High Value Care Collaborative
August 2018
Lead Well. Be Well. Care Well.

Learn more at aha.org/physicians
AGENDA

- Welcome
- Overview
  - Curriculum
  - Mentors
- Co-sponsors:
  - Costs of Care
  - ABIM Foundation (Choosing Wisely)
- High-Value Care Culture Survey
High-Value Care Collaborative

- Website of resources
  [https://www.aha.org/high-value-care-resources](https://www.aha.org/high-value-care-resources)

- How it works
  - Webinar schedule
    [https://www.aha.org/high-value-care-webinars](https://www.aha.org/high-value-care-webinars)
  - Team support
# High-Value Care Collaborative Curriculum

**All Program Materials:** [https://www.aha.org/high-value-care-program-materials](https://www.aha.org/high-value-care-program-materials)

**Overall Webinar Schedule:** [https://www.aha.org/node/37003](https://www.aha.org/node/37003)

<table>
<thead>
<tr>
<th>Month</th>
<th>Phase</th>
<th>Topic</th>
<th>Lead</th>
<th>Description</th>
<th>Resources/Supporting tools</th>
</tr>
</thead>
</table>
| Aug-Sept | Establish Team | Webinar (1): Kick Off | AHA and partner team leads | Review collaborative objective, program, timeline, teams | Program timeline and resource library overview  
|       |       | Identify collaborative working team | Collaborative Participants | List of working team members, roles and contact info | AHA guideline on collaborative team composition [https://www.aha.org/node/37001](https://www.aha.org/node/37001)  
|       |       | Complete High Value Care Culture Survey | Collaborative Participants | All team members should review the High Value Care Culture domains, resources and complete the survey as a pre-assessment. | High Value Care Culture Domains: [http://www.highvaluecareculturesurvey.com/tour-domains/](http://www.highvaluecareculturesurvey.com/tour-domains/)  
Survey questions: [http://www.highvaluecareculturesurvey.com/using-the-survey/](http://www.highvaluecareculturesurvey.com/using-the-survey/) (Please note, link will be sent with the survey to complete for purposes of the program)  
|       |       | Determine area(s) of inappropriate use to address | Collaborative Participants | Description of current problem with inappropriate use, causes, current hurdles and enemies of the anal | Choosing Wisely: Where Should I Start? [http://www.choosingwisely.org/where-should-i-start/](http://www.choosingwisely.org/where-should-i-start/)  
Choosing Wisely: Clinician Lists |
**Mentors**

**Alpesh Amin, MD**  
Professor & Chair of Medicine and Executive Director, Hospitalist Program, University of California, Irvine

**Amy Compton-Phillips, MD**  
EVP & Chief Clinical Officer, Providence Health & Services

**Reshma Gupta, MD**  
Medical Director for Quality and Value & Assistant Professor, Division of General Internal Medicine & Health Services Research, UCLA Health  
Outreach and Evaluation Director, Director of Teaching Value in Healthcare Learning Network, Costs of Care

**Sunny Jha, MD**  
Clinical Assistant Professor of Anesthesiology  
Keck School of Medicine, University of Southern California

**Chris Moriates, MD**  
Associate Professor, Department of Internal Medicine  
Assistant Dean for Healthcare Value  
Department of Medical Education  
Dell Medical School  
The University of Texas at Austin
Neel Shah, MD, MPP
Founder and Executive Director, Costs of Care
Assistant Professor of Obstetrics, Gynecology and Reproductive Biology
Harvard Medical School
Director, Delivery Decisions Initiative, Ariadne Labs
THE CHOOSING WISELY® CAMPAIGN

American Hospital Association
High Value Care Collaborative Opening Webinar
August 6, 2018
Choosing Wisely is an initiative of the ABIM Foundation to help clinicians and patients engage in conversations about the overuse of tests and procedures and to support physician efforts to help patients make smart, effective choices.
3 Fundamental Principles
- Primacy of patient welfare
- Patient autonomy
- Social justice

10 Commitments
- Professional competence
- Honesty, confidentiality and appropriate patient relations
- Improving quality of care
- Improving access to care
- Just distribution of resources
- Scientific knowledge
- Avoiding conflict of interest
- Professional code of conduct
Lessons Learned

