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Development and Clinical Applicability of an Educational Guidebook for Managing Diabetes with Cognitive Impairment

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Abstract

Background: *A correlation between diabetes and cognitive impairment is supported in the literature. People with both diabetes and cognitive impairment have on average lower medical adherence, self-care abilities, and decision-making capacity than their peers with diabetes only, often leading to poor glycemic control and complications. Enhanced professional support and resource integration are needed to improve care quality and reduce the burden of family caregivers.*
Purpose: *The goal of this study is to develop an educational guidebook for diabetes educators designed to improve the management of diabetes in patients with cognitive impairment and then establish expert validity and evaluate its clinical applicability.*
Methods: *The educational guidebook was developed based on a literature review and the findings of prior research. Expert validity was established using a modified Delphi method, and diabetes educators were invited to implement the guidebook in diabetes education to evaluate its applicability.*
Results: *The educational guidebook developed in this study covers an introduction to diabetes and cognitive impairment, recommendations for diabetes educators, care challenges and recommended strategies, and family support. The expert content validity score was 1.0, and 78.6% of the diabetes educators in the applicability assessment rated the content as important and clear. Furthermore, the qualitative data confirmed the guidebook as a practical and effective tool in diabetes education.*
Conclusions: *The developed guidebook demonstrated excellent expert validity and clinical applicability, reflecting a high level of endorsement from diabetes educators. It is well suited to addressing the challenges faced in diabetes care by patients with cognitive impairment. The guidebook should be integrated into continuing education for diabetes educators and tailored to meet the specific needs of different institutions.*

Keywords: *cognitive impairment; dementia; diabetes education; family caregiver.*

INTRODUCTION

Value-based health care (VBHC) has been proposed as a paradigm shift in health-care management in response to rising health-care costs and quality deficiencies (Porter et al., 2016; Porter and Teisberg, 2006). According to Porter and Teisberg (2006), value is the result of patients' experienced outcome from the care that was provided, divided by the cost to deliver that outcome, and is referred to as "the value quota." Consequently, the focus of VBHC is increasing the value quota by delivering better health outcomes as experienced and defined by the patient—a complex mix not only of survival but also of how the patient feels, functions, and recovers—while striving for cost containment or cost reduction (Porter, 2009).

The challenge of using the concept of "value" is that it means different things to different people in different contexts and episodes. Value is a construct that comprises both attitudes and experiences

and is affected by the context and the situation (Sanchez-Fernandez and Iniesta-Bonillo, 2006; Benson et al., 2003) and by one's identity, regardless of whether that identity is of a clinician (e.g., professional care provider), a non-clinician (manager, finance), or a patient. In modern health-care management, concepts such as quality-adjusted life-years within health economics, which combine life years gained with the patient's perception of quality of life, conceptualise value as not only life-prolonging treatment outcomes, but also as the patient living a fulfilling life. According to the Institute of Medicine, one of the priorities for health care is to start asking patients "what matters to you?" rather than "what is the matter with you?" (Kebede, 2016).

Scholars argue that value is "satisfaction of a want," that is, the product of the trade-off in a normative picture of the product or service acquired (DeSouza, 1992). Woodruff and Gardial (1996) suggested that value includes a relation between the "want" of a service or product, the recipient, and the actual perception from using the service or product. While value could be discussed as a universal perception that combines attitudes, traditions, and symbols, it may not be directly associated with the outcome (Fredriksson et al., 2015). Therefore, the concept of value could be understood differently between different clinicians (Erichsen et al., 2015), as well as between clinicians and non-clinicians (in this article defined as hospital personnel not directly interacting with patients).

The perceptions, assumptions, and attitudes of groups of people, such as clinicians and non-clinicians, form a shared common logic that, together with symbols and rituals, is institutionalised internally as well as externally by its members and the surrounding context (Lindberg, 2014). Professional logics are legitimised and brought to the surface by material things and symbols that provide a normative framework, or "rules of legitimacy" (Lindberg, 2014). Therefore, different logics are established via action and practice. Research has shown that different logics can simultaneously compete (Nilsson and Sandoff, 2017) and co-exist within an organisation, not least in institutional environments with strong professional groups, such as in health care (Arman et al., 2014; Wikström and Dellve, 2009). Well-established institutions with strong professional groups, such as hospitals, can also have a set of shared assumptions and symbols across professional logics that define institutional logic (Scott, 2008a, 2008b).

