



# CIP2015

4<sup>TH</sup> GLOBAL CONGRESS FOR  
CONSENSUS IN PEDIATRICS & CHILD HEALTH



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MARCH 19-22, 2015 | BUDAPEST, HUNGARY





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# *PHILIPPE EVRARD*

UNIVERSITY OF PARIS – DIDEROT MEDICAL  
SCHOOL

ROBERT – DEBRÉ PEDIATRIC HOSPITAL  
(ASSISTANCE PUBLIQUE – HÔPITAUX DE PARIS)

# **EVALUATION, CONSENSUS & ALERTS FOR CHILD CARE AND CHILD HEALTH**

- 1. QUALITY ASSESSMENTS***
- 2. METHODS OF  
CONSENSUS AND ALERTS***
- 3. NETWORKS***

# QUALITY ASSESSMENTS

- Health products
- Health organizations
  - ▣ Accreditations

*Two crucial observations:*

- *Every system is perfectly designed to get the results it gets. Paul Batalden*
- *Each issue is extremely « systems sensitive » (empowering diversity) > consensus of consensuses*

# Health Products

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- European Medicines Agency (EMA, EU)
- Food and Drug Administration (FDA, USA)
- Pharmaceuticals and Medical Devices Agency (PMDA, Japan)

# QUALITY ASSESSMENT *HEALTH CARE PRODUCTS*

After the market approval by EMA, FDA, or PMDA for European, American and Japanese populations, health insurers assess the **cost effectiveness** allowing decisions for price, reimbursement and volume of dissemination

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# Quality assessment of health care products

## INSIGHT & LESSONS



**HARMONY**



**LIBERTY**

***Laurent DEGOS***



# Quality assessment of health care products

## SOCIAL VALUES

utility, accountability, equality, harmony, liberty...



UTILITY =  
COST OF OPPORTUNITY =  
**COLLECTIVE INTEREST**



EQUALITY =  
LOSS OF OPPORTUNITY =  
**INDIVIDUAL INTEREST**

*Laurent DEGOS, 2015*

# Quality assessment of health care products

## INSIGHT & LESSONS



### UTILITY

cost-qaly threshold: **REIMBURSEMENT**



### ACCOUNTABILITY

willingness to pay : **PRICING**



### EQUALITY

stratification:

**VOLUME (or price x volume)**

# A **binary** approach

## *Individual interests versus* *Collective interests*

- More efficacy (individual) *versus* more safety and sustainability (collective)
- More facilities for a patient *versus* better distribution of available tools
- Patients health *versus* optimization of common resources

# A complex dilemma

1. A binary approach
2. The search of underlying values
3. Insight and lessons

**QUALITY OF** health care products

health care organizations

**SAFETY** policy (guilty or no blame - no shame)

prescriptive strategy or autonomy

# Quality assessment of health care organizations

## CONSEQUENCE OF THE BINARY APPROACH

### MANAGERIAL:

**Requirements effectively in place**

Accreditation, process indicators, certification

### MEDICAL:

**Clinical Outcomes of patients**

Mortality, complications, quality of life

**NO CORRELATION BETWEEN ASSESSMENT OF  
PROCESSES  
AND CLINICAL OUTCOMES**

# Safety assessment of health care activity

Two French inquiries, carried out at 5 years interval in 2004 and 2009 **did not disclose any change in the rate of severe adverse events in health care organizations**

There is an urgent need to create and to couple morbidity – mortality assessment with accreditation parameters

