

EDITORIALS

Managing Superutilizers—Staying Patient Centered Is the Solution

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We have known for years that the distribution of healthcare expenditures in the United States is skewed, with a small portion of the population consuming a disproportionately high share of resources. In 2010, 1% of the population accounted for 21.4% of the \$1.3 trillion spent on healthcare.¹ Growing evidence documents that most of these high-cost patients are not receiving coordinated care, preventive care, or care in the most appropriate settings.² The term *superutilizer* describes individuals with complex physical, behavioral, and social needs who have frequent emergency department (ED) visits and multiple costly hospital admissions.³ Not surprisingly, multiple superutilizer programs and new funding opportunities target this population attempting to reduce their healthcare costs while improving their care, as public and private insurers shift to value-based care.⁴

Beginning in 2006, the Robert Wood Johnson Foundation supported the Camden Coalition⁵ with 3 grants to develop a community-based approach to identify high-utilizer patients and provide them with coordinated medical and social services.⁶ These programs include community-based teams that focus on the highest utilizers in a specific geographic area and provide intensive outpatient case management. Building on these efforts, the Center for Medicare and Medicaid Innovation (CMMI) awarded 2 Health Care Innovation Awards totaling \$17.2 million to target Medicaid superutilizers.⁷ Through its State Innovation Models initiative, CMMI also encourages states to pilot superutilizer programs to increase care coordination and support of persons with certain risk factors such as homelessness or mental illness.⁸ Additionally, the National Governors Association developed a 1-year, multistate policy academy to develop state-level capacity and state action plans that guide how to improve the delivery and financing of care for superutilizers.⁹

With all these ongoing activities in the setting of a paucity of research identifying the most cost-efficient practices to manage super-utilizers, we are glad to see

the *Journal of Hospital Medicine* publish an evaluation of a quality-improvement project targeting superutilizers.¹⁰ Mercer and colleagues at Duke University Hospital show that developing an individualized care plan and integrating it into their electronic health record (EHR) reduced hospital admissions, but not ED visits. Although we applaud the reportedly individualized patient approach and recognize the effort required to refer patients to a more appropriate care setting, we believe the researchers neglected 3 important components for the intervention: (1) patient engagement in developing individualized care plans, (2) care coordination integrated with community collaboration, and (3) feedback on continuum of care relayed back to providers. The managing strategies mentioned in the article seem to have evolved exclusively from the provider's perspective, a common mistake that the Patient-Centered Outcomes Research Institute emphasizes must be avoided. We are concerned about the lack of clarity regarding the "set of management strategies focused on providing high-quality care while limiting unnecessary admissions" reported by them. We fear this strategy was imposed on patients and not developed collaboratively with them. Effective interventions for superutilizers should do more than just guide providers' actions, but also connect services to the patient's needs. There should be coordination and continuous improvement of these efforts, which requires engagement of the patient and their community with feedback to the system.

Possibly most important, an individualized approach to superutilizers needs to be patient-centered—prioritizing patient goals and preferences, selecting interventions and services guided by the needs of the individual, and emphasizing modifiable outcomes that matter to the patient. Such a patient-centered approach goes beyond the individual patient to incorporate information about social support and family dynamics, highlighting the role of caregivers. Patients and their caregivers must be engaged or activated to ensure adherence to appropriate care and behaviors in any superutilizer programs. Additionally, individualized patient-centered care plans should be dynamic and bidirectional to accommodate changes in health priorities that may occur over time. Such lack of patient and community engagement may explain why ED-visit frequency was unchanged in their study.

The approach of having a Complex Care Plan Committee deserves attention as it appropriately included the right people at the academic medical center.

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However, why is it voluntary? Should not an important, or even essential, committee such as this be supported by the health system? Moreover, although the care plan developed by members of the committee possesses understandable aspects to be considered in a patient's care, why is this not shown to the patient for their input? Instead of being "done" to the patient, we recommend including patients in this process, believing such patient engagement would improve care further and likely yield sustained changes. We suggest the researchers remember the maxim "nothing about me, without me."

Patients who use the most healthcare services typically have complicated social situations that directly impact their ability to improve their health and stay well.^{2,11} Addressing the social determinants of health is not a new concept; however, creating healthy communities as a core responsibility of the healthcare industry is. Contributing to the dizzying state of change in US healthcare are efforts to shift to value-based purchasing and population health management.¹² This transformation from a fee-for-service hospital-centric industry into one focused on the continuum of care requires outreach into communities where superutilizers live. Ultimately, all healthcare is local, as this is where patients receive the vast majority of their care. Improving quality and reducing costs requires healthcare providers to work together on a collaborative mission that focuses on the needs of patients and community, not just efforts to reduce utilization. Even hospitalists must forge collaborative relationships with skilled nursing facilities and patient-centered medical homes.

Given the successes of some superutilizer programs,³ a key issue is how to scale or disseminate such labor-intensive highly individualized programs. Each patient has very complex and specific medical, behavioral, and social needs that require creativity and flexibility to adequately address these needs. Without question, patients and/or their caregivers should be members of the care team aiming to optimize their care. Unfortunately, our current healthcare system is not designed to address the complexity and uniqueness of each superutilizer. Nonetheless, summarizing patients' history into the EHR and integrating recommendations offers an opportunity to share information as originally hoped by the transition from

paper-based records. It additionally offers an opportunity to learn from use of this information as academic medical centers aim to become learning health systems.¹³ Future implementation science research in this area should assess how to scale patient-centered approaches to care, particularly for those with chronic illness and other vulnerabilities. We must eschew efforts that solely focus on reducing utilization by patients without involving them; after all, they are the focus of healthcare.

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