Barriers to Care in Chronic Disease: How to Bridge the Treatment Gap

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Over the past few decades, the management of chronic disease has assumed a greater role in health care. Diseases such as diabetes, chronic obstructive pulmonary disease, and depression—and their associated complications—have replaced acute disorders as the leading cause of morbidity, mortality, and health care expenditures.1,2 Our understanding of the pathophysiology and treatment of many chronic diseases has increased in recent years. However, improvements in patient outcomes have not kept pace with the advances in knowledge.

A large gap exists between the latest treatment guidelines for many chronic diseases and the translation of these recommendations into everyday patient care.1,2 For example, only 30% to 45% of patients with diabetes in the United States are reaching the American Diabetes Association goals for hemoglobin A1c (HbA1c), low-density lipoprotein cholesterol levels, or blood pressure. Only 7% achieve goal in all 3 of these quality indicators.3

In this article, I explore the reasons for the current treatment gap in chronic care and suggest a number of measures that might help "bridge the gap."

WHY CHRONIC CARE REQUIRES A DIFFERENT APPROACH

Acute care assessment and skills. The traditional approach to health care is based on the acute care model. In this model, the patient is a passive recipient of care; often, he or she is bedbound. The illness is likely to be short-lived, and the objective of care is cure and return to a pre-illness state of health. The clinician writes orders, and often, multiple individuals carry them out. The decisions that underlie the orders are based on in-depth knowledge of pathophysiology and pharmacology and the skills required to apply that knowledge.

In acute care, the results of treatment are measurable and are achieved in a short period of time. Thus, for the clinician, acute care provides immediate gratification that is directly linked to his or her decisions. Physicians and other clinicians receive the most exciting and memorable part of their training in acute care settings.

The acute care model is extremely important and is responsible for the saving of many lives. However, it does not provide an effective model for chronic care.

Chronic care assessment and skills. Chronic disease is different.2 Cure is usually not possible; results are measured by different standards, and clinician gratification is delayed—sometimes for years. Quality care for chronic disease is usually assessed by how well patients adhere to medication regimens, adopt recommended lifestyle changes, and, as a result, achieve the standards set forth in quality-of-care guidelines. Thus, patients are not passive recipients of care but active and equal partners in the management of their chronic disease (eg, diabetes).

Because patients are integrally involved in the management of their problem—and because they act based on values that derive from family, culture, religion, gender, socioeconomic status, and past experience with illness—chronic care decision making requires the skillful integration of an understanding of patient values and experiences with knowledge of the pathophysiology and pharmacology of the disease in question. Coaching, facilitating, and encouraging are essential to the clinical care of chronic disease.

Chronic care does not provide immediate gratification. Thus, clinicians who have expectations of gratification commensurate with that experienced in acute care will encounter significant frustration. Younger physicians, especially those still in training, have the most difficulty in adapting to chronic care because their experience consists largely or wholly of training in acute care models.

BLAME VERSUS BARRIERS

When the standards set forth in quality-of-care guidelines are not met—as they often are not in...
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chronic care settings—there is a tendency to assign blame. Usually, the patient is the one on whom blame is fixed. This may seem justified. After all, the patient is responsible for taking medication, adopting lifestyle changes, and meeting disease management guidelines. The attitude that underlies a clinician's frustration and assignment of blame may be expressed with labels such as "noncompliant," "nonadherent," "gomer," or "train wreck."

Words like "adherence" and "compliance" have become established in the vocabulary of medicine. However, these words represent dysfunctional concepts. This is because they tend to limit consideration of the possible causes of a problem solely to patient-related factors. If the clinician considers only the patient as a possible object of blame, solutions are limited.

