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Chronic Health Care

It Is So Much Different Than Acute Health Care—Or It *Should* Be

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The traditional acute health care model works well for acute injuries and illnesses but is unlikely to achieve good outcomes in managing chronic health care conditions. Positive outcomes in chronic illness management requires multiple referrals from the primary care provider for a multidisciplinary team, relinquished control by the health care providers as they coach the patient into the active role of self-care life skills and daily management of their health, and active learning, participation, and accountability of the patient.

Keywords: *chronic; care; illness; medical home; patient centered; acute; health care model; self-care behaviors*

Do patients know the difference between a chronic illness and an acute illness? Do they understand that the medical approach to treating chronic illness is much different from the approach to treat any acute illness they may have? Perhaps, even more important is the question, "Do health care providers understand the different approach necessary for positive outcomes in the management of chronic illnesses?"

Chronic Health Care Versus Acute Health Care

Historically, the health care system has been based on an acute care model. The care is episodic, based on the needs of a patient to feel better. The patient frequently waits to seek the help of the medical professional until signs and symptoms of an illness begin to interfere with the daily activities of living. When patients enter the health care system, they are more likely to assume a passive, "victim" role. They give the list of signs and symptoms to the health care provider, submit to additional testing if necessary, and listen to the diagnosis and recommended treatment plan. The health care provider has the role of the expert who will fix whatever is wrong. If the patient is compliant with all recommendations, full recovery from the acute illness is the expected outcome. This health care model generally works well for acute injuries and illnesses. It is not as likely to provide positive outcomes for a chronic illness.

A chronic illness generally develops slowly, over many months or years, and the patient may not be aware of its development until it is well advanced. Or it may be discovered when the patient comes to the provider for an unrelated acute illness.

> Unlike acute disease, chronic illnesses have multiple causes that vary over time and include heredity, lifestyle factors (smoking, lack of exercise, poor diet, stress, etc.), exposure to environmental factors, and physiological factors . . . the lack of a regular or predictable pattern is a major characteristic of most chronic illnesses. (Lorig, Sobel, Laurent, Gonzalez, & Minor, 2006, p. 2)

Between the traditional acute care model and the current development of a chronic care model, the United States has been working toward disease prevention with the guidelines promoted in such programs as Healthy People 2010 (www.healthypeople.gov, 2009). The preventative health model promotes regular visits to the family physician for early detection and interventions of various health risks with scheduled screenings such as mammograms and prostate exams. Although patients may be proactive in scheduling the recommended appointments, they often continue to assume a passive role. They submit to the tests and wait to be told the results and recommended follow-up. There are still a great number of patients who do not follow the guidelines of recommended screenings and do not schedule routine visits with their physicians. Screenings are beneficial in many cases, but even when all screenings are done, they might miss the early diagnosis of chronic illnesses.

Sometimes the line between acute illness and chronic illness is blurred. Where does one stop and the other begin? For example, glucose toxicity and diabetes ketoacidosis may be defined as acute illnesses and need immediate intervention of the health care team for positive outcomes. Lab results and the patient's condition will define the recovery state. The acute health care model of accurate diagnosis and appropriate intervention are appropriate and effective. However, if the patient is discharged with the diagnosis of diabetes, the acute health care model loses its effectiveness for positive outcomes. There are no short-term interventions that will lead to a clear state of recovery.

Well-managed chronic illnesses with positive outcomes require the daily management of a well-informed, involved, and active patient. Long-term, changing interventions are required and will hopefully lead to good control of the chronic illness, which is not the same as a complete recovery from an acute illness. How do the patient and health care professional transition from acute to chronic care health care?

