

# Individualized Care Plans: A New Healthcare Delivery Model

**MYRL WEINBERG, CAE**

President, National Health Council

The utilization of care coordination is increasingly recognized as one way to bring true value to the delivery of healthcare. The Commonwealth Fund, a private foundation that supports independent research on healthcare issues, issued a report in 2009 that identified “accountable, accessible, patient-focused, and coordinated care” as one of its goals. The report further envisioned “a health system that provides patients with personal sources of care who know their medical history, ensures timely access, helps coordinate care, and uses essential clinical data with an emphasis on health and disease prevention.”<sup>1</sup>

From the patient’s perspective, true value in healthcare (represented by the center dot in the **Figure**) incorporates both health research and the patient’s personal circumstances, which include the individual’s genetic, ethnic, religious, and socioeconomic status at the point of care. The National Health Council describes this scenario as balancing sound science (left side of the **Figure**) with patient-focused application (right side of the **Figure**). The best care coordination combines health and medical research, clinical expertise, and patient preference within a delivery system that pays for integrated care (bottom of **Figure**) and rewards compliance and adherence with limited or no out-of-pocket expenses (top of **Figure**).

## REFORM OF THE HEALTHCARE DELIVERY PROCESS

Jack Wennberg, MD, a leading US expert on medical practice variation, states that to improve the quality of healthcare and control costs responsibly, there need to be organized delivery systems that are “aimed at rationalizing care processes.”<sup>2</sup>

There is nothing more rational when it comes to the healthcare delivery process than focusing first on the end user of the system—the patient.

The Geisinger Health System in Pennsylvania began in late 2005 to implement new programs to improve patient

care, including the use of electronic health records and a personal health navigator to better manage chronic diseases. Preliminary results have been encouraging. Two pilot sites reported first-year results including a 20% reduction in hospital admissions and a 7% savings in medical costs.<sup>3</sup> Reforms to the healthcare delivery model, such as the Geisinger Health System programs, focus on helping patients proactively manage their health, which often prevents the need for more serious and expensive acute care after a health crisis.

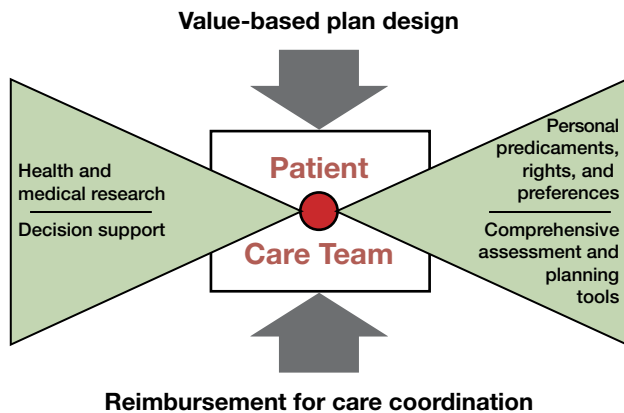
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## RECOGNITION OF INDIVIDUAL PATIENT PREFERENCES

By developing and implementing a specific care plan for each patient with complex chronic conditions within a coordinated care approach, evidence-based medicine is better aligned with the patient’s needs. To create such an individualized care plan (ICP), a healthcare provider would use comprehensive assessment tools to carefully consider the patient’s unique health history and lifestyle before recommending a treatment regimen. People have different life goals, process health information differently, and require different treatment plans that address their conditions and their own particular biologic makeup.

This is particularly true for the more than 133 million people with chronic diseases. Typically, they have multiple, complex conditions requiring treatment plans that weave together different medical specialties. The ICP would consider

**Figure. A Delivery Model for Patients With Chronic Conditions**



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the patient's age, sex, ethnicity, comorbid health conditions, support systems, cultural and religious beliefs, ability or willingness to make changes in nutrition or exercise, and the ability to take on complex medication regimens or other therapies, to name only a few considerations.

**REWARDS FOR COMPLIANCE AND ADHERENCE**

The healthcare needs of people with chronic diseases and disabilities account for approximately 75% of the healthcare dollars spent in this country.<sup>4</sup> Creating a care coordination delivery system to help this segment of the population better manage their health—as opposed to just treating their conditions in isolation—will address the dual goals of better outcomes and elimination of unwanted and unnecessary care. Government and private studies have found that much of the \$2.5 trillion spent on healthcare each year is for duplicated tests and unneeded procedures.<sup>5</sup>

For those patients with multiple complex conditions who drive the ever-increasing cost of healthcare in this country, it makes sense to provide ICPs. New delivery models (eg, the Geisinger programs) are proving to be the most cost-effective health reform strategies available. Combined with other recommendations, such practices could reduce the growth in healthcare spending by \$3 trillion by 2020 according to Commonwealth Fund estimates.<sup>1</sup> Patient adherence and compliance, which lead to better health outcomes, also increase when the patient's wants and needs are the focus of the treatment plan and out-of-pocket costs are within their means.

An ICP would come with explicit patient responsibilities: be a willing and engaged participant in the development and execution of an ICP and reap the benefits of lower out-of-pocket costs, or go back to the current

system where others make the healthcare decisions and the patient pays more.

**UTILIZATION OF A CARE COORDINATOR**

Hand-in-hand with health and medical research, personal patient preferences, and plan design is the need for a care coordinator to bring all the elements into alignment. Whether a care coordination plan is modeled after the Geisinger model or others being tested in this country, it must be flexible. The patient care coordinator might be a physician in some instances. In other cases, it might be a nurse or social worker. At times, the focus could be on strengthening the patient's body. At other times, the focus would be on preparing the patient's mind for inevitable death. Just as the life goals of a human being change over time, so too must the healthcare system be flexible to help the individual fulfill those life goals.

The National Health Council posed the concept of a care coordinator and ICP to several focus groups of patients and their family caregivers. Their initial response was that the concept is too good to be true. The more they talked about how this new model compared with the healthcare they currently receive, the more excited they became.

Their dream of a more normal life through a better designed healthcare delivery system should give us strength to make enhanced care coordination plans a reality.

**Author Affiliation:** From the National Health Council, Washington, DC.

**Address correspondence to:** Myrl Weinberg, CAE, President, National Health Council, 1730 M St NW, Ste 500, Washington, DC 20036-4561. E-mail: mweinberg@nhcouncil.org.

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