Health-Care Leadership

Avolio et al. (2009) conclude that leadership in health-care organisations is characterised by complex interactions between "the co-existence of an emerging, government-prescribed, results-oriented approach to leadership (the new institution) with a more traditional professional value-based approach (the old institution)" (p. 664). The hospital is an institution that comprises complex interplay between different logics. According to Glouberman and Mintzberg (2001), there are four foundational logics in the hospital context: community (politicians and policymakers), control (managers and administrators), cure (biomedical expertise, physicians), and care (nursing and other health professionals). There is a great divide among those who work clinically (physicians, nurses, and other health professionals) and those who do not (policymakers and managers). Each logic is driven by its own way of understanding rules and regulations, and this explains why discrepancies and frustration can occur when different logics with limited shared understandings need to co-operate in creating good quality patient care (Andersson, 2015).

Earlier studies on leadership in health-care organisations have suggested that distributed leadership is an approach to handle the influence of multiple institutional logics in the external context (cf. Currie and Lockett, 2011; Currie et al., 2009a, 2009b). Another example is Currie et al. (2011), which highlights the potential of distributed leadership and "managed partnerships" in health-care organisations. It is concluded that distributed leadership in health-care organisations supports the enactment of inherent bureaucracy, power differentials between network participants, and a strong centralized performance management policy regime. Accordingly, it is suggested in leadership research that health-care organisations require a certain type of leadership, and one could argue that the concept of VBHC (Porter and Teisberg, 2006) is a way towards integrating "the old institution

with the new institution" by granting patients the power to define the value of different health-care outcomes.

The implementation of VBHC challenges both the institutional and professional logics of different groups in the hospital. It is a concept impacting both management and professionals, which means that the success of implementing VBHC in a hospital is likely to be affected by how well the concept is explicitly focused on providing enhanced value for patients—by some researchers considered the one dimension that can unite the different logics in the hospital context (Nilsson et al., 2017). A recent scoping review by van Staalduinen et al. (2022) indicates that there is a lack of understanding of how VBHC is conceptualised and implemented in hospitals. It reveals that most hospitals adopt only a few components of VBHC, primarily focusing on measuring outcomes and costs, with limited examination of the effects and strategies of VBHC implementation.

The review underscores the need for a unified conceptualisation of VBHC and concludes with a call for an interdisciplinary approach integrating insights from both health care and the broader management research community to further advance this field. This study responds to that call for research and will explore the perception of value among different groups within the health-care setting, as implementing VBHC is likely to result in confrontations between different perspectives and logics within the health-care organisation.

Aim

To explore the perception of value among stakeholders with different professional logics (clinicians and non-clinicians) during the implementation of VBHC.

METHOD

Design and Setting

This study used a qualitative design using interviews with different stakeholders during the implementation of VBHC at a large university hospital in Sweden. This methodology aligns well with our objective, as it delves into understanding the meanings individuals assign to their experiences within their natural contexts, as emphasised by Malterud (2001, 2014). Interviews were selected as our method for gathering empirical data, as they provide a direct avenue to comprehend the world from the perspectives of others, an approach advocated by Kvale and Brinkman (2009). The choice of a qualitative approach, particularly through interviews, is apt for capturing the nuanced views of various stakeholders involved in VBHC implementation. These stakeholders, who bring different professional logics to the table, offer rich insights into the concept of value as perceived in their unique roles and experiences.

Qualitative Data Collection and Analysis

In the qualitative analysis, stakeholders involved in the ongoing implementation of VBHC for one year beginning in March 2014 were interviewed. We interviewed five stakeholders (non-clinicians and clinicians) who had a strategic role in the implementation of VBHC, and 14 stakeholders (non-clinicians and clinicians) who worked hands-on with the implementation at the hospital. The majority of health-care professionals (80%) had combined clinician and managerial positions.

Semi-structured interviews were performed to capture interviewees' perceptions of value with a focus on outcome versus cost (the value quota), focusing on patients' perception of value and the ability to capture individual patient costs in the organisation. Primarily open-ended questions were posed. All interviewees received both written and oral information about the research project and gave their consent to participate in the study. All interviews were tape-recorded (duration from 27 to 70 minutes) and transcribed verbatim.

Two members from the interdisciplinary research group performed the initial analysis by reading the transcripts several times. Qualitative content analysis (Graneheim and Lundman, 2004) was used to structure and analyse the text. Graneheim and Lundman's (2004) content analysis method is a structured approach in qualitative research, starting with the identification of "meaning units" in the text, which are clusters of words, sentences, or paragraphs with a central meaning related to the study's objectives. These meaning units are then condensed, shortening the text while preserving its core content to make the data more manageable. Following this, the condensed units are coded, assigning labels or categories that reflect their content and context. These codes are grouped into subcategories based on similarities, and then into broader categories, representing a higher level of abstraction.

