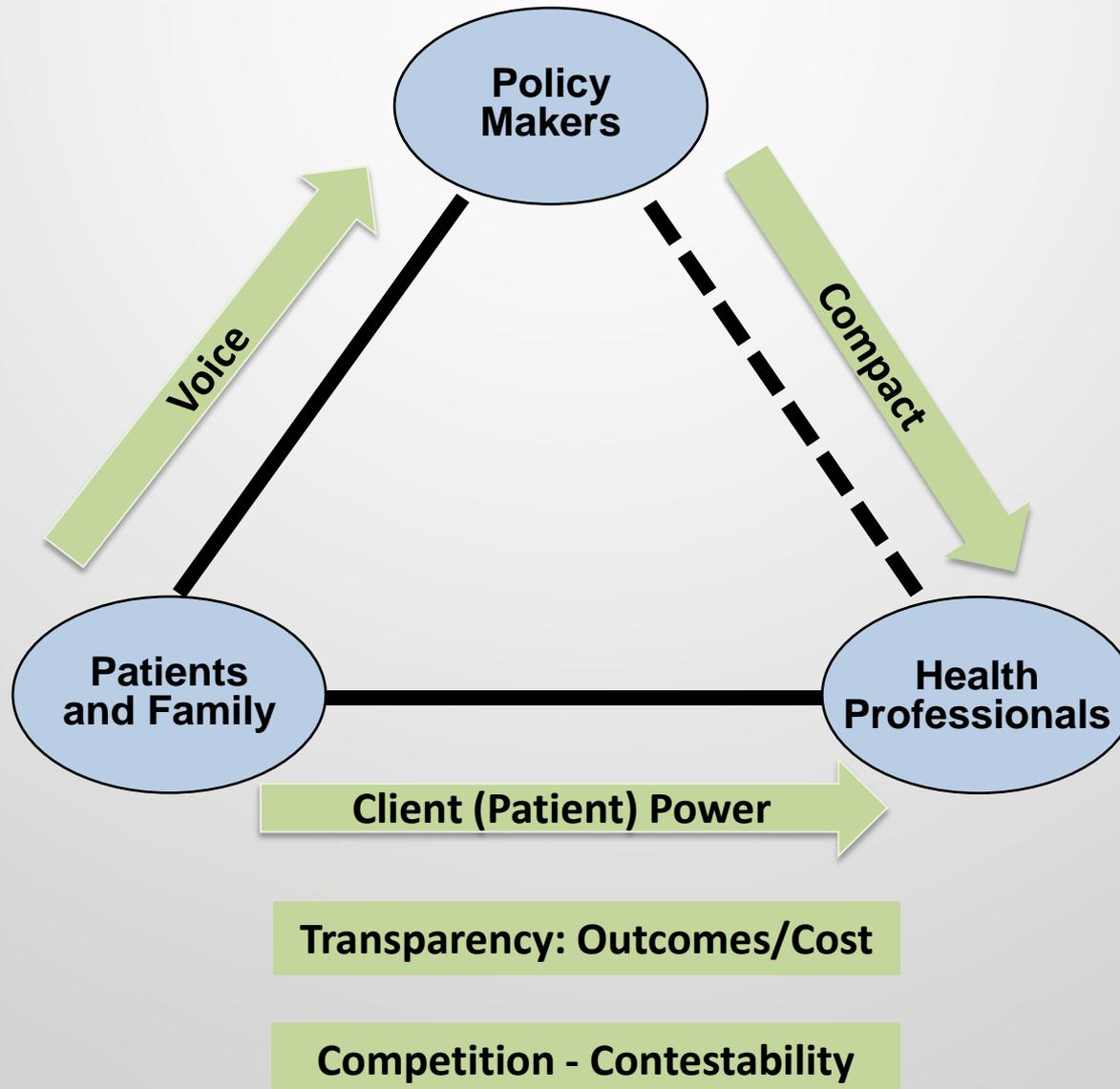
How bothersome will sexual dysfunction be?