- Power of messaging and framing
- Simple rules
- Engagement and partnership
- Bottom-up approach with support
- Need for system and performance improvement approaches
Multi-Component Intervention

1. Identify **targeted recommendations & clinicians**
2. Identify **metric** to be used
3. **Education** on recommendations & clinical pathways
4. **Peer-to-peer** comparison/ academic detailing
5. **Clinical decision support & order sets**
6. **Align rewards**, financial & non-financial
7. **Prepare patient** – materials in exam room, waiting room
The “Top 12” Recommendations That Are Reducing Overuse

April 18, 2018

ABIM Foundation staff identified a “Top 12” list of Choosing Wisely recommendations that drove the largest decrease in unnecessary tests and procedures. This list was created using an analysis of reports created by the Incremental cost-effectiveness ratio (ICER) and successful implementation projects gathered through grantee metrics, peer-reviewed journals and an informal environmental scan of implementation within the Choosing Wisely learning network. Sources included 18 peer-reviewed journals, 14 health systems and 34 self-reported results from learning network members. Success was defined as a 10 percent decrease in unnecessary tests or procedures. Analysis by ICER and publication in peer-reviewed journals was weighted.

The Choosing Wisely “Top 12” include:

1. **Use of antibiotics in patients with upper respiratory infections** – Based on recommendations from American Academy of Allergy, Asthma & Immunology, American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians and Infectious Diseases Society of America

2. **Imaging for nonspecific low back pain** – Based on recommendations from American Academy of Family Physicians, American Association of Neurological Surgeons and Congress of Neurological Surgeons, American Chiropractic Association, American College of Emergency Physicians, American College of Physicians, American Society of Anesthesiologists-Pain Management and North American Spine Society

3. **Imaging for uncomplicated or stable headaches** – Based on recommendations from American College of Radiology

4. **Vitamin-D testing** – Based on recommendations from American Academy of Pediatrics, American Society for Clinical Pathology and Endocrine Society

5. **Repetitive CBC and labs** – Based on recommendations from Critical Care Societies Collaborative and Society of Hospital Medicine

6. **In-patient blood utilization** – Based on recommendations from AABB, American College of Obstetricians and Gynecologists, American Society of Anesthesiologists, American Society of Hematology, Critical Care Societies Collaborative and Society of Hospital Medicine
7. Routine annual cervical cytology screening (Pap tests) – Based on recommendations from American College of Obstetricians and Gynecologists and American Society for Colposcopy and Cervical Pathology

8. Benzodiazepines for adults 65 years of age and older – Based on recommendations from American Academy of Nursing and American Geriatrics Society

9. Preoperative testing in patients scheduled to undergo low- and/or intermediate-risk non-cardiac surgery – Based on recommendations from American Academy of Ophthalmology, American College of Physicians, American College of Radiology, American College of Surgeons, American Society of Anesthesiologists, American Society for Clinical Pathology, American Society of Echocardiography and Society of Thoracic Surgeons

10. Telemetry in non-invasive care unit – Based on recommendations from Society of Hospital Medicine

11. Antibiotics beyond 72 hours for inpatients with no signs of infection – Based on recommendations from Society for Healthcare Epidemiology of America

12. DEXA scans – Based on recommendations from American Academy of Family Physicians and American College of Rheumatology

Interested in implementing Choosing Wisely and engaging patients? Get started with resources and advice for clinicians, health care professionals, community organizations and employers looking to implement Choosing Wisely and engage patients.
ICER Baseline Reports

In 2014, the ABIM Foundation, with support from the Robert Wood Johnson Foundation, provided funding to the Institute for Clinical and Economic Review (ICER) to provide brief analyses on several specialty societies’ Choosing Wisely recommendations around commonly overused tests and treatments.

Each of the reports, entitled “Choosing Wisely® Recommendation Analysis: Prioritizing Opportunities for Reducing Inappropriate Care,” explore current practice variation and costs, and examine the sociological forces that contribute to the overuse of the tests and treatments. Each report also includes a summary rating of the extent and harms of overuse, the difficulty of practice change, and the potential for savings.