The final step is the development of categories and themes, which are threads of underlying meaning that tie together the condensed units, codes, subcategories, and categories, ultimately providing a narrative that reflects the essence of the participants' experiences and perceptions in relation to the research question. This process ensures that the analysis remains grounded in the data, allowing for meaningful interpretation and a credible understanding of the research topic. In the first naïve coding, we used inductive reasoning to analyse the text, focusing our approach on the perception of value and the relationship between outcome and cost as the creators of value. After the naïve coding, categories were created to further structure the data related to value perception.

In the second stage, a more deductive approach was chosen where we used the concept of professional logic to find differences between interviewees with a clinical or non-clinical background to investigate differences and similarities between different institutional logics with regard to the perception of value. The manifested and latent messages were discussed and revised among the authors to reach an agreement about coding and the formulation of themes. The qualitative analysis was structured using NVivo 9 software (QRS International).

The study conformed to the ethical standards expressed by the World Medical Association's (2013) Declaration of Helsinki. Participants were provided with detailed information about the study both via email and phone. Ethical demands for qualitative research, including informed consent, confidentiality, the consequences of the study, and the role of the researchers, were carefully considered and followed.

RESULTS

In total, the study comprised 19 interviewees divided into clinicians and non-clinicians, as they were driven by separate professional logics. Two main categories emerged from the analysis: the different logic's impact on value and the challenge of working with cost.

The Different Logic's Impact on Value

Interviewees perceived VBHC as a helpful tool to increase the value delivered to individual patients. However, there were differences between clinicians and non-clinicians regarding the perception of value. Clinicians frequently appreciated VBHC, as they perceived its introduction as an opportunity to focus more on outcomes for patients and less on cost containment. In contrast, non-clinicians talked about VBHC in terms of a strategic framework for the governance of health-care organizations, or as a framework for closely monitoring different continuous improvement processes.

When asked specifically about what value meant to them, the interviewees focused primarily on how outcomes were discussed within their own professional group. It is notable that many of the clinicians did not explicitly mention costs, one of the central aspects of the VBHC value quota. Non-clinicians perceived outcomes as the key component driving value, but frequently described value as related to costs, and occasionally, explicitly described value as related to efficiency, as intended by the concept of VBHC. Some interviewees indicated that the introduction of VBHC contributed to an increased focus on clinical outcomes at all levels of the hospital hierarchy, suggesting a shift in

institutional logic at the studied hospital from the managerial control logic of care production (volume and flow) towards a greater focus on medical outcomes and the professional cure and care logic.

The Challenge of Working with Cost

Most interviewees perceived costs per care episode as difficult to track accurately. The current accounting systems did not support this at the studied hospital. Securing the full cost for all involved health-care providers over the full care cycle was perceived as desirable by interviewees, but virtually impossible to accomplish. Non-clinicians and clinicians used different terms when describing costs. Some referred to cost as an "investment," while others considered it an "expense." Some interviewees, particularly clinicians, expressed the opinion that investments to improve outcomes and efficiency were impossible (e.g., hiring more physicians able to see patients) if the improvement increased costs.

The lack of exact per-patient cost data forced the project groups implementing VBHC at the case hospital to work with different proxies for cost. They focused on the activities demanding the most resources—that is, cost drivers, such as the length of hospital stays or the number of follow-up visits.

DISCUSSION

While value is a central concept in VBHC, the perception of value differed among the stakeholder groups at the studied hospital. The majority of respondents did not appear to focus much on costs or cost containment, even though that objective is as potent as improving outcomes for enhancing the value quota within the VBHC framework. Clinicians talked about value as a dynamic concept depending on the view of the patient and the context, and put forward the fact that better outcomes sometimes require higher costs or more resources. While that clinical perception surely makes sense, it was evident that clinicians did not fully understand the value quota and more often talked about improving outcomes rather than reducing costs. It might be interesting to note that the concept of VBHC entitles you to increase costs if the value quota is improving. In other words, as long as the increase in outcome value, as perceived by the patient, is larger than the additional cost for achieving such value, an increase in resources is possible (Porter and Teisberg, 2006).