Traditional Care Model Team Leader: The Physician

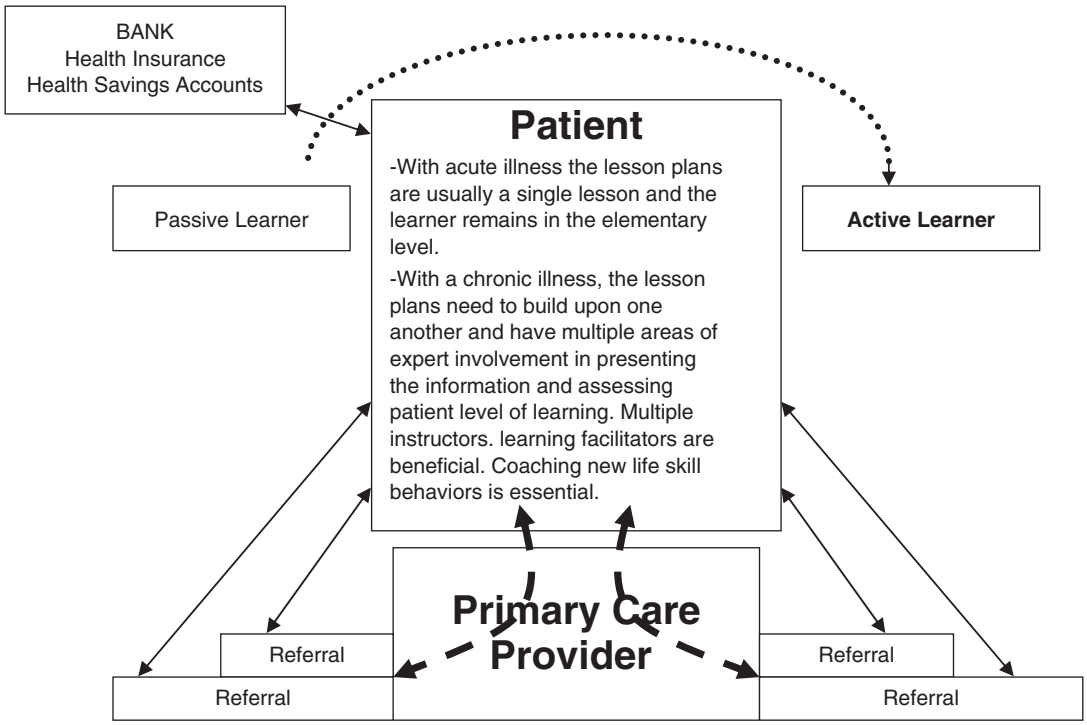
In the traditional acute health care model, the physician is seen as the leader of the team. The physician reviews the signs and symptoms, orders additional tests as indicated, makes a diagnosis, and prescribes the appropriate interventions, which will usually include medications, surgery, and/or therapies. Other health care professionals such as nurses, pharmacists, therapists, and other specialists may participate in implementing the interventions at the physician's direction. Most health care professionals entered their field of specialty with the intent of *providing* the patient with the specialized care that an ill person would require. The expert guides the uninformed through the needed steps to wellness. Patients learn to be compliant and remain a passive recipient of health care. This health care model works very well for acute injuries and illnesses such as the broken arm, appendicitis, or other hundreds of acute illnesses that attack the body. However, the model fails to achieve the same results in chronic illnesses. Chronic diseases such as diabetes, arthritis, hypertension, emphysema, and others require a new approach.

Chronic Care Model Team Leader: Who Is in Charge?

In a chronic care model of health care, the patient must move from a passive recipient of health care to an active participant in the care plan of the chronic illness. This may be a difficult adjustment for both the health care professionals and the patient. After all, how can the uninformed patient become an equal and active team member with the highly educated health care professionals? The truth is the uninformed, passive patient is generally not even willing to consider becoming part of the team in charge of his own health. He relies on the health care team to restore him to a state of health, with little effort to understand the disease he is living with on a daily basis. Often the health care provider believes he/she has explained the disease to the patient and completes the explanation with "Do you have any questions?" In fact, the information has simply overwhelmed the patient who does not know or understand enough to formulate a question. The patient will leave the office believing that if he/she takes the prescribed medication, all will be well. It is definitely time to change the mindset of both patient and health care professional.