Baseline reports are available for recommendations around:

- Carotid Artery Stenosis Screening in Asymptomatic Patients
- PCI For Stable Ischemic Heart Disease
- Annual PAP Testing in Women 30-65 Years of Age
- Imaging for Nonspecific Low Back Pain
- Imaging for Uncomplicated Headache
- Preoperative Stress Testing
Clinical Recommendations

Avoid computed tomography (CT) scans of the head in emergency department patients with minor head injury who are at low risk based on validated decision rules.

- Minor head injury is uncommon cause for visiting an emergency department. The majority of minor head injuries do not lead to injuries such as skull fractures or bleeding in the brain that can be diagnosed by a CT scan. If CT scans expose patients to radiation, it is unnecessary and potentially harmful.

Avoid placing indwelling urinary catheters in the emergency department for either urine output monitoring in stable patients who can void, or for patient or staff convenience.

- Indwelling urinary catheters are placed in patients in the emergency department to assist with urinary continence, to monitor urine output or for patient comfort. Catheter-associated urinary tract infection (CAUTI) is the most common hospital-acquired infection in the U.S., and can be prevented by using a non-irritating urinary catheter. Emergency Physician and NPs should discuss the need for a urinary catheter with a patient and/or family members, in conjunction with other options available. Emergency physicians and NPs should consider the use of indwelling catheter by patients with a history of urinary incontinence.

Don't delay engaging available palliative and hospice care services in the emergency department for patients likely to benefit.

- Palliative care is a medical care that provides comfort and relief of symptoms for patients who have chronic, incurable or serious diseases. Palliative care is not a substitute for curative treatment. Education about palliative and hospice care services can benefit patients and their family members. Early referral to the emergency department for hospice and palliative care services can benefit patients and their families.

Avoid antibiotics and wound cultures in emergency department patients with uncomplicated skin and soft tissue abscesses after successful incision and drainage and with adequate medical follow-up.

- Delaying antibiotic use is a frequent reason for visiting an emergency department. Some infections, called abscesses, become walled off and form pus under the skin. Opening and draining an abscess is the appropriate treatment. Antibiotics often benefit the abscess but the infection can be treated by draining the abscess without antibiotics. Additionally, culture of the drainage is not usually performed as the result will not affect the antibiotic treatment.

Avoid instituting intravenous (IV) fluids before doing a trial of oral rehydration therapy in uncomplicated emergency department cases of mild to moderate dehydration in children.

- Fluids for children who present to the emergency department for dehydration require fluid replacement. To avoid the risk of potential complications of an IV in children, it is particularly important to be careful. Giving a medication for nausea or anxiety to patients with nausea and vomiting can improve fluid reabsorption. This change may be made as needed during the trial of oral fluid intake, even if no IV fluids are used for them to be administered.

Consumer Translation

Avoid unnecessary treatments in the ER
A discussion with the doctor can help you make the best decision.

It can be hard to say “No” in the emergency department. But talking with your emergency room (ER) doctor may help you avoid costly testing.

That's why the American College of Emergency Physicians lists three common procedures you should know about:

- CT scans of the head for minor injury
- Urinary catheters
- Antibiotics and cultures for abscesses

CT scans have risks and cost a lot. CT scans use radiation, which can increase the risk of cancer. Children, especially infants, have greater risks because their brains are still developing.

Services in the ER cost a lot, because of fees for doctors, services, and facilities. A CT scan can add over $2,000 to your costs.
Patient Brochures
Wallet Cards
Mobile App

Learn more:
www.choosingwisely.org/patient-resources

5 QUESTIONS to Ask Your Doctor Before You Get Any Test, Treatment, or Procedure

1. Do I really need this test or procedure?
2. What are the risks and side effects?
3. Are there simpler, safer options?
4. What happens if I don’t do anything?
5. How much does it cost, and will my insurance pay for it?
Choosing Wisely Website

www.ChoosingWisely.org/Resources

Where Should I Start?
Information on the origins of the campaign, accounts from early adopters, and anecdotes from patients on the effects of overtreatment

Am I Choosing Wisely?
Learning modules for clinicians that help improve clinical reasoning skills, avoid unnecessary testing and ordering, and improve the delivery of high-value care

