Population Care Management Program in an Integrated Healthcare System

How to Delay the Progression of Chronic Renal Failure Through Patient Education And Empowerment Activities

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- **Abstract:** Kaiser Permanente is America's leading integrated health care organization. Founded in 1945, it is a non-profit, group practice prepayment program with headquarters in Oakland, Ca. Kaiser Permanente serves the needs of 9.2 million members in 19 states and the District of Columbia.

  Patients with chronic diseases are the most complex, expensive and highest utilizers of our healthcare system. By moving from management of symptoms to a proactive POPULATION MANAGEMENT approach, we are able to identify patients at risk and manage their disease before they are acutely ill or at end of life.

  Our model can be applied to any population or disease management program. We'd like to share the business case for population/care management and the progress we have made in Southern California Kaiser Permanente in our pre-ESRD and ESRD programs. Our program is customized to the individual member, assures a comprehensive approach and continuity of care and results in high quality outcomes in a cost effective manner.

  The multidisciplinary teams are led by the Renal Nursing Care Coordinator, who plays a critical role in the program's success. Her focus is on quality of care, customer service and overseeing costs of care.
- **Introduction.** The management of the enormous number of patients treated in outpatient settings is the most significant element in maintaining and restoring health in the nation's population. Combining all the involved skills and technologies in a smooth, effective, and continuing effort is not an easy task. **Defining care management.** The definition of nursing case management varies depending on the discipline that is employed, the personnel and staff mix used, and the setting in which the model is implemented. Primarily borrowing principles from managed care systems, nursing care management is an approach that focuses on the coordination, integration, and direct delivery of patient services. It places internal controls on the resources used for care. Such management emphasizes early assessment and intervention, comprehensive care planning, and inclusive service system referrals. Specific roles for the RN as care manager emerge within the care management concept: assessor, planner, coordinator, collaborator, advocate, counselor, educator, and evaluator. In addition to these management and professional roles, the RN must possess clinical expertise in the care of patients targeted for case management.
- **The care management process:** Care management models serve as the hub for the delivery of multi-levels of patient care within the ambulatory setting. For example, if a patient experiences a health crisis at his residence or during a visit to the health care provider, he is placed in one of five levels of care. *(See yellow box)*
- **Dialysis care management—Making the case.** Caring for ESRD patients is a challenge because of their comorbid conditions. Therefore, a disease management program, using renal care managers, must focus on the overall management needs of this highly complicated patient, rather than those of the kidney disease itself. The most effective means of managing this population is a field-based program using nurses to coordinate the care for the patients among the various medical providers they use.

The care management process: Case management models serve as the hub for the delivery of multi-levels of patient care within the ambulatory setting. For example, if a patient experiences a health crisis at his residence or during a visit to the health care provider, he is placed in one of the following categories:

- **Level I: Defined treatment on a short-term basis**
- **Level II: Intensive care via visits, followed by telephone management until discharge**
- **Level III: Continuous long-term care management via coordination with other services and monthly visits**
- **Level IV: Home health services with minimal dependence on external services**
- **Level V: Coordination of care, which provides a linkage between the health care facility and client's residence**

Core components of our model include:

- **Early identification of patients at risk**
- **Risk stratification**
- **Clinical practice guidelines**
- **Proactive management**
- **Care coordination**
- **Patient education**
- **Outcome measurement**
- **Continuous improvement**

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