In contrast, non-clinicians' perception of value appeared to be more aligned with a cost-controlling or at least a cost-focused perspective. While many interviewees indicated that the deficiencies of current accounting systems hamper the understanding of costs, the results show a discrepancy in the concept of value between clinicians and non-clinicians. At the same time, the results presented experiences of how VBHC was experienced as a shift from the managerial control logic towards more of the professional cure and care logic. This aligns with the notion of hybrid organisations blending management logics with clinical logics, as found by Ramsdal and Bjorkquist (2019) in another VBHC implementation.

The challenge of working with costs was clearly articulated. Hospital accounting systems were highlighted as creating a virtually impossible situation for capturing costs per care episode. Other research studying value-based implementation work has found that improved coordination among health professionals contributes to increased cost-effectiveness (Miettinen and Tenhunen, 2020). The uncertainty introduced by the ambiguous term "value" may present an obstacle to organisations attempting to manage a shift in how they operate, as the ambiguity can introduce friction between professional groups, management, and patients and providers. Paradoxically, this uncertainty around what value means could also be a leadership opportunity and a way of integrating the different perceptions among multiple stakeholders.

Drawing on previous research, we suggest that the managerial model of distributed leadership—with a focus on increased influence via co-creation among involved actors, the understanding of different needs and conditions, and integration via interpersonal interactions rather than formal roles and responsibilities—provides a fertile ground to further VBHC (Avolio et al., 2009; Currie and

Lockett, 2011; Harris and DeFlaminis, 2016). In light of this, creating a shared understanding of the value concept among involved stakeholders may be pivotal to enhancing future implementation processes of VBHC.

The different perceptions of the term "value" found in this study are potentially connected to the different meanings in many leadership terms and the potential dichotomy between management versus leadership. While this empirically informed study will not dissect specific terms, we suggest that regardless of terminological definitions, the key challenge in practice is balancing clinical bedside needs with economic constraints. Bååthe et al. (2022) argued that health-care top managers need to balance the quality of patient care, the economy, and professional engagement to increase sustainability in health care. They further suggest that this balancing act is not an anomaly top managers can eradicate; instead, managers should deliberately act with a notion of continuous balancing in mind, which can create virtuous development spirals where managers and health professionals closely collaborate. Hence, co-creation through distributed leadership may be of great importance for sustaining organisational development (Avolio et al., 2009; Currie et al., 2011; Spillane, 2005; Harris and DeFlaminis, 2016). When co-creative practices emerge in a constructive and trusting way, the relationship between managers and health professionals can develop into joint agency, benefiting all health-care development (Raelin, 2016).

At the same time, a study by Nilsson and Sandoff (2017) shows the importance of goal setting, role descriptions, and leadership expectations while implementing VBHC, which in previous implementation research has been described as a contextual dialogue with the aim of integrating different ways of understanding (Bååthe and Norbäck, 2013). Bååthe and Norbäck present how both managerial and professional understandings need to be—and can be—modified, outlining how that contextual dialogue can happen as a conversation-based collaborative perspective. This provides an alternative to the prevailing managerial control perspective, and they suggest the initiator responsibility lies firmly at the managerial level.

It was clear from the empirical results that clinicians and non-clinicians had different perspectives, and research agrees that it should not be taken for granted that people involved in a change process share the same goals, commitment, or understanding of the concept being implemented (Schein, 1993; Loup and Koller, 2005). Storkholm et al. (2017) further this line of reasoning by presenting a successful change story integrating managerial and professional needs and wants. Their work shows that when leadership deliberately adopts the perspective of clinical professionals when initiating a change process—focusing on improving patient quality in the care process instead of focusing purely on the economy—engagement from clinicians is likely to follow. Storkholm et al. clarify that economic results are also improved, but now as a positive side effect of enabling patient care to be delivered in a more efficient and effective way.

While the patient in VBHC is described by Porter as acting as a "consumer" who chooses the best provider based on outcomes or costs, we suggest there are no consumers of health care, just individuals seeking medical, nursing, or other health-care services. The logic of the patient may not be transferable to the underlying assumption of a customer being both able and willing to compare value for money—that is, price-performance ratios provided by different health-care providers. From a European perspective, there is insufficient evidence that patient choice as a competitive driver in health care has improved outcomes or reduced costs (Anell et al., 2012; Okma and Crivelli, 2013; Siciliani et al., 2022). At the same time, the modern patient is more than a passive recipient of care or a consumer of services alone; rather, the patient should be acknowledged as a partner in care, co-creating value together (Coulter et al., 2015; Britten et al., 2020).

