

Systematic Health Management: The Time Has Come to Do the Right Thing for Each Person

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The statistics and statements about how the current US healthcare system is failing patients and consumers continue like a beating drum. Examples of overutilization, underutilization, and misutilization of care are so common that many have become numb to their significance. Ten years ago, a report from the Institute of Medicine cited the alarming statistic that 98,000 preventable deaths occurred in hospitals every year, or the equivalent of several jumbo jets crashing regularly.¹ Now we learn from an article published in April in *Health Affairs* that this number may be 10 times greater.²

The best evidence suggests that necessary care is provided just over 50% of the time,³ whereas the wrong care is administered up to 30% of the time,³ contributing to an estimated \$600 billion to \$800 billion in waste, or “unwarranted variations” in care.⁴ Still, these healthcare patterns persist and claim an ever-increasing percentage of national gross domestic product and personal income.

All stakeholders in healthcare—including patients, clinicians, payers, and employers—claim to be ready for change. Benefits and care that match the specific needs of a patient are highly regarded by consumers, payers, clinicians, and employers alike.⁵ Furthermore, when such approaches are taken, they routinely show dramatic improvements in quality, cost, and patient satisfaction.⁶ Finally, many new solutions and care-delivery models are available, such as patient-centered medical homes (PCMHs), accountable care organizations (ACOs), payment bundling, value-based benefits, member-centric care management, and highly predictive analytics, each of which can now be delivered in a scalable and automated fashion. A recent report for the National Quality Forum conducted by RAND catalogued 11 different categories of insurance and care-delivery models that have shown the ability to improve quality and lower cost.⁷ This is but one of several studies that highlight the opportunity that is available for improving US healthcare.



What Approach Do We Need to Take?

Why is there such a disconnect between what people need and what actually happens? After 10 to 20 years of good-faith concern and effort, there is precious little to show in terms of quality and value improvement, except for our collective awareness of the challenges. Even with the recent passage of healthcare reform legislation, including a

committed \$10 billion for innovation that improves quality and lowers cost, most experts are not yet ready to declare victory over inappropriate care. In fact, most experts are cautious about how soon we will see any significant improvements. Why is that the case?

The simple answer is that we really do not have a healthcare “system,” meaning that we do not have a systematic approach to improving value. Instead, a fragmented collection of approaches, most of which are based on individual encounters and reimbursement schemes, reward activity rather than impact. By contrast, a systematic approach would identify and deliver precisely the care that is needed in each case, for each person.

As TriZetto’s founder and chairman Jeff Margolis stated, “Systematic health management is about proactively looking across populations of people—from the healthy to the chronically ill—to help healthy people stay healthy, sick people not get sicker, and patients along the entire spectrum improve their health status. Systematic health management includes identifying and segmenting people into groups according to their health needs, developing a health improvement plan or patient ‘itinerary,’ and monitoring progress over time to ensure that health goals are met.”⁸

Put another way, systematic health management requires information, actions, and payments that are aligned to provide the right care to the right individuals in the right setting at the right time. This is easy to say, but incredibly difficult to do. However, in one form or another, that is exactly the challenge we must meet if we want to move beyond analyzing our problems to actually solving them.

Step 1: Defining the population to be served. Typically, most clinicians do not manage populations, they manage individuals; therefore, the first disconnect is between groups of individuals defined by disease category, insurance coverage, or employer affiliation versus individual patients. Solving this disconnect in the short run is extremely challenging, but newer care models, such as PCMH, episode-of-care payment, and ACOs, bring the notion of a population or group of individuals to the delivery system.

Even without these new structures, clinicians should appreciate that individuals are a population of one, meaning that an individual's needs are not defined solely or even largely by events surrounding a single visit; instead, a patient's health changes over a period of time. Most critical events and decisions occur between interactions with the delivery system, and some of the most critical factors are independent of the clinical visit itself. At the same time, those who consider individuals part of a defined population, such as payers and employers, should appreciate that populations are composed of individuals, and these individuals have unique needs based on their individual health and socioeconomic status, their educational level, their behavior motivation, and their insurance benefits.

Step 2: Determining the health needs of a population and the individuals within it. The critical difference between a population and an individual highlights the second critical step in systematic health management: specifically determining the health needs of a population and, more important, of the individuals who comprise it. Although this can be a complicated process, it comes down to determining the appropriate care for each individual, referencing evidence-based medicine guidelines when they exist. This can be relatively simple, such as a preventive health-screening test for everyone of a certain age, or a monitoring test for everyone with a specific condition, such as diabetes.