How Can I Implement Choosing Wisely in My Community?
Information for community organizations and employers looking to engage patients in the campaign

How Can I Implement Choosing Wisely in My Practice or Health System?
Information for clinicians or health system leaders looking to start a program at their organization

Tools for clinicians
Getting Started

Where Should I Start?
Information on the origins of the campaign, accounts from early adopters, and anecdotes from patients on the effects of overtreatment

Am I Choosing Wisely?
Learning modules for clinicians that help them hone communication skills, avoid unnecessary testing and overcome barriers to delivering high-value care

How Can I Implement Choosing Wisely in My Practice or Health System?
Information for clinicians or health system leaders looking to start a program at their organization

How Can I Implement Choosing Wisely in My Community?
Information for community organizations and employers looking to engage patients in the campaign

Get the App
Download the Choosing Wisely app on your iPhone/iPad or Android device.

Updates From the Field
Monthly updates on organizations advancing Choosing Wisely.
How Can I Implement Choosing Wisely In My Practice or Health System?

Whether looking to implement Choosing Wisely on a large or small scale, the following resources can help guide physicians looking to align their practice with the campaign.

Getting Started

- The Institute for Clinical and Economic Review completed an analysis of several of the Choosing Wisely recommendations that explore current practice variation and costs, and examine the sociological forces that contribute to the overuse of the tests and treatments. Each report also includes a summary rating of the extent and harms of overuse, the difficulty of practice change, and the potential for savings. (These recommendations might be a good starting place for deciding which recommendations to focus on implementing.)
- Email Washington State Health Alliance to request technical specifications that include 31 claims-based measures of Choosing Wisely recommendations and three clinical-based measures. All are updated to ICD-10. If you are interested in implementation, these measures are all Choosing Wisely-specific.

Other Resources to Address Overuse

- The Centers for Disease Control and Prevention's "Get Smart About Antibiotics" campaign addresses the dangers of unnecessary antibiotics. This information can be used in conjunction with the Choosing Wisely materials to help inform providers about the push to reduce antibiotics prescriptions.
- Modules created by Kognito walk users through simulated encounters from either the patient or provider point of view to aid conversations about avoiding unnecessary antibiotics.
- Part of its Steps Forward set of practice improvement strategies, the American Medical Association created a module to help physicians advance Choosing Wisely in their practice.
- These interactive instructional modules were intended to enhance physician and patient communication around the specialty society recommendations from the Choosing Wisely campaign.
- These videos can be used on your website, social media or in your waiting room to raise awareness about Choosing Wisely.
Information on the issue of overuse and ways in which Choosing Wisely is affecting patient care.

Getting Started > Resource Library > Physician Communication Modules

Physician Communication Modules

The ABIM Foundation funded the Drexel University College of Medicine to develop a set of interactive instructional modules to enhance physician and patient communication around the specialty society recommendations from the Choosing Wisely campaign. Developed in collaboration with nine medical specialty societies, these modules are designed to help physicians, patients and other health care stakeholders think and talk about overuse of health care resources by providing strategies for physicians to build trust and address patient attitudes and beliefs that more care is not always better care.

Modules

- ABIM Foundation
- American Academy of Allergy, Asthma & Immunology
- American Academy of Family Physicians
- American Academy of Pediatrics
- American College of Cardiologists
- American College of Physicians
- American College of Radiology
- American Gastrointestinal Association
- American Society of Nephrology
- American Society of Nuclear Cardiology

The Choosing Wisely communication modules are available to all users free of charge and are not intended for commercial use.

How to Navigate the Modules
American Academy of Family Physicians' Choosing Wisely® Communication Module

Bellinda K. Schoof, MHA, CPHQ, Doug Campos-Outcalt, MD, MPA, and Pamela M. Duke, MD

Provide Clear Information Based on Best Evidence

Patients want their doctor to provide health-related information and often feel they are not getting enough information.

- Studies show that patients want their physicians to provide information.
- Physicians overestimate the time they spend educating patients and underestimate how much information their patients want.
- Studies have shown that clinical outcomes such as blood pressure improve when physicians provide clear information.
- Effective patient education improves adherence to plans.
- Patient education programs that include self-management strategies result in reduced healthcare utilization, less lost work time and improvement in symptoms.