Traditionally, the logic of medicine—driven by improving outcomes and treatment efficacy—is considered the most influential and powerful. This could impact the chances of other logics being heard at both the strategic and operational levels of VBHC, such as the logic of care (e.g., nursing) or the logic of control (e.g., management). We therefore argue that the implementation of VBHC needs to actively work towards balancing stakeholders' multiple needs and integrating different logics, while

also providing dedicated space to further the patient's voice in this change process (Nilsson et al., 2017). While the voices of clinicians and non-clinicians are important, the voice of the patient must be further incorporated to develop a sustainable health-care model that is more efficient and effective while becoming increasingly person-centred (Britten et al., 2016; Coulter et al., 2015).

Limitations and Suggestions for Future Research

While the scope of VBHC is holistic and includes all levels of health care, including patients' residences and primary care centres, this study was limited in scope to the hospital setting. The collected data were primarily limited to the implementation of VBHC at one hospital, so while it may not be possible to extrapolate the findings, one should remember that in qualitative research, unlike quantitative research, the goal is not statistical generalisation. Qualitative methodology does not produce findings that claim general applicability irrespective of context. Instead, there is a deliberate focus on contextual specificity. However, as suggested by Malterud (2001, 2014), this focus on context does not preclude transferability. Van Maanen and Barley (1984) found significant commonalities in health-care contexts across the Western world, and Larsson (2009) suggests that the usage of a piece of research is a dynamic act completed if, and only if, someone else can make sense of situations, processes, or other phenomena with the help of descriptions from research texts.

Another limitation is that our data represent an implementation process that occurred almost ten years ago. The discontinuation of VBHC in Sweden in 2017 was primarily due to a scandal involving unethical practices between a consultancy group and a top university hospital, which significantly tarnished VBHC’s reputation and halted its progress nationwide (Krohwinkel et al., 2019). Despite this setback in Sweden, VBHC remains a topic of interest and implementation globally, with the Swedish experience offering valuable lessons for other countries. Our study aims to address the knowledge gap identified in the 2022 scoping review by van Staalduinen et al., focusing on implementation challenges and strategies. By sharing our insights, we contribute to the advancement of VBHC discussions and practices worldwide, echoing the call for an interdisciplinary approach combining health-care insights with broader management research to enrich the VBHC dialogue.

Qualitative research, including interviews, inherently involves a degree of subjectivity. The interpretation of qualitative data can be influenced by researchers' perspectives, biases, and the specific context in which data were collected. The interviewees in this study were predominantly clinicians in managerial positions, a selective sampling that could lead to a biased perspective compared with health-care professionals in non-managerial roles or different settings. Qualitative research often grapples with such selection biases; by operating within an interdisciplinary and multi-professional research group, we worked to balance the risk of one voice or profession overpowering others. A significant limitation of this study is the lack of qualitative data from patients. Patients are key stakeholders in VBHC, and while this study focused on hospital employees, the exclusion of patient voices should be acknowledged, as it can lead to an incomplete understanding of VBHC implementation challenges.

Future research in VBHC should prioritise including patient perspectives to understand how the value ratio evolves over time with the implementation of value-based health-care practices. This exploration should examine whether improvements in the value ratio result from enhancing clinical outcomes that patients value (the numerator), increasing efficiency by reducing costs (the denominator), or a combination of both. Importantly, research should also consider studies where patients are actively involved in educating hospital staff about the outcomes they value most. This participatory approach could lead to co-creative development processes aimed at enhancing the value ratio, taking into account that increasing value may also involve accepting higher costs when it leads to outcomes that patients deem significantly valuable.

CONCLUSIONS

Our findings indicate that there are large variations in how different hospital stakeholders perceive the concept of value when implementing VBHC. In the present study, clinicians—primarily represented by physicians—appeared to have a dominant influence on this logic. Improving clinical outcomes was considered the most important way to improve the value of health care provided, prioritising outcomes over cost containment or cost reduction.

If the concept of value within VBHC is driven by clinicians' traditional assumptions of what value means to patients, there is a risk that history will simply be repeated and the international goal for more person-centred care innovation will not be met. While clinicians' voices are important, a multitude of voices must be integrated, including patients' and non-clinicians', for VBHC to become a sustainable care model and deliver on the promise of allowing patients' voices to be heard while increasing health-care efficiency and effectiveness. Health-care leaders need to ensure that patients' and non-clinicians' perceptions of value are integrated and balanced with clinical perceptions if VBHC is to deliver on its promise.

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