**Facilitators Guide**

**Description**: This guide is intended to help the faculty deliver this interactive, 60-minute discussion reviewing potential pervasive barriers to the delivery of high value care, and provides tools for effective communication with patients and colleagues. This is the fifth in a series of six sessions. The slides also include notes so you may want to print these up along with this guide before your presentation.

**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 works 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. American College of Chest Physician and American Thoracic Society. Five Things Physicians and Patients Should Question. Philadelphia, PA: Choosing Wisely; 2013. Available from: <http://www.choosingwisely.org/societies/american-college-of-chest-physicians-and-american-thoracic-society> Accessed 11/20/2017

5. American College of Emergency Physicians. Ten Things Physicians and Patients Should Question. Philadelphia, PA: Choosing Wisely; 2013. Available from: <http://www.choosingwisely.org/societies/american-college-of-emergency-physicians> Accessed 11/20/2017

6. American Academy of Family Physicians. Fifteen Things Physicians and Patients Should Question. Philadelphia, PA: Choosing Wisely; 2012. Available from: <http://www.choosingwisely.org/societies/american-academy-of-family-physicians> Accessed 11/20/2017

7. American Academy of Allergy, Asthma, and Immunology. Ten Things Physicians and Patients Should Question. Philadelphia, PA: Choosing Wisely; 2012. Available from: <http://www.choosingwisely.org/societies/american-academy-of-allergy-asthma-immunology/>. Accessed 11/20/2017

8. Lewin, K. [Frontiers in Group Dynamics: Concept, Method and Reality in Social Science; Social Equilibria and Social Change](http://hum.sagepub.com/content/1/1/5.full.pdf+html). Human Relations. June 1947. **1**: 5–41. [doi](https://en.wikipedia.org/wiki/Digital_object_identifier):[10.1177/001872674700100103](https://doi.org/10.1177/001872674700100103).

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**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 * Ask the residents to turn to the person sitting next to them and draft a quick list of barriers to providing high value care, considering both provider- and system-level issues. * 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. * 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 #8-10: Present the case of a low-risk patient requesting a chest CT to screen for lung cancer. Poll the large group with a show of hands - who thinks it’s inappropriate to order a CT for this patient? Who would order it anyway? From those remaining hands- can you give reasons why? If no hands still up, ask the group for reasons why a physician might order anyway. * Reveal slide #10, which shows the ATS/Chest recommendations against low dose CT screening in low risk individuals. * Slide #11: 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 #12: Ask the residents to talk in their small groups about the principles of patient-centered discussion and to share how they might approach this patient or dealt with similar issues in the past. Review the principles of patient-centered communication on slide 13 and introduce the high value conversation guide. **Provide HVC conversation guide to the participants.** | 10 minutes |
| 4 | **Case 2: Responding to patient requests for treatment**   * Slides #14-15: 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 his treatment plan. **Focus on the use of the high value conversation guide for discussion and role playing.** * Slide #17: 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 #18: Present the case, highlighting the conflict between your assessment and expectations from the consultant and the response you received. * Slide #19: 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 highlights from their discussion. * Slide #20: Discuss how to frame a good consult question and the rationale for why this is important. Go over slide #21 for the follow-up to Case 3. * Slide #22-24: Discuss local culture and the hidden curriculum of medical school and residency. Have the residents brainstorm ideas for how to address local culture or hidden curriculum issues in their hospital. * Discuss the potential solutions or strategies to address local culture or hidden curriculum on slide #25. Unfreeze, change, freeze are the Lewin’s stages of change, which point out that you have to deliberately break old habits or culture, institute a change, and then make sure that it sticks. The figure on the right demonstrates that depending on the influence and involvement of the stakeholders you want to involve in the change, you have to use different strategies. | 15 minutes |
| 6 | Wrap-up and summary   * Review summary slide and go over final thoughts. | 5 minutes |