**Introduction to the New Version of the High Value Care Curriculum**

The High Value Care Curriculum (HVC) has been jointly developed by the American College of Physicians (ACP) and the Alliance for Academic Internal Medicine (AAIM) in an effort to address the “critical seventh general competency for physicians” as defined by Weinberger (1). This curriculum was initially released in July of 2012 and now is available in a condensed and updated format. The newer version of the curriculum can be completed in 6 hours and includes more multimedia content and a robust program director toolbox to help faculty and program directors measure curricular impact and individual resident performance in high value care.

**Background**

Healthcare costs in the United States are increasing at an unsustainable rate: $253 billion in 1980 to $714 billion in 1990 to nearly $2.6 trillion in 2010. What’s even more remarkable is the general agreement that approximately 30% of healthcare costs (more than $750 billion annually) are wasted care, care that is potentially avoidable and would not negatively affect the quality of care if eliminated (2). Examples of such care include overuse and misuse of diagnostic testing, avoidable hospitalization and re-hospitalization, and overuse of emergency department services. At the same time, there is growing concern that medical expenditures, particularly those borne by the Federal government under Medicare and Medicaid, are contributing significantly to the burgeoning Federal deficit and this country’s weakening economy. Graduate medical education provides an opportunity to shape the habits of future physicians regarding cost-consciousness and stewardship of resources, especially as it imprints their long-term practice behaviors.

The overarching goal of this curriculum is to move internal medicine residents and practicing doctors from the dotted curve below to the new solid curve in Figure 1, or from A to C. Shifting the curve upward allows for better outcomes for the same costs.

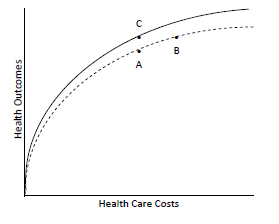


Figure 1: A is less expensive than B but also gives you less health outcome (however outcome may be measured). C, in comparison, costs the same as A, but provides an improved health outcome.

**Preparatory Reading**

As you prepare to deliver this curriculum, we strongly recommend that you read the background articles as well as peruse the Choosing Wisely website ([www.choosingwisely.org](http://www.choosingwisely.org)). Owens et al. describe the core concepts to evaluate benefits, harms and costs of medical interventions and provide an easy framework for you to consider two broad categories of interventions: those that provide minimal or no health benefit, and those that provide net benefit (3). For the latter group, it then becomes necessary to develop a quantitative assessment of their costs alongside their benefits relative to harms to ultimately determine their value. Cost effectiveness is one such tool that can be used in this analysis. Owens et al. emphasize that higher cost care does not always mean better care, and thus, as drivers of care and the overall cost of healthcare services, we should focus on the value that such care provides.

The ACP along with the ABIM and the European Federation of Internal Medicine together have articulated the 3 core principles and 10 commitments of medical professionalism in The Physician Charter.(4) Medical Professionalism as described in the core principle of Social Justice demands that all physicians be just stewards of finite resources. Weinberger proposes that high value, cost-conscious care should be added as a critical seventh competency for physicians within the framework of the ACGME core competencies (1). He urges medical educators to consider the various factors within a training program that might drive overuse of diagnostic tests, such as criticism by faculty who ask, “Why didn’t you order test X?”, or the institutional culture that creates incentives for clinicians to overuse technologies or delivery services in more expensive settings in order to generate more revenue and profit. Since faculty rarely teach about the cost implications of their care, this curriculum will help you address Weinberger’s call to action – ensuring residents recognize and understand the issues of escalating healthcare costs. We all must become part of the solution to the problem of wasteful medical expenditures through thoughtful ordering of tests, avoiding duplicate studies, and preventing unnecessary hospitalizations.

Qaseem focuses his discussion on the use of screening and diagnostic tests with an introduction to the Choosing Wisely campaign (5). Choosing Wisely has challenged medical societies to identify the “Top 5” list, or the five tests or procedures commonly used in their specialties whose necessity should be questioned and discussed. To date thirty-four specialty societies have released their lists. ACP’s working group that identified areas of overuse and misuse of care in internal medicine went even further and published a list of 37 tests that it believes clinicians use in a way that is inconsistent with high value, cost-conscious care (6). This paper would serve as important reading material for your audience participants.