# **EVALUATION, CONSENSUS & ALERTS FOR CHILD CARE AND CHILD HEALTH**

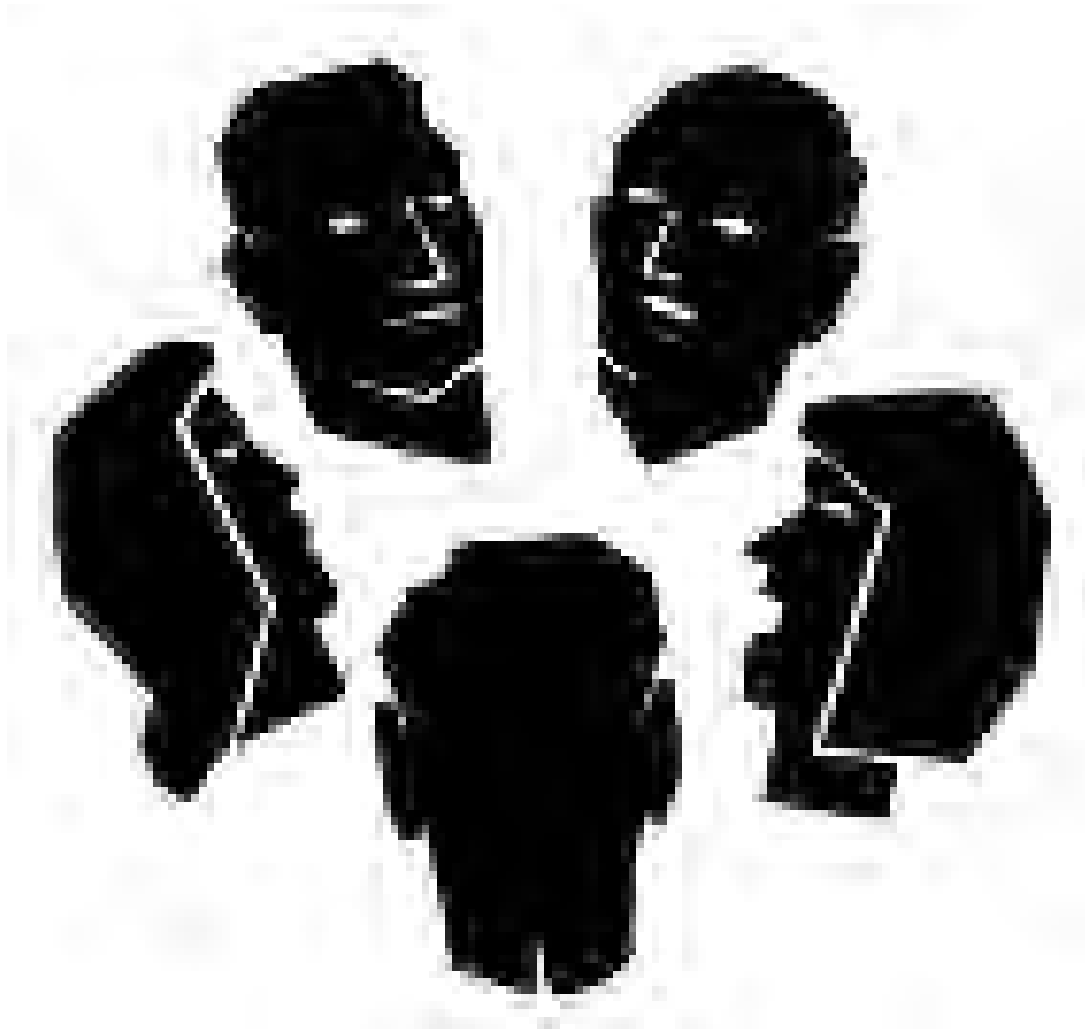
## ***1. QUALITY ASSESSMENTS***

## ***2. METHODS OF CONSENSUS AND ALERTS TO IMPROVE CHILD CARE AND HEALTH***

## ***3. NETWORKS***



## *The consensus processes : new tools*



Jones J , Hunter D BMJ 1995;311:376-380

BMJ



# Consensus (*Latin: feel together*)

- **Definition** (*Merriam – Webster*):
  - ▣ 1st: general agreement;
  - ▣ 2<sup>nd</sup>: group solidarity of belief or sentiment
- **Consensus decision making process:**
  - ▣ 1st: agreement of most participants;
  - ▣ 2<sup>nd</sup>: resolution or mitigation of minority objections

*A few words about*

# History of the consensus processes

- **Iroquois Haudenosaunee (1142)**
- **Quaker model (17th century)**
- **Women's liberation movement**
- **Ringi-sho (Japan) and Mass Gen Hosp (Boston) : *bottom to the top***
- **ISO (Intl Organization for Standardization)**
- **Consensus Development Program NIH: OMAR (1977)**
- **NICE, U-K (1999)**
- **KCE, Belgium (2002)**
- **Haute Autorité de Santé, France (2004)**

