

# Care, Whether it's Called Population- or Disease-Management, Sidney Garfield, MD, Would Like the Idea



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In the 1930s, Sidney Garfield, MD, established the foundation for Permanente Medicine in the Mojave Desert while providing care for workers building the Los Angeles Aqueduct. He combined caring for the sick and injured with analysis and confrontation of the causes of his patients' acute need for care. A frequently told, perhaps apocryphal story recounts Dr Garfield taking a hammer in hand after clinic hours to go to the worksite and pound in the protruding nails that were causing puncture wounds sustained by workers that filled his clinic day. Dr Garfield systematically approached the problem, knowing that while all workers seemed at some risk of injury, he was unable to know exactly which ones would eventually suffer. So he sought and found a solution that improved the health of the entire population being served.

In this issue of *The Permanente Journal*, Peter Crooks, MD, shares the continuation of this Kaiser Permanente (KP) tradition of excellent population care, describing the success attained by him and his colleagues in the Southern California Permanente Medical Group in systematically improving care for patients with end stage renal disease (ESRD) (page 93). By addressing this clinical challenge with creativity and

persistence, a new benchmark for effective and efficient ESRD care has been established. Dr Crooks provides several examples of elevated performance and enhanced outcomes. Key factors include the development of effective care teams featuring new and expanded clinical roles such as the renal nurse specialist, evolution of a patient management system to ensure each patient gets the right intervention at the right time even if they don't have a scheduled medical office visit and active inclusion of the patient and their family members in care and care planning.

Were he to read of this success with ESRD, Dr Garfield no doubt would have recognized the overall themes. However, he also likely

would have been at least temporarily vexed in sorting out the bewildering profusion of terms that have evolved to describe approaches for systematically caring for the upstream and immediate needs of a population: Care Management, Chronic Conditions Management,

Population Management, Population Care Management, Case Management and Disease Management to pick perhaps the most common. Equally new and perhaps confusing may have been the associated clinical roles and titles of individuals such as case and care man-

ers, health coach, health educator, and nurse and pharmacist clinical specialists. Finally, while caring for the population is part of the KP "genetic code," Dr Garfield certainly would have been pleasantly surprised to see similar interventions being developed widely outside KP: within medical groups, delivered by health plans, and even by a relatively new health care entity, the Disease Management Company.

I'd address the proliferation and colloquialization of terms to Dr Garfield in the following way: "Don't worry too much about what it's called!" I'd explain:

Increasingly robust and organized efforts within KP and elsewhere are efficiently and effectively linking whole populations of patients to the resources and people who can improve and sustain their health. It's beyond the scope of this commentary to fully catalog, but the scope of population-focused care includes population identification and stratification, member tracking, case management, inreach and outreach, and patient education. Chronic conditions, such as diabetes and heart disease are a common focus of these efforts, as are resource intense clinical challenges like ESRD and cancer. Program development has been fueled by a growing evidence base supporting a wide range of effective interventions for even early stages of the targeted conditions.

Care management, population care, disease management, and simi-

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lar terms are highly overlapping and pragmatically indistinguishable “means” in systematic pursuit of the same “end”—improved health outcomes for a population of patients. While debated academically, the distinctions are increasingly blurred and, at least to the patient, probably not all that important to discriminate.

Some thoughts on why we have several terms for what is about the same thing follow:

- “Population care” is often used to capture a broad view of the entire spectrum of care needs and interventions for populations of patients, seeking differentiation from a central disease focus. A population encompasses the most impaired and ill through to those in the earliest stages or even just at risk for a condition. Implied in optimal population care across this range of need is the ability to stratify the members of a population for their severity of illness and needs and use this information about risk in planning and delivering care. Care management and disease management programs as commonly practiced in 2005 generally address a wide scope of population needs including risk assessment and allocation of appropriate interventions across multiple and often comorbid diseases.
- Care Management seeks to emphasize the delivery of care as an organizing principle rather than the disease itself.
- The Disease Management Association of America defines Disease Management as “a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant.”<sup>1</sup>

The term disease management has been criticized for emphasizing a single disease process over the complex care needs of individual patients who often have significant co-morbidities. However, while Disease Management initially tended to focus on only one condition at a time, in most circumstances now a spectrum of common chronic conditions can be addressed concurrently to better align with the multiple and complex needs of larger patient populations.