However, to truly ensure that warranted (vs unwarranted) care is delivered, it is essential to go beyond the one-size-fits-all approach and apply sophisticated analytics, behavior awareness, and preference-sensitive information to smaller groups of individuals. A form of "mass customization," this allows scarce resources to be applied to those individuals who need certain interventions the most. A simple but real example of this approach using commercially available analytics demonstrates the ability to target 10 times fewer individuals to achieve a better cost and quality outcome when the right analytic and behavior modification approaches are taken.⁹

A critical complement to the information that informs the right management approach is the application of financial reimbursement or incentives that

encourage individuals and clinicians to "do the right thing" (or to not do the wrong thing). This can take many forms, but for patients it means reward systems that promote taking specific actions that are known to improve their particular health status.

For clinicians it means providing the reimbursement and workflow support that reinforces the clinically appropriate recommendations and actions for an individual patient, even when they are part of a larger population.

Step 3: Management approaches that facilitate doing the right thing. The last step is the use of solutions and management approaches that make doing the right thing something that can be applied broadly without the need for new workflow or manual processes. This may take the form of information technology, new work processes, or organizational realignments, but in the end, these are all enablers of the ultimate goal: providing the right care to individual patients in a way that supports the clinical process.

Applying the Systematic Health Management

Approach: Value-Based Insurance Design and PCMH

Theory is good, but identifying specific health needs of individuals and designing interventions to promote the right actions are not trivial tasks. It is essential to take first steps; we can afford neither inaction nor passivity in addressing poor clinical outcomes and rising healthcare costs. However, when blunt cost-control measures are applied indiscriminately across groups of individuals, even small changes have shown dramatic and negative effects on quality for patients, especially those with chronic diseases.^{10,11}

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The good news is that many examples of pursuing the right strategy exist already, and recent healthcare reform legislation promotes widespread adoption. For consumers, programs to promote the right health activities for individuals are called value-based insurance design (VBID). These programs have generally been promoted by innovative employers and payers through customized and increasingly individualized benefit design. Typically, these programs take the form of reduced or eliminated copayments, incentives or rewards for preventive health screenings, completion of health risk appraisals and well-

ness programs, or elimination of cost barriers for critical medications.

Growing evidence consistently shows improved health, patient satisfaction, and decreased overall costs from using VBID, especially when focused on individuals with chronic illness.^{12,13} Notable examples include programs by Pitney Bowes; the city of Springfield, OR; the provider-sponsored Health Alliance Medical Plans in Illinois; and healthcare payer WellPoint, among many others.¹⁴

Encouraging patients to do the right thing is critical, but so is encouraging clinicians. Although there are many ways to support and incentivize clinicians, one of the most promising approaches to promoting individualized care is the PCMH model. In this model, physicians and their staff are given individual patient information and financial incentives to optimize care in conjunction with the patient.

Enabling processes and information can include the use of electronic medical records, electronic prescribing, extended office hours, automated reminder systems, identification of gaps in care, and appropriate referral support. Appropriate referral support consists of meeting outstanding care needs, appropriate referrals, evidence-based treatment options, and information necessary to make good decisions about treatment options. Several formal studies have shown improvements in quality, reduction in hospitalizations and emergency department visits, and improved patient satisfaction with PCMH,⁶ not to mention high clinician satisfaction.

How well do VBID and PCMH programs work together? Alternately, is there any systematic approach to encouraging patients and clinicians to do the right thing? The answer, to date, is no. VBID programs have largely been implemented independently of PCMH programs and often are driven by reasons other than those that drive PCMH.

This is not surprising, given the fragmentation of our healthcare (non)system, but the failure to coordinate patient and clinician incentives based on a common set of objectives can compromise the intended outcome and even create confusion regarding health goals. There is, however, increasing awareness that VBID and PCMH are 2 sides of the same coin, driven by a common set of objectives that the patient and the clinician should embrace and promote.

The Road Ahead: Long but Straight

Despite years of discussion, we are truly just at the beginning of systematic health management. There are now proven processes, case examples, technology, and policy directives that make systematic health management a true possibility and imperative, perhaps for the first time. The tough news is that the road is long. The good news is that the road is very straight and logical: determine what each individual needs to optimize his or her own health and then create processes and incentives for the patient and the clinician to promote that behavior. For most of us, moving forward is always better than being stuck in place—it is time to get on with it. ■

Author Disclosure Statement

Dr Rideout reported no conflicts of interest.

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