Learning from Variation in Patients' Preferences to Deliver What is Valued

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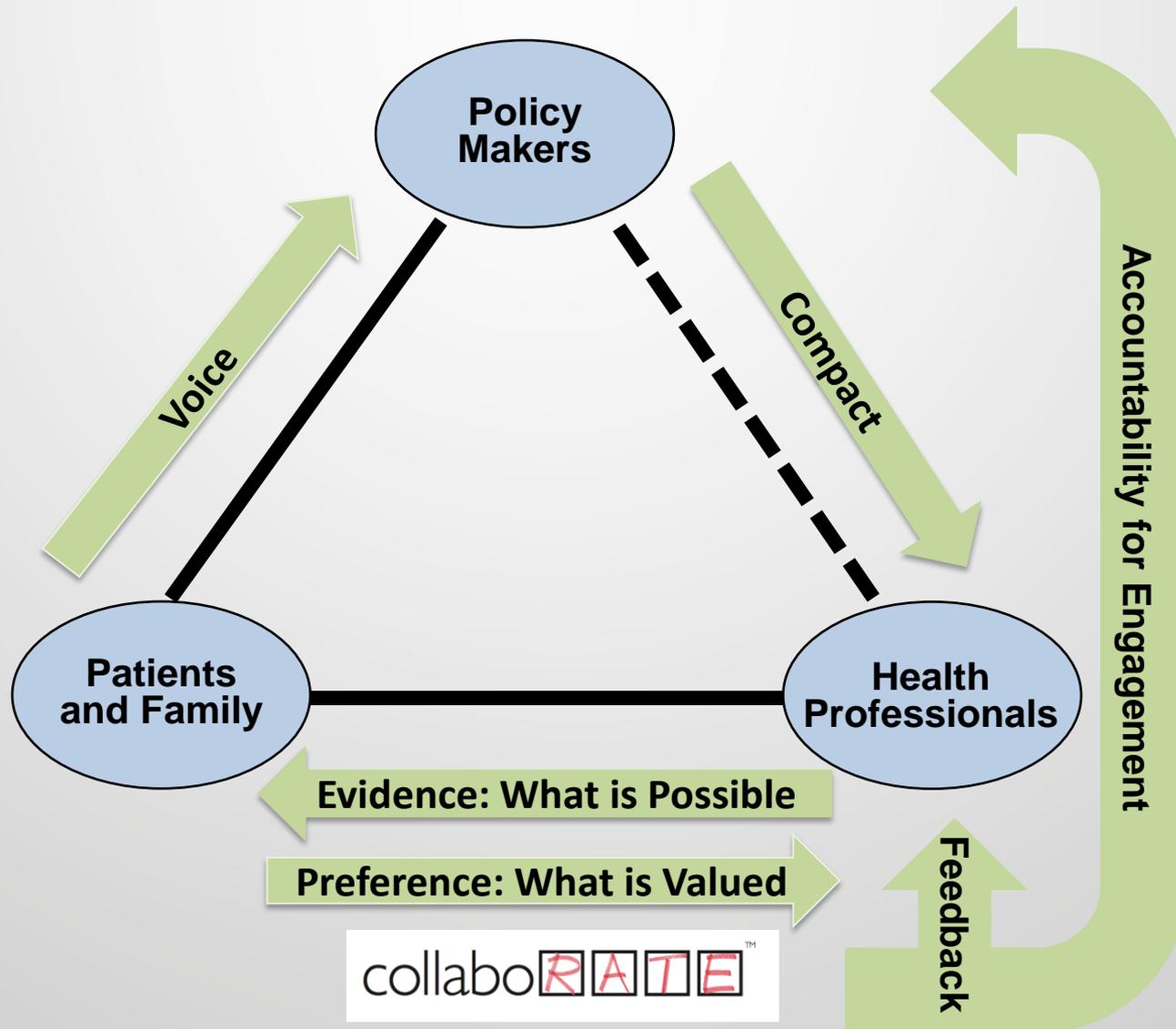