Today, we need to seriously reeducate the patients and health care professionals to understand a chronic health care model. The patient *needs* to be an expert in his or her own chronic disease(s), take accountability for learning how to eat healthy (not a norm with the standard American diet) and staying active. Edward H. Wagner states, "If a provider is willing to relinquish some control, patients can be convinced to self-manage" (Wagner, 1998). In an environment of defensive medicine, it often feels very risky to relinquish control. Can we expect patients to adjust and titrate their insulin dosage? Will a referral to a dietician, diabetes educator, and community diabetes education classes give them information the primary provider may not be familiar with at this time? Yet, without these referrals and expectation of the well-informed patient, how can the patient be moved from being a passive to active participant in the health care team? To relinquish control requires a redefined relationship. Instead of the physician as leader of a team, with the other professionals being the team members and the patient the passive recipient of care, the physician's role becomes principal of an educational team, coordinating the instructors and star pupil to achieve positive outcomes. The patient needs the guidance and coaching of the entire health care team to move from a passive, elementary learner to an active, advanced learner. Health care providers need to learn how to facilitate the patients' growth in acquiring new life skills. Just as the education system has teachers and professors with specific areas of expertise who work together to advance the student from elementary learning to advanced degrees, the health care system has physicians, nurses, therapists, and others with specific

Figure 1
Chronic Health Care Model—Team Advancing Learning and Self-Management 1 (TALAS 1)



Source: Scruggs (2009).

areas of expertise who need to work together to advance the patient with chronic illness from elementary understanding to advanced management of their disease.

