

IN AN ERA OF PATIENT ENGAGEMENT, NEW IMPORTANCE AND NEW PURPOSE FOR INDEPENDENT MEDICAL EDUCATION

With healthcare's growing focus on patient engagement, IME has a high-visibility opportunity to demonstrate its ability to effect measurable change on knowledge, behavior, and health outcomes.

BY DAVE CHASE AND CHRISTINA HOFFMAN



Engaging the Patient: A Call to Action

Decades and billions of dollars have been invested in the advancement of independent medical education (IME), with an almost sole focus on physicians and the healthcare providers (HCPs). The charge of IME has been to educate clinicians, with the belief that heightened knowledge will lead to more competent practice behavior and ultimately better patient outcomes. As such, designers of medical education have long regarded the patient's role as ancillary, with little recognition for their direct involvement in health care or influence over its outcome. Standard-fare patient education materials have evolved little since their inception and certainly at nowhere near the pace of IME for clinicians. However, with dramatic shifts in the healthcare enterprise prompting recognition that informed, participatory patients are critical to improved outcomes, IME is now poised to provide patients with the knowledge and tools needed to engage collaboratively with their HCPs and to assume an increased ownership role in their own health. As efforts to achieve this goal accelerate, medical education must at the same time prepare clinicians to accept this new partnership and evolve their attitudes and practice behaviors accordingly.

The appearance of the government-mandated Patient Protection and Affordable Care Act (ACA) validated emerging recognition that advancing the practice of health care requires participation by patients far beyond the fleeting moments they spend with their HCP during an office visit. Established in 2010 and enacted in 2013, the ACA dictated a dramatic shift from the traditional fee-for-volume reimbursement model for physicians treating patients on federal healthcare programs to one that recognizes fee-for-value. Put simply, the government will no longer pay HCPs based on the amount of treatment they deliver, but rather based on the impact

Dave Chase is the founder of the patient relationship-management company Avado and Senior Vice President at WebMD.

Christina Hoffman, MS, is Executive Director at Medscape Education. Her work as a county health department educator for the State of Kansas was recognized as exemplary.



or quality of that treatment. The ACA legislation set out a National Quality Strategy (NQS) and with it the “triple aim” for safer care, affordable care, and population health. The NQS establishes 6 national priorities for achieving healthcare quality, one of which is “Patient & Family Engagement.” The government is not alone in its desire to replace more health care with better health care. Private payers are equally behind what has been termed the “Quality Movement,” upsetting traditionally held beliefs about who influences healthcare outcomes and who needs education to improve those outcomes.

Engagement: A Definition

The Center for Advancing Health currently defines patient engagement as “[A]ctions individuals must take to obtain the greatest benefit from the health care services available to them.” Further, “engagement signifies that a person is involved in a process through which he harmonizes robust information and professional advice with his own needs, preferences and abilities in order to prevent, manage and cure disease.”¹ For patients to successfully contribute toward their own health outcomes, they need to know how to serve as positive and effective participants. For clinicians, medical knowledge is recognized as being fundamental to the practice of medicine, and core competencies are recognized as putting knowledge into effective practice. Likewise, patient engagement relies on more than simple medical knowledge about health issues. Patients need to learn not just what they need to do differently to engage in their own health care but also procedural skills on how to do it. In response, HCPs need help in understanding what it means to have engaged patients in their practice and how to foster engagement from patients while maintaining an effective and efficient practice.

It’s Not Just about Engaging the Patient

As identified in the NQS national priorities, “family” is an important element in any discussion of patient engagement. As traditional concepts of a patient’s limited role in health care are challenged, so, too, must the idea that the patient alone is the sole participant in or influencer over what impacts care outside the face-to-face clinical encounter. Patients often rely on support from people around them to interact with the healthcare system. This reliance is especially evident when those patients are children, the mentally challenged, or the elderly, as all may depend on others to help them know when to seek and how to gain access to care, as well as understanding and following clinician instructions.

Beyond circumstances where patient ability requires aid from other individuals to facilitate the healthcare experience, relationship dynamics may simply be the basis for engaging multiple individuals, such as the case with spouses who act on behalf of their significant other. Thus, the definition of “patient” in the context of patient engagement must include advocates, caregivers, and family members. If the intent of the NQS efforts is to engage patients in the pursuit of more efficient and effective care, then patients must be the focus of the design and delivery of education aimed at achieving engagement.