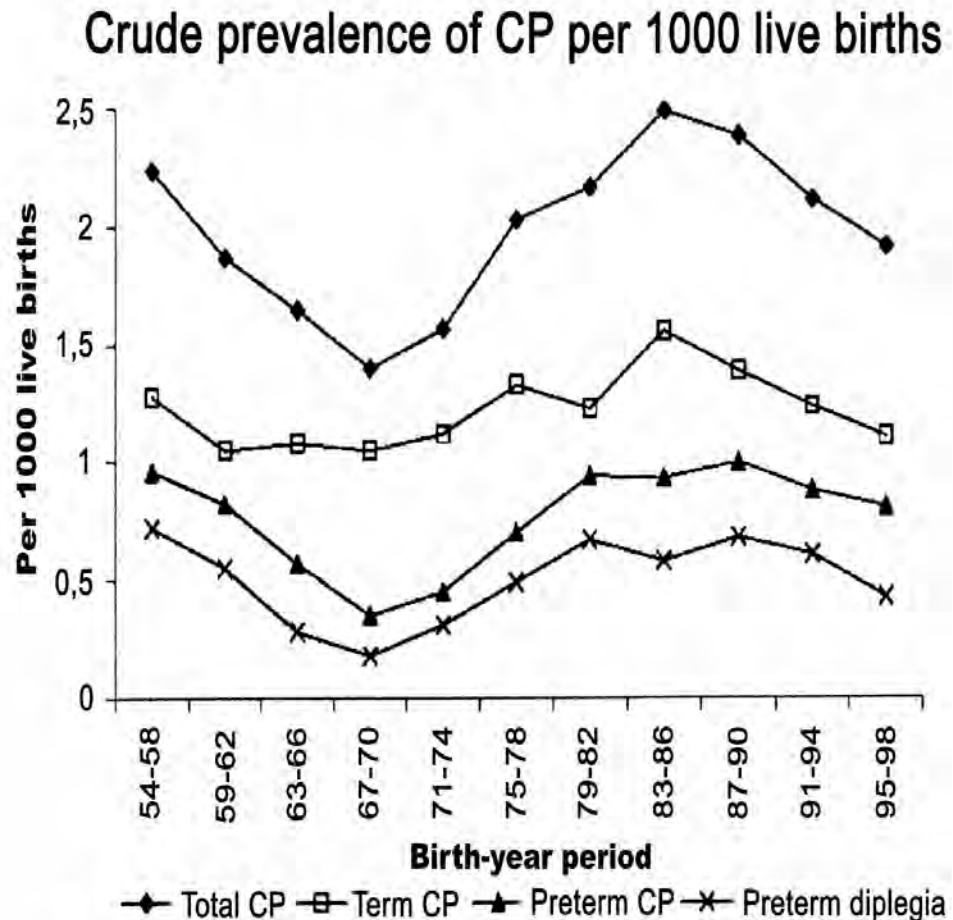
# Famous **failures** of the consensus process

**Neurological prognosis of preterm births**

**1970 – 1985**

***More than 1,000***

***« consensus panels »***



# Consensus: clinical dangers and bias

## Bias

- ❑ **Collective opinion, dictatorship of majority, politically correct**
- ❑ **Dominance**
- ❑ **Abilene paradox**
- ❑ **Time consuming**

## Remedies

- ❑ **Financer's declaration of objectives**
- ❑ **Appropriate selection of participants**
- ❑ **Synthesis of the prexistant information**
- ❑ **Veto**
- ❑ **Definition of agreement degrees**

# Abilene paradox

***A group can unanimously agree on a course of action that no individual member of the group desires because no one individual is willing to go against the perceived will of the decision – making body.***

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# Methods for consensus

- **Delphi Method**
- **Nominal Group Technique**
- **Consensus Conferences**
- **RAND / UCLA**

