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## DISEASE MANAGEMENT: PLAUSIBLE PREJUDICES?

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After listening to me describe disease management programs being implemented by care providers at BJC Health System for patients with congestive heart failure, diabetes, or asthma, some physicians have argued, “What’s new here? We’ve been practicing preventive medicine for decades!” Others have been heard to say with some exasperation, “Personally, I don’t manage *diseases*. I manage the care of my patients.”

Some observers extol the disease management approach to patient care as “new wine in new bottles” and claim it is a new paradigm for health care [1]. Proponents of this view maintain that population-based disease management is dramatically different from the traditional, physician-patient-based cottage industry model of health care delivery. Other critics warn that disease management programs can disrupt the continuity of a patient’s care and create perverse financial incentives to treat high-risk patients (ie, those who use the majority of intensive care services) at the expense of the less severely ill (ie, those who can benefit from long-term preventive services) [2].

Given this range of opinions about disease management—from nothing new to serious threat to equitable distribution of health care—not surprisingly I have my own questions about the disease management approach:

- Does disease management represent a true paradigm shift [3] in the theory of medical practice? That is, is it a frame-breaking, quantum leap away from the prevailing belief system?
- Are the scope and outcomes of disease management programs designed and implemented by for-profit vendors significantly different from those designed and implemented by physicians and the health care delivery systems they direct?
- Can physicians trust that patients with complex medical problems will receive safe and comprehensive care in disease management programs without a substantial increase in their own workload?

I invite readers to consider my questions as they read this issue of *Seminars in Medical Practice*, which provides an introduction to the principles and practice of disease management. In the first article, Dr. Conill and Dr. Horowitz review the theory and evolution of disease management and remind us that current methods of financing health care in the United States determine to

a large extent the structure of delivery systems. Large purchasers of health care (eg, employers, health plans) for populations of patients wish to manage their costs. In response, providers are banding together to form novel provider organizations (eg, independent provider associations, integrated delivery systems) to accept prospective payment as well as financial and clinical responsibility in order to capture the business of caring for these large patient populations. Coming full circle, market forces have driven the development of new organizational models that require control of a continuum of care from primary and specialty care services through acute and chronic care facilities and make a disease management approach to care delivery possible [1]. In theory, properly designed disease management programs are more *effective* (achieve better clinical outcomes), more *efficient* (save physicians’ time and achieve cost savings), and more *integrated* than care requiring countless individual actions in innumerable doctor-patient contacts.

Having asked readers to consider my questions about disease management, it seems only fair that I reveal my prejudices. As to whether disease management represents a true paradigm shift in the theory of health care delivery, I think it does not. Public health models have long been population-based and built upon the notion that broadly applied interventions for primary prevention (eg, childhood immunizations) and secondary prevention (eg, tight diabetic control to reduce subsequent heart attack and stroke) can improve the health of communities and reduce long-term consumption of precious health care resources.

The novelty of disease management becomes apparent when one considers the differences between for-profit disease management programs and those designed and implemented by physicians. As noted by Dr. Conill and Dr. Horowitz, early disease management programs initiated by for-profit companies were driven by an agenda to sell more disease-specific medications and services. Rather than managing processes of care, these efforts have focused on managing access to costly health care services such as physician visits, and they have tended to marginalize the role of the primary care provider.

In contrast, provider-sponsored disease management programs invoke a social contract between the patient and health care provider, as exemplified by the approach implemented at Lovelace Health Systems and described

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by Dr. Friedman and colleagues in the second article. Rather than waiting for the patient to become desperately ill and in need of intensive acute services, these providers are making a compact with their patients. What I hear them saying is, "We will identify the diseases that matter in your life, and we will follow their course with you throughout your lifetime. We will work to help you reduce the burden of a disease by: increasing your understanding of your illness, its treatment, and how you can participate in its management; actively monitoring its signs and symptoms; and intervening early and aggressively to lessen its impact on your quality of life."

In response to my third question, I would urge the reader to consider the clinical vignette of Ms. Herrera in the article by Dr. Friedman and colleagues. Ms. Herrera has suffered through 7 years of poorly controlled diabetes marked by a cumbersome, poorly integrated, and ultimately unsuccessful treatment program. After 1 year in the Lovelace Diabetes Episodes of Care<sup>®</sup> program, with coordinated access to and consistent support from her primary care provider, diabetes educator, and dietitian, Ms. Herrera finds herself under excellent diabetic control and feeling that she and her physician are at last "in charge" of her diabetes. With the systematic approach to monitoring, alerting, and intervening offered by the program's team of providers, Ms. Herrera has received all of the American Diabetes Association's

recommended testing, examinations, and evidence-based medical care. I would venture to guess that her doctor, who now spends more time talking to her at each visit than he does searching out lab results or trying to wangle an appointment for ancillary service, is as satisfied a "consumer" of the program as Ms. Herrera is.

The truly novel promise of this approach to care is making access to the right treatment (evidence-based medicine), at the right time (through proactive monitoring, early intervention, ease of access to care), in the right setting, using the right amount of clinical resources (be it at home or in a physician's office rather than in the emergency department or hospital) an *expectation* rather than an *exception* to the rule of receiving health care services.

Please read the articles that follow and decide for yourself whether my prejudices about the potential of disease management to greatly enhance the quality of care we deliver are plausible or not.

#### References

1. Harris JM Jr. Disease management: new wine in new bottles? *Ann Intern Med* 1996;124:838-42.
2. Bodenheimer T. Disease management—promises and pitfalls. *N Engl J Med* 1999;340:1202-5.
3. Kuhn TS. *The structure of scientific revolutions*. 3rd ed. Chicago (IL): University of Chicago Press; 1996.

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