Helping Patients Choose Wisely

Angela Coulter
angela@angelacoulter.com
Delivering High Value Health Care 10/01/17
@acpatient
NHS drawing up list of hospital departments to be closed amid financial crisis

NHS crisis deepens as delays push hospitals to ‘breaking point’

Revealed / NHS plans radical cuts to fight growing deficit in health budget

NHS chiefs plotting a 'glut' of service closures across the country to tackle £460million black hole

- NHS England trusts sent letters asking to name struggling departments
- Hospitals may have to move services to larger hospitals or close them
- BMA Chairman Mark Porter said health service is reaching a 'crisis point'
What to do?

- Close hospital beds
- Shift care into the community
- Merge A&E departments
- Rethink staffing models
- Close community hospitals
- Get a grip on specialist services
- Reconfigure primary care
- Target high need, high cost patients
- Strengthen prevention

Choosing Wisely
- Eliminate waste
- Manage demand
- Engage professionals/patients/public
How Will the Public Respond to the Crisis?
Change the Terms of the Debate

- More is not always better
- Harms caused by medical intervention = patient safety issue
- Unnecessary care = unnecessary risk + cost
- Efficiency = better for everyone
Choosing Wisely

Launched by ABIM Foundation in 2012
Aims to promote better conversations between clinicians and patients, helping them to choose care that is:
• Supported by evidence
• Not duplicative of other tests or procedures already received
• Free from harm
• Truly necessary
• Congruent with patients’ values
Key Features

- Medically led
- ‘Top Five’ lists – ‘things that providers and patients should question’
- Participatory approach
- Transparent, evidence-based
- Patient partnerships
- Public communications
- Evaluation
Choosing Wisely Goes Global

- USA
  - now involves 70 medical societies and 450 recommendations
- 2012 Netherlands
- 2014 Canada
- 2015 Australia
- 2016 UK (AoMRC)

- Germany
- Italy
- Japan
- New Zealand
- South Korea
- Switzerland
Engaging Patients and Public

- Inviting direct involvement
- Providing patient information
- Building public awareness
- Supporting better conversations
Direct Involvement

- Partnerships with patient/consumer groups
- Campaign strategy
- Top Five selection
- Designing and testing patient information
- Media campaigns
- Evaluating impact
Patient Information

• Educational materials about benefits, harms and uncertainties of tests and treatments

• Choosing Wisely US partnership with Consumer Reports and other patient/consumer organisations and employers

• UK – National Voices, links to NHS Choices and other patient info
Public Awareness

• Social marketing
• Media relations
• Public information broadcasts
• Involvement in documentaries
• Campaign materials
• Repetition of messages
LESS IS MORE can often be the best way
Questions to Ask

• Do I really need this test, treatment or procedure?
• What are the risks or downsides?
• What are the possible side-effects?
• Are there simpler, safer options?
• What will happen if I do nothing?
Clinicians and patients working together to select tests, treatments, management or support options based on clinical evidence and the patient’s informed preferences.
Patient Decision Aids: the Evidence

• In 115 trials involving 34,444 participants, use has led to:
  – Greater knowledge
  – More accurate risk perceptions
  – Greater comfort with decisions
  – Greater participation in decision-making
  – Fewer people remaining undecided
  – Fewer patients choosing major surgery

Stacey et al. Cochrane Database of Systematic Reviews, 2014
Patient Decision Aids Reduce Rates of Elective Surgery by 20%: Cochrane Review

Review: Decision aids for people facing health treatment or screening decisions
Comparison: 0 Choice
Outcome: 1 Choice: Surgery over conservative option: DA vs usual care