# The Delphi process takes its name from the Delphic oracle's skills of interpretation and foresight



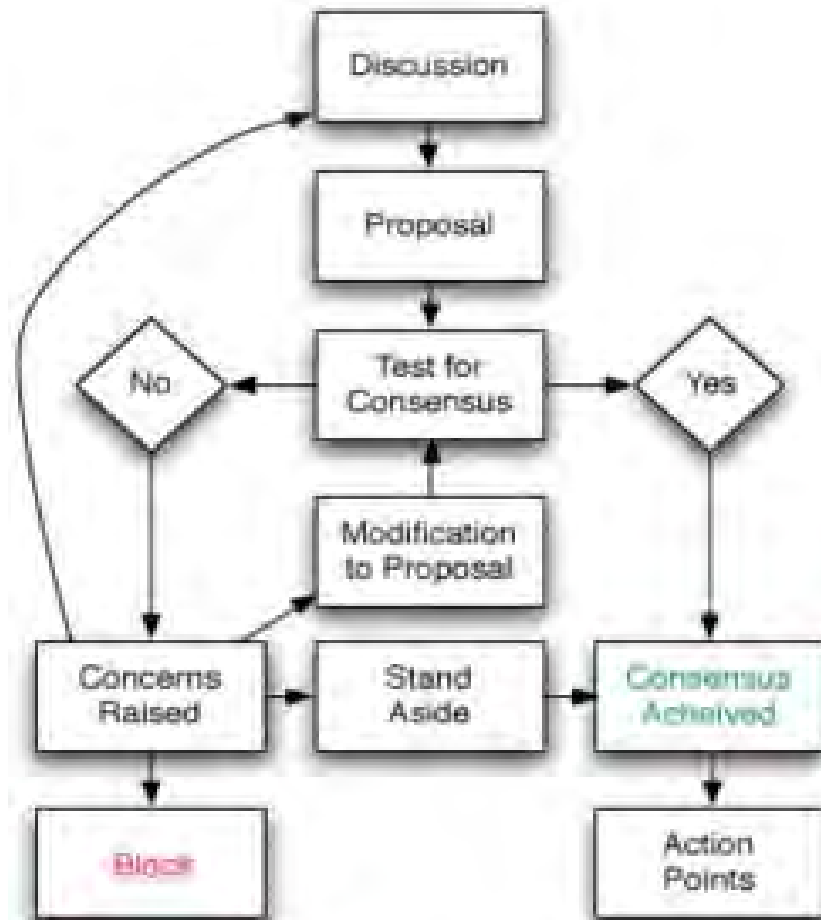
Jones J , Hunter D BMJ 1995;311:376-380



	<b>DELPHI</b>	<b>Nominal group</b>	<b>RAND / UCLA</b>	<b>Consensus panel</b>
<b>Goals</b>	<b>To obtain a final, convergent opinion</b>	<b>To reach a hierarchical order of priorities</b>	<b>Evaluation of the legitimate use of tools and treatments</b>	<b>Production of written recommendations</b>
<b>Method</b>	<ul style="list-style-type: none"> <li>• Questionnaire</li> <li>• <b>Individual anonymous answers</b></li> <li>• <b>Feedback</b></li> <li>• Pre-established rules</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Two anonymous individual tours (during a meeting)</b></li> <li>• <b>Avoidance of dominance</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Combination of the Delphi and Nominal Group Technique</b></li> </ul>	<ul style="list-style-type: none"> <li>* <b>Combination of #1, #2, and #3</b></li> <li>• <b>Public debate</b></li> <li>• <b>Consensus of the jury (in private)</b></li> </ul>

# The consensus decision-making process in itself: *flowchart*

- > Not only the agreement of most participants
- > But also the resolution or mitigation of minority objections



	Levels of evidence		Level of recommendations
1	<ul style="list-style-type: none"> <li>• Robust comparative randomised trials</li> <li>• Meta-analysis of randomized trials</li> <li>• Decisional analysis based on robust studies</li> </ul>	A	Fully proved
2	<ul style="list-style-type: none"> <li>• Weak comparative randomized trials</li> <li>• Well runned non randomized studies</li> <li>• Studies of cohorts</li> </ul>	B	Scientific assumption
3	<ul style="list-style-type: none"> <li>• Studies of witness cases</li> </ul>	C	Low level of proof
4	<ul style="list-style-type: none"> <li>• Comparative studies with bias</li> <li>• Retrospective studies</li> </ul>	C	Low level

# Evidence – based practice

(Gordon Guyatt, 1980, McMaster)

## Bases

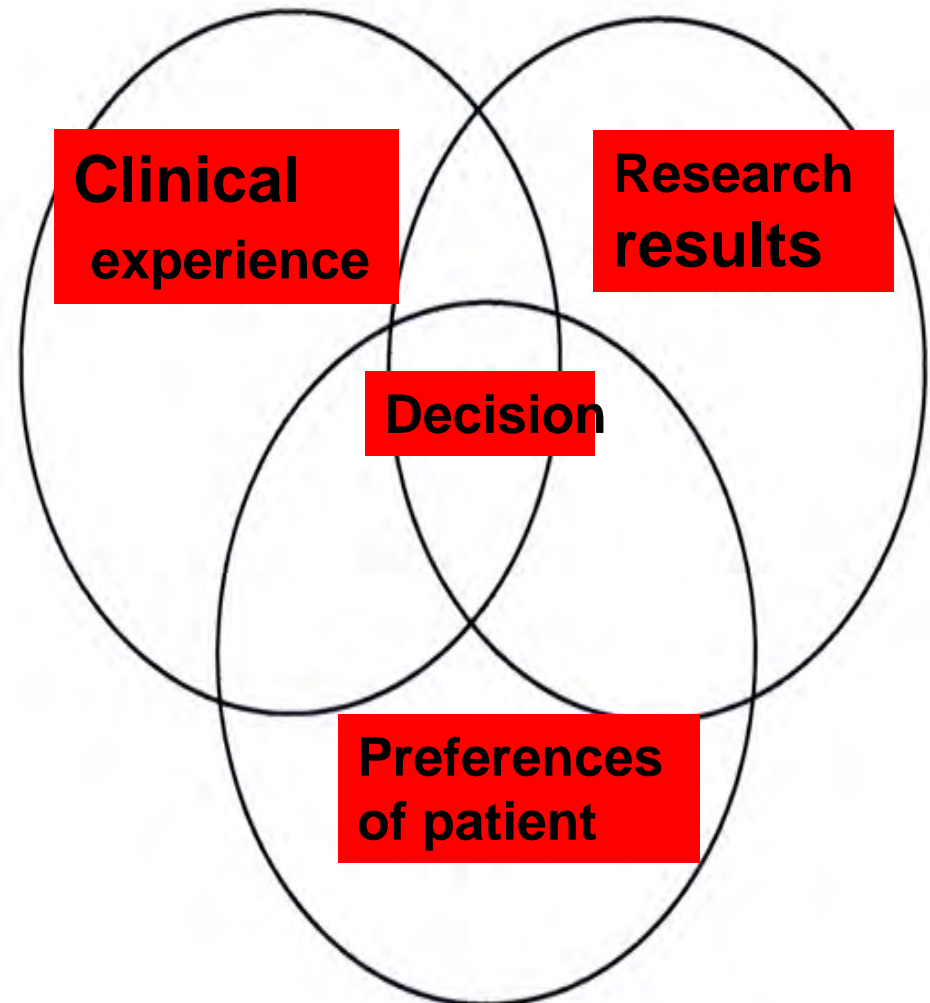
- From systematic reviews from of double-blind, placebo-controlled (at the top) to conventional wisdom (at the bottom)
- Meta-analyses
- Recognizes the individual factors (« best prediction » as debate continues)
- *Ex cathedra* by medical experts: least valid form of evidence and sometimes dangerous