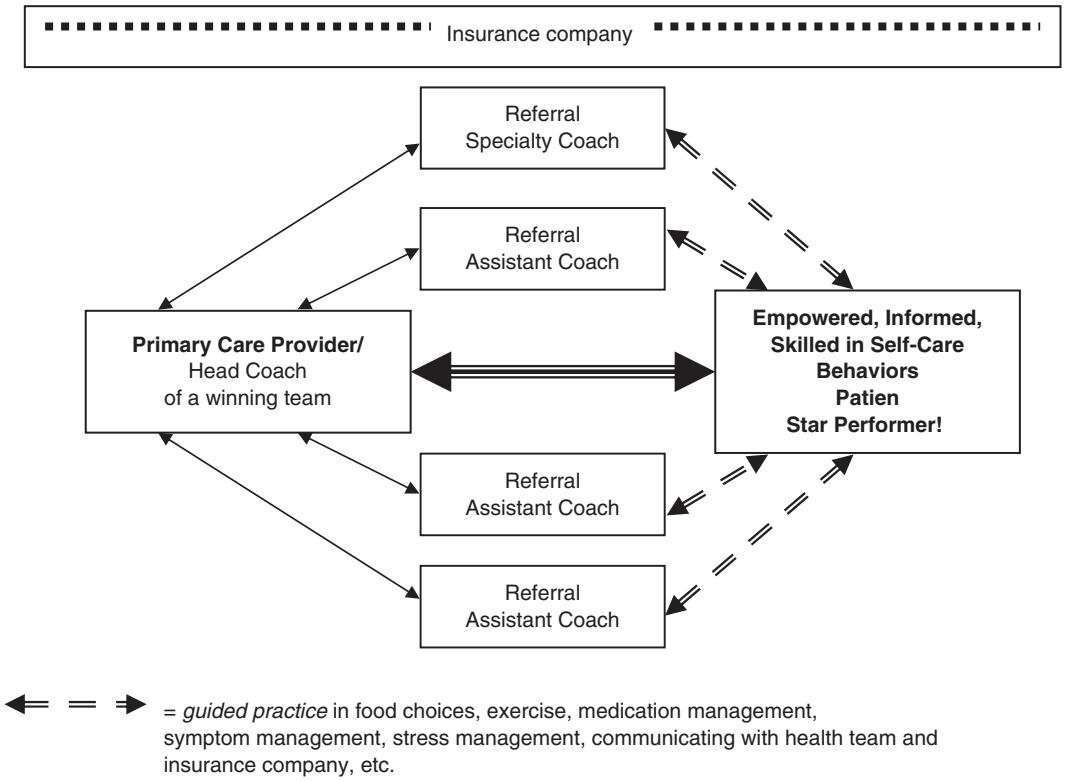
New Roles

One way of looking at the new roles of the health care providers and patient is referred to as TALAS 1, "Team Advancing Learning and Self-management," shown in Figure 1 (Scruggs, 2009). In this model, the patient is assuming the primary responsibility of managing the day-to-day challenges of living with a chronic condition. The patient is most likely to succeed if there is a broad base of support from a multidisciplinary health care team. The physician should not assume a solo role in helping the patient manage a chronic illness. Referrals to additional health care providers, community resources, and support groups are an essential element of chronic health care management. Better outcomes can be achieved with additional coaches available to encourage, support, and instruct the patient's development of new lifestyle skills and understanding of the disease process. Patients also need to learn to communicate directly with their insurance companies to get optimum coverage for good control of any chronic health condition. Learning exactly what the insurance covers for physician support and additional benefits for referrals will help patients know how health care dollars can be spent. Physicians often know what services they offer that will be covered by insurance but may not know what other benefits a specific insurance plan offers. At each patient/provider interaction, patients should be coached in ways to talk to their insurance provider regarding covered options for positive management of any chronic condition.

Another view of transitioning from acute to chronic care is shown in Figure 2—TALAS 2. In this model, the health care team functions like the coaches of a sports team and each patient is one of the team's star players. The physician assumes the role of the head coach with a number of very talented assistant and specialty coaches. Each coach will help the star player develop and improve specific skills. It will be the player's responsibility to practice the skills every day to achieve a level of skill that assures he or she will remain a valued member of a winning team.

An example of the difference in approaches can be seen in the management of diabetes. The physician sees the patient, with symptoms of fatigue, polyuria, and polydipsia. The physician orders lab work that shows a

Figure 2
Chronic Health Care Model—Team Advancing Learning and Self-Management 2 (TALAS 2)



Source: Scruggs (2009).

Table 1
AADE7 Self-Care Behaviors

1. Healthy eating
2. Stay active
3. Monitor
4. Medications
5. Problem solving
6. Risk reduction
7. Healthy coping

Source: American Association of Diabetes Education (2003).

blood glucose value of 350 and makes the diagnosis of diabetes. He then prescribes Metformin 500 bid and ideally makes a referral to the local diabetes educator and dietician.

When the patient arrives at the diabetes education center for assessment, two questions may be asked initially: "What motivated you to attend diabetes classes, and what do you hope to learn today? The patient indoctrinated in the acute health care model may respond, "My doctor told me to come. I want you to tell me what I can eat—just tell me what to eat and that's what I'll do." The patient who becomes indoctrinated in a chronic health care model might respond, "I know I have a lot to learn about living well with my diabetes and this is the first step. I hope to learn how I can determine what defines a healthy choice in foods." The American Association of Diabetes Educators (AADE) has outlined seven self-care behaviors that will help patients live well with diabetes (AADE7, 2003).

The key factor is that these are "Self" care behaviors. The AADE7 can easily be extrapolated to outline self-care behaviors for managing many chronic illnesses. The health care team can and should instruct, coach, support, and advise the patient. However, positive outcomes can only be expected if the patient becomes an active learner and participant in implementing the daily activities of living well with chronic illness. Changing lifestyle choices is not an easy task. Learning new skills requires daily practice and the support and advice of a good coaching team. For a patient with diabetes, the team includes the physician, a dietician, a diabetes nurse educator, a pharmacist, and perhaps an endocrinologist, exercise physiologist, podiatrist, ophthalmologist, dentist, social worker, home health nurse, and others.

