

# Less Is More: Developing Your Faculty to Implement the High Value, Cost-Conscious Care Curriculum

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**ACP**  
AMERICAN COLLEGE OF PHYSICIANS®  
INTERNAL MEDICINE | Doctors for Adults®

**AAIM**  
Alliance for Academic Internal Medicine

## Also Known As... Herding Cats to Bend the Cost Curve



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## Goals

- To introduce the content and structure of the AAIM/ACP High Value, Cost-Conscious Care Curriculum
- To identify where this material could be integrated into their existing program curriculum
- To apply new tools for interactive learning to this content
- To explore possible metrics to assess curricular effectiveness

## Workshop Outline

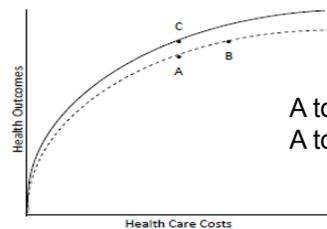
- Overview of the HVCCC- *Daisy Smith*
- Barriers to Implementing HVCCC- *Darilyn Moyer*
- Strategies for Teaching Small Groups - *Lia Logio*
- Evaluation: What Does Success Look Like - *Jessica Dine*
- Data from Residencies and Practicing Physicians - *Jessica Dine*
- Wrap Up and Lessons Learned to Date- *Daisy Smith*

## Why did we develop this curriculum?

- Health care expenditures are increasing at an unsustainable rate -projected to reach 20% of our GDP by 2020
- Up to 30% (\$765 billion) per year have been identified as potentially avoidable; many of these costs attributed to unnecessary services
- Belief that it is part of every physicians professional responsibility to use health care resources judiciously
- Residents and students receive little or no training on appropriate resource utilization, and rarely get feedback on their resource utilization and its impact on cost of care

## Shifting focus: More ≠ Better

- Get trainees to understand and focus on health care **value**
- Before using a test or treatment, they should consider the potential benefits and potential harms and costs.
- More care is better care  High value, customized care is better care



## Framework and Content

- Introduces a simple, step-wise framework for the delivery of high value care.
- Engages residents in small group activities organized around actual patient cases and real bills that require careful analysis of benefits, harms, and costs plus the use of evidence-based, shared decision making.

## Value, Cost and Health Care

**Cost ≠ Value**

**Cost ≠ Cost of Test**

- Cost = cost of test plus downstream costs, benefits and harms
- High-cost interventions may provide good value because they are highly beneficial; some may not
- Low-cost interventions may have little or no value if they provide little benefit or increase downstream costs; some may have high value

## Can you think of specific examples?

	High Value	Low Value
High Cost		
Low Cost		

## Steps Toward High-Value, Cost-Conscious Care<sup>1</sup>

- **Step one:** Understand the benefits, harms, and relative costs of the interventions that you are considering
- **Step two:** Decrease or eliminate the use of interventions that provide no benefits and/or may be harmful
- **Step three:** Choose interventions and care settings that maximize benefits, minimize harms, and reduce costs (using comparative-effectiveness and cost-effectiveness data)
- **Step four:** Customize a care plan with the patient that incorporates their values and addresses their concerns
- **Step five:** Identify system level opportunities to improve outcomes, minimize harms, and reduce healthcare waste

<sup>1</sup>Owens, D. *Ann Intern Med.* 2011;154:174-180

## Curriculum Overview

- First step is to review the “Curriculum Overview” guide at [www.highvaluecarecurriculum.org](http://www.highvaluecarecurriculum.org)
- Thanks to our 12 Core IM Programs that participated in the development of the curriculum and who have agreed to beta test it
- Look for ACP/AAIM webinars and curriculum adjustments as each module is road tested

## Ten Module Curriculum

- |                                     |   |
|-------------------------------------|---|
| • Introduction to Healthcare Value  | • Screening and Prevention                |
| • Waste, Costs, Over-ordering Tests | • Balancing Benefits with Harms and Costs |
| • Health Insurance                  | • High Value Medication Prescribing       |
| • Costs and Payment Models          | • Barriers to HVCCC                       |
| • Biostatistics Concepts To Know    | • Local Quality Improvement Project       |

## Curriculum Structure

- Sequential immersion into the issues around value and cost
- Simple 5-step framework provides the foundation
- Examples cases from both the outpatient and inpatient settings
- A Facilitator's Guide accompanies each module to help prepare faculty to deliver the session in a time efficient manner

