



## On the Radar

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### On the Radar

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### Shared Decision Making Symposium: Developing tools and skills for clinical practice

Free live webcast on Thursday, 16 October 2014 (9.00am–1pm AEDT)

Shared decision making involves the integration of a patient's values, goals and concerns with the best available evidence about benefits, risks and uncertainties of treatment, in order to come to appropriate health care decisions.

Co-hosted by the Australian Commission on Safety and Quality in Health Care and the University of Sydney's Centre for Medical Psychology and Evidence-Based Decision Making (CeMPED) the symposium will include:

- Tools and skills for effective shared decision making
- Current implementation issues for clinical practice
- Presentations by International experts, Australian experts & panel discussion.

For information and details about how to access the webcast visit <http://www.safetyandquality.gov.au/our-work/shared-decision-making/shared-decision-making-symposium/>

Registration is not required, just visit the website on the day.

Not available to watch the live webcast? A recording of the symposium will be available the following day.

For further information about the symposium contact [shannon.mckinn@sydney.edu.au](mailto:shannon.mckinn@sydney.edu.au)

## Reports

*Person-centred care: from ideas to action. Bringing together the evidence on shared decision making and self-management support*

Ahmad N, Ellins J, Krelle H, Lawrie M

London: The Health Foundation; 2014. p. 100.

*Ideas into action: person-centred care in practice. What to consider when implementing shared decision making and self-management support. Learning Report*

Health Foundation

London: The Health Foundation; 2014. p. 20.

URL	<a href="http://www.health.org.uk/publications/person-centred-care-from-ideas-to-action/">http://www.health.org.uk/publications/person-centred-care-from-ideas-to-action/</a> (Research report) <a href="http://www.health.org.uk/publications/ideas-into-action-person-centred-care-in-practice/">http://www.health.org.uk/publications/ideas-into-action-person-centred-care-in-practice/</a> (Learning report)
TRIM	D14-34550 (Research report) D14-34553 (Learning report)
Notes	The UK's Health Foundation has published this report that seeks to bring together the evidence on shared decision making and self-management support, with the aim of providing greater coherence and clarity in debates about person-centred care. This <b>Research report</b> explores the conceptual relationship between shared decision making and self-management support, the policy and practice environment, the evidence base about their impact and what works in implementing them in routine NHS practice. The accompanying <b>Learning report</b> provides information for health care professionals, commissioners and providers looking to <b>implement self-management support and shared decision making</b> in order to realise a person-centred approach to health care. The Health Foundation has also produced an 'in brief' summary and analysis report. This looks at the implications of the research for policy makers and those responsible for providing strategic direction, in order to assist them in moving person-centred care and support from an aspiration to day-to-day, routine practice.

For information on the Commission's work on consumer and patient centred care, see <http://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/>

For information on the Commission's work on shared decision making, see <http://www.safetyandquality.gov.au/our-work/shared-decision-making/>

*Shared Decision-Making Strategies for Best Care: Patient Decision Aids*. Discussion paper  
 Alston C, Berger Z, Brownlee S, Elwyn G, Fowler Jr. FJ, Hall LK, et al  
 Washington D.C.: Institute of Medicine; 2014. p. 54.

URL	<a href="http://www.iom.edu/Global/Perspectives/2014/SDMforBestCare.aspx">http://www.iom.edu/Global/Perspectives/2014/SDMforBestCare.aspx</a>
Notes	This discussion paper, following an (US) Institute of Medicine Roundtable on Value and Science-Driven Health Care, suggests suggest ways to integrating the ideals and practices of shared decision making (SDM) into routine clinical practice. The authors identify steps in shirting expectations and behaviours of patients and clinicians, including <b>certifying decision aids, establishing measurement standards</b> for SDM, using health information technology to facilitate <b>information exchange</b> , and expanding the role of employers, funders and payers in supporting certified decision aids. The authors also summarised the case for implementing SDM, and the potential benefits.

*National Action Plan for Adverse Drug Event Prevention*

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion

Washington, D.C.: U.S. Department of Health and Human Services; 2014. p. 190.