Click on the video to see an example of how to provide clear information based on best evidence.

- Explain your recommendations using the guidelines as a reference.
- Keep explanations simple and avoid medical jargon.
- Acknowledge that guidelines are not a “one size fits all.”
- You may need to discuss key evidence about risks, benefits and research supporting the guidelines.
- Use written materials to support your recommendations.
Updates from the Field

June 2018

- Using Blood Wisely
- Updates on an Epidemic: Efforts to Promote Safe Opioid Prescribing
- Implementing Choosing Wisely in Rural Communities
- Choosing Wisely Summer Reads

May 2018

- Report: Engaging patients in Choosing Wisely
- Helping Patients Get Some Shut-Eye at Mount Sinai
- Two New Choosing Wisely Lists
- New Grant to Continue Choosing Wisely Implementation Efforts

April 2018

- Choosing Wisely at the Right Time
- The "Top 12" Recommendations That Are Reducing Overuse
- Helping Patients Take Care of Themselves

March 2018

- Smart Care California Dashboard Drives Alignment
Learning Networks and Communities

- **Health System Leaders** – Tim Lynch, Senior Director of Programs, at tlynch@abim.org

- **Choosing Wisely Learning Network** – Kelly Rand, Program Manager, at krand@abim.org
Learning and Research Communities

Teaching Value in Health Care/Costs of Care – Reshma Gupta at r44gupta@ucla.edu

Research Community on Low-Value Care – Rosina Pradhananga at Rosina.Pradhananga@AcademyHealth.org
System and Performance Improvement

- Programmed 180 Choosing Wisely recommendations into EHR
- Alerted physicians who attempted to order test or treatment referenced by Choosing Wisely
- Links to society recommendation and Consumer Reports materials
- $6 million in annual cost savings in aggregate from implementing Choosing Wisely recommendations across system

Scott Weingarten, MD
Senior Vice President
Chief Clinical Transformation Officer
Evidence of Cultural Change

From why didn’t you order that test to why did you order that test? *From thoroughness to appropriateness*
Interventions

• Clinical decision support
• Comparative performance feedback
• Best practice alerts
• Patient education materials
• Physician champions

Results

• Henry Ford
  • 57% decrease in Vitamin D tests
  • 27% decrease in imaging for low back pain
• Detroit Medical Center
  • 33% drop in Vitamin D tests
Reduction in Pre-Op Screenings

Interventions
• Established new guidelines for pre-cataract surgery
• Changed workflows, surgery requirements
• Physician champions
• Clinical education

Results
• 37% drop in chest X-rays
• 83% decrease in EKG testing
• 87% decrease in lab tests

VALUE Added
6 more mos. of improved vision
THANK YOU

For More Information:
www.choosingwisely.org | www.abimfoundation.org

@ABIMFoundation  #choosingwisely
Creating a High-value Care Culture

Understand how to Measure and Target Improvements

Reshma Gupta, MD, MSHPM

- UCLA Health, Medical Director for Quality and Value
- Costs of Care, Outreach and Evaluation Director, Director of Teaching Value in Healthcare Learning Network
- Assistant Professor, Division of General Internal Medicine & Health Services Research, UCLA

Twitter: @ReshmaGuptaMD
Objectives

• Discuss the role of culture in creating a high-value care environment

• Discuss the High-value Care Culture Survey
  • Purpose
  • Development
  • Approach to understand results
Culture is the Water We Swim In and Takes Time to Change

**Swimming Upstream: Creating a Culture of High-Value Care**

Reshma Gupta, MD, MSHPM, and Christopher Moriates, MD

Abstract

As health system leaders strategize the best ways to encourage the transition toward value-based health care, the underlying culture—defined as a system of shared assumptions, values, beliefs, and norms existing within an environment—continues to shape clinician practice patterns. The current prevailing medical culture contributes to overtesting, overtreatment, and health care waste. Choosing Wisely lists, appropriateness criteria, and guidelines codify best practices, but academic medicine as a whole must recognize that faculty and trainees are all largely still operating within the same cultural climate. Addressing this culture, on both local and national levels, is imperative for engaging clinicians in reforms and creating sustained changes that will deliver on the promise of better health care value. This Perspective outlines four steps for health system leaders to understand, cultivate, and maintain cultural changes toward value-based care: (1) Build

If healthcare practitioners are fish, high value care culture is the water we swim in.

