COMMENTARY

Confronting the Hidden Curriculum of High-Value Care Education

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Nearly a decade ago, Porter[1] issued a call to restructure health care to focus on maximizing value, defined as the outcomes achieved over the cost of providing that care. By focusing on value, physicians and health systems are encouraged to switch from providing high-volume care, with an implicit assumption that more care leads to better outcomes, to a more balanced approach. This value-focused approach emphasizes providing care that leads to the most benefit to patients while minimizing the harms, wasted resources, and excess costs associated with overuse[2] and overdiagnosis.[3] Although the health care field has become more aware of the need to improve value, over the last decade we have continued to see increasing overall health spending,[4] including pediatric-specific health spending.[5]

These national data support the idea that bending the cost curve and achieving high-value care (HVC) are difficult and will take time. Sustained success will likely require a multifaceted approach incorporating both national policy changes and local institutional commitments to creating a culture of value. One essential ingredient will be high-quality, HVC education. Shared knowledge of HVC principles throughout an institution can create a foundation and shared understanding for practice change. Currently, the vast majority of residency training programs have no formal training in understanding cost and value in health care,[6,7] and there is evidence that many physicians and trainees have poor knowledge of the cost, risks, and benefits of the care they provide.[8–10] Formal curricula have been developed to address some of these knowledge gaps and are starting to be used directly to train faculty and trainees via didactic sessions and case review. However, a large portion of ongoing education for both trainees and physicians occurs outside the bounds of formal teaching sessions through informal teaching and the role-modeled behavior we observe.[11] As we seek to develop local cultures of HVC, it's important to understand this "hidden curriculum" and the way it may interact with our educational efforts.[12] In this edition of *Hospital Pediatrics*, Beck et al[13] seek to better understand one of these informal educational environments: the inpatient rooms and hallways where most clinical care decisions are discussed and finalized.

In their cross-sectional observational study, the author team uses a previously validated tool[14] for measuring the quantity and types of HVC discussions occurring during family-centered rounds at a single institution. Over a 4-month time period, the team observed 87 separate rounding sessions with a total of 660 patient encounters and an average rounding time for each session of 103 minutes. The HVC Rounding Tool was used to measure discussions in 3 categorical groups: quality, cost, and patient values. Within each group was a list of specific observable HVC discussions. Beck et al[13] found that only 29% of patient rounding encounters contained at least 1 HVC discussion. This proportion was the same for both general medicine and subspecialty services, and only

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4.5% of patient rounding sessions had multiple HVC discussions. The types of discussion that occurred were evenly spread across the topic categories of quality, cost, and patient values.

The results also provide insight into who commonly leads HVC discussions. Attending physicians and fellows were the most likely, comprising 41% of observed discussions. Residents and medical students initiated 31% of discussions, and parents or family initiated 12% of discussions. The remaining discussions were spread among the multidisciplinary care team including nurses (7%), pharmacists (6%), and social workers and case managers (2%). These results provide key preliminary insights into the frequency and types of HVC conversations that occur in this specific care environment. The ability to measure HVC discussions in the course of actual patient care has important implications for how we understand informal education and has potential as a measure of the impact of HVC education on practice change.

As the author team notes, the work has several important limitations. By only measuring those care discussions that occurred during rounding times, other HVC discussions that occur at other times may have been missed. These may include other high-yield times to discuss value such as conversations with consultants, resident sign-out, and discussions with patients and families later in the day. In addition, the observation of only a single day of rounds may have missed longitudinal HVC discussions that occurred over the course of a patient's stay. This study provides an important starting point for characterizing value-based discussions in the context of family-centered rounds; however, as a single site study, it is unclear if a daily discussion rate of 29% is below average or exemplary. These limitations provide important context for future work to better understand the national range of practice in HVC discussions on rounds.