URL	<a href="http://www.health.gov/hai/ade.asp#final">http://www.health.gov/hai/ade.asp#final</a>
TRIM	D14-34156
Notes	<p>The US government Office of Disease Prevention and Health Promotion has released the final version of the (US) <i>National Action Plan for Adverse Drug Event Prevention</i>.</p> <p>The ADE Action Plan addresses a defined group of Adverse Drug Events (ADEs) that are considered to be common, clinically significant, preventable, and measurable; resulting from high-priority drug classes; and occurring largely in high-risk populations.</p> <p>Three key drug classes identified as initial targets for the ADE Action Plan include:</p> <ul style="list-style-type: none"> <li>• <b>Anticoagulants</b> (primary ADE of concern: bleeding)</li> <li>• <b>Diabetes agents</b> (primary ADE of concern: hypoglycaemia)</li> <li>• <b>Opioids</b> (primary ADE of concern: accidental overdoses, over-sedation, respiratory depression)</li> </ul> <p>The ADE Action Plan identifies a four-pronged approach:</p> <ul style="list-style-type: none"> <li>• <b>Surveillance</b> — Coordinate existing federal surveillance resources and data to assess the health burden and rates of ADEs.</li> <li>• <b>Prevention</b> — Share existing evidence-based prevention tools across federal agencies and with non-federal health care providers and patients.</li> <li>• <b>Incentives and Oversight</b> — Explore opportunities, including financial incentives and oversight authorities, to promote ADE prevention.</li> <li>• <b>Research</b> — Identify current knowledge gaps and future research needs (unanswered questions) for ADE prevention.</li> </ul>

For information on the Commission’s work on medication safety, see [www.safetyandquality.gov.au/our-work/medication-safety/](http://www.safetyandquality.gov.au/our-work/medication-safety/)

*Variation in the Care of Surgical Conditions: Cerebral Aneurysms*

Bekelis K, Goodney PR, Dzebisashvili N, Goodman DC, Bronner KK

Hanover, NH: The Dartmouth Institute for Health Policy and Clinical Practice; 2014.

URL	<a href="http://www.dartmouthatlas.org/downloads/reports/Cerebral_aneurysm_report_09_30_14.pdf">http://www.dartmouthatlas.org/downloads/reports/Cerebral_aneurysm_report_09_30_14.pdf</a>
TRIM	D14-34279
Notes	<p>This is the second in a series of six reports into surgical variation in the USA (the first being on obesity and the future reports will cover surgical treatments for diabetes/peripheral artery disease, spinal stenosis, organ failure (transplantation) and prostate cancer).</p> <p>Topics covered in this report on cerebral aneurysms include the frequency of the condition, the decision about whether to treat unruptured aneurysms, and which treatment to use. As noted in the Foreword, this report also takes a longitudinal view as “The changes over time in which procedure is favored to treat aneurysms are particularly fascinating, driven as they appear to be by a mix of clinical evidence—including emerging long-term results—and physicians’ opinions and personal experience.”</p>

For information on the Commission’s work on variation in health care, ee

<http://www.safetyandquality.gov.au/our-work/variation-in-health-care/>

### Journal articles

*Less is not always more: embracing (appropriate) medical intensity*

Burke LG, Jha AK

BMJ Quality & Safety. 2014 [epub].

DOI	<a href="http://dx.doi.org/10.1136/bmjqs-2014-003586">http://dx.doi.org/10.1136/bmjqs-2014-003586</a>
Notes	<p>Central to debates about variation in care, overuse, ‘less is more’, ‘Choosing Wisely’ and the like is the question of what is the right rate, what is appropriate. This editorial in <i>BMJ Quality and Safety</i> discusses the issue in terms of ‘medical intensity’ and medical culture. The solution appears, again, to take us to patient-centred care: “The optimal level of intensity of <b>care needs to be tailored to the patient's needs and wishes and supported by high-quality evidence</b> whenever possible. Optimal care for patients with serious illness frequently requires complex care in expensive settings. This level of intensity, applied to seriously ill patients, can lead to better outcomes. Applying the same level of intensity to a different patient population is likely to lead to waste and potentially worse clinical outcomes.”</p>

*Applying a Science-Based Method to Improve Perinatal Care: The Institute for Healthcare Improvement Perinatal Improvement Community*

Bisognano M, Cherouny PH, Gullo S

Obstetrics & Gynecology. 2014;124(4):810-4 10.1097/AOG.0000000000000474.