## Limits

- Conflicts of interest
- Dominance
- Nonadherence, clinical inertia, therapeutic inertia
- Defective information

# Evidence – based practice

**EBM fully recognizes multiple factors and individualized medicine**



# Two forms of state-of-art statements

## Consensus statements

- **New information**
- **Recent or ongoing medical research**
- **No specific algorithms or guidelines for practice**

## Reevaluation of medical practices: algorithms and guidelines

- **Cost**
- **Available expertise**
- **Available technology**
- **Local practice circumstances**

# Frequent failures of well planned consensus conferences

> Nonadherence

> Clinical inertia

> Therapeutic inertia

*J.D. Allen et al., JMCP, 2009*

**TABLE 1** Factors Contributing to Apparent Clinical Inertia<sup>a</sup>

Clinician <sup>b</sup>	Patient	Health System
<ul style="list-style-type: none"> <li>• Failure to initiate treatment</li> <li>• Failure to titrate treatment to goal</li> <li>• Failure to set clear goals</li> <li>• Underestimation of patient need</li> <li>• Failure to identify and manage comorbid conditions such as depression</li> <li>• Insufficient time</li> <li>• Insufficient focus or emphasis on goal attainment</li> <li>• Reactive rather than proactive care</li> </ul>	<ul style="list-style-type: none"> <li>• Medication side effects</li> <li>• Too many medications</li> <li>• Forgetfulness</li> <li>• Cost of medication</li> <li>• Denial of disease</li> <li>• Denial of disease severity</li> <li>• Perception of low susceptibility</li> <li>• Absence of disease symptoms</li> <li>• Mistrust of clinician</li> <li>• Poor communication with clinician</li> <li>• Low health literacy</li> <li>• Mental illness, depression, substance abuse</li> <li>• Lifestyle</li> </ul>	<ul style="list-style-type: none"> <li>• No clinical guideline</li> <li>• No disease registry</li> <li>• No visit planning</li> <li>• No active patient outreach</li> <li>• No decision support</li> <li>• No team approach to care or lack of care coordination</li> <li>• Poor communication between clinician and office staff</li> <li>• <b>Ex cathedra medical experts: often dangerous</b></li> </ul>

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CARE AND CHILD HEALTH**

**1. QUALITY ASSESSMENTS**

**2. METHODS OF CONSENSUS AND ALERTS**

**3. NETWORKS**

***TWO EXAMPLES:***

**\* *AUTISM***

**\* *RMEF***



# GOOD PRACTICE FOR AUTISM (ASD)

- 1. Haute Autorité de Santé (HAS), France, 2012**
- 2. National Institute for Health and Care Excellence (NICE), United Kingdom, 2013**
- 3. Federaal Kenniscentrum - Centre fédéral d'Expertise des Soins de Santé (KCE), Belgium, 2014**

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2. *METHODS OF CONSENSUS AND ALERTS*

