

Original Publication

OPEN ACCESS

# Reforming Your Health Care Reform Curriculum

Karen Friedman, MD\*, Ankita Sagar, MD, MPH, Saima Chaudhry, MD, MSHS

\*Corresponding author: [kfriedma@nshs.edu](mailto:kfriedma@nshs.edu)

**Citation:** Friedman K, Sagar A, Chaudhry S. Reforming your health care reform curriculum. *MedEdPORTAL*. 2016;12:10413. [https://doi.org/10.15766/mep\\_2374-8265.10413](https://doi.org/10.15766/mep_2374-8265.10413)

**Copyright:** © 2016 Friedman et al. This is an open-access publication distributed under the terms of the Creative Commons Attribution-NonCommercial-Share Alike license.

## Abstract

**Introduction:** The landscape of health care is changing drastically, and the future within which our residents practice medicine will look very different than today's current health care system. Our residency program created a weeklong introduction to health care reform in the United States for residents.

**Methods:** The materials for faculty facilitators associated with this publication include PowerPoint presentations, a debate script on bundled payments, and an evaluation survey. The weeklong curriculum requires 7 hours of scheduled time from all learners, with an additional 5 hours for the residents and faculty running the debate. The survey completed at the end of the week showed that on a query of interest in health care reform (1 = *no interest*, 5 = *very interested*), interest level increased from an average score of 2.35 pre-session to an average score of 3.61 post-session. Self-reported basic understanding of all areas queried increased from pre- to post-session. **Discussion:** This endeavor works best as a collaboration between residency program directors, associate program directors, residents, and other willing parties at one's home institution as the didactics were designed to include all PGY levels. Overall, this method of introducing a very complicated topic was well received by the residents, who voted to continue the weeklong curriculum going forward.

## Keywords

Systems-Based Practice, Health Care Reform, Debate

## Appendices

- A. Health Reform Week Schedule.docx
- B. Payment and Delivery System Reform-A Primer .pptx
- C. Your Research Can Influence Health Policy.pptx
- D. Guide to Presentations .docx
- E. Debate Role-Play Characters.pptx
- F. Resident Debate Script .docx
- G. Reform Week Survey.docx

*All appendices are peer reviewed as integral parts of the Original Publication.*

## Educational Objectives

By the end of this module, learners will be able to:

1. Discuss the factors driving health care reform.
2. Define and describe the components of both payment and delivery reform.
3. Define and describe the risks and opportunities of payment reform.
4. Explain how residents can influence policy reform.
5. Recognize medical policy and politics in their state.
6. Define and discuss high-value, cost-conscious care.
7. Apply gained knowledge of health care reform through a mock debate.

## Introduction

It is our experience that most residents possess little understanding of the outside world they will practice in upon graduation. They have a very basic understanding of the health care system and less understanding of current policy and health care reform. While this information falls under the ACGME competency of systems-based practice, most programs do not have a structured format to teach the content. Additionally, residents may be disinterested as it is not information that is queried on the board exams. We developed this curriculum as a health care reform week to both fill the gaps in residents' knowledge and spark enthusiasm for the topic. The curriculum was created by faculty at the Hofstra Northwell School of Medicine, one of the largest not-for-profit health care systems in the country, where we were able to leverage the skills and enthusiasm for the topic of several faculty members. The scheduling was intended to reach as many of our 132 residents as possible, and as everyone was

expected to attend the noon conferences and grand rounds, we teleconferenced these to both of our campuses.

## Methods

The creation of a health reform week should start with organizing the overall structure of the week. The sample schedule (Appendix A) lists a suggested organization of the didactic sessions as well as the speakers we chose for each, but this can be adapted to whomever is appropriate at your institution. Noon conference times worked best for us since we already had rooms reserved and were also able to set up teleconferencing to our other sites. Grand rounds can be done at the designated time within your department.

The first day includes the 1- to 1.5-hour presentation/workshop titled Payment and Delivery System Reform: A Primer (Appendix B). This presentation can be given by any knowledgeable faculty member as it aims to impart to the residents a basic understanding of jargon they will be hearing throughout the week. You can use the think, pair, share method throughout the presentation to encourage discussion on the relevant topics such as fee-for-service and value-based purchasing.

The second day includes 2 hours of lecture on two topics. The first hour is a lecture titled Your Research Can Influence Health Policy (Appendix C). This talk was given by one of our associate program directors and focuses on advocacy, GME financing, and the Institute of Medicine reports. The second hour is a lecture on managing high-risk populations and risk-based contracting that was given by the medical director of our insurance company. While we were unable to get permission to include the full lecture, the outline and overall goals are included in Appendix D to aid replication at other institutions.