DOI	<a href="http://dx.doi.org/10.1097/AOG.0000000000000474">http://dx.doi.org/10.1097/AOG.0000000000000474</a>
Notes	<p>This paper describes how the (US) Institute for Healthcare Improvement has worked with clinical teams to help improve care for mothers and newborns through the Perinatal Improvement Community. The article describes the origins of and the early challenges faced by the Community, the IHI’s approach to improvement, and the growing role of the IHI ‘Triple Aim’.</p>

	The Community has been working to reduce early elective deliveries (EEDs) and rates of caesarean sections. The authors report that in one of the Community’s cohorts, early elective deliveries were reduced from a mean of 15.3 percent to a mean of 1.2 percent over two years, and teams reporting data reached the target of zero EEDs in the final month of the measurement period.
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*The Opportunity Cost of Futile Treatment in the ICU\**

Huynh TN, Kleerup EC, Raj PP, Wenger NS

Critical Care Medicine. 2014;42(9):1977-82 10.097/CCM.0000000000000402.

DOI	<a href="http://dx.doi.org/10.1097/CCM.0000000000000402">http://dx.doi.org/10.1097/CCM.0000000000000402</a>
Notes	<p>The cost of care, as measured in various ways, is often discussed. This can be in terms of affordability, sustainability or even appropriateness. This paper considers another ‘cost’, that of opportunity cost, specifically in relation to intensive care unit (ICU) care. Opportunity cost refers to the ‘cost’ of choosing to take one course thereby removes the opportunity to take another course. In this case, providing ‘futile’ treatment to terminally ill patients in the ICU precludes the treatment of other patients.</p> <p>This paper reports on a study that surveyed physicians in five US ICUs over 3 months. The clinicians identified patients receiving futile treatment and the study identified days when an ICU was full and contained at least one patient who was receiving futile treatment and evaluated the number of patients waiting for ICU admission more than 4 hours in the emergency department or more than 1 day at an outside hospital.</p> <p>The authors report that in the 5 ICUs 36 critical care specialists made 6,916 assessments on 1,136 patients of whom 123 were assessed to receive futile treatment. It was found that a full ICU was less likely to contain a patient receiving futile treatment compared with an ICU with available beds (38% vs 68%) – suggesting that there is an awareness of the issue. On 72 (16%) days, an ICU was full and contained at least one patient receiving futile treatment. During these days, 33 patients boarded in the emergency department for more than 4 hours after admitted to the ICU team, nine patients waited more than 1 day to be transferred from an outside hospital, and 15 patients cancelled the transfer request after waiting more than 1 day. Two patients died while waiting to be transferred.</p> <p>As the authors conclude: “Futile critical care was associated with delays in care to other patients.” Thus, once patients are receiving ‘futile care’ the question is whether the ICU is the most appropriate place for the patient to be – both for the patient and for other patients who may benefit from ICU care.</p>

*Orthogeriatric services associated with lower 30-day mortality for older patients who undergo surgery for hip fracture*

Zeltzer J, Mitchell RJ, Toson B, Harris IA, Ahmad L, Close J.

Med J Aust 2014;201(7):409-411.

DOI	<a href="http://dx.doi.org/10.5694/mja14.00055">http://dx.doi.org/10.5694/mja14.00055</a>
Notes	Using data linkage, this study looked at mortality within 30 days of hip fracture surgery for patients older than 65 years who were admitted to NSW public hospitals between 2009 and 2011. The rate of mortality was statistically lower for hospitals which offered an orthogeriatric service during the period of study (6.2% v 8.4%; P < 0.002%). Length of stay (LOS) was also longer (26 vs 22 days).

