**Facilitators Guide**

**Description**: This guide is intended to help the faculty deliver this 60-minute discussion reviewing potential pervasive barriers to the delivery of high value care, and providing tools for effective communication with patients and colleagues. This is the fifth in a series of six sessions.

**Learning Objectives**:

•Describe the barriers to high value care in clinical practice and explore ways to overcome these barriers

•Weigh the efficacy and safety of medical interventions to avoid inappropriate use and harm

•Practice negotiating a care plan with patients that incorporates their values and addresses their concerns

•Explain the importance of local culture in your practice decisions

**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 PowerPoint presentation and white board or flip chart for recording group work.

**References:**

1. Studdert DM, Mello MM, Sage WM, et al. Defensive medicine among high-risk specialist physicians in a volatile malpractice environment. JAMA. 2005 Jun 1;293(21):2609-17. [PMID: 15928282]
2. Studdert DM, Mello MM, Gawande AA, et al. Claims, errors, and compensation payments in medical malpractice litigation. N Engl J Med. 2006 May 11;354(19):2024-33. [PMID: 16687715]
3. Gallagher TH, Studdert DM, Levinson W. Disclosing harmful medical errors to patients. N Engl J Med. 2007 Jun 28;356(26):2713-9. [PMID: 17596606]
4. Lee F. An approach using retrospective data to guide the design of a targeted clinical decision support intervention to reduce inappropriately ordered DXA scans [thesis]. New York, NY: Weill Medical College of Cornell University; 2014. Publication no. 1525999.
5. Ong S, Nakase J, Moran GJ, et al. Antibiotic use for emergency department patients with upper respiratory infections: prescribing practices, patient expectations, and patient satisfaction. Ann Emerg Med. 2007 Sep;50(3):213-20. [PMID: 17467120]
6. Wilson W, Taubert KA, Gewitz M, et al. Prevention of infective endocarditis: guidelines from the American Heart Association: a guideline from the American Heart Association Rheumatic Fever, Endocarditis, and Kawasaki Disease Committee, Council on Cardiovascular Disease in the Young, and the Council on Clinical Cardiology, Council on Cardiovascular Surgery and Anesthesia, and the Quality of Care and Outcomes Research Interdisciplinary Working Group. Circulation. 2007 Oct 9;116(15):1736-54. [PMID: 17446442]
7. Jin R, Zelinka ES, McDonald J, et al. Effect of hospital culture on blood transfusion in cardiac procedures. Ann Thorac Surg. 2013 Apr;95(4):1269-74. [PMID: 23040823]
8. Liao JM, Thomas EJ, Bell SK. Speaking up about the dangers of the hidden curriculum. Health Aff (Millwood). 2014 Jan;33(1):168-71. [PMID: 24395948]
9. Lee T, Pappius EM, Goldman L. Impact of inter-physician communication on the effectiveness of medical consultations. Am J Med. 1983 Jan;74(1):106-12. [PMID: 6849320]

**Presentation #5 Instructions**

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| Step | Description | Estimated Time |
| 1 | Welcome participants; introduce speaker; identify the reason for the discussion, including:   * The importance of understanding barriers to high value care in order to overcome them * Explain the learning objectives on slide 2 * Briefly discuss the potential barriers listed on slide 3, and note that there are many barriers, but in this talk, we will focus on the barriers highlighted on slide 4 | 5 minutes |
| 2 | Barrier 1: Defensive Medicine   * Slides 5-6: Explain what defensive medicine is and its prevalence. Use data to **dispel the myth that ordering more tests protects doctors from lawsuits**. * Slide 7: Emphasize that open communication is key to avoiding malpractice. Also go over the various pilot programs and data that support this notion, including the University of Michigan and VA in Lexington, KY, which found that lawsuits declined after they implemented an open disclosure policy which mandated an open discussion with the family following a mistake. More information can be found at <http://www.uofmhealth.org/michigan-model-medical-malpractice-and-patient-safety-umhs#summary>. Can discuss this model more extensively if time allows.   *Transition to Case 1 with something along the lines of “Now that we’ve discussed the first barrier, let’s talk about the next one, 'Responding to Patient Requests.'”* | 5 minutes |
| 3 | Case 1: Responding to patient requests for testing   * Slides 8-9: Present the case of a patient requesting a DEXA scan. Discuss as a large group whether they would order a scan and whether it would benefit the patient. * Slides 10-11: Discuss the recommendations of the Choosing Wisely committee that recommends DEXA scans not be ordered for patients unless they meet certain age or risk factor criteria. Use the data on slide 11 to show that physician practice does not always line up with established guidelines and recommendations. * Slide 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 responsibility to explain to them why we are not giving them what they asked for. Clear communication is key. * Slides 13-14: Ask the group to describe key principles of patient-centered communication. Ask how they would discuss not doing tests with patients. Review the principles of patient-centered communication on slide 14 and introduce the high value conversation guide. **Provide HVC conversation guide to the participants.** | 10 minutes |
| 4 | Case 2: Responding to patient request for treatment   * Slides 15-16: Present the case and emphasize the conflict between what the patient wants and what you think is medically indicated. * Slide 17: Divide participants into pairs or small groups to answer the questions and practice role-playing a discussion with this patient about her treatment plan. **Focus on the use of the high value conversation guide for discussion and role playing.** * Slide 18: Have groups vote on what they decided to do. Highlight why option A is not a good compromise: risk of potential harms for the patient (*C. difficile*, allergic reaction) and for society (antibiotic resistance). | 15 minutes |
| 5 | Case 3: Local Culture   * Slide 19: Present the case. * Slide 20: Ask the participants to think/pair/share about what went wrong and how they could better frame a question for the consultant. Ask some groups to share. * Slide 21: Discuss how to frame a good consult question and the rationale for why this is important. Go over slide 22 for the follow-up to Case 3. * Slide 23-25: Discuss local culture and the hidden curriculum of medical school and residency. Have the residents identify the challenges they experience in asking for or receiving consults and what they believe to be the “local culture” in their hospital. Present some possible solutions. * You may want to mention the AMA guidelines that state: “One physician is in charge of a patient’s care and the attending physician has the overall responsibility for the patient’s treatment.” Furthermore, consultants should only advise and make recommendations on problems that are within their scope of practice. | 15 minutes |
| 6 | Wrap-up and summary   * Review summary slide and go over final thoughts. | 5 minutes |