## Modules/Facilitator's Guides

- All are freely available on the curriculum website
- Become facile with the facilitator's guide, resources and module before presenting
- Each Facilitator's Guide has learning objectives, audience/setting, equipment required and suggested readings
- Each Facilitator's Guide has step wise instructions with estimated timeline

# Providing High Value Cost-Conscious Care:

## Barriers

## Learning Objectives for this session

- Understand the barriers to high value care in clinical practice
- Know how to think about diagnostic tests and treatments in order to avoid inappropriate use
- Practice negotiating a care plan with patients that incorporates their values and addresses their concerns.
- Identify goals: two things to start doing and two things to stop doing to overcome barriers to high value care

## Case #1- Back Pain<sup>1</sup>

- Chief complaint: I need an MRI for my back
- 45 year old male presents with 2 weeks of low back pain that has not remitted and is affecting his productivity at work. He denies radiation to the legs, weakness, numbness, bowel or bladder incontinence, or any other neurological symptoms or fever.
- PMH: unremarkable
- Medication: Tylenol as needed with some relief
- Social/Family Hx: Works as a banker, occasionally uses alcohol, denies illicit drug use. No family history of cancer
- Physical Exam (including neurologic exam): normal

## Large Group Questions

Do you think an MRI would benefit this patient?

Would you order an MRI?



## The Guidelines<sup>2,3</sup>

Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the ACP and the American Pain Society- 2007

- Recommendation 2: Clinicians should not routinely obtain imaging or other diagnostic tests in patients with nonspecific low back pain.
- Recommendation 3: Perform diagnostic imaging and testing for patients with low back pain when severe or progressive neurologic deficits are present or when serious underlying conditions are suspected.

## What do Physicians actually do?<sup>4</sup>

- About 40% of family practice and 13% of internal medicine physicians reported ordering routine diagnostic imaging for acute low back pain.
- In the absence of any worrisome features,
  - 22% of physicians would obtain lumbar spine radiography for acute low back pain without sciatica and
  - 62% would do so for low back pain with sciatica.

## What are the potential barriers to high-value use of diagnostic tests?

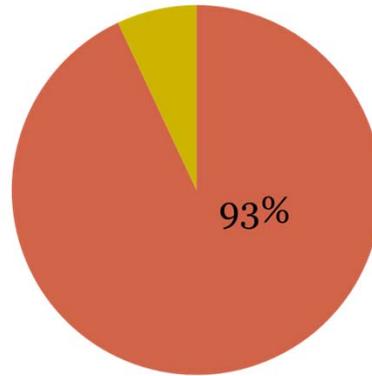
- Lack of guidelines
- Poor familiarity with guidelines
- Lack of knowledge of costs- including the impact of setting on cost
- Defensive medicine (i.e. fear of litigation)
- Time pressure (emphasis on shorter LOS and productivity)  
Explaining to patients why tests/treatments are not indicated takes time.
- Discomfort with diagnostic uncertainty
- Local standards of care
- Misaligned financial incentives
- Lack of appreciation of harms
- Patient expectations
- Lack of centrally available information on prior tests

## Defensive Medicine

“Defensive medicine occurs when doctors order tests, procedures, or visits... primarily to reduce their exposure to malpractice liability.”  
(Congressional OTA 1994)

*Raise your hand if you have ever practiced defensive medicine or seen it practiced*

## Defensive Medicine is very (very) common!<sup>6</sup>



93% of Pennsylvania physicians from multiple specialties reported practicing defensive medicine

## Defensive medicine does NOT protect against malpractice<sup>7</sup>

- Malpractice claims can be arbitrary and hard to prevent: 40% of malpractice claims do not involve medical errors
- More care is not better care as tests and treatments have harms associated with them that may lead to malpractice
- Lack of follow up of abnormal test results often leads to malpractice litigation- don't order the test if you don't plan on following it up and acting on the results
- Tips to avoid malpractice: listen to your patients and carefully document decision making including discussion of side effects and risks of all tests and treatments

## Patient expectations<sup>8</sup>

- Patients often think that more testing is better
- Physicians have legitimate concerns about patient satisfaction, which may be tied to reimbursement
- Physicians may not accurately assess patient expectations, and patient satisfaction has many correlates (better understanding of their illness correlates well with patient satisfaction)

## Patient expectations for LBP<sup>9</sup>

- Patients often want imaging
- They also want a clear diagnosis, shared decision-making, acknowledgment that their symptoms are real
- Effective communication may contribute more to satisfaction than the specific management plan