Referral Process: Acute Care Model

Unfortunately, in many areas of the acute care model, referrals are not made. Physicians assume the patient understands and can implement the instructions to "watch what you eat and get more exercise." This approach is like a sports team, without a head coach, being told, "play to win." If no one is looking at the entire team, identifying the strengths and weaknesses, and defining the approach and specific plays, it is very unlikely that the outcomes will be positive. In today's health care system, patients with newly diagnosed diabetes may or may not be given a glucometer and may or may not be taught how to use the instrument to test morning blood sugar levels, and too frequently do not know what target blood sugar they are expected to reach. They often leave the office having no understanding that the medication prescribed will not "fix" the illness that has just been diagnosed. With little understanding of the disease, it is often difficult to find the motivation to change diet or exercise habits, even if they had the energy and an idea of how to implement the needed changes. The patients believe they are in the "compliant" patient behavior if they take the daily medication prescribed. The fatigue associated with many chronic illnesses is an additional barrier to lifestyle change attempts without the support and encouragement of a strong, multidisciplinary health care team. Within months the diabetes is "out of control," medications are increased, and the patient is often assumed to be "'noncompliant." The truth is, the acute health care model has failed to provide the patient with the needed skills to live well with this chronic illness.

Referral Process: Chronic Health Care Model

In a new chronic health care model, when the physician diagnoses a chronic illness, he or she ideally begins the transition phase from acute care to chronic care with a clear statement to the patient, such as

> You have a chronic illness. There is currently no cure for this disease; however, you may live a healthier life than someone without a chronic illness if you choose to become an active participant in promoting your healthy lifestyle. There are a number of referrals I can give you to help you achieve good management of your health.

Other members of the health care team who the patient is referred to should reinforce the message, by making statements such as, "You have a chronic illness which can have very good outcomes if you learn all you can about the disease you are living with and know how each daily choice will impact your health."

Literature Review Findings

In the literature review, there are two well-documented models of health care that have moved from the acute, episodic care to a consistent health promotion/chronic care model. The first is called the Chronic Care Model, as described in the article "Chronic Disease Management: What Will It Take to Improve Care for Chronic Illness?" (Wagner, 1998). A discussion of the development and related studies of this model can also be found on the Web site http://www.improvingchroniccare.org. This model includes the scope of the community resources and policies, the organization of health care delivery, patient-centered services, and productive interactions between an informed, empowered patient and family and the prepared, proactive practice team.

> The staff at the MacColl Institute for Healthcare Innovation developed the CCM by drawing on available literature about promising strategies for chronic illness management, and organizing that literature in a new more accessible way. The Model was further refined during a nine month planning project supported by The Robert Wood Johnson Foundation, and revised based on input from a large panel of national experts. It was then used to collect data and analyze innovative programs recommended by experts. RWJF funded the MacColl Institute to test the Model nationally across varied health care settings, creating the national program, "Improving Chronic Illness Care (ICIC)." (Improving Chronic Illness Care, 2009)

In reviewing the data collected in these studies, the Cochran Review stated there were "no successful outcomes that do not include non-physician team members" (Improving Chronic Illness Care, 2009). In his presentation to the Epidemiology, Biostatistics and Clinical Research Methods 6th Annual Summer Session, Dr. Wagner stated, "The one apparently necessary but not sufficient intervention was self management. Patient directed interventions. Of the twenty studies that included some effort to increase the skills and knowledge of patients, nineteen of those showed positive effects" (Improving Chronic Illness Care, 2009). In effective chronic care, the physician should not be a solo act and the patient cannot be a passive member of the team.