Finally, Laine offers a few simple questions to ask before ordering tests (7). She asks us all to slow down and consider if the test is a duplicate test, if it will change the management of the patient, and to recognize its potential risk and any possible down-stream effect from false-positive results.

**The Framework**

For each of the modules, residents will be directed to use a five step framework to develop the skills of practicing high value, cost-conscious care. You should become comfortable discussing the various steps of the framework to facilitate the teaching sessions.

* **Step 1**: Understand the benefits, harms, and relative costs of the interventions you are considering
* **Step 2**: Decrease or eliminate the use of interventions that provide no benefits and/or may be harmful
* **Step 3**: Choose interventions and care settings that maximize benefits, minimize harms, and reduce costs. Use comparative effectiveness and cost effectiveness data where available
* **Step 4**: Customize a care plan with each patient that incorporates the patient’s values and addresses patient and family concerns
* **Step 5**: Identify system level opportunities to improve outcomes, minimize harms, and reduce healthcare waste

**The Curriculum**

Six modules are provided. When presented in order, they provide a robust immersion into the issues around value and cost in healthcare, each using important examples within the field of internal medicine to engage the participants. Each module offers several inpatient and outpatient cases allowing the curriculum to flexibly fit into the needs of each program. All or a selected few of the modules can be presented independently since the framework is re-introduced in each one.

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|  | **Topic** | **Example Cases Included** |
| **1** | **Eliminating Healthcare Waste and Over-ordering of Tests** | Headache, heart failure, deep venous thrombosis |
| **2** | **Healthcare Costs and Payment Models** | Appendicitis, sports injury, osteomyelitis |
| **3** | **Utilizing Biostatistics in Diagnosis, Screening and Prevention** | Chest pain, periodic health examination, chemoprevention |
| **4** | **High Value Medication Prescribing** | Seasonal allergies, discharge medication reconciliation |
| **5** | **Overcoming Barriers to High Value Care** | Low back pain, URI, septic joint |
| **6** | **High Value Quality Improvement** |  |

**Facilitating Active Learning**

Two of the most important goals of delivering this curriculum are to make it locally relevant and to actively engage the learners in discussion about the issues. To help you achieve success, we offer these important concepts for small group, participatory discussion and for getting active audience participation.

Effective facilitation involves asking questions to promote thinking and reflection on the material presented. Ask participants to consider the information and think out loud about what it means for them. As the information is shared, the facilitator should work to understand the meaning for the participants and make connections between individuals, between ideas and concepts, and between the various concerns or trouble spots that are raised in the discussion.

Good facilitation also includes managing both the content and the process. Watch how the conversation unfolds and be sure to notice participants who are listening intently, but not participating. They have something to say and may provide balance to the discussion. The discussion should be an exploration of the new ideas with real time spent on wrestling with the concepts and how they might be applied in practice.

Individual participants should be empowered to own their point of view and share it with the group to help foster group learning by illustrating how others think about the topic at hand. At the end of each presentation, each participant in the small group or the audience should be asked to identify two things they will start doing as well as two things they will stop doing that will promote high value cost-conscious care. Then ask participants to commit to these four things by writing them down and e-mailing them to themselves. Follow up teaching sessions can begin by asking the participants to share how their practice patterns have changed or to reflect on if and how the information has changed their thinking.

**Active Learning Tools**

We suggest the following tools and strategies to foster active learning. Many of these are also suggested in the individual module facilitator guides. Alternatively, you may choose to engage your learners in different ways that fit your local environment better.