## Talking to patients about NOT doing things

### Principles of patient-centered discussions

- Find out where the patient is coming from
  - “What are you afraid we will find?”
  - “What do you think is going on and what are you worried about?”
- Explain your reasons
  - “The good news is that you don’t have any worrisome symptoms”
- Make it clear that you are on the patient’s side
  - “I wish more testing would help you, but it could actually make things worse”
- Contract for a clear follow-up plan and review red flag signs and symptoms
  - “I want to see you in 2 weeks, but call sooner if you have leg weakness”

## What was the hospital charge for an MRI of the lumbar spine?

1. About \$1000
2. Between \$1000 and \$3000
3. Between \$3000 and \$5000
4. Between \$5000 and \$7000
5. Over \$7000



## Misaligned financial incentives

- Our health care system rewards doing tests
- Physicians may directly benefit financially from doing a test, and are seldom financially harmed.
- New systems of care (such as ACOs) are designed to align incentives to maximize care quality.

How might this relate to local standard of care?

## Case #2- Sore Throat<sup>10</sup>

### Chief complaint: I need antibiotics

- 27 yo woman presents with 3 days of sore throat, cough, congestion and sneezing
- Neg PMHx, no meds, no allergies
- She works as a hospital administrator and has no exposure to young children
- PE-normal vitals, unremarkable except for erythema of the oropharynx with a single 2mm patch of exudate on her R tonsil and no adenopathy

## The Conflict

- The patient is getting on an airplane the next day to go to a series of important meetings. She is worried about strep throat. She asks you “How will I get antibiotics if I get sicker?”
- She wants an antibiotic prescribed or at the very least a prescription to take with her
- There is a > 80% chance that her illness is viral and will not respond to antibiotics and you do not believe that antibiotics are indicated

## Small Group Work

Break into small groups to discuss the following questions :

- How would you resolve the conflict between what the patient wants and what you feel is medically indicated?
  - How much should you accommodate patient wishes for treatments with little or no prospect of benefit and the possibility of harm?
- § Take turns being the doctor and the patient and practice having this discussion

## Report Back: What did you decide to do?

- a. Start antibiotics now
- b. Give prescription for antibiotics to fill in case she worsens
- c. No antibiotics, provide education, reassurance and follow up



## Steps Toward High Value, Cost-Conscious Care<sup>11</sup>

- Step one:** Understand the benefits, harms, and relative costs of the interventions that you are considering
- Step two:** Decrease or eliminate the use of interventions that provide no benefits and/or may be harmful
- Step three:** Choose interventions and care settings that maximize benefits, minimize harms, and reduce costs (using comparative-effectiveness and cost-effectiveness data)
- Step four:** Customize a care plan with the patient that incorporates their values and addresses their concerns
- Step five:** Identify system level opportunities to improve outcomes, minimize harms, and reduce healthcare waste

## Action Plan



### START:

- Following high quality guidelines to avoid unnecessary tests and treatments
- Taking the time to explain to patients why you are not doing something that is not indicated

### STOP:

- Ordering more tests and treatments to protect yourself from malpractice suits
- Giving the patients what they think they need, when there is no evidence for patient benefit

## References

1. Case slides by Krishan Soni, MD (UCSF)
2. Chou R et al. Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society. *Ann Intern Med.* 2007 ; 147:478-91.
3. Chou R et al. Diagnostic imaging for low back pain: advice for high-value health care from the ACP. *Annals* 2011. 154:181-9
4. Dilorio D et al. A survey of primary care physician practice patterns and adherence to acute low back problem guidelines. *Arch Fam Med.* 2000 9:1015-21
5. 2011 ITE residents questionnaire
6. Studdert DM et al. Defensive medicine among high-risk specialist physicians in a volatile malpractice environment. *JAMA.* 2005;293:2609-17

## References

7. Studdert DM et al. Claims, errors, and compensation payments in medical malpractice litigation. *N Engl J Med.* 2006;354:2024-33.
8. Ong S et al. Antibiotic use for emergency department patients with upper respiratory infections: prescribing practices, patient expectations, and patient satisfaction. *Ann Emerg Med.* 2007;50:213-20
9. Verbeek J et al. Patient expectations of treatment for back pain: a systematic review of qualitative and quantitative studies. *Spine* 2004. 29(20):2309-18
10. ACP Ethics Case Study by Lois Snyder
11. Adapted from Owens, D et al. *Ann Intern Med.* 2011;154:174-180

## Providing High Value-Cost-Conscious Care: Barriers to High Value, Cost-Conscious Care Presentation #9 of 10

**Description:** This guide is intended to help the faculty deliver this 60-minute discussion on the cost implications of low back pain and patient centered approaches to discussing diagnostic testing. This module builds on concepts reviewed during 8 previous 1 hour sessions.