The second model is called The Medical Home. "The basic premise of the medical home concept is continual care that is managed and coordinated by a personal physician with the right tools will lead to better health outcomes" (Medical Home, 2009). *The Boston Globe* reports,

> What distinguishes a medical home from a conventional practice is a comprehensive approach to care from prevention through hospitalization that provides as many services as possible in one location and coordinates all other care, using both a personal touch and electronic medical records. In addition, the medical home provides easy access to medical staff through same-day office appointments, weekend, and evening hours, e-mail, and phone . . . doctors offer one-stop shopping for physical and mental care, provide group as well as individual visits, and recently began encouraging patients to e-mail their doctors and view portions of their computerized medical record through a secure website. (Dembner, 2008)

Although the literature describes the medical home model as including the components of the chronic care model, the focus seems to be on increasing the satisfaction of primary care physicians. This is an important component of improving the health care system. It is as important to have enough well-trained primary care physicians for the health care system as it is to have excellent principals in each school and dynamic, effective head coaches for each sports team.

> But the movement has also brought hype, as many medical practices claim to be a medical home without putting all the elements in place. "It's become a phenomenal marketing term," said Dr. Chuck Kilo, a Portland, Ore, medical home pioneer. (Dembner, 2008)

Summation

As the chronic care model is focusing on the overall system and the medical home model is focusing on physician satisfaction, each system mentions the need for an informed, empowered, engaged patient. Both systems have seemed to bury that component, placing more emphasis on the physician role. That may be a very good focus for the entities promoting these systems. But new opportunities for additional support of engaging patients are waiting to be implemented. For positive outcomes from either system, or the new systems yet to be developed, the patient must be engaged. Now is the time to start. Relinquish control and coach the patient to assume responsibility for knowing, managing, and practicing self-care skills.

Here are some key steps to take to begin to refocus on a chronic care, patient responsible care delivery model:

1. Clearly distinguish a chronic illness/condition from an acute illness and explain this difference to the patient.
2. Keep in mind that health care providers must lead the patient from passive to active role by relinquishing the role of autocratic authority and stating expectations of patient leadership in health care decisions of chronic care.
3. Describe the "team of coaches" (TALAS 2) approach to the patient and the need for daily practice of new skills for living well with a chronic illness.
4. Encourage patient to be involved in selecting appropriate referrals (dietician, physical therapist for exercises, certified educators for diabetes, cardiovascular care, stress management, etc.), community resources, and support groups for team of health care coaches.
5. Assess patient's level of learning from elementary to advanced learner as provider relinquishes control and patient is accountable for daily management.
6. Encourage life-long learning—for both health care providers and patients in health promotion interventions.

References

American Association of Diabetes Educators (AADE7). (2003). Retrieved June 15, 2008, from http://www.diabeteseducator.org/ProfessionalResources/AADE7/

Dembner, A. (2008, May 19). A more welcoming model for care. *Boston Globe*. Retrieved March 31, 2009, from www.boston.com/news/health/articles/2008/05/19/a_more_welcoming_model_for_care

Healthy People 2010. (2009). Retrieved April 10, 2009, from www.healthypeople.gov

Medical Home. (2009). Retrieved March 31, 2009, from http://en.wikipedia.org/wiki/Medical_home

Improving Chronic Illness Care. (2009). Retrieved March 31, 2009, from http://www.improvingchroniccare.org

Lorig, K., Sobel, D., Laurent, D., Gonzalez, V., & Minor, M. (2006). *Living a healthy life with chronic conditions. Self management of heart disease, arthritis, diabetes, asthma, bronchitis, emphysema and others* (3rd ed.). Boulder, CO: Bull.

Scruggs, B. (2009). *This is not a broken arm: Patients role of self management in diabetes.* Presented to patient support groups of the Kansas City Regional Association of Diabetes Educators, Kansas City, MO.

Wagner, E. H. (1998). Chronic disease management: What will it take to improve care for chronic illness? *Effective Clinical Practice, 1*, 2-4. Retrieved June 15, 2008, from www.improvingchroniccare.org

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