Learning from Patients' Preferences for System Reform



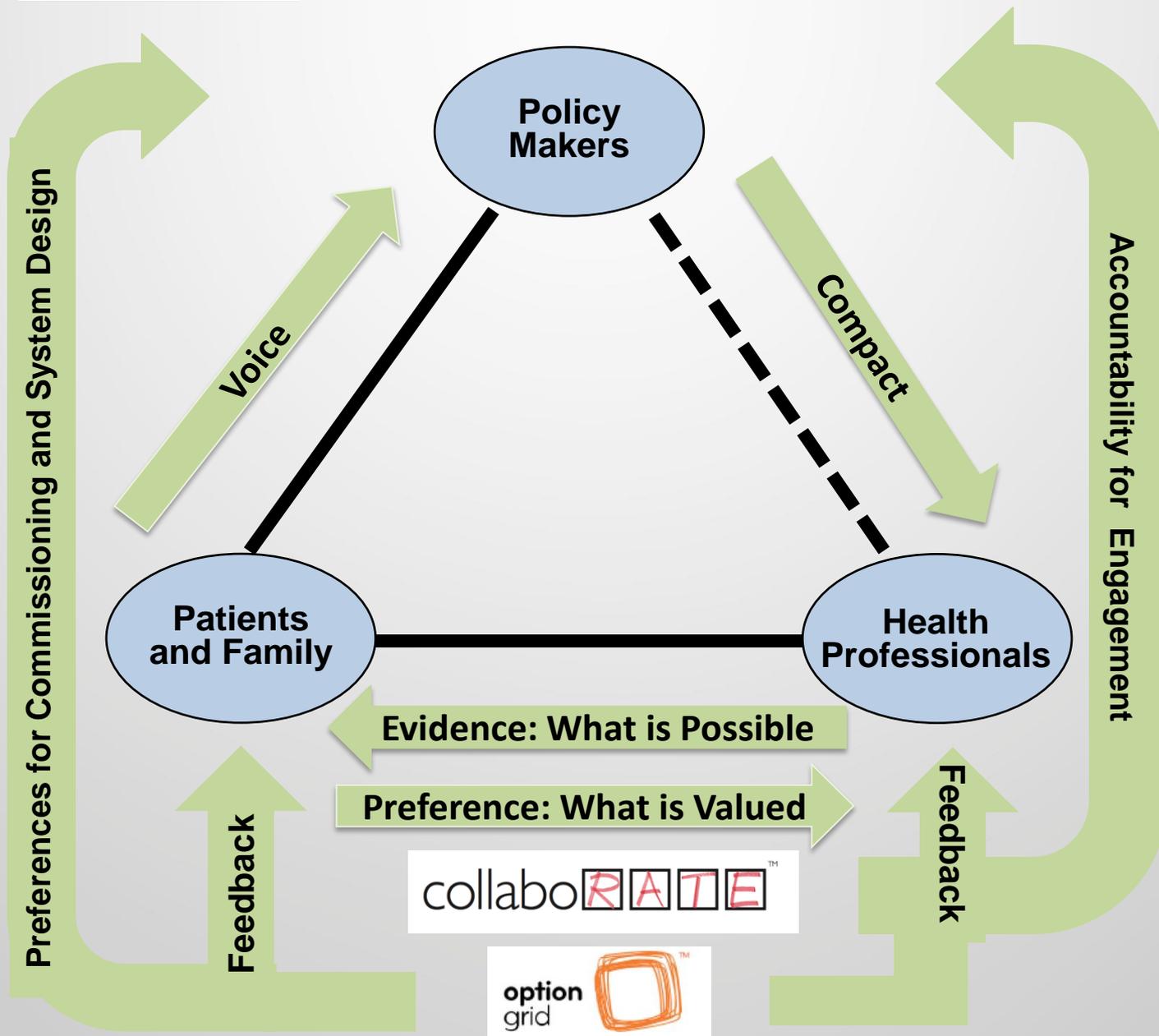
Learning from Patients' Preferences for System Reform

Giving Clinical Teams the Measures to Hold Themselves Accountable

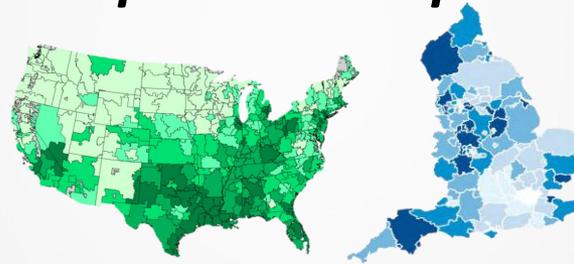


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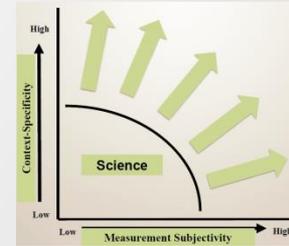
Giving System Leaders the Data they Need to Hold Themselves Accountable