The third day is also two parts, starting with grand rounds in the morning; however, others may choose to do this session on whichever morning grand rounds are typically scheduled. Plan to invite a speaker who is well versed and knowledgeable about health care reform in your state. At our institution, two residents per year do a monthlong rotation in Albany, New York, with the New York Chapter of the American College of Physicians (ACP). Through this maintained connection, we are able to invite the ACP New York Chapter's executive director, who is a lobbyist and can provide an update about what is new and ongoing with state policies. Then, in the afternoon of third day, there is a 1-hour lecture on high-value, cost-conscious care. ACP offers free resources for this presentation online (see Appendix D) for any faculty member to give this talk.

The fourth day is the resident debate, which requires a good deal of preparation. First, you need to select eight residents who will fill the eight roles described in Appendix E. In preparation for the debate, we instruct the eight residents to review their roles (Appendix F) and read three additional readings for a deeper understanding of the material.<sup>1-3</sup> Our program director served as moderator, but any capable faculty can do this. We had a practice run-through prior to actual debate, but this is not required. Faculty and fellows were invited to attend the debate, and the chairman queried the audience at the end. Having the chairman support our week both at grand rounds and by participating in the debate added credibility to our work.

Following the debate, we conduct a retrospective pre/post knowledge survey (Appendix G) in order to gauge the level of self-reported knowledge change. The 11-question survey asked the residents to circle their degree of understanding of the material before and after health care reform week on a Likert scale (1 = no knowledge, 5 = very knowledgeable) for the first 10 questions. The eleventh question used a separate Likert scale (1 = no interest, 5 = very interested) to gauge residents' overall interest in the topic of health care reform.

## Results

A total of 53 residents completed the survey, but the surveys of the eight residents who participated in the role-play (acting residents) were analyzed separately. The full results are listed in the [Table](#). Of the 45 nonacting residents from PGY-1 ( $n = 23$ ), PGY-2 ( $n = 9$ ), and PGY-3 ( $n = 13$ ) who completed the survey,

attendance averaged at 4.7 out of the six sessions. The eight acting residents were PGY-2 and PGY-3 and attended an average of 5.25 out of the six sessions. The first 10 survey questions asked for self-reported pre- and postsession understanding of 10 topics. All of the 10 knowledge questions had a self-reported increase in knowledge from pre- to postsession attendance. For nonacting residents, the lowest percentage increase was 53% on question 5, which asked about knowledge of GME financing. The greatest percentage increase was 122% on question 10, the pros and cons of bundled payments. Similar results were found for acting residents, who had a 35% increase on question 5 and a 176% increase on question 10. The final question asked the residents to rate their interest in health care reform pre- and postsession on a scale of 1-5 (1 = no interest, 5 = very interested). The presession score was an interest level of 2.35, and the postsession score was an interest level of 3.61 for nonacting residents, which was a 54% increase in interest. For the eight acting residents, there was a 79% increase in interest for the topic.

**Table.** Retrospective Pre-/Postsession Survey Results for Acting and Nonacting Residents

Question	Acting Residents <sup>a</sup>			Nonacting Residents <sup>b</sup>		
	Presession Average	Postsession Average	Percent Increase	Presession Average	Postsession Average	Percent Increase
On a scale of 1-5, <sup>c</sup> please rate your basic understanding of: 1. The following models of payment: fee-for-service, value-based purchasing, bundled payments, Medicare shared savings program, accountable care organizations, and capitation.	1.63	3.88	138.46	1.87	3.64	94.95
2. How your future practice will be impacted by the above payment reforms.	1.63	4.13	153.85	1.73	3.33	92.22
3. The extent our institution is engaging in risk-based contracting.	1.38	3.75	172.73	1.68	3.17	88.76
4. How care management will be an important resource for managing our high-risk patient population.	2.25	4.25	88.89	2.09	3.66	74.77
5. How GME is financed.	2.50	3.38	35.00	2.08	3.19	53.64
6. What challenges academic medicine will face in maintaining GME funding moving forward.	2.00	3.50	75.00	1.85	3.00	62.24
7. The barriers to providing high-value care in our health system.	2.63	4.63	76.19	2.17	3.89	79.13
8. How health care legislation is a large portion of New York's annual budget.	2.14	3.71	73.33	2.09	3.43	64.29
9. The important advocacy roles physicians can play in health care reform.	2.75	4.25	54.55	2.25	3.63	61.11
10. The pros and cons of bundled payments.	1.63	4.50	176.92	1.79	3.98	122.09
11. On a scale of 1-5, <sup>d</sup> please tell us your interest level in health care reform.	2.33	4.17	78.57	2.35	3.61	53.70

<sup>a</sup>n = 8.

<sup>b</sup>n = 45.

