Chronic care is a large and growing part of the lives of patients, families, and clinicians. Chronic care models move practice from primarily episodic, acute care to longitudinal, proactive, planned care. Clinicians providing biofeedback and self-regulation techniques have a place in this larger picture of chronic care—in areas such as patient self-management, prepared practice teams, productive interactions, and care system design. The self-regulation approaches effectively address factors of high priority to patients and clinicians.

What Matters to Patients and Clinicians When It Comes to Chronic Care?

Chronic care involves not only individual clinicians who treat individual patients but also the creation of practical systems of care and teamwork that reach out to populations as well as to the individuals who happen to come in to the clinic. The well-known, evidence-based chronic care model, or planned care model, outlines the various aspects of chronic care as a total system (Von Korff, Gruman, Schaeffer, Curry, & Wagner, 1997; Wagner, Austin, & Von Korff, 1996). Both patients and clinicians are concerned with the evolution of traditional episodic acute care practice to proactive, planned, longitudinal care, which can include both chronic care and prevention (Glasgow, Orleans, Wagner, Curry, & Solberg, 2001).

A few elements of Wagner et al.’s (1996) chronic care model include (a) informed, activated patients linked to prepared practice teams through productive interactions; (b) patient self-management support; and (c) delivery system design, which involves team care, planned visits, and proactive follow-up.

How Do You Appeal to What Matters?

The emergence of systems of chronic care (most often in primary care) creates several avenues for biofeedback and applied psychophysiology clinicians to become a clearly defined asset in this larger picture and team. But clinicians may ask, “How do I define myself and my services in this picture? What is the significance of what I do for chronic care and primary care?”

Biofeedback clinicians can appeal in several ways to what already matters to primary care and specialty clinicians who are developing improved models of chronic care.

Patient Self-Management

It is well known that in chronic illness, the patient is on the team. Informed, activated patients participating in patient self-management are essential to making medical or psychological interventions stick over the long haul to produce sturdy individual and population health outcomes for chronic illness. If biofeedback clinicians identify themselves and what they do with patient self-management, they will occupy a familiar and valuable place in the larger scheme of things in chronic care and primary care systems.

Relaxation and enhanced awareness and control of chronic overarousal (and of other psychophysologic reactions that contribute to or complicate the care of chronic conditions) can be an important part of an overall care plan for a particular patient and in planning care resources for a population of patients. Clinicians can explicitly make this connection and tailor their work to the kinds of self-management needed for the particular chronic illnesses of their patients and clinic population.

Moreover, patient self-management means improving a sense of self-efficacy, confidence, and ability to interact with symptoms in a constructive way. Biofeedback clinicians know the moves for this and can become a positive force in clinician teams devoted to chronic illness care. This includes but goes beyond a narrow idea of doing biofeedback. In this sense, the significance of doing biofeedback is patient self-management and self-efficacy. If patients or other clinicians on an extended chronic illness care team aren’t that familiar or don’t relate that well to biofeedback as a technique, they can certainly relate to its purpose, namely, supporting patient self-management. If patients indeed show better self-management as a result, this will appeal to what matters to everyone.

Note that in this larger picture of chronic care, the biofeedback clinician is not identifying himself or herself as a clinician with a technique “in a silo.” Rather than...
saying in effect, “I run a biofeedback clinic—send me biofeedback referrals,” the clinician identifies with the larger enterprise of chronic care and points out how self-regulation techniques are a way to advance that larger agenda (“I’m part of a primary care team and concentrate on patient self-management of symptoms and distress.”). Moreover, the clinician is willing and able to talk about more than the biofeedback technique while engaging patients (and the care teams) in their larger quest to manage chronic conditions.

**Prepared Practice Teams**

When it comes to chronic care, no one has all the marbles. The patient, of course, must be on the team. Various kinds of providers show up on the field including primary care physicians, specialty physicians, nurse practitioners, care managers, and mental health or behavioral health clinicians, in addition to those who do biofeedback or other forms of self-regulation techniques.