Learning from Variation to Deliver What is Valued Overcoming Conceptual and Operational Barriers

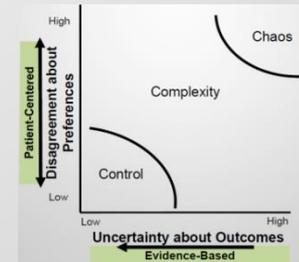


Learn from Variation



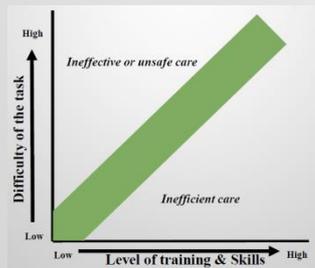
Bring the Discipline of Science

Processes
Costs
Outcomes
Preferences

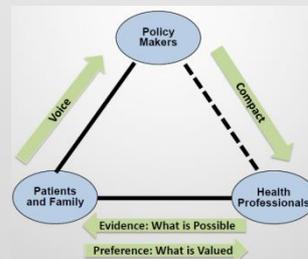


Be Guided by Simple Rules

Organize for Innovation

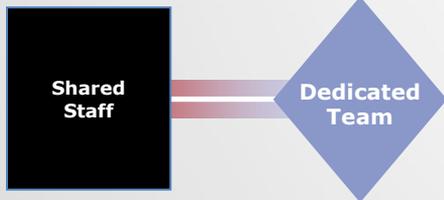


Deliver with Teams



Deliver What is Valued

Summary



The BMJ-Dartmouth Initiative

Challenging Assumptions and Testing Hypotheses on a Global Scale

Delivering health with integrity of purpose

Health systems must learn how to co-produce and deliver services that patients and the public value

Albert Mulley *director*¹, Tessa Richards *senior editor/patient partnership*², Kamran Abbasi *international editor*²

¹Dartmouth Center for Healthcare Delivery Science, Hanover, New Hampshire, USA; ²The BMJ