<sup>c</sup>Likert scale (1 = no knowledge, 5 = very knowledgeable).

<sup>d</sup>Likert scale (1 = no interest, 5 = very interested).

## Discussion

The current literature for teaching health policy and health care reform is very sparse. Patel, Davis, and Lypson in 2011 stated that “medical education has failed to keep up with policy changes as the US health care system has evolved.”<sup>4</sup> Part of the reason for this is that health care reform can be a challenging subject for residents to embrace and faculty to teach. However, failure to teach health policy to rising physicians can mean a detrimental future for them and their patients.<sup>4</sup> Given the dearth of literature describing the outcomes of teaching this type of curriculum,<sup>4</sup> we decided to start small with a 1-week curriculum to begin the health policy conversation with our residents. Each presentation during the week built upon the others and laid the groundwork for the debate at the week’s end. The successful use of debate in facilitating the study of health care reform is reported in the literature by Nguyen and Hirsch.<sup>5</sup> The results of our survey showed that not only did the residents’ self-reported knowledge base increase in all areas taught but also the interest level for the topic of health care reform increased. We assessed resident self-reported understanding of various health reform topics using a 5-point Likert scale, with 5 being strongly agree and 1 being strongly disagree. Assessing self-reported knowledge and skills acquisition has been done in other evaluations of educational interventions using a retrospective pre-/posttest design. This methodology has been shown to reduce bias in the assessment of participants’ self-

assessed knowledge and skills acquisition compared to the traditional pre- and posttest design. This is because it is known that the use of a scale to rate trainees before and after exposure to a training intervention may change because of the training intervention in question.<sup>6</sup> While our survey is not a true test of the residents' knowledge, our main goal was to assess the residents' desire to have health reform topics provided in the curriculum and gain exposure to this topic.

We had a very successful health care reform week for many reasons. First and foremost, our program director was extremely knowledgeable on the subject and was the visionary behind the debate and lecture topics to include. This was accentuated by our two chief residents who, having completed an advocacy elective, also shared their enthusiasm and knowledge with their peers. Our large program size also helped with our success as we had many other faculty members who were willing participants. If you come from a smaller institution, you might try to leverage nontraditional faculty, such as the medical director, executive director, or anyone else who is knowledgeable, to help lead certain discussions. As this is a reproducible 1-week curriculum composed of lectures and activities, it can be changed every year to include different topics and speakers. Given that GME financing had the smallest percentage gain in participant understanding, we plan to add additional material on this topic in the upcoming year.

---

**Karen Friedman, MD:** Vice Chair for Education, Hofstra Northwell School of Medicine at Hofstra University; Assistant Professor, Department of Medicine, Hofstra Northwell School of Medicine at Hofstra University

**Ankita Sagar, MD, MPH:** Assistant Professor, Department of Medicine, Hofstra Northwell School of Medicine at Hofstra University

**Saima Chaudhry, MD, MSHS:** Vice President of Academic Affairs, Memorial Health Care System

---

#### Disclosures

None to report.

#### Funding/Support

None to report.

#### Ethical Approval

Reported as not applicable.

---

## References

1. de Brantes F, Berenson R, Burton R. Payment reform: bundled episodes vs. global payments—a debate between Francois de Brantes and Robert Berenson. Robert Wood Johnson Foundation Web site. <http://www.rwjf.org/en/library/research/2012/09/payment-reform--bundled-episodes-vs--global-payments.html>. Published September 2012.
  2. Weeks WB, Rau SS, Wadsworth EB, Weinstein JN. The unintended consequences of bundled payments. *Ann Intern Med*. 2013;158(1):62-64. <http://dx.doi.org/10.7326/0003-4819-158-1-201301010-00012>
  3. Struijs JN, Baan CA. Integrating care through bundled payment—lessons from the Netherlands. *N Engl J Med*. 2011;364(11):990-991. <http://dx.doi.org/10.1056/NEJMp1011849>
  4. Patel MS, Davis MM, Lypson ML. Advancing medical education by teaching health policy. *N Engl J Med*. 2011;364(8):695-697. <http://dx.doi.org/10.1056/NEJMp1009202>
  5. Nguyen VQ, Hirsch MA. Use of a policy debate to teach residents about health care reform. *J Grad Med Educ*. 2011;3(3):376-378. <http://dx.doi.org/10.4300/JGME-03-03-32>
  6. Skeff KM, Stratos GA, Bergen MR, Regula DP Jr. A pilot study of faculty development for basic science teachers. *Acad Med*. 1998;73(6):701-704. <http://dx.doi.org/10.1097/00001888-199806000-00018>
- 

**Received:** November 18, 2015 | **Accepted:** April 14, 2016 | **Published:** June 10, 2016