**Learning Objectives:**

- Understand the barriers to high value care in clinical practice
- Know how to think about diagnostic tests and treatments in order to avoid inappropriate use
- Practice negotiating a care plan with the patient that incorporates their values and addresses their concerns.
- Identify goals: two things to start doing and two things to stop doing in order to overcome barriers to high value care

**Audience/Setting:** The intended audience for this module is internal medicine residents and faculty. Large group setting with time and space for small group work within the session is best.

**Equipment Required:** computer with LCD projector for power point presentation, white board or flip chart for recording group work, local MRI pricing which can provide an accurate answer for the question, and optional (if available) local data on rates of self-reported defensive medicine. Audience response -can be an electronic polling method, simple note cards, or simply a raising of hands.

**References:**

- 1 Chou R, Qaseem A., Owens DK, Shekelle P, Imaging for Low Back Pain: Advice for High-Value Health Care From the American College of Physicians, *Ann Intern Med.* 2011;154:181-189.
- 2 Ong S et al. Antibiotic use for emergency department patients with upper respiratory infections: prescribing practices, patient expectations, and patient satisfaction. *Ann Emerg Med.* 2007;50:213-20

**Providing High Value-Cost-Conscious Care:  
Barriers to High Value, Cost-Conscious Care  
Presentation #9 of 10**

**Module Nine Instructions**

Step	Description	Estimated Time
1	<p>Welcome participants, introduce speaker, identify the reason for the discussion including:</p> <ul style="list-style-type: none"> <li>The importance of understanding barriers to high value care in order to overcome them.</li> <li>Explain the learning objectives on slide 2.</li> </ul>	5 minutes
2	<p>Case #1: Non-specific low back pain</p> <ul style="list-style-type: none"> <li>Emphasize that the patient presents asking for an MRI.</li> <li>Slide 4: Poll the audience and ask what they would do in this situation and why.</li> <li>Slide 5: Briefly review ACP guidelines. Note that MRIs are not recommended for non-specific low back pain since they do not improve outcomes (which are very good regardless) and may lead to more disability.</li> </ul>	10 minutes

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3	<p>Underlying causes of overuse</p> <ul style="list-style-type: none"> <li>Slide 6: Point out that despite strong guidelines, physicians continue to order imaging in non-specific low back pain.</li> <li>Slide 7: Discuss the list and point out that following up on test results) can be time consuming. Have the group create a top five list for their local institution making the number one barrier the most important one.</li> <li>Slides 8-10 Discuss defensive medicine. Define it; talk about its prevalence; and use data to dispel the myth that ordering more tests protects doctors from law suits.</li> <li>Slides 11-12: Discuss patient expectations and the process of talking to patients about not doing things. Emphasize that patients (unlike customers) are not always right and it is our ethical responsibility to explain to them why we are not giving them what they asked for.</li> <li>Slide 13: Ask the group how they would discuss not doing tests with patients. Review the principles of patient-centered communication.</li> <li>Slide 14: Awareness of cost may be a barrier. Ask participants to vote on the correct answer. Point out that setting affects cost, e.g. an MRI in the ED can cost twice as much as outpatient. Internet resources on cost: <a href="http://www.healthcarebluebook.com">www.healthcarebluebook.com</a>, <a href="http://www.clearhealthcosts.com">www.clearhealthcosts.com</a>, <a href="http://www.newchoicehealth.com">www.newchoicehealth.com</a></li> <li>Slide 15 Financial incentives may drive the culture of care and create local standards for what is generally accepted.</li> </ul>	15 minutes
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4	<p>Case #2: Sore Throat</p> <ul style="list-style-type: none"> <li>Slides 16-17: Present the case and emphasize the conflict between what the patient wants and what you think is medically indicated</li> <li>Slide 18: Divide participants into pairs or small groups to answer the questions and practice role-playing a discussion with this patient about her treatment plan.</li> <li>Slide 19: Have groups vote on what they decided to do. Highlight why option B is not a good compromise. It still has risk of potential harms for the patient (C. difficile, allergic reaction) and for society (antibiotic resistance), and reinforces the common belief that antibiotics are effective in viral URI's.</li> <li>Slide 20: Review the steps in the framework. Point out that they have been practicing step 4 this session.</li> </ul>	20 minutes
5	<p>Wrap-up and summary</p> <ul style="list-style-type: none"> <li>Ask participants to commit to two things they will start doing and two things they will stop to overcome barriers to high value care.</li> </ul>	5 minutes

**Barriers to Implementation?**

What do you envision as the main barriers to implementing this curriculum?