But a big group of clinicians on the field does not a team make. The keyword is *prepared*. This means prepared for each other, with a reasonable division of labor, scope of practice, and communication system so that the right hand knows what the left hand is doing. It means a shared plan of care that is carried out by the right person in the right ways and at the right time, and a shared chart, tracking system, or automated medical record that can keep track of all this.

Prepared also poses the question, “Prepared for what and whom?” It means prepared for patients with common conditions (i.e., diabetes, asthma, congestive heart failure, and depression) at the very least. Neurological conditions are increasingly part of the chronic care landscape, even in younger people. Prepared means understanding the big picture of these conditions and knowing what other people do, not just your own piece of it. Prepared also means expecting to see the predictable kinds and sizes of populations of patients with chronic conditions in your setting. Prepared means creating systems that help clinics and health plans reach out proactively to patients who may not be coming in when they should, not just treating those who happen to show up asking for services.

Finally, prepared means watching what is happening with your team’s chronic care plans and communication and making changes when they are not working, rather than letting patients fall through the cracks. This may mean instituting a care manager function, which is most often a task of one or more persons on the care team rather than a separate person. As the motto says, “Preventing the classic and predictable fragmentations and misunderstandings in care may be the most important part of your job.” Psychosocially oriented clinicians often do very well with this formal or informal role. Doing this well appeals to what matters to everyone.

The mottos quoted here were captured from case discussions by C. J. Peek (Peek & Heinrich, 1995). Table 1 shows a larger collection of mottos cited by Dr. Peek for chronic care management.

Prepared also means prepared for complexity, as in multiple interacting biomedical, psychological, social, and cultural factors along with complexity stemming from

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**Table 1. Mottos for chronic care management by C. J. Peek, PhD**

1. When it comes to chronic care, no one has all the marbles.
2. The general ability to work well across disciplines on behalf of patients is good clinicianship.
3. Preventing the classic and predictable fragmentations and misunderstandings in care may be the most important part of your job.
4. Hold the baton until you are sure that the next person has it and knows he or she has it.
5. The right kind of time at the front of a case saves time over the life of the case.
6. Most difficult patients started out merely as complex.
7. Evaluation of the patient’s case goes along with evaluation of the patient.
8. Health care relationship problems can complicate health problems.
9. Patients can’t participate effectively in care plans that they don’t understand and embrace.
10. Clinicians must be able to show how every move and technique serves the care plan.
11. Disability management is often bigger than symptom management.
12. Be sure the treatment doesn’t increase the disability.
13. Groom patients for referral—make sure patients can verbalize why they are going to the next clinician.
14. Patient resistance is usually a sign of a problem in approach, negotiation, or timing.
social chaos, difficult patient-clinician relationships, or a history of distrust and bad experiences in the care system. Patients bring all this complexity with them, not just their diseases and conditions. Any clinician who is willing to assess and address such sources of complexity is valued indeed in the long run, even if it may take extra time in the moment. As the motto says, “The right kind of time at the front of a case saves time over the life of the case.” Furthermore, addressing complexity from the start can improve patient-clinician relationships and prevent clinical situations from becoming more and more complicated and distressing. As the motto says, “Most difficult patients started out merely as complex.”

Prepared also means prepared to “build the ship as we sail it” (Baird, 1995) because the systems for chronic care are still under construction. Biofeedback clinicians are often prepared or raised in disciplines that emphasize systems thinking, which refers to the entire mind-body interaction, self-regulation, and the strengths that individuals can bring to their own physical systems. These clinicians need only deliberately extend this basic savvy to the larger picture of interacting clinical factors and to the care systems within which everyone has to function. The clinician can be a person who not only treats the patient but also facilitates improvement in the system of care on which all patients depend. Although clinicians do not usually think of themselves as major influences on care system design or operations, increasing demand for systems thinking and clinician leadership has led me to give workshops on the organizationally effective clinician.