(Gupta, Moriates. “Swimming Upstream: Creating a Culture of High-value Care.” Acad Med. 2016.)

(Ravasi, Shultz. “Responding to organizational identity threats: Exploring the role of organizational culture.” Acad Manag J. 2006.)
Culture is Associated with Overuse and Clinical Outcomes

• 97% of emergency medicine physicians reported unnecessary imaging testing. Authors believe reflects a cultural response to uncertainty.

• Institutional culture and policies are associated with medical trainees feeling compelled to offer the choice of resuscitation in all clinical situations regardless of whether they believed it was clinically appropriate.

• Systematic review found consistent association between positive organizational culture and outcomes including mortality.

• Higher patient safety culture survey scores are associated with clinical behaviors and improved patient outcomes across health systems

(Kanzaria HK. Acad Emerg Med 2015.)
(Dzeng E. JAMA Intern Med 2015.)
(Braithwaite J. BMJ Open. 2017.)
(Singer S. Health Serv Res. 2009.)
(Berry JC. J Patient Saf 2016.)
Hidden Curriculum = part of culture

- Imbalanced focus on identifying rare cases
- Sins of omission > sins of commission
- Misperception that considering cost is not aligned with patient interests
“Organizations will generally try to create needed change without addressing, budgeting for, or having the patience for culture change.
• God bless them if they are successful.
• The vast majority won’t be.

Leaders cannot create culture, but they MUST create the conditions for a great one to emerge.”
Objectives

• Discuss the role of culture in creating a high-value care environment

• Discuss the High-value Care Culture Survey
  • Purpose
  • Development
  • Approach to understand results
Developing a High Value Care Culture Survey (HVCCS™)

Patient safety culture surveys are widely used in hospitals for benchmarking and identifying areas of improvement. No such tool exists for HVCC.

**Methods:**
1. Create a High Value Care Culture Conceptual Model

![Conceptual Model Diagram]

- Physician Characteristics
- Patient Characteristics
- National Guidelines & Regulations
- Physician’s Prediction of Cost and Quality Outcomes to Patient and Health System
- Value-based Clinical Decision Making
- Organizational Culture
- Organizational Structural

2. Develop Survey Items: Modified Delphi Process (nationally representative key stakeholders, n=28)

3. Survey Administration:

<table>
<thead>
<tr>
<th>Center</th>
<th>Residents</th>
<th>Hospitalists</th>
<th>Resident Response Rate</th>
<th>Hospitalist Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Center A</td>
<td>81</td>
<td>47</td>
<td>98% (79)</td>
<td>83% (39)</td>
</tr>
<tr>
<td>Center B</td>
<td>81</td>
<td>44</td>
<td>77% (62)</td>
<td>77% (34)</td>
</tr>
</tbody>
</table>
Identifying Targets to Improve High-Value Care Culture

About HVCCS  The Survey

www.highvaluecareculturesurvey.com
Scores differed consistently across the two pilot centers. (Center B had higher HVCCS scores overall and in 3 of 4 domains tested).

HVCCS positively correlated with institution’s CMS Value-Based Purchasing scores.
Conclusions:
• Health system leaders and program directors can use this survey to identify target areas for improvements and monitor the effects of high value care initiatives.
• Provides initial support for reliability and validity of the HVCCS.

12 Site Follow-up Study:
• Medicine residents and hospitalists completed the HVCCS across 4 university, 4 community, 4 county centers. HVCCS and Value-based Purchasing scores correlated.

<table>
<thead>
<tr>
<th>Medical Center Type</th>
<th>Spearman Rank Correlation (r)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community and University Medical Centers</td>
<td>0.71</td>
<td>0.047</td>
</tr>
</tbody>
</table>

Value-based purchasing scores do not adjust for patient sociodemographic factors. Further evaluation is needed among county medical centers.

(Gupta R. “The Association of Hospitalist Productivity Payments and High-Value Care Culture.” Acad Med. 2018.)
(Gupta R. “High-Value Care Culture among the Future Physician Workforce.” 2018.)
Leadership and Health System Messaging

• Consists of 17 questions.