	Factors associated with orthogeriatrics (geriatricians providing care in consultation with the orthopaedics team) that might contribute to better outcomes include “medical optimisation before surgery, prevention and early detection of medical complications, better coordination of care, better communication between staff responsible for care, and better management of comorbidities”. Whether an orthogeriatrics approach was the cause for the observed lower mortality could not be determined in this study, nor could the appropriateness of the longer LOS.
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*BMJ Quality and Safety* online first articles

URL	<a href="http://qualitysafety.bmj.com/content/early/recent">http://qualitysafety.bmj.com/content/early/recent</a>
Notes	<p><i>BMJ Quality and Safety</i> has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> <li>• Key characteristics of successful <b>quality improvement curricula in physician education</b>: a realist review (Anne C Jones, Scott A Shipman, Greg Ogrinc)</li> <li>• Editorial: Less is not always more: embracing (<b>appropriate</b>) <b>medical intensity</b> (Laura G Burke, Ashish K Jha)</li> <li>• Correspondence: Challenging the systems approach: <b>why adverse event rates are not improving</b> (Philip Levitt)</li> <li>• Correspondence response: <b>The bad apple theory won't work</b>: response to ‘Challenging the systems approach: why adverse event rates are not improving’ by Dr Levitt (Sidney W A Dekker, Nancy G Leveson)</li> </ul>

**Online resources**

*Can we use a smartphone App and the simple barcode to improve patient safety, monitor compliance and reduce costs?*

<http://isqua.org/education/webinars/can-we-use-a-smartphone-app-and-the-simple-barcode-to-improve-patient-safety-monitor-compliance-and-reduce-costs-yes-we-scan!-with-feargal-mc-groarty>

Webinar presented by Feargal McGroarty, Project Manager at the Irish National Haemophilia System describing an innovative solution that uses the patient’s smartphone and tracks medication, gathers clinical information, increases recording compliance as well as alerting the patient to potential hazards with respect to their medication.

*[UK] NICE Evidence Updates*

<https://www.evidence.nhs.uk/about-evidence-services/bulletins-and-alerts/evidence-updates>

The UK’s National Institute for Health and Care Excellence (NICE) has published updates on their Evidence Updates site. The new updates are on ‘**infection**’ and **Crohn’s disease**.

A new Evidence Update focuses on a summary of selected new evidence relevant to NICE clinical guideline 139 ‘**Prevention and control of healthcare-associated infections in primary and community care**’ (2012).

<https://www.evidence.nhs.uk/evidence-update-64>

A new Evidence Update focuses on a summary of selected new evidence relevant to NICE clinical guideline 152 ‘**Crohn’s disease: management in adults, children and young people**’ (2012).

<https://www.evidence.nhs.uk/evidence-update-65>

[USA] *Preventing Adverse Drug Events: Individualizing Glycemic Targets Using Health Literacy Strategies*

[http://health.gov/hai/training.asp#prevent\\_ades](http://health.gov/hai/training.asp#prevent_ades)

This interactive eLearning course from the (US government) Office of Disease Prevention and Health Promotion teaches health care providers how to:

- Apply health literacy strategies to provide personalized care for patients with diabetes, and to help them understand and act on information to prevent hypoglycaemia
- Apply current, evidence-based guidelines for individualizing glycaemic target goals
- Adopt the teach-back method and shared decision-making in the health care setting.

[USA] *Effective Health Care Program reports*

<http://effectivehealthcare.ahrq.gov/>

The US Agency for Healthcare Research and Quality (AHRQ) has an Effective Health Care (EHC) Program.

The EHC has released the following final reports:

*Imaging Tests for the Diagnosis and Staging of Pancreatic Adenocarcinoma*

<http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayProduct&productID=1972>

*The Effectiveness and Risks of Long-Term Opioid Treatment of Chronic Pain*

<http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayProduct&productID=1971>

*The Empirical Evidence of Bias in Trials Measuring Treatment Differences*

<http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayProduct&productID=1977>

*Imaging Techniques for Treatment Evaluation for Metastatic Breast Cancer*

<http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayProduct&productID=1981>

The EHC has also released the following consumer and clinician summaries:

*Therapies for Children With Autism Spectrum Disorder* (consumer summary)

<http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1974>

*Comparative Effectiveness of Therapies for Children With Autism Spectrum Disorder* (clinician summary) <http://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1975>

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