

Engaging Patients in Education for Self-Management in an Accountable Care Environment

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Accountability for quality health outcomes at low cost is a priority discussion in nearly all medical circles, but particularly among primary care providers of diabetes care. Accountable care organizations (ACOs) and patient-centered medical home (PCMH) models have assigned accountability to providers who, in turn, are reengineering the way they provide care, integrating evidence-based practice guidelines, quality metrics of success, and algorithms that improve quality and reduce costs. However, physicians, payers, and employers are only beginning to understand and appreciate their underutilized resource for enhancing accountability: the patients.

Engaging patients to make good decisions about their health and health care is recognized as crucial but requires incentives and techniques with which most are unfamiliar. At the heart of assuming responsibility for this shared decision making is the well-tested concept of the educated patient. Indeed, PCMH pilot projects of integrated care management that have been successful have placed a high premium on educated patients who actively share in decision making for assuming self-management and personal responsibility.^{1,2}

The value of patient education in diabetes self-management need not be debated. Studies demonstrate that knowledge and skills facilitating key self-care behaviors are successful in

improving metabolic and psychosocial outcomes, as well as providing cost savings.^{3,4} Patient education certification programs based on evidence-based standards for diabetes self-management education (DSME) have been in existence for more than 20 years, and reimbursement for these programs is steadily improving.

Although this type of education intervention is meant to improve patients' ability to self-manage diabetes through knowledge and skill development, the educational benefit itself is underutilized, particularly in people living in underserved areas.⁴ Physician variability in referring patients for DSME suggests that poor access to certified programs may not be entirely responsible for underutilization.

Just as provider education is continuous throughout a career, becoming a self-manager of diabetes must be recognized as continuous throughout patients' lifetime. It would be unrealistic to hold patients responsible for sharing in the decision making for their health outcomes if they did not have access to the knowledge, skills, confidence, and problem-solving techniques to incorporate desired behaviors into their daily lives.^{5,6} Thus, a single intervention in a diabetes education program is not enough to effectively manage diabetes for a lifetime or to sustain the gains made in education.

Ongoing self-management education support that includes

problem-solving and shared decision-making skills development will be the responsibility of primary care providers and their teams in the future chronic care model. In addition to formalized education if available, providers will need to offer educational interventions that are simple and cost-effective, can be performed by available team members, are personalized and individualized to their patients, and can be easily tracked, monitored, and reported.

Electronic data management is a key element of success in ACO and PCMH models. However, a major concern for providers trying to track and monitor educational interventions is that currently available large electronic data systems do not support monitoring the nature or outcomes of educational or behavioral interventions or their correlation to health outcomes. Advanced population management systems are being developed, and some are available and capable of interfacing with electronic reporting systems such as that made by Epic. This offers the opportunity to integrate education interventions with health outcomes in the future.

The Expanded Diabetes Education Team

Certified diabetes educators (CDEs) trained in problem-solving skill development are increasingly found in provider organizations, facilitating both individual and group education. Their interventions contribute to

accountability for guideline adherence and improved outcome measures.^{5,6} In the accountable chronic care model, patient education to assume self-management responsibility is provided and reinforced by an expanded scope of team members, including CDEs, nurses, dietitians, pharmacists, medical office staff, and even some health-club personnel or community health workers. Primary care providers in ACOs and the PCMH model are ultimately accountable for coordinating patients' access to education. This does not mean they need to provide the education personally, but rather that they engage the expanded team to achieve improved outcomes. This leaves providers free to focus on medical management decisions with patients.

Principles of adult learning suggest that individuals learn when they perceive the need to learn—in other words, because they desire a new skill or want to solve a problem. Education and training in such an environment takes on a new look as “teachable moments” are prompted by patients' or family members' questions, concerns, or problems. This education is personalized, simple, and brief, perhaps only 2–10 minutes in length. A local pharmacist, for example, may have monthly or biweekly contact with a patient that provides the opportunity for a teachable moment; in some cases, this has been shown to be beneficial in improving medical outcomes.⁷ A medical office assistant who weighs a patient may also have a unique opportunity to engage the patient in assessing a problem that can be addressed with a problem-solving skill.

The remainder of this article explains how busy primary care providers, pharmacists, office personnel, and other team members use principles of adult education to make the most of such encounters.

A Practical Approach to Patient Education

Helping patients become responsible self-managers means helping them learn what they need to know (both knowledge and skills) and to feel competent and confident enough to use their knowledge to cope with and manage their diabetes. Toward that end, modifying an approach already familiar to health professionals through the current continuing medical education delivery model can be useful.⁸

The ATOM approach (which stands for Assess, Teach/Train to a desired Outcome, and Measure results) integrates continuous assessment efforts throughout the educational process to achieve desired outcomes (Figure 1). A successful education encounter begins with the end (desired outcome) in mind. The desired outcome, whether it be counting carbohydrates or injecting insulin, drives the nature

of the assessment and the educational intervention. Measuring the result of the intervention and the gap between what is desired and what actually is then acts as the new needs assessment.