Please commit your thoughts in writing on an index card in the next 5 minutes.

Please pair up with someone nearby and share your thoughts in the next 5 minutes.

## Implementation in Your Program

- Who?
- What?
- Where?
- When?
- How?
- Why - hopefully we've already answered for you.

## Facilitator's guides emphasize interactivity

### Explanation of active learning tools

- Think-Pair-Share
- Audience Response Systems/Polling
- Small Group Work
- Worksheets
- "Wicked" Questions
- Talking Stick
- Pre Session Work
- Wiki

## Each Module: Five + Two + Two

### Five Step framework reinforced for each topic.

1. Understand the benefits, harms, and relative costs of the interventions that you are considering
2. Decrease or eliminate the use of interventions that provide no benefits and/or may be harmful
3. Choose interventions and care settings that maximize benefits, minimize harms, and reduce costs (using comparative-effectiveness and cost-effectiveness data)
4. Customize a care plan with the patient that incorporates their values and addresses their concerns
5. Identify system level opportunities to improve outcomes, minimize harms, and reduce healthcare waste

At the end of each module, each participant should be asked to identify

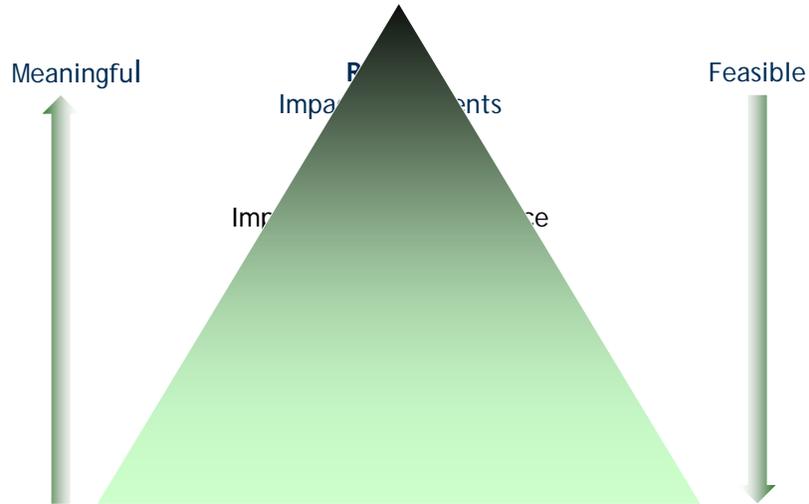
**Two** things they will **START** doing & **Two** things they will **STOP** doing  
...as a result of the workshop

## Demonstration: Four Scenarios

Groups of 8-10 people each

1. PE Case (Module1) - Worksheet
2. DVT Case (Module 1) - Small Group Work
3. Diagnostic Testing (Module 2) - Wicked Question
4. Diagnostic Testing (Module 2) - Small Group Work & Worksheet

## Evaluation: What Does Success Look Like?



## Can you think of specific examples?

Kirkpatrick's Hierarchy	Potential Outcome Measures
Results (Impact on Patients)	
Behavior (Impact on Clinical Care)	
Learning (Skills or Knowledge)	
Reaction (Satisfaction, Preference)	