**Productive Interactions**

The term *productive interactions*, also from the chronic care model, refers to the basic chemistry for good results in an effective chronic care or primary care system. Of course, clinics produce services. But productive interactions between patients, families, and all stripes of clinicians are needed for results and hence are the basic product. Biofeedback clinicians are educated to be sensitive to patient-clinician communication, interviewing, teamwork, appropriate pacing, and staying with the patient’s goals and way of talking. This talent is valuable on any chronic care or primary care team. Any clinician who can anticipate and prevent the predictable “dropped stitches” or misunderstandings and make difficult clinical conversations easier will be welcomed in any clinic.

**Care System Design**

Productive interactions also need to take place on the organizational level if they are to be sustainable at the clinical level. For example, constant tension or warfare between clinical, operational, and financial concerns and advocates can burn up energy and creativity needed for patient care. Any system of care that works for patients and clinicians will need to harmonize these aspects or views of the whole (Patterson, Bischoff, Peek, Heinrich, & Scherger, 2002; Peek & Heinrich, 1995). If a care system fails clinically, it obviously fails. If a clinic fails operationally, it also fails—in a different way. And if the clinic fails financially, it also fails—disrupting hundreds of patient-clinician relationships. The only way to succeed is to take a multidimensional design approach (a three-world view) that harmonizes clinical, operational, and financial perspectives of the one underlying health care enterprise. This is a matter of good design and good leadership that employs productive interactions at an organizational level to harmonize clinical, operational, and financial perspectives for long-term success. Again, good systems thinkers such as clinicians, who can balance multiple perspectives at the same time, can excel at this if they put their minds to it.

**Good Clinicianship Across Disciplines**

Health care professionals involved in chronic care are called on to work together across their disciplines, sharing an overall care plan in which each clinician plays a different part. This means being able to appreciate each other and generate understanding and connection across disciplines. This general ability to work well with other clinicians on behalf of patients is good clinicianship, just as musicians recognize good musicianship across players of different musical instruments.

I will close with a parable emphasizing the need to identify with more than your chosen techniques as a soloist and develop skills as an ensemblist:

> I once knew a music teacher who distinguished between instrument lessons and music lessons. He always said your first instrument is the hardest, because you have to learn music along with it. He sensitized his students to fundamental skills and sensibilities that transcend any one instrument, but unite them all under the umbrella of music. He emphasized things like timing, harmony, reading music, intonation, communication with the ensemble, improvising, recovering from mistakes, controlling anxiety, rehearsing, learning your own strengths and weaknesses. For him this was musicianship and was more fundamental than any one instrument. He said you can later learn other instruments much more easily because you don’t have to learn music again. But he...
I believe this music metaphor is very apt for clinicians of our many disciplines who are increasingly expected to play well together, mean something to each other, and appeal to what matters to patients and clinicians in the growing field of chronic care. As a particular kind of professional, we each play an instrument in the ensemble of health care professions, yet we must also cultivate good clinicianship just as musicians need to cultivate good musicianship. Even musicians who have never played together can often sit down and play together quite well, united by their shared musicianship. We need more than ever to share a common ground of good clinicianship regardless of our particular professional ethnicity. Otherwise, divisive, competitive, or self-serving professional and guild interests can rob people of energy and work against everything we value for patients and families.

**Conclusion**

Chronic care invites clinicians to take influential places in the larger emerging systems of care and to assume influential roles in care system design. Biofeedback clinicians can no longer be soloists limited to their own techniques and discipline; they must become ensemblists who appeal to what matters to the larger team and to the population of chronic care patients. Clinicians will need to identify with the cause of integrative chronic care as well as with biofeedback. In chronic care, productive interactions among clinicians of all stripes matter to everyone, especially patients. Their care depends on it. Clinicians owe it to patients to develop productive ways of working with each other (good clinicianship); this element is just as critical as is honing the particular techniques of one’s own discipline.

**References**


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