• Covers engagement with frontline clinicians, leadership visibility and support, high quality communication about quality and safety of care, role modeling, and pride and formal training in value-based care.

• Low scores among individual questions in this factor can identify areas for improvement.

• It will be important to review the specific questions for which your clinicians report lower scores and identify with your team and coach where there are opportunities to improve.
Example) Supervisors in my group review my performance based on decisions that lead to delivering quality care at lower cost…

More than half of clinicians disagree that supervisors review value performance.

Data on value performance could be provided to supervisors, and expectations could be established to incorporate this into routine evaluations.
Example) My group is actively implementing projects that address costs of care...

Nearly 45% of clinicians disagree that their group is actively implementing projects.

Leadership could develop systems to encourage initiatives including financial or non-financial incentives, competitions, and resource support.
Example) My group openly discusses ways to deliver quality care at lower cost within my group...

Only 37% of clinicians agree that their groups have open discussions.

Leaders could create time in meetings and evaluations to discuss methods and concerns to improve high value performance.
Example) My group has formal training to address healthcare value...

46% of clinicians disagree that their groups have formal training.

Leaders could create protected time and suggest resources to clinicians to gain skills in high-value decision making.
Data Access and Transparency

• Consists of two questions.

• This second factor focuses on the availability of cost data for frontline clinicians.

**Questions**: (Disagree to Agree Scale)

Clinicians in my group have access to information about the costs of tests and procedures they order or provide

When clinicians in my group have questions about costs, they know where to go to find answers.
Example) When clinicians in my group have questions about costs, they know where to go to find answers…

There is agreement about lack of access to cost information.

Centers with lower scores in this domain may need to prioritize creating reliable cost databases and providing this data to clinicians.
Comfort with Cost Conversations

- Consists of three questions.
- This factor covers comfort of clinicians to have conversations about costs of care with patients.
- Recent studies show that patients are worked about healthcare costs and want to talk about costs with their physicians.

**Questions:** (Disagree to Agree Scale)

<table>
<thead>
<tr>
<th>Patients that I see are uncomfortable discussing costs of tests or treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinicians in my group are uncomfortable discussing costs of tests or treatments with patients</td>
</tr>
<tr>
<td>Clinicians in my group feel that it is not the role of physicians to discuss costs of tests or treatments with patients</td>
</tr>
</tbody>
</table>
Example) Clinicians in my group are uncomfortable discussing costs of tests or treatments with patients...

There is great variability in responses with only 1/3 who disagree.

Consider training clinicians to have discussions about the costs of their care with patients.
Blame-free Environment

- Consists of two questions.
- Focuses on a sense of individual blame within divisions, practice groups and training programs.

**Questions: (Disagree to Agree Scale)**

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>In my group, clinicians’ fear of legal repercussions affects how often they order unneeded tests or procedures</td>
<td>Agree</td>
</tr>
<tr>
<td>Individual clinicians get blamed for medical or surgical complications</td>
<td>Agree</td>
</tr>
</tbody>
</table>
Example) In my group, clinicians’ fear of legal repercussions affects how often they order unneeded tests or procedures…

Nearly 50% of clinicians agree.

Consider focusing on promoting evidence-based practice and giving clinicians information to fairly weight the risks and benefits of defensive medicine.

Consider creating a non-punative environment with system leaders.
Approaching Data

• There are no goal benchmarks for metrics at this time, though we can use this survey to compare to other hospital groups. We recommend instead for you as a group to use the results to identify potential areas for improvement and to monitor/measure for success.

• These are complex issues and improvement may require additional infrastructure. We do not expect to get to 100% for each metric.

• We suggest working closely with your coaches to plan out when and how to administer surveys to obtain high response rates (e.g. required meetings, using on-line formats to email). We suggest administering at baseline and at 6 or 12 month time points.

• Coaches can also help reflect on areas of opportunity.
We hope the HVCCS™ will help you begin improving culture at your institutions!
Elisa Arespacochaga
Vice President, AHA Physician Alliance
312-422-3329
elisa@aha.org

You are invited to learn more about the AHA Physician Alliance at
www.aha.org/physicians