<table>
<thead>
<tr>
<th>Study or subgroup</th>
<th>Decision Aid n/N</th>
<th>Usual Care n/N</th>
<th>Risk Ratio N+H, Random, 95% CI</th>
<th>Weight</th>
<th>Risk Ratio N+H, Random, 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 As treated analysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ayres 2011</td>
<td>36/172</td>
<td>43/173</td>
<td>8.8 %</td>
<td>0.71 (0.51, 0.99)</td>
<td></td>
</tr>
<tr>
<td>Albin 2004</td>
<td>60/103</td>
<td>91/100</td>
<td>11.7 %</td>
<td>0.64 (0.54, 0.75)</td>
<td></td>
</tr>
<tr>
<td>Barry 1997</td>
<td>8/103</td>
<td>16/116</td>
<td>3.3 %</td>
<td>0.56 (0.25, 1.26)</td>
<td></td>
</tr>
<tr>
<td>Bernstein 1998</td>
<td>25/51</td>
<td>28/48</td>
<td>7.9 %</td>
<td>0.70 (0.48, 1.03)</td>
<td></td>
</tr>
<tr>
<td>Barry 2004</td>
<td>42/120</td>
<td>49/107</td>
<td>9.0 %</td>
<td>0.76 (0.55, 1.05)</td>
<td></td>
</tr>
<tr>
<td>Jhajhia-Weiss 2011</td>
<td>16/44</td>
<td>20/29</td>
<td>6.5 %</td>
<td>0.89 (0.50, 1.27)</td>
<td></td>
</tr>
<tr>
<td>Kennedy 2002</td>
<td>82/253</td>
<td>101/244</td>
<td>10.7 %</td>
<td>0.78 (0.62, 0.99)</td>
<td></td>
</tr>
<tr>
<td>Morgan 2000</td>
<td>45/96</td>
<td>63/95</td>
<td>10.4 %</td>
<td>0.79 (0.62, 1.01)</td>
<td></td>
</tr>
<tr>
<td>Murray 2011</td>
<td>6/54</td>
<td>1/48</td>
<td>0.6 %</td>
<td>5.33 (0.67, 42.73)</td>
<td></td>
</tr>
<tr>
<td>Probst 2007</td>
<td>7/56</td>
<td>3/56</td>
<td>1.5 %</td>
<td>2.33 (0.64, 8.57)</td>
<td></td>
</tr>
<tr>
<td>Schwartz 2009</td>
<td>18/54</td>
<td>15/114</td>
<td>4.8 %</td>
<td>2.14 (1.15, 3.95)</td>
<td></td>
</tr>
<tr>
<td>Solberg 2010</td>
<td>40/103</td>
<td>56/112</td>
<td>9.3 %</td>
<td>0.78 (0.57, 1.05)</td>
<td></td>
</tr>
<tr>
<td>Vederniöö 2009</td>
<td>2/39</td>
<td>5/41</td>
<td>1.1 %</td>
<td>0.42 (0.09, 2.04)</td>
<td></td>
</tr>
<tr>
<td>Vurola 2006</td>
<td>98/179</td>
<td>88/179</td>
<td>11.2 %</td>
<td>1.08 (0.69, 1.62)</td>
<td></td>
</tr>
<tr>
<td>Whelan 2004</td>
<td>6/94</td>
<td>26/107</td>
<td>3.1 %</td>
<td>0.25 (0.11, 0.61)</td>
<td></td>
</tr>
<tr>
<td><strong>Subtotal (95% CI)</strong></td>
<td><strong>1436</strong></td>
<td><strong>1479</strong></td>
<td><strong>100.0 %</strong></td>
<td><strong>0.80 [0.67, 0.95]</strong></td>
<td><strong>0.80 [0.67, 0.95]</strong></td>
</tr>
</tbody>
</table>

Total events: 437 (Decision Aid, DA) vs 415 (Usual Care)
Heterogeneity: Tau² = 0.08, Chisq = 39.35, df = 14 (P = 0.00023), I² = 65%
Test for overall effect: Z = 2.60 (P = 0.0094)
Shared Decision Making Reduces Use of Antibiotics for Respiratory Tract Infection by 40%: Cochrane Review

Shared Decision Making in Orthopaedics

- Hip: 820 intervention vs 968 control
- Knee: 3,510 intervention vs 4,217 control

- 26% fewer hip replacements
- 38% fewer knee replacements
- Estimated cost reduction of 12-21% over six months

Arterburn et al. Health Affairs 2012
Key Components of Shared Decision Making

1. **Information**
   Reliable, balanced, evidence-based information outlining prevention, treatment, or management options, outcomes and uncertainties

2. **Deliberation**
   Decision support with clinician or health coach to clarify options, preferences, goals and action plan (personalised care planning)

3. **Implementation**
   System for recording, communicating and implementing patient’s preferences
Challenges

• Nature of Top Five recommendations
• Availability of relevant, good quality patient information
• Provision of training and support for shared decision making
• Cost of social marketing campaigns
• Role of lay involvement in medical societies