Starting with the end in mind in diabetes is clearly directed toward achieving specific behaviors that educators know to be necessary for successful self-management. This does not mean that the people providing the education makes the decision about which outcome will be tackled. In fact, patients and educators need to mutually agree on the outcome they wish to achieve as part of the shared decision-making process.

Step 1: Assess

Individuals with diabetes need to learn many concepts and procedures to successfully live with and self-manage their disease. They must be able to take the knowledge and skills regard-

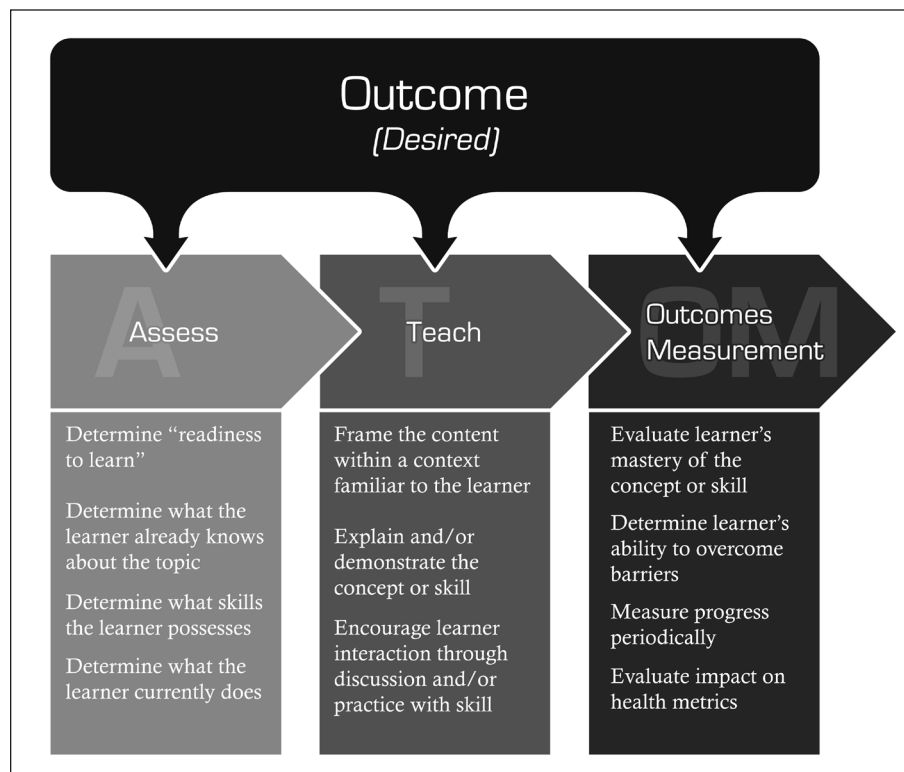


Fig 1. The ATOM Learning Model.

ing what to do and how to do it and then feel both capable and confident in integrating their knowledge into their daily lives. Overcoming barriers and obstacles to actually doing what is necessary is the final step needed for a successful outcome (Figure 2).

Because most adults have some knowledge of diabetes and even more knowledge about what behavioral strategies work for them, the role of health care provider team members is to assess what patients already know (declarative knowledge) or know how to do (procedural knowledge). At diagnosis, team members should first address the patients' fears and concerns about the diagnosis by asking what is most concerning for them.

To that end, the assessment might include starting a dialogue by asking a simple, open-ended question such as, "What do you know about diabetes and its management?" or "What is your biggest concern or fear about being diagnosed with diabetes?" In this way, providers can measure the gap between what is and what should be and determine whether and how they need to close that knowledge

gap. Asking open-ended assessment questions can also shed light on patients' ability to learn and grasp specific concepts, language barriers, level of diabetes-related distress, health literacy, and other pertinent self-management issues.

Continuous assessment of the educational needs of patient-learners requires taking advantage of every interaction between team members and patients. Patients' ability to take on responsibility is affected by constantly changing factors in their life such as the daily hassles of caring for diabetes, general life stresses, changing health, other priorities, and work and family responsibilities. This suggests that knowledge is not translated into sustained behavior until patients learn to incorporate their skills into their everyday life by overcoming barriers and engaging in spontaneous problem solving.