HCPs NEED HELP IN UNDERSTANDING WHAT IT MEANS TO HAVE ENGAGED PATIENTS IN THEIR PRACTICE.

Who Is in Control of Health Outcomes?

Engaging patients requires educating them on how to respond to or avoid a health condition, as well as the treatment and lifestyle changes they can make to improve their health. Knowing when and to what degree a patient should be involved in decision making is an important consideration. Less participation is generally called for in highly acute situations involving life-or-death decisions, where timing and expertise-level behind those decisions are critical factors in the outcome (eg, myocardial infarction/heart attack). Currently, however, more HCP time and healthcare expenditures are consumed in the management of low-acuity, chronic disease conditions like obesity, hypertension, dyslipidemia, chronic heart failure, asthma, and chronic obstructive pulmonary disease. In such low-acuity situations, the patient is the most important member of the care team. The decisions made by the patient have a far greater impact on the outcome than those made by anyone else on the professional healthcare team.²

Relieving the Pressure on the Point of Care

Patients and providers are equally critical members of the same team. As with any concerted effort where multiple contributors are working toward the same goal, proper patient engagement means understanding roles and coordinating tactics.

Traditionally, patients are not equipped with either the knowledge or skills required to make informed decisions. Providers, on the other hand, have unwittingly served as barriers to engagement as the result of training that fosters a hierarchical approach to the clinical interaction. To resolve the obstacles that inhibit successful patient-provider teamwork, long-held beliefs about roles, responsibilities, and processes must be questioned and addressed.

TRADITIONALLY, PATIENTS ARE NOT EQUIPPED WITH EITHER THE KNOWLEDGE OR SKILLS REQUIRED TO MAKE INFORMED DECISIONS.

The average number of annual patient-clinician visits varies by type of encounter (new vs returning patients and acute vs chronic disease state); however a 2010 National Ambulatory Medical Care Survey from the Centers for Disease Control reports that Americans average 3.32 visits with clinicians per year. Assuming an average visit length of 15 minutes, patients spend less than one hour of the approximately 6000 waking hours each year in clinical encounters. Research indicates that the information imparted to patients and family members during these brief visits is not digested nor successfully translated into adherence of HCP guidance or instructions. Rather, more than 40% of the information provided during a healthcare visit is forgotten, and what patients actually remember is often incorrect.³

Given the enormous pressure placed on the brief point-of-care interaction between the HCP and patient, redefining the concept of point of care is critical not only for improved patient outcomes but also to satisfy the many and varied system, governmental, and payer requirements. The intended value of the point-of-care interaction must be achieved through contribution from the patient over a course of time rather than solely by the HCP in a hurried moment. Specifically, clinicians need to be equipped for delivering more than “sick care,” or therapeutic efforts to treat a particular disease or condition, so that they can focus more on providing “health care.” Accordingly, patients need to work toward adjusting their role within the clinical encounter so that they come to their visits having prepared for a more mutual encounter and leave with the knowledge and acceptance that the visit naturally assumes a level of post-work or “homework.” A new approach to patient education, one that is focused on engagement and includes mechanisms for measurability, presents the opportunity to leverage the proven attributes of IME.

SIDEBAR 1

ALIGNED EDUCATION: A CASE STUDY

In February of 2013, a six-part initiative on sexual health, enlarged prostate and low testosterone was launched—a three-segment series of courses designed for the consumer users of WebMD and a three-segment series of courses for Medscape clinician members. Both patients and providers received guidance on the same topics, but programs were aligned respective of their role in the healthcare encounter. Clinician education on the topic of benign prostatic hyperplasia (BPH) included a “recommendation to learn,” a tool for directing patients diagnosed with BPH to educational activities designed to improve adherence to treatment recommendations. Ultimately more than 16,000 consumers and nearly 40,000 providers participated in the educational initiative over the course of one year. Both patients and providers demonstrated improvement in knowledge after engaging in the activities. Most notably, self-reported attitudes and intentions of patients were changed as a result of participation in the coursework.

