

National Quality Strategy: Input from the *Society for Medical Decision Making*

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The Society for Medical Decision Making (SMDM) has provided a scholarly forum that connects and educates researchers, providers, policymakers, and the public for more than 35 years. The Society has a long-standing commitment to improving health outcomes through systematic approaches to clinical decision making and policy-formation in health care. SMDM is therefore in a position to provide a deep and broad view of the opportunities at this juncture in the Nation's effort to improve health care quality for its citizens. In our reactions to the National Quality Strategy (NQS) below, we underline our specific proposals for action, consideration, and leadership.

Starting with the three goals embraced by the NQS (broadly defined as “better health”, “affordable care”, “healthy populations, healthy communities”), we initially saw no gaps. However, upon further reflection, members of our society have been at the forefront of pointing out ethical concerns in health care. Given the private-public partnership goals underlying the NQS, as well as the role of agents in health care, a close consideration of ethics needs to undergird all elements of the NQS. Therefore, we propose to modify the care goal, by stating “Ethical and Affordable Care”, or incorporate ethics directly in all goals. Barriers and opportunities to achieve more affordable care are likely to be squarely within the domain of ethics. For example, a barrier to developing strategies to make care more affordable is the public's distrust of many of health care's stakeholders and their interests, as seen in the “death panel” flare. On the flip side, an opportunity for saving money ethically may ensue from heightened transparency around payment and profit in healthcare delivery. Although health care professionals need to make a living, they have sworn to put the individual patients' welfare ahead of their own monetary concerns. Should all health care organizations, not-for-profit or for-profit, also pledge to put the patients' welfare ahead of their revenues and/or profits, with their leaders held to the same pledge? What accountability and transparency is required for health care providers, for health care organizations, and for health care leaders? How can the nation assure that the clinical evidence base, clinical education, and health care policymaking are maximally free from the influence of vested interests? A national quality goal related to ethical care would reinforce the need to raise and address such questions. Some guidelines have been written¹, and others may be needed. In the upcoming SMDM annual meeting, the theme (Ethics, Economics and Ethics) reinforces our commitment to the centrality of ethical behavior in health care.

¹ IOM Report on conflicts of interest: <http://www.iom.edu/Reports/2009/Conflict-of-Interest-in-Medical-Research-Education-and-Practice.aspx>; UN guidelines for pharmaceutical companies: http://www.essex.ac.uk/human_rights_centre/research/rth/docs/GA2008.pdf; U4 guidelines on setting up organizational ethics policies: <http://www.cmi.no/publications/file/?3344=organisational-ethics-policies-a-primer>

Throughout our history, SMDM members have focused their intellects on ways to discern and incorporate patient preferences in decision making. This scientific area will continue to need close attention, and rigorous methods to assure that patient's preferences are truly reflected in decisions at the bedside, as well as policy level decisions with the potential to affect great numbers of patients. Members of SMDM have developed patient decision support aids and tools, and continue to research their development and implementation. National efforts in Europe are underway to support the use of these tools. For example, NHS Direct is currently running a project to develop decision aids online to help patients make informed healthcare choices in the first national web-based project of its kind in the UK.² The works of past SMDM presidents Hilary Llewellyn-Thomas, Annette O'Connor and Michael Barry could be consulted for more information on this rich area of research supportive of the National Quality Strategy.

Another area of strong interest and expertise within SMDM is decision modeling. What is the role of this type of mathematical approach to clinical and policy questions related to health care quality? As Atul Gawande noted in his plenary at the recent AHRQ annual meeting, health services researchers are the "laptop kids" who bring sophistication with data to understand patterns of failure and success in the health care delivery system. We propose that the NQS seek to make use of modelers' expertise to glean as much insight as possible from health care problems where uncertainty exists (as it usually does). Decision modeling exercises and results have informed screening recommendations by the USPSTF and professional societies. Past president Karen Kuntz has led the development and application of population level simulation models to evaluate existing cancer control strategies, as well as the expected impact of future strategies.³ In addition, related analytic methods, such as value of information, are also relevant to improving quality for the nation. For example, see past SMDM president David Meltzer's description of the expected population value of quality indicator reporting (EPVQIR) in a recent IOM report on the "Future Directions for the National Healthcare Quality and Disparities Reports."⁴ Many other examples of national modeling efforts to guide policy making have arisen from SMDM members' research.

Continuous methods development in the areas of evidence-based medicine and evidence-based health care delivery are needed. What methods translate well from comparisons of two medications to comparisons of more complex care strategies (sequences of diagnostic tests and treatments)? And even more challenging, how should evaluations of alternative systems of care best be conducted to establish evidence about what works best, and under what circumstances? While advances in methods may not make headlines like new medical discoveries of delivery system success stories, history tells us that

² http://www.institute.nhs.uk/nhs_alert/guest_editorials/july_2010_guest_editorial.html

³ A Population Policy Model for Colorectal Cancer: <http://cisnet.cancer.gov/grants/colorectal/kuntz.html>

⁴ Appendix F: The Expected Population Value of Quality Indicator Reporting (EPV-QIR): A Framework for Prioritizing Healthcare Performance Measurement, by David Meltzer and Jeanette Chung. http://books.nap.edu/openbook.php?record_id=12846&page=175#

sound analysis is likely to be the cornerstone for achieving the goals of the NQS. Innovations in methods will need just as much attention as innovations in delivery systems. We propose federal leadership and new incentives to create infrastructure that gives those with academic careers a national stage for their methods research. Much progress will be made at the local level. However, academic investigators have difficulties publishing studies focused on small geographic footprints. Can the NQS provide resources to engage academics in local, pilot studies, which if successful could lead to larger funded projects to assess ways to scale effective new approaches to achieving the NQS goals? Ideally, research funding mechanisms for junior investigators to senior investigators (perhaps some who are re-tooling themselves) will be created to build a bridge for researchers to go from funded involvement at the local level to funded involvement at the point where national attention is warranted. Such a mechanism makes academic publications more likely, with rewards not only to the researcher, but also to the field through wide availability of solid evidence (i.e., peer-reviewed, rigorous study results and transparent, replicable methods) on topics of importance to the NQS.

How might implementation-oriented research be better fostered? First, as with the call for input on the NQS, it is critical that the government communicate with researchers the challenges federal and state implementers are facing in making progress on the NQS. Potentially social networking approaches might support connections among groups by interest area, and across sectors so that researchers, practitioners, policy makers, etc. have access to each other in real-time. For each of the areas highlighted in the NQS, we need receptor sites for trying out new ideas, and monitoring the effects. For example:

NQS Area: Person-centeredness, family engagement (not location or provider centered). Need to have networks of patients and families who want to engage in the improvement enterprise, and how to's for working with them effectively as a function of where one sits (e.g., a researcher at a university who wants to have input on his/her research project; a State Medicaid Director who wants input on program choices; a community collaborative who has put everyone together except the patient stakeholders)

Finally, we need a public scorecard of progress – who is on board, what are they doing, and what have they accomplished, and how do they prove what they've done, and is it replicable elsewhere? Quality improvement requires action from many. To pass the mom/dad test, we need a way to make public the work and names of those in health services research and those in the field who are making improvements to the health care system. The public understands investments in research to cure cancer. But do they understand investments to troubleshoot and innovate in the way that care is delivered, ways that new discoveries get to everyone, how the health of a population has improved? We all have to keep working to highlight what we do that makes a difference, and delivers on the goals and plans of the NQS. Professional societies, especially those dedicated to advancing evaluative methods such as SMDM, should be included as active partners in the NQS.