## Evaluation: What Does Success Look Like?

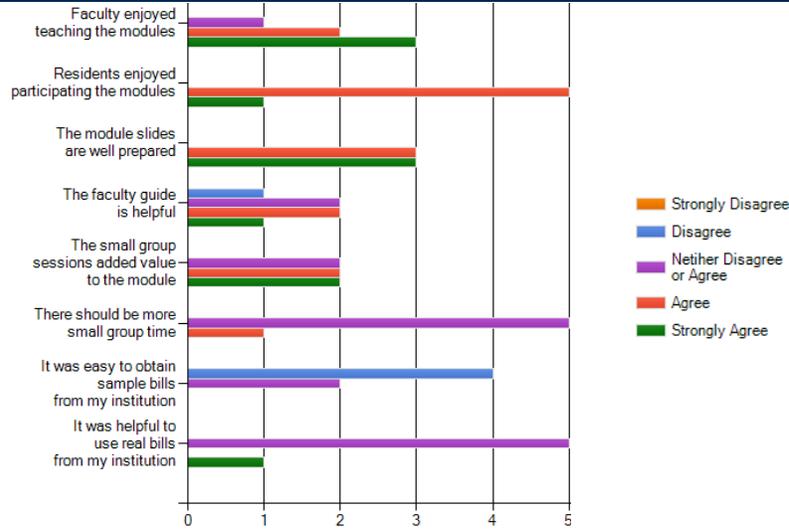
Kirkpatrick's Hierarchy	Potential Outcome Measures
Results (Impact on Patients)	Length of stay Readmission Rate Mortality
Behavior (Impact on Clinical Care)	Reduction in laboratory tests ordered Use of specific guidelines Implementation of discharge planning rounds
Learning (Skills or Knowledge)	Knowledge test Application test (e.g. what would you order) Residents start own QI projects
Reaction (Satisfaction, Preference)	Evaluation by interns and residents Evaluation by faculty Residents start own QI projects



## Curriculum Dissemination and Evaluation

- Over 1200 individuals have accessed the curriculum to date
- Approximately 16% of those accessing the curriculum are residents and students
- Plan to survey these individuals in February to get feedback about the curriculum
- Other metrics are a resident survey, a program director's survey and a high value care sub-score on the IM ITE which we plan to track over several years

## Data from Residency Programs

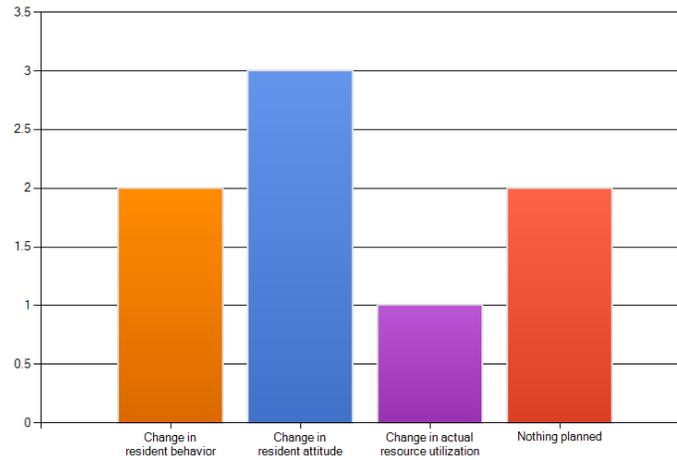


## Resident Comments on Specific Modules

- “Good picture of insurance in this country”
- “It was brief and to the point; easy to understand”
- “Bringing more attention to the insurance issues of patients”
- “I particularly enjoyed the case scenarios”
- “The presentation helped us to know how to cut down on prescription costs and still prescribe equally effective drugs”
- “It is a very important topic that needs to be understood because this can really help our patients. The presentation is good, concise and informative”
- “Real life examples help put the cost of brand name drugs in proper perspective”

## Data from Residency Programs

Are you planning on measuring any of the following potential outcomes related to this curriculum?



## Data from Practicing Physicians

- A web survey was sent to 4,000 randomly selected ACP members who spend 50% or more of their time in direct patient care
  - 427 responded
- There is a need among practicing internists for the high value, cost-conscious care educational program
  - Finding estimates of costs and potential harms
  - Balancing potential benefits with costs and harms
  - Discussing harms, costs and alternatives with patients
  - Incorporating patient values and concerns

## Data from Practicing Physicians

- The majority of respondents report performing the following behaviors at least “some of the time” when caring for patients
  - Ordering additional tests because of discomfort with diagnostic uncertainty (74%)
  - Ordering additional tests to protect against a malpractice suit (65%)
  - Ordering additional tests out of concern about inadequate patient follow up or access (59%)
  - Ordering basic tests because it saves time (50%)

## Steps Toward High-Value, Cost-Conscious Care<sup>1</sup>

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<sup>1</sup>Owens, D. *Ann Intern Med.* 2011;154:174-180



## Wrap Up/Q & A

As a result of this workshop, can you identify

- Two things to START doing?
- Two things to STOP doing?

Any questions about the curriculum?