REFERENCES:

1. A New Definition of Patient Engagement: What is Engagement, and Why is it Important? Center for Advancing Health, 2010. www.cfah.org. Accessed June 4, 2014.
2. Oldenburg J, Chase D, Christensen KT, Tritle B, eds. Engage! Transforming Healthcare Through Digital Patient Engagement. Healthcare Information and Management Systems Society; 2013.
3. Kessels, R “Patients’ Memory for Medical Information.” Journal of the Royal Society of Medicine 2003; Vol. 96: 219 – 222

SIDEBAR 2

PATIENT ENGAGEMENT IN ACTION

Noteworthy responses to the patient-engagement imperative include the following:

Engage! Transforming Healthcare through Digital Patient Engagement

Authored by Dave Chase, this 2013 “book of the year” from the Healthcare Information and Management Systems Society (HIMSS) includes a case study from Bas Bloem in which clinicians are asked to assume a mentor role within the clinical encounter, engaging in dialogue rather than monologue with patients.

Participatory Medicine: Patient-Provider Communication

This Medscape educational program by Doctors Alan Greene and Daniel B. Hoch includes guidance for clinicians on making small changes in their practice that will facilitate patient engagement. (<http://www.medscape.org/viewarticle/817720>)

Flip the Clinic

Borrowing from the Kahn Academy’s concept of “Flipping the Classroom,” The Robert Wood Johnson Foundation created a way to relieve pressure from an encounter (such as a classroom lesson) by distributing pressure to the periods before and after the encounter. Flip the Clinic is described as “employing new tools, technologies, and strategies to empower patients to be more informed and more engaged when they walk into the doctor’s office and better equipped to improve their health when they walk out the door.” (www.fliptheclinic.org)

IME’s Next-Generation Opportunity

With recognition of the need for increased focus on patient engagement, confirmed by the ACA and the NQS’s priorities, creators of IME have the opportunity to apply their expertise toward aligning patient and clinician education, and elevating patient education beyond the status of a passive information resource to a tool of active engagement.

And, most importantly, developers of IME have the capability to design and deliver patient education that carries with it the same potential for outcomes measurement that has been used consistently for professional medical education.

IME designed to drive patient engagement could take 3 forms:

- Clinician-targeted education, where patient-engagement tools and resources accompany a continuing medical education (CME) activity and the clinician serves as an intermediary by “prescribing” engagement resources to patients.
- Aligned patient-clinician education, in which separate but corresponding programs are developed that address both patient and clinician roles around a single topic, and for which learner audiences are recruited separately. Here, the patient has direct access to engagement resources (see Sidebar 1).
- Patient-only education, which prepares patients and caregivers to take more active roles in addressing patients’ health issues, both inside and outside the face-to-face clinician encounter.

PROVIDERS OF IME ARE WELL POISED TO APPLY THE PROVEN TECHNIQUES BEHIND THE SUCCESSES OF CME TOWARD EDUCATION AIMED AT ENGAGING THE PATIENT.

With specific regard to patient-only education, which has typically been sponsored by commercial interests, independent patient education, following the CME model, has the potential to offer a series of new benefits. Promotionally sponsored patient education may be viewed as biased and not offering sufficiently rigorous measurability. Furthermore, it is subject to potentially lengthy medical, legal, and regulatory review. Independent patient education offers:

- Credibility, as its development is free from commercial influence
- Measurable impact gained from the application of methods proven via certified CME
- A mechanism for clearly responding to the quality movement
- A means for aligning learning to the appropriate health literacy level
- A tool for achieving improved adherence

Providers of IME are well poised to apply the proven techniques behind the successes of CME toward education aimed at engaging the patient. By using targeted recruitment, program design, and engagement devices that have kept clinicians participating in education and demonstrating measurable knowledge, behavior, and competence change, IME can transform patient education from brochures that are easily discarded or forgotten into compelling programs that improve knowledge, change attitudes, and foster participation in one’s own health care. Already, leaders in healthcare education are creating and delivering programs in response to the patient-engagement imperative (see Sidebar 2). With the quality movement well underway and the quest for patient engagement in full force, IME has ahead of it a new era of designing and delivering education toward the goal of better practice, more participatory patients, and improved health care. ■