## 3. *NETWORKS*

*TWO EXAMPLES:*

\* *AUTISM*

\* *RMEF*

*(RÉSEAU MÈRE – ENFANT DE LA  
FRANCOPHONIE)*



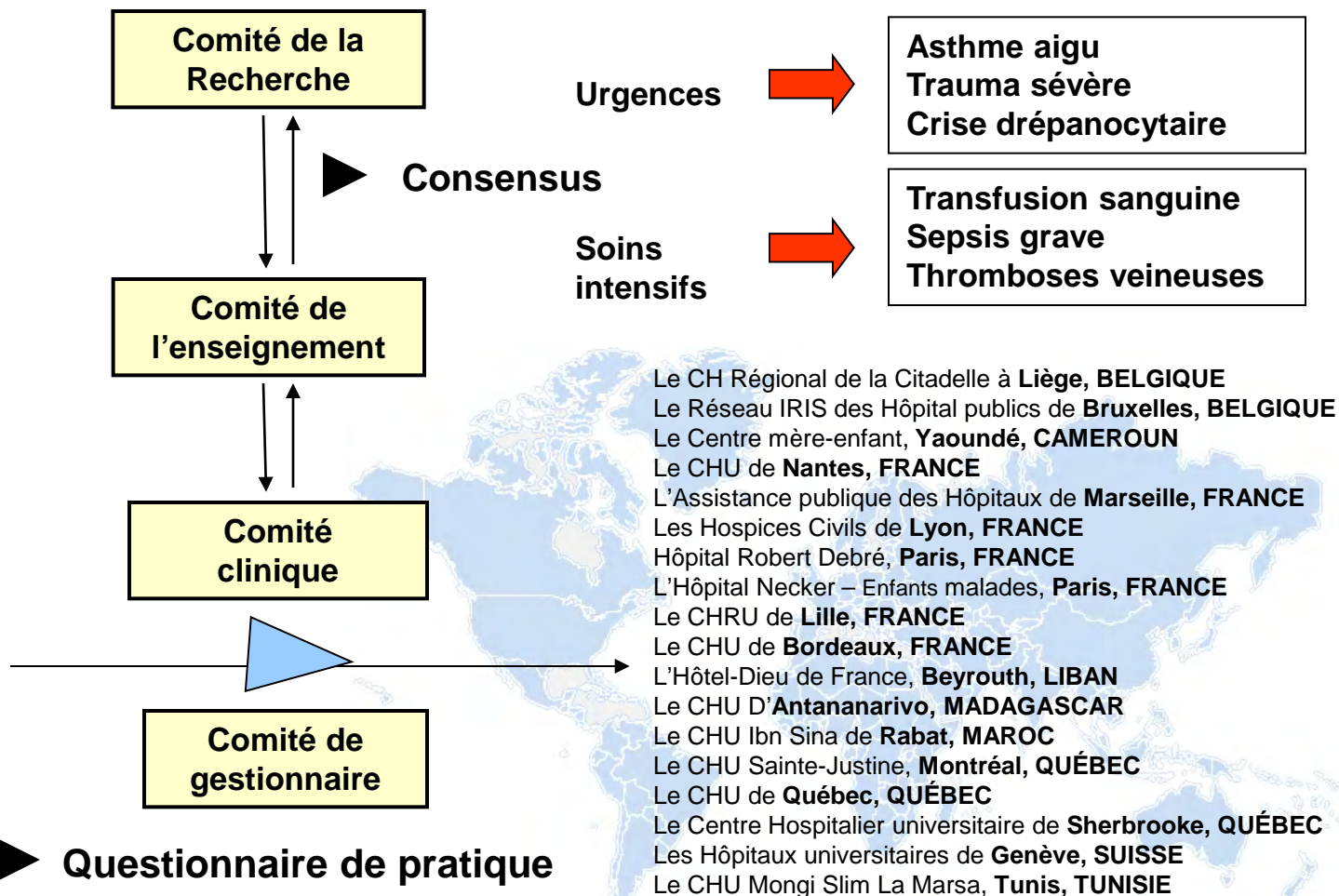
Réseau mère-enfant  
de la Francophonie



The 1<sup>st</sup> Global Congress for  
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Réseau mère-enfant  
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# CHALLENGES

## Common challenges: internal and external environment

- ❑ Needs exceed the offer
- ❑ New expectations of patients and teams
- ❑ Shortage of highly trained specific human resources
- ❑ Delay of acquisition of new technologies
- ❑ Bureaucratic constraints
- ❑ Changes of social and economic environment

## Specific challenges : growth and renovation

- ❑ New projects
- ❑ Renovations
- ❑ Fusions, merging and réorientation of objectives

*Le RMEF, Francis Brunet, FHF, Paris, mai 2014*

*Global supply of health professionals. N.Crisp and L.Chen. NEJM 2014;370:950-7.*

*Harnessing the power of default options to improve healthcare. NEJM 2007;357:1340-4.*

*Strategy for UK Life Sciences. [www.bis.gov.uk](http://www.bis.gov.uk).*

# Barriers to Innovation

- **Physicians' barriers to guideline implementation**
  - No time, no financial incentive
  - Guidelines are too theoretical and/or overcomplicated
  - Perceived lack of applicability due to patient characteristics or clinical situation
- **Teams' barriers:**
  - Shared decision-making has not been widely adopted
  - Lack of teamwork and inter team collaboration
  - Time constraints of health professional team (in working together)
- **System barriers:**
  - Model of care delivery doesn't allow implementing evidence
  - Lack of appropriate settings and technologies
  - System organization doesn't allow continuum of care

*1- Graham. European Society of Cardiology 2006; 13:839-45; 2- Gravel. Implementation Science 2006; 1(16); 3- Chaillet. Obstetrics & Gynecology 2006; 108(5): 1234-45*



# Transfer of knowledge

- **Knowledge translation requires to define**
  - ▣ Object: guideline, protocol, pathway
  - ▣ Target: patients population, acuity and severity
  - ▣ Effector: Physician, team, multiple teams
  - ▣ System: organized or not
  
- **Overcoming barriers needs planning**
  - ▣ Prospective identification of efficient strategies & barriers to change
  - ▣ Multifaceted interventions rather than single strategies

