SHARED DECISION MAKING –
WHY PATIENTS’ PREFERENCES MATTER

Hong Kong Hospital Authority Convention 2013
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Director, The Dartmouth Center for Health Care Delivery Science

Hong Kong
May 16, 2013
• **Dartmouth**: 1769
  - 1 of 8 in the Ivy League
  - #1 in US for Teaching
  - Top-10 university in America
  - Among the highest endowments

• **Geisel School of Medicine**: 1796
  - 4th oldest in US

• **Tuck School of Business**: 1900
  - Oldest in US
  - #1 in US (*Wall Street Journal*, 2007)
  - #1 in the world (*The Economist*, 2011)

• **Thayer School of Engineering**: 1867
  - Among the oldest in the US
Dartmouth’s Commitment to Serve Health Care Reform

Dartmouth College
Tuck School of Business at Dartmouth
Thayer School of Engineering at Dartmouth
Geisel School of Medicine at Dartmouth
The Dartmouth Institute for Health Policy & Clinical Practice
Dartmouth-Hitchcock Medical Center
Jim Yong Kim
17th President of Dartmouth, 2009
12th President of the World Bank, 2012
Dartmouth’s Commitment to Serve Health Care Reform in China

A Five-Year Agreement Between Dartmouth and Ministry of Health Signed in Beijing, October 17, 2011
Why Dartmouth?

First-in-the-world Shared Decision Making Center

The Dartmouth Atlas

Global Reach and Impact

Dartmouth-Hitchcock Medical Center

Health Care Delivery Science e-Learning

Geisel School of Medicine at Dartmouth

Tuck School of Business at Dartmouth
Variation: Dartmouth’s Insight into Understanding of Health Care

The Initial Discovery
Vermont, 1973

10-fold Variation in Surgery Rates

Current Analysis
United States, 2011

3-fold Variation in Per-person Cost
Variation: More Care Does Not Equal Better Care

Higher Cost Health Care Associated with:

- No Better Outcomes in Mortality & Function

Patient’s viewpoint:
- Difficulty seeing doctors
- Longer wait times

Doctor’s viewpoint:
- More difficulty admitting patients into hospitals
- More difficulty obtaining specialist referrals
- Poor perceived quality of professional communication
- Poor perceived quality of patient relationships
- Poor perceived ability to provide high quality care

Variation: More Care Does Not Equal Better Care
Factors Affecting Supply of Health Care

Economy
- Available resources
- Expenditure on healthcare

Health system
- Hospitals, beds
- Primary care facilities
- Doctors, nurses and other staff

Practice styles
- Time, funding, motivators
- Clinical evidence, uncertainties, insufficient knowledge
- Training, attitudes, when to intervene
Factors Affecting Demand of Health Care

Demand for health care

- Demographic change
- Illness, lifestyles
- Industry, commercial
- Travel, movement, pandemics
- Health understanding
- Information, media, internet
- Patients’ expectations, preferences
- Involvement, competence, confidence
The Problem

Patients: making decisions in the face of avoidable lack of knowledge

Clinicians: poorly “diagnosing” patients’ preferences, leading to underuse, overuse and waste

Poor decision quality
* A process in which clinicians and patients work together to select tests, treatments, management or support packages, based on clinical evidence and the patient’s informed preferences.

Shared Decision Making
Sharing Expertise

**Clinician**
- Diagnosis
- Disease cause
- Prognosis
- Treatment options
- Outcome probabilities

**Patient**
- Experience of illness
- Social circumstances
- Attitude to risk
- Values
- Preferences
Key Components of Shared Decision Making

1. Reliable, unbiased, evidence-based information outlining treatment options, outcomes and uncertainties

2. Counselling with clinician or health coach to clarify decision options and preferences

3. System for recording, communicating and acting on patient’s preferences
When is it Appropriate?

- When people face major healthcare decisions where there is more than one acceptable option

- When people with chronic conditions want to be involved in planning their care, living healthier lifestyles, and increasing their ability to self-manage
What Patients Need to Know

• Is there more than one way to treat my condition?
• Will treatment help the symptoms?
• Benefits and harms?
• Is treatment necessary?
• Healing time?
• Impact on quality of life?
• What can I do to help myself?
Patient Decision Aids

Information on.....
- Medical problem
- Treatment options
- Outcomes with and without treatment
- Uncertainties
- Personal preferences
- Balanced
- Evidence-based
Variations in Hysterectomy Rates in England

- Hysterectomy is (usually) optional
- Population-based hysterectomy rates vary more than 3x between local areas
- Patients’ values and preferences should influence decisions
Decision Tool + Decision Support

- Helped patients form preferences
- Reduced hysterectomy rates
- Information + identifying preference was cost-effective
- Patient satisfaction increased

Kennedy et al. JAMA 2002; 288: 2701-8
Decision Tool + Coaching in Gynaecology

Treatment costs ($) over 2 years

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Cost ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usual care</td>
<td>2751</td>
</tr>
<tr>
<td>Decision tool</td>
<td>2026</td>
</tr>
<tr>
<td>Decision tool + coaching</td>
<td>1566</td>
</tr>
</tbody>
</table>
Impact of Better Decisions on Surgery Rates: 
Coronary Artery Disease

CABG rates decreased 26% to a rate lower than all 306 regions
Decision Tools: The Evidence

In 86 trials addressing 35 different screening or treatment decisions, 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, 2011
“It’s about the relationship between us and our patients.”

~ Rushika Fernandopulle, MD
CEO, Iora Health
Effective and Efficient Teamwork for High Value Service

- Shared goals
- Shared Knowledge
- Mutual Respect

Ineffective or unsafe care

Inefficient care
Engaging Populations and Patients

The Key to Productivity in Health Care

A toolkit for patient self management

M Pignone, UNC

- Declaration of Alma Ata, 1978 – “The people have a right and duty to participate individually and collectively in the planning and implementation of their health care”

- The Wanless Report, 2002 – The English National Health Service could save £30 billion annually by engaging patients

Games for community-based disease prevention

M Flanagan, Dartmouth
The Wennberg International Collaborative

- International network composed of: Australia, Canada, France, Germany, Italy, Japan, Kosovo, Netherlands, New Zealand, Norway, Spain, Switzerland, United Kingdom, and the United States
Longstanding Partnerships in the United Kingdom
The National Health Service, Foundations, Universities

- The NHS Commissioning Board and Right Care UK
- The Health Foundation Improvement Science Commission
- The King’s Fund’s First International Visiting Fellow
  - Learning from Practice Variation
  - Shared Decision Making
  - Commissioning Services
- Academic Health Science Centers
  - University College London
  - Imperial College
  - King’s College
As a result of the NHS Plan, capacity to revascularize coronary arteries was significantly increased in England 2001-2008. In 2010, for the 152 PCTs in England, elective coronary stenting varied more than 8-fold from 11.2 per 100,000 to 92.4 per 100,000.
Dartmouth-Salzburg Global Health Care Seminars

September 2011 + November 2012 with the World Bank + December 2013

September 2011 – Sixty Health Care Leaders from 27 Countries
Multinational Coalition for Health Care Delivery Science

- **China-UK-US Trilateral Coalition** using common models, methods and measures and thereby able learn from each other’s innovations.

- **India as a vibrant reverse innovation marketplace** in low-cost production of health care.

- **Rwanda and Peru as strong implementation partners** in acute and palliative cancer care, mental health, and other delivery areas.

- **Dartmouth-Salzburg-WBI HCDS Partnership** building a global knowledge exchange and e-Learning networks.