- Free-standing Disease Management companies have emerged in the last several years focused exclusively on providing, quite logically, Disease Management services for the chronically ill. While disease management programs are often overlaid on the fee-for-service health care delivery system, the population care delivered within KP is increasingly seen as a benchmark for the disease management “industry.” For example, in both 2003 and 2004, KP received awards from the national disease management industry for outstanding disease management care delivered by a health plan and by a managed care organization.

Finally, when this systematized care occurs (in sum or in part) on a case-by-case basis with close individual attention by members of a care team, as is the case with Dr Crooks report on ESRD, use of the term case management makes sense for that individualized care. Case management is often closely linked with broader and less individualized care/disease/population approaches.

Once past the naming exercise, I would expect Dr Garfield to ask if this approach is successful. As an

organization, we can respond with an unequivocal yes:

- KP’s approach to care and disease management has achieved dramatic health improvements. Studies within KP and elsewhere have consistently documented marked improvements in clinical processes (eg, testing frequency), intermediate health outcomes (eg test results) and patient satisfaction with systematized care for multiple conditions. The linkage of these improvements to actual clinical outcomes (eg control of disease and death rates) is generally less convincingly documented to date, arguably because of the longer timeframe necessary to see these desired benefits.<sup>2</sup> Even with that constraint, examples like the Northern California region’s substantial decrease in deaths from heart disease to the point that it is no longer the leading cause of mortality among its members are increasingly documented.
- KP’s approach to care and disease management saves money compared to cost trends, and delivers high value for health care purchasers and consumers alike. A recent study of the programs run by The Permanente Medical Group in Northern California documented dramatic improvements in quality of care and a savings of \$200 million in one year (relative to expected cost trends) for patients with certain conditions.<sup>3</sup>

The portfolio of interventions described by Dr Crooks is successful. Patient outcomes have been im-

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proved and higher value is being obtained for the financial investment in this systematic approach to care. However, where Dr Crooks concludes, in reference to systematized population-based care, that “The health care industry seems to have realized that some things are just too important to leave to the doctor,” I would offer the friendly amendment that what he and his colleagues have achieved is an evolved and more robustly supported system of care actively led by doctors, not one passing them by, even as some aspects of care leave the exam room and the doctor office visit for other venues.

I also suspect we will see even more notable improvements in re-

nal care in coming years. The program described focused on the patients with kidney disease with the highest current needs, those on dialysis and/or receiving transplantation. The potential for further improvement in population health will be amplified as the course and complications of “upstream” causes of renal failure such as diabetes and hypertension yield to complementary population-based approaches. The most cost-effective approach to managing ESRD for a whole population over time is probably to decrease substantially the number of patients sustaining severe insults to renal function in the first place—in a manner reminiscent of pounding nails more than 70 years

ago. I believe Dr Garfield would like this approach. ❖

#### References

1. DMAA.org [Web page on the Internet]. Disease Management Association of America, Definition of Disease Management [cited 2005 January 10]. Available from: [www.dmaa.org/definition.html](http://www.dmaa.org/definition.html).
2. Ofman JJ, Badamgarav E, Henning JM, et al. Does disease management improve clinical and economic outcomes in patients with chronic diseases? A systematic review. *Am J Med* 2004 Aug 1;117(3):182-92.
3. Crosson FJ, Madvig P. Does population management of chronic disease lead to lower costs of care? *Health Aff (Millwood)* 2004 Nov-Dec;23(6):76-8.

## Encouraging The Heart

A leader who Encourages the Heart is one who encourages other people; recognizes people's contributions; praises people for a job well done; gives support and appreciation; finds ways to publicly celebrate and tells others about the group's good work.

— *“The Leadership Challenge,” Kouzes and Posner, Jossey-Bass*