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| **1** | **Think-Pair-Share** | Ask a provocative question and give each participant a few minutes to reflect and write down answers. Then ask participants to pair up and discuss their thinking with their partner. After a few minutes of paired discussions, ask for volunteers to share important observations with the larger group. |
| **2** | **Audience Response Systems** | High technology or low technology audience response systems allow participants to commit to an answer to multiple choice questions. Examples include clickers/smartphones/3x5 color-coded cards. This technique provides the facilitator with a real-time assessment of what the audience knows about a topic and can help identify knowledge gaps. |
| **3** | **Small Group Work** | There are three variations of small group work: one task with multiple components (all groups/same tasks); multiple short tasks (all groups/same tasks); or multiple short tasks (all groups/different tasks). How complicated the tasks are will determine which variation to use. Encourage participation from all group members and ask for reports at the end of each task assignment. |
| **4** | **Worksheets** | Create a table or worksheet for individuals to complete, applying a new approach. Requires that you build in time for reflection and thoughtful work. |
| **5** | **Wicked Questions** | Ahead of time, craft a question that sets up an internal conflict that exposes assumptions that we hold about an issue. Example: How does the fast and hectic pace of academic medicine provide a rich environment for mentoring the younger generation? Ask participants to consider their answers or thoughts to such a question. Share in groups to promote discussion and active learning. |
| **6** | **Talking Stick** | This can be used with a wicked question or any provocative idea. Organize groups into a circle/round tables. Have a physical stick to pass from one person to another. During the first round, each member of the group gets one minute to share thoughts and then passes the stick to another member (facilitator times it). For the second round, each person gets two minutes to comment on the collection of what’s already been said. After the second round, put down the stick and facilitate an inclusive discussion. |
| **7** | **Pre-Session Work** | Assign work before the session that may include reflecting on an interesting question, bringing a case/problem to discuss, or completing a worksheet on topic. |
| **8** | **Wiki** | Direct participants to an online wiki where they can read articles related to the discussion and post comments with references. Their comments and opinions become part of the dialogue and debate for ongoing discussion and learning about the topic. |

**Program Director’s Toolbox**

This toolbox includes a retrospective, pre-post survey that you can give to your residents after completing the six hour curriculum to measure its effectiveness. In addition, tools to help faculty and program directors assess resident competence in high value care milestones are provided. Examples include a high value care educational prescription, a framework for resident audit and feedback in high value care, and a sample evaluation form that uses includes NAS milestones related to high value care.

**References:**

1. Weinberger SE. Providing high-value, cost-conscious care: a critical 7th general competency for physicians. Ann Intern Med. 2011; 155:386-388.
2. Institute of Medicine.The Healthcare Imperative: Lowering Costs and Improving Outcomes. Washington, DC: National Academies Pr; 2010.
3. Owens DK, Qaseem A, Chou R, Shekelle P. High-value, cost-conscious health care: concepts for clinicians to evaluate the benefits, harms, and costs of medical interventions. Ann Intern Med. 2011; 154:174-180.
4. Blank L, Kimball H, McDonald W, Merino J. Medical professionalism in the new millennium: a physician charter 15 months later. Ann Intern Med. 2003; 138:839-41.
5. Cassel CK, Guest JA. Choosing Wisely: Helping physicians and patients make smart decisions about their care. JAMA 2012;307:1801-1802.
6. Qaseem A, Alguire P, Dallas P, Feinberg LE, Fitzgerald FT, Horwitch C, Humphrey L, LeBlond R, Moyer D, Wiese JG, Weinberger S. Appropriate use of screening and diagnostic tests to foster high-value, cost-conscious care. Ann Intern Med. 2012; 156:147-149.
7. Laine C. High-value testing begins with a few simple questions. Ann Intern Med. 2012;156:162-163.

**Other Important Resources:**

The internet has some other great resources for you to compare costs in healthcare. You may want to peruse these as part of your preparation or refer participants to them during the active learning portion of each module.

* Healthcare Blue Book is a free consumer guide to help patients understand fair prices for healthcare services in their areas.

[www.healthcarebluebook.com](http://www.healthcarebluebook.com)

* National campaign to promote conversations between physicians and patients in choosing care that is evidence based, free from harm, and truly necessary as supported by organizations representing medical specialists.

[www.choosingwisely.org](http://www.choosingwisely.org)

* Wikipedia and Consumer Reports have started a health article review project based on the references from this curriculum. As an optional assignment, residents can read and comment on articles. Click on the link below to see an instructional video for this 20 minute process. <http://en.wikipedia.org/wiki/Wikipedia:Health_Article_Review_Project>