A broader and more helpful approach is to scrap the concepts of blame, adherence, and compliance, and adopt instead the concept of barriers. The term "barriers to care" does not have the pejorative connotations of "blame" and thus seems less inflammatory and less likely to provoke a defensive response. A review of the literature on adherence and compliance reveals a number of patient-, provider-, and system-related barriers that can impede the achievement of treatment goals. The Table lists some of these barriers.

| Table — Barriers to achievement of treatment goals in chronic care |
|-----------------------------|------------------|-----------------|-----------------|
| **Patient-related**         | **Provider-related** | **System-related** |
| • Lack of trust in physician and office staff | • Lack of time | • High copayments |
| • Lack of understanding of treatment regimen | • Lack of system support (eg, office organization not conducive to creating a supportive environment) | • Frequent refill requirements |
| • Costs and side effects of treatment greater than benefit | • Lack of reimbursement for counseling | • Frequent staff turnover |
| • Lack of transportation | • Major focus on acute medical problems | • Lack of cultural and literacy issues |
| • Inability to pay for medication | • Failure to explain prescribed regimen | • Lack of training in management of chronic disease |
| • Depression | • Assumption (incorrect) of patient adherence | • Lack of training in handling cultural and literacy issues |
REMOVING BARRIERS TO CARE
The following strategies provide a helpful starting point for recognizing and removing barriers to care that may exist in your practice or community.12,16

Patients need support, not blame.
Many clinicians focus on patient-related factors as the causes of problems and neglect provider- and system-related causes. If patients are not supported, they do not feel empowered. And patients who do not feel empowered are more likely to have negative attitudes towards prescribed treatment.

Remember that several barriers may be present at the same time.
The ability of patients to follow treatment plans in an optimal manner is frequently compromised by more than one barrier. Addressing one barrier without addressing the others is rarely productive.

Individually tailored interventions are required.
No single strategy works for all patients. Interventions must be adapted to incorporate the values and experiences a particular patient has absorbed from family, culture, religion, gender, socioeconomic status, and past experience with the illness. This requires a thorough assessment of each patient.

Follow-up is mandatory.
Patients are at different stages of readiness to accept health recommendations. In addition to assessing a patient's readiness, follow-up is a means for supporting patient efforts.

Health professionals need to be trained to deal with barriers.
Current medical schools, residency programs, and continuing education systems are oriented mainly to acute care training in the hospital. Students are often exposed to mediocre and disorganized examples of outpatient chronic disease care.16 Outpatient management of chronic disease and ways to address barriers to care do not receive the emphasis required to effect change. Centers of practice excellence for outpatient chronic disease care are needed both for training and for the development of innovative ways of dealing with barriers to care.

Clinicians need to recognize the challenge of clinical and therapeutic inertia.
The "inertia barrier" is defined as a failure to intensify therapy when treatment goals are unmet. To overcome this barrier, clinicians need trustworthy data systems that inform them of how well they are doing at achieving quality goals (e.g., how many patients with diabetes have achieved an HbA1c of less than 7%). At present, most do not seem comfortable with data that show how well they are meeting treatment goals. This may be because most of their experience with such data involves data generated by insurance companies; thus, they tend to be skeptical about the intent of data collection. Overcoming the inertia barrier will require meaningful clinician involvement in treatment goal definition, data collection methods, and peer teaching of ways to address unmet treatment goals.

Community resources can help deal with some barriers.
Social and economic issues are often best resolved through the mobilization of community organizations. Churches, schools, and service organizations may be able to help deal with barriers. For example, a church car pool might provide transportation to health care facilities, or the local Kiwanis Club or Jaycees might raise funds to purchase a community van for this purpose.

A multidisciplinary approach is needed.
Office staff can play an important role in educating patients and in ensuring that recurring tests and examinations are carried out. The involvement of professionals from other disciplines and organizations is needed in the management of most chronic diseases. However, coordinating this involvement and facilitating communication between the various professionals can present challenges. Lack of or insufficient communication between treating professionals is a major barrier to
optimal chronic disease care.
For an example of how some of these principles take shape when applied in a real-life setting, see the clinical scenario and discussion in the Box.

References: REFERENCES:

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