The findings of Beck et al[13] reinforce the need to further develop physician leaders as role-models and teachers of HVC. We have come to understand that the practice and behaviors learned in training often carry forward into clinical careers,[15] and the authors of several recent studies have identified a lack of supervisor role models as a factor driving low-value care for residents.[16,17] Increasing the comfort and knowledge of attending physicians to discuss HVC with trainees may help address this shortcoming. Lower participation by residents, medical students, and nonphysician team members also underscores the need to empower all levels of learners and multidisciplinary team members to initiate value discussions. This difference in frequency may be driven by knowledge gaps or perceptions of what types of discussion are appropriate for certain roles. Understanding what drives this differential may help guide efforts to increase discussions of value either through improved knowledge or clear role definitions.

As institutions and physicians determine how best to encourage HVC, the findings of Beck et al[13] support the idea that formal curricula are necessary but likely not sufficient. We should strive to expand the HVC educational environment beyond the lecture hall to include any place where patient care occurs. How do we ensure that the informal and hidden curriculum augments our formal HVC education instead of hindering it? The results of a recent review indicated that knowledge transmission combined with facilitation of reflective practice and a supportive HVC environment may lead to success.[18] In particular, an educational system focused on 4 concepts may achieve this multilevel goal (Fig 1). First, it is important to build a shared understanding of HVC concepts through formal curricula for physicians, trainees, nurses, pharmacists, and all staff within an organization. We know there is a high prevalence of poor knowledge of cost, benefits, and harms.[8–10] Improving this knowledge deficit can empower all levels of care providers to engage in value discussions, and a shared understanding of key HVC concepts creates a common language for discussing these topics. Second, barriers to teaching can be reduced through building skills and providing scripts for how best to incorporate HVC discussions into everyday clinical interactions. Training physicians and the other leaders of care teams through the use of role-play, scripts, or coaching may increase awareness of discussion opportunities and skills for how to frame these conversations within the clinical environment. Third, clear opportunities to discuss value can be defined through standardized pathways and quality improvement interventions focused on value. Aligning educational efforts with ongoing quality improvement efforts provides a clear and commonly agreed on goal that can be discussed and reinforced in the clinical environment. Finally, systems to provide clear feedback on HVC education and clinical outcomes will be important. Providing accessible information on how individuals, teams, and the health system are performing in both discussions of value

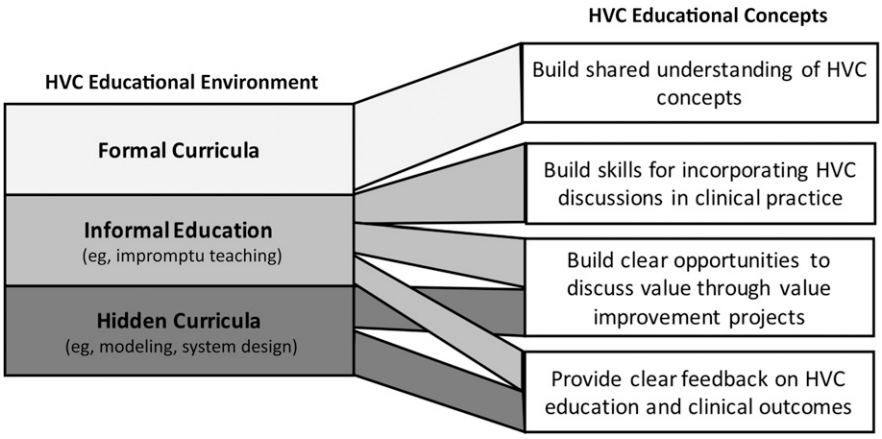

FIGURE 1 Multilevel educational interventions and their relationship to formal, informal, and hidden curricula. HVC, high-value care.

and patient care outcomes can reinforce HVC teaching opportunities and reflective practice. Future work to develop and pilot test instruments like the HVC Rounding Tool are an important step toward creating multilevel HVC educational interventions.

Through their important work to establish a reliable measurement tool and baseline rates for conversations around value, Beck et al[13] have set the stage for physicians to be able to provide valuable feedback to their peers on the frequency with which they address value in the daily clinical rounding environment. As we continue to investigate the best methods to develop HVC learning environments and address the hidden curriculum of HVC education, this type of feedback will likely play an increasingly important role in physician learning and systems change.

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