From “Bench to Bedside”

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DESIGNING COMPARATIVE EFFECTIVENESS RESEARCH THAT IMPACTS CLINICAL PRACTICE

SHARON LEVINE MD
THE PERMANENTE MEDICAL GROUP
KAISER PERMANENTE
OCTOBER 19, 2011
HEALTH INDUSTRY FORUM

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