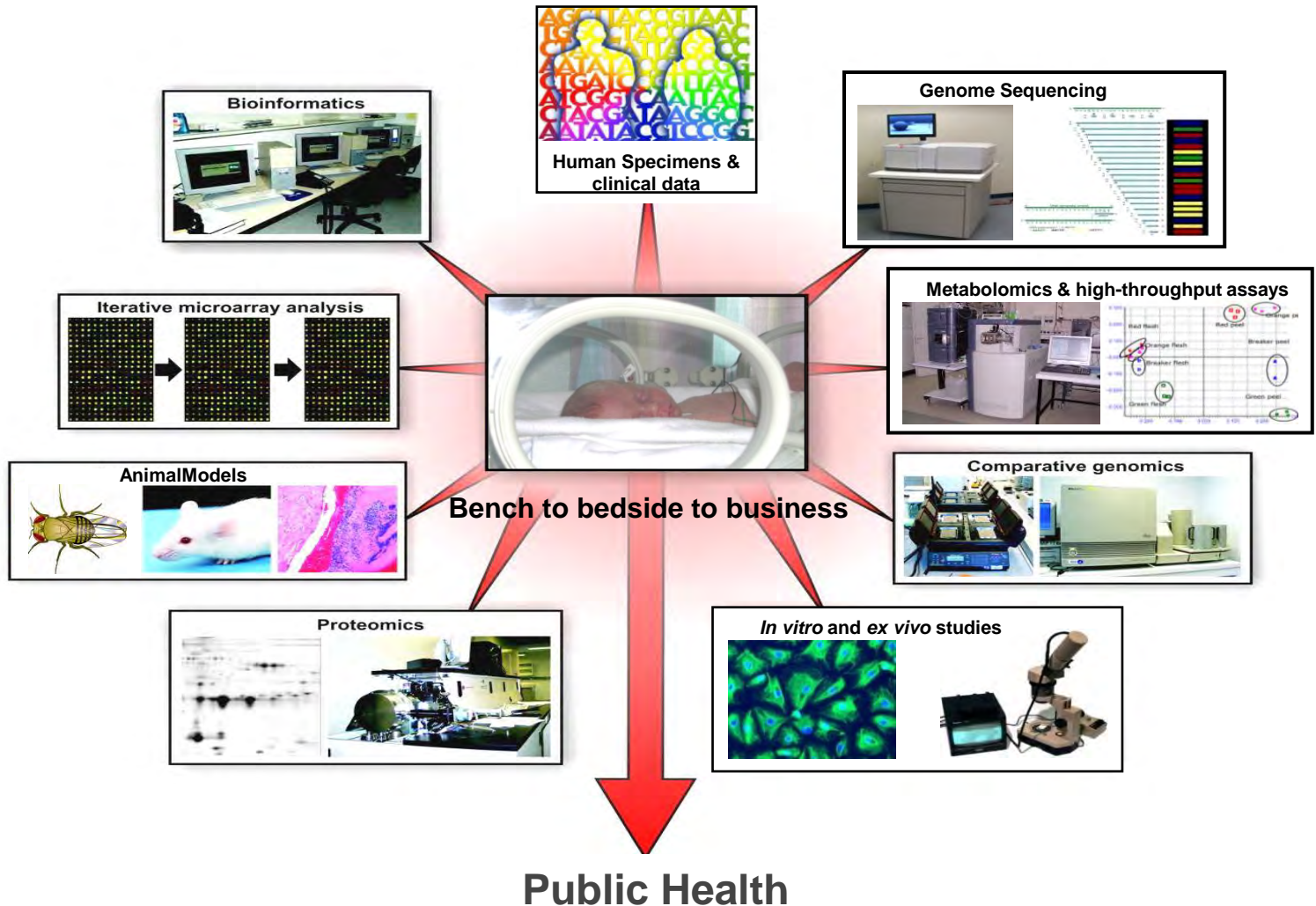




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# Sharing of data bases



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# *Suggestions submitted to Manuel and Shimon for CIP priorities (1)*

## **Main programs**

- **Brainstorming and think tank before consensus conferences**
- **Clinical guidelines deriving from consensus conferences and state-of-the-science conferences**
- **Consensus and personalized care** (*suggested by Fabrice Brunet, RMEF*)
- **How to avoid conflicts between consensus and research** (*the snapshot in time; support to research and strategic planning*)

## **Satellite activities**

- **Global exchanges between global, continental and national consensus, state-of-the-science and guidelines / algorithms conferences**
- **Conflicts between state of the art and public health**
- **Limits and failures of evidence – based medicine**

# ***Suggestions submitted to Manuel and Shimon for CIP priorities (2)***

- **Partnership with international agencies for pediatric healthcare strategy**
- **The pediatric hospital of the future**
- **Support to networks**
  
- ***Every system is perfectly designed to get the results it gets. Paul Batalden***
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19/80

A. P. [unclear] et Ghislain Evvard, à la cordiale

P. L. [unclear]

# Les six domaines d'intervention de NICE

- 1. Sur les caractéristiques fondamentales de l'autisme**
- 2. Sur les comportements perturbateurs**
- 3. Sur les caractéristiques associées**
- 4. Amélioration de l'impact de l'autisme sur les familles**
- 5. Effets secondaires liés aux différentes interventions**
- 6. Organisation générale de l'offre de soins**