Step 2: Teach/train

Good teachers do not tell patients what to do, but rather engage them in a discussion. Much of what we have learned about teaching or training adults comes from both job train-

ing research and patient-education research and can be distilled into four key adult-learning principles: readiness, experience, autonomy, and action.⁹

Readiness means focusing on learners' needs at the time they are ready to learn. Adults come to a learning situation with their own priorities and needs. Usually, this means there is something in it for them such as solving a problem, avoiding a problem, or creating an opportunity. Helping patients become responsible for their diabetes care involves helping them understand the value of learning and adopting new skills or behaviors. Readiness to learn new skills also depends on personal factors such as available time, daily family issues, and finances. Furthermore, emotions can affect readiness by creating a fatalistic or negative view of learning how to be a self-manager. For example, discussing blood glucose monitoring when patients are angry or depressed about their diagnosis is rarely effective.

Capitalizing on patients' life experiences will lead to more effective learning. During the needs assessment, learners are invited to share what they know about a behavior such as getting physical activity, their past experiences with this behavior, their attitudes or beliefs about the topic, their cultural beliefs, and their own perceived strengths or deficiencies about the behavior. Building on their experience and addressing any related issues potentiates learning.

All adults desire *autonomy*, including the ability to make their own decisions. Personal autonomy and responsibility for health care, from patients' perspectives, can only be realized if they are treated as independent and capable. Providing opportunities during teaching or training for learners to make

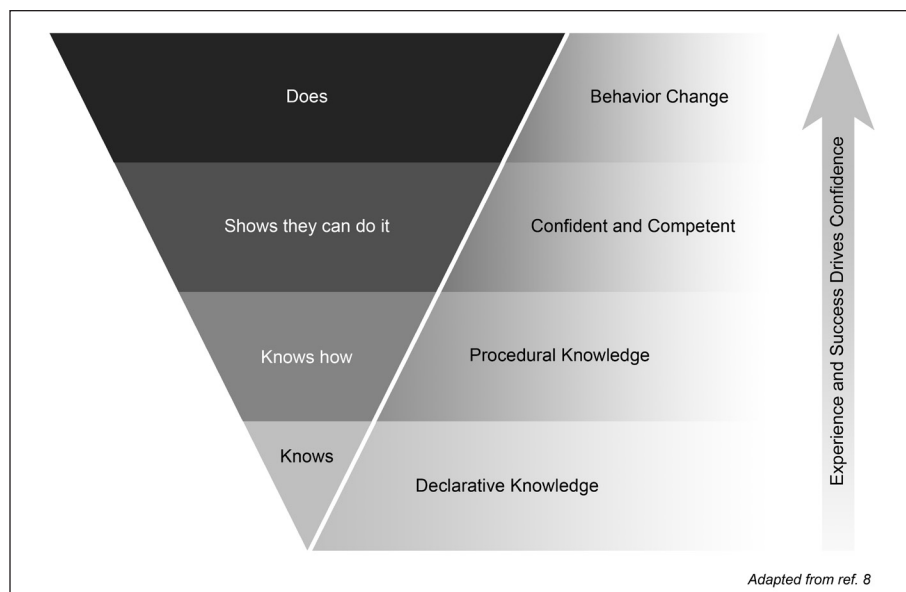


Fig 2. Framework for assessing learning needs.

decisions, set personal goals, and create action plans is a requirement. Helping patients anticipate barriers and devise strategies to overcome those barriers is an important component of this process.

Finally, taking *action* requires learners to be able to use and practice what they have learned with some immediacy. Adults learning a new job skill, for example, must use the skill immediately, or they lose both interest and the knowledge or skill they have acquired. The same is true for patients acquiring new diabetes self-management concepts and skills. Creating opportunities during the learning session to practice skills such as monitoring blood glucose, reading food labels, and choosing portion sizes can help patients incorporate such skills into their daily lives.

Step 3: Outcome measurement

Measuring outcomes or obtaining metrics is something with which health care professionals are becoming increasingly familiar. Measuring against Healthcare Effectiveness Data and Information Set metrics, National Committee for Quality Assurance (NCQA) guidelines, and individual organization recommendations provides the feedback necessary for continuous quality improvement. Measuring outcomes also provides feedback to patients, providers, and the entire clinical practice about the effectiveness of their educational interventions.

Just as in quality-improvement initiatives, outcomes can be measured in terms of adoption of a process (such as checking A1C levels, exercising, or taking medications) or in terms of actual health outcomes (such as the percentage improvement in A1C level or weight change). Behavior changes can be both processes and health outcomes. For example, reducing calories could be a process that leads to the medical outcome of weight loss. On the other hand, reading labels and measuring portions can be a process leading to calorie reduction, which can itself be a desired outcome related to improved health outcomes.

Because measurement is key to future reimbursement and quality improvement, it is important to recognize that outcome measures can be both individual (related to competence or performance) and population-based (related to the aggregated group performing the behaviors). Patient self-reported outcomes are also being considered as NCQA outcome measures for the future, suggesting that both providers and patients will need to become knowledgeable about outcomes. As providers and patients recognize the value of measuring outcomes, both benefit from improved patient health, enhanced personal satisfaction, and the potential for cost savings.

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