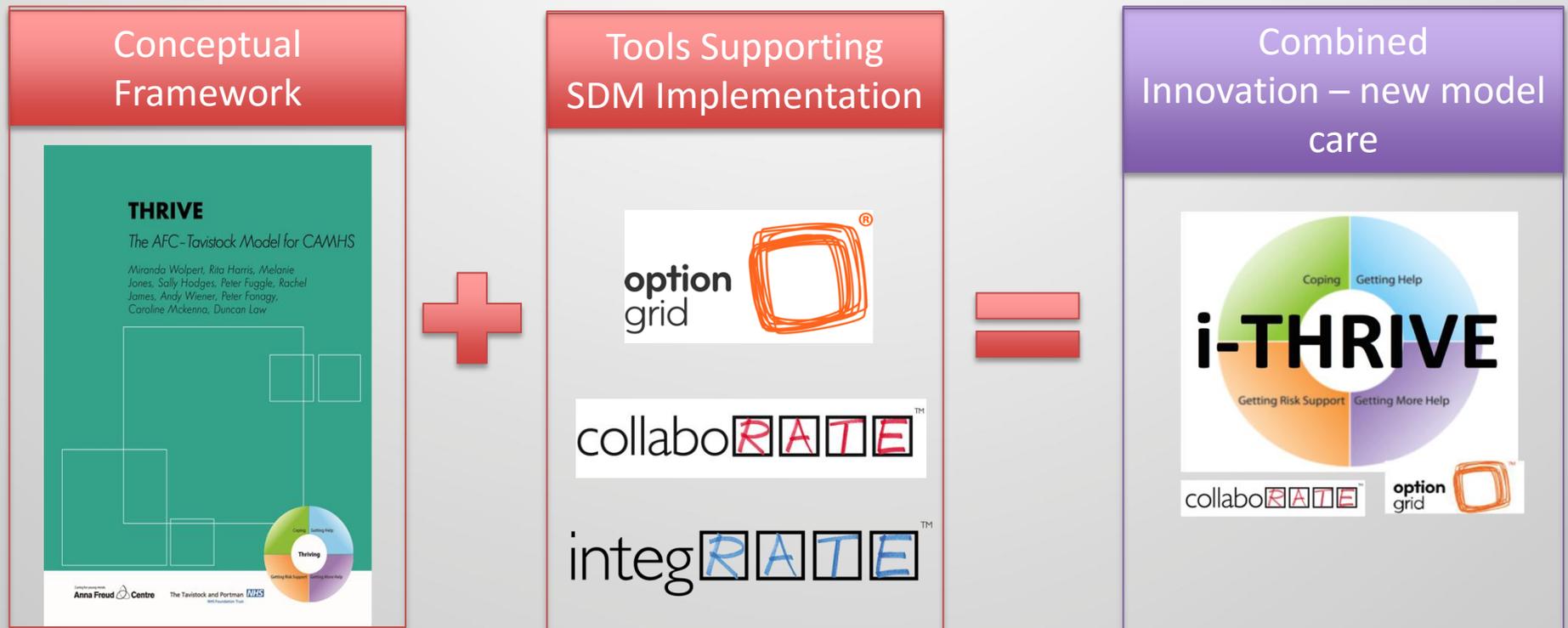
EDITORIALS

The Care They Need and Want – No Less But No More

**Children and
Adolescents with
Mental and
Behavioral Health
Needs**

iTHRIVE: Understanding a Priority Population's Needs and Wants

- A National Innovation Accelerator bringing together the model of care for children & young people's mental health called THRIVE with tools to support SDM; CollaboRATE, InteGRATE and Option Grids.
- This will enable the implementation (i) of THRIVE using the SDM tools.



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The Care They Need and Want – No Less But No More

**Children and
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Needs**

**People who Need
Support to be
Productively
Employed in their
Middle Years**

**People who Need
Care and
Compassion due to
Frailty or when
Death is Near**

Archie Cochrane's Education at Elsterhorst: A Silent Misdiagnosis

"Another event at Elsterhorst had a marked effect on me. The Germans dumped a young Soviet prisoner in my ward late one night. The ward was full, so I put him in my room as he was moribund and screaming and I did not want to wake the ward.

I examined him. He had obvious gross bilateral cavitation and a severe pleural rub. I thought the latter was the cause of the pain and the screaming. I had no morphia, just aspirin, which had no effect.

I felt desperate. I knew very little Russian then and there was no one in the ward who did. I finally instinctively sat down on the bed and took him in my arms, and the screaming stopped almost at once. He died peacefully in my arms a few hours later.

It was not the pleurisy that caused the screaming but loneliness. It was a wonderful education about the care of the dying.

I was ashamed of my misdiagnosis and kept the story secret."



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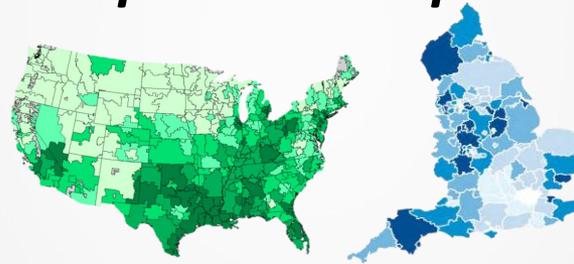
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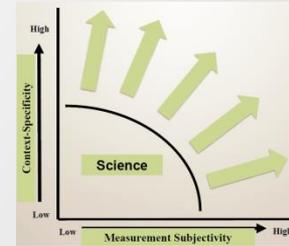
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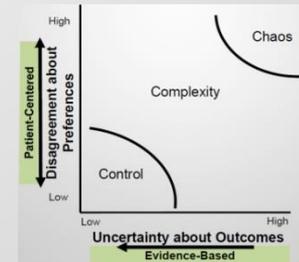


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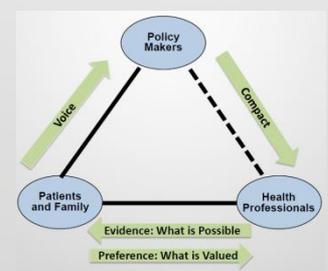
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