# Spécificités des recommandations KCE

- 1. Accessibilité à tous des soins à domicile et résidentiels (tous réseaux), rendue opposable**
- 2. Choix possibles en toutes circonstances**
- 3. Enseignements normaux et spéciaux adaptés, avec possibilité de choix**
- 4. Formation et soutien des professionnels**
- 5. Concertation systémique**
- 6. Recherches sur PECS, LEAP, ESDM – Denver, TEACHH, thérapies langage et parole, neuropharmacologie**

# Approches complémentaires de recherche NICE, RU (2013) – KCE, BE (2014)

- **Evaluation objective des approches psychothérapeutiques de type Thurin – Cohen – Falissard**
- **Approches systémiques Bertalanffy de type Wintgens**
- **Elaboration des aspects affectifs, systémiques et familiaux des thérapies dites comportementales et éducatives**





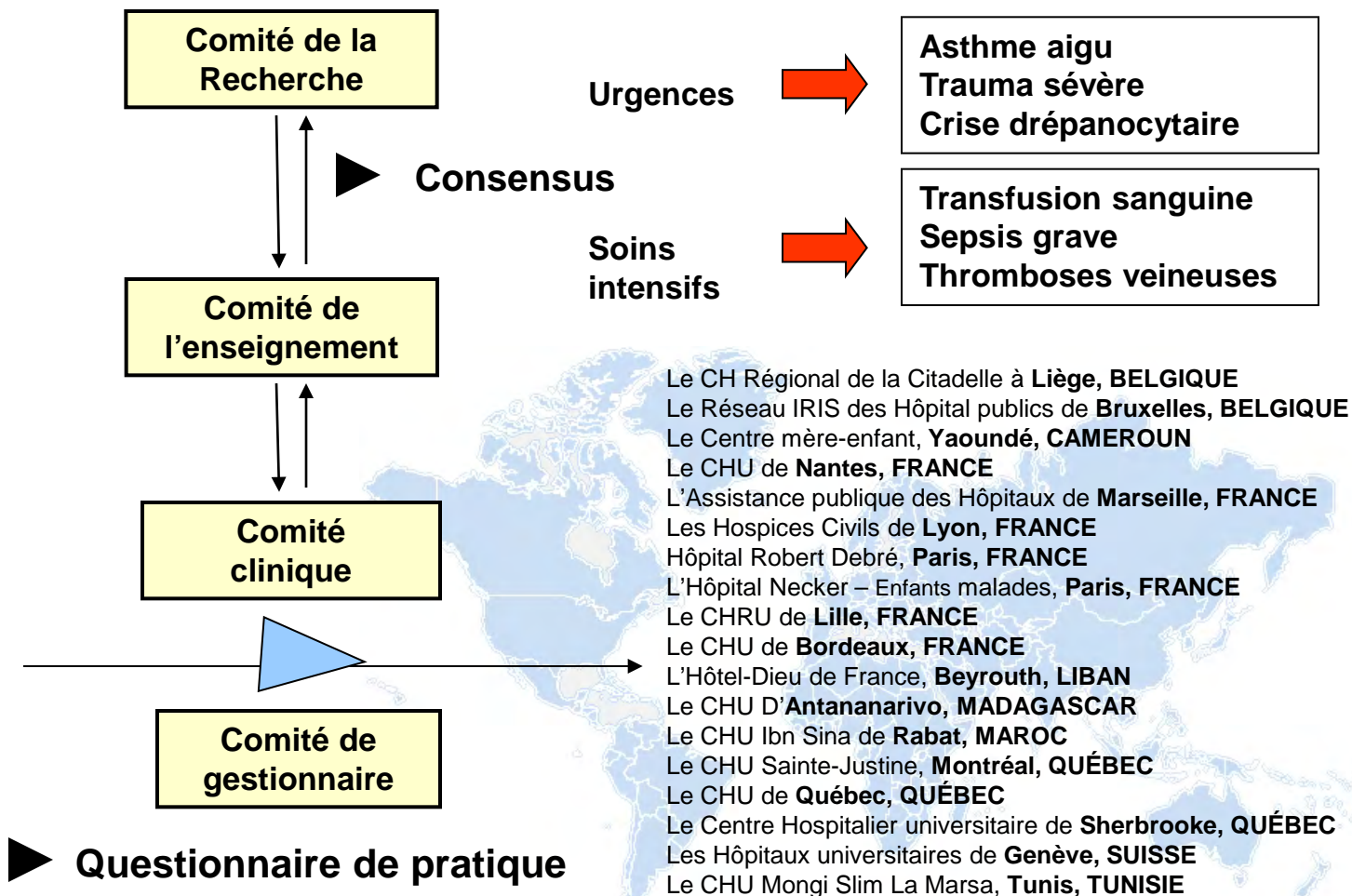
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# RMEF un laboratoire vivant international

