

Point of View

The Role of Health Advocacy in Disease Management

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ENTERING THE 21ST CENTURY, our system of medical care is increasingly complex, fragmented, and inefficient. From a user's perspective, the super-specialization of medical services, the incredible array of technology available for diagnosis and treatment, and the explosion in our understanding of genetics and the pathophysiology of disease belie the underlying frustration individuals feel when they cease being objective observers of a miraculous system of care and become "patients."

The health benefits environment is equally dysfunctional. An unrelenting spiral of increasing costs has placed our longstanding approach of funding payments (ie, employer- or government-provided insurance and health benefits) under siege. Total health spending in the United States now accounts for almost 15% of our Gross Domestic Product. Medical costs are increasing year over year at double-digit rates, far outstripping the ability of employers pressured by the competitive forces of a global economy to keep up. None of this even begins to address the cost of lost productivity as employees, sandwiched between their children and their parents, struggle to deal with medical issues during business hours.

Not surprisingly, with no place else to turn for relief, employers increasingly have shifted financial responsibility for the cost of health care to employees. In an effort to couch what is essentially a salary reduction in more comfortable terms, health policy pundits have

touted the value of putting the patient at the center of health care, noting that an empowered or "activated" patient is the best insurance against wasteful consumption, inefficiency, and even medical errors. As this year's presenter of the highly regarded Shattuck Lecture, Senator and physician William Frist wrote, "The focus of the 21st-century health care system must be the patient. . . . The new system must be responsive primarily to individual consumers, rather than to third-party payers. . . . Health care will not improve in a sustained and substantial way until consumers drive it."¹ At issue, however, is whether the average American is at all prepared to accept this responsibility. Being increasingly responsible for your own medical care does not automatically make you a better or smarter health care consumer.

THE WEAKNESS OF THE DISEASE MANAGEMENT MODEL

Patient care is and always must be the physician's responsibility. The role of third parties should be to support and, where possible, augment, enhance, and add value to this relationship. Most specifically, by using their capital to develop data tools to analyze the process and outcomes of care, compare it to internal and external standards, and report the findings to both practitioners and users, health plans have

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Health Advocate, Inc. is an independent consumer health advocacy and support organization. Information about the company can be found at: <www.healthadvocate.com>.

an unparalleled opportunity to improve the quality of, and reduce the variation in, the care that patients (members) receive. Disease management programs, whether done in-house or outsourced to specialized vendors, are the outgrowth of this data processing and interpretive ability, as those responsible for paying for care attempt to engage those with chronic illness and their physicians in better care management.

To be successful, disease management programs must engage both the treating physicians and the patient in the care process. Unfortunately, these external programs add another layer to an already burdened medical delivery system. Effective outreach is costly, and many initiatives are of questionable value, either because they are ill conceived or because neither the physician nor the patient pays sufficient attention to the suggested course of action. Is there any evidence that sending a postcard of general information to the family of a child identified as having “mild” asthma (because they filled a prescription for an asthma medication) is cost-effective or otherwise helpful?

Regardless, the most severe criticism of disease management programs is that they are poorly utilized. Although such programs are being embraced by health plans, employers, and the Centers for Medicare and Medicaid Services (CMS), there are few impartial, objective, and well-controlled studies approaching the rigor associated with other medical research that attest to their cost-effectiveness when applied broadly to large populations. Such research is hampered by the relatively small percentage of the targeted group who typically agree to enroll in the programs and who, once enrolled, continue to participate for a long enough time to allow us to measure meaningful outcomes. Although we recognize the long-term nature of the need for care of chronic diseases, budgetary priorities often force a focus only on short-term results and immediate cost savings. Skeptics point out that, even if one accepts that there is at least some information suggesting cost savings for those who participate in some programs, medical costs continue to rise.

THE ROLE OF HEALTH ADVOCACY

Disease management programs, even those driven by attempts at predictive data modeling, suffer by being reactive. The programs are perceived by patients and by some physicians as external to the patient care model. They are driven not by what individuals say they want, but by what the health plan believes their needs to be. They are an attempt to convince the consumer that he or she should want to take better care of their health in a particular fashion, and by their nature, these programs are at least a subtle indictment of the care the individual is (or more likely, is not) receiving. According to a survey conducted by the Kaiser Family Foundation,² 71% of consumers are at least “somewhat worried” that their health plan is more interested in saving money than in the best treatment for its members. Is it any wonder that so few people participate in programs managed or sponsored by their health plan?

Health advocacy turns this dynamic on its head. Rather than telling the patient what to want, we respond to those who contact us with a need. Rather than representing the insurer, we represent the subscriber. We advocate for the right answer, with no motive other than helping the employee to the best possible solution.

At the same time, the interaction allows the health advocate to suggest to the user that there are important other actions and services they might consider. For example, the subscriber may call because they feel that a bill for emergency room services was processed incorrectly by their health plan. We will work to get the adjustment made or clarify the benefit limits, whichever is appropriate. We recognize, however, that the individual only had a claim because they required and received care. The emergency room visit may have been necessitated by some complication of a chronic illness, like diabetes, and may reflect the fact that the subscriber has underlying issues with their care of their condition. In interventional models, this is referred to as a “teachable moment.” It affords the health advocate the opportunity to discuss care management, provide timely health information, and connect the subscriber to, for example, a disease management program sponsored by their health plan or em-

ployer. Contacted at another time, the member may have had little interest in the information provided by the disease management program. At the point of contact with their health advocate, they are more likely motivated to take action and more likely to participate in such programs. Although it is still early in our experience, *our* anecdotal information suggests that the involvement of a health advocate increases participation, compliance, and persistence in chronic condition care programs.

HEALTH ADVOCACY AS THE SINGLE POINT OF CONTACT FOR THE SUBSCRIBER

Health advocacy is a logical complement of a comprehensive approach to care support. Our programs are distinctly consumer focused. We are a single point of contact for the individual facing a health-related issue who has no idea how to get their need addressed. We serve as the human interface in what can be an all-too-impersonal system. We are the “anti-Internet,” the haven for those who press “0” to reach an operator when greeted by a voice response unit. We get a surprising number of cell phone calls from patients leaving their physician’s office who have no idea what their doctor said or what they are expected to do.

In our health advocacy program, half of what we are asked to do by our subscribers involves the administrative side of medicine: bills, benefits, claims, grievances, and appeals. The other half relates to clinical issues that range from identifying in-network physicians to treat complex conditions, to sorting through the list of participating primary care offices to find one with evening hours for a working mother. It does not matter whether the subscriber’s need is due to a work-related injury, an automobile accident, or their dental, pharmacy, or mental health benefits. The goal is to answer the question, address the concern, provide trusted information, and connect the caller securely to other resources appropriate to his or her needs. Our interface is with the treating physician, the health plan, and other caregivers and support services. When there are disease management programs in place, we make the connection to

them. When there are not, we play the role, attempting not to duplicate what others have been hired to do, but filling any gaps that exist in the subscriber’s medical delivery model. The result is a personal connection to care, a personal, human touch, and a more efficient and satisfying experience.

THE ROLE FOR HEALTH ADVOCACY

As costs increase and consumers bear a larger burden of responsibility for their own medical care, health advocacy programs will continue to grow in popularity. The challenge is to make health care more efficient and effective. Because we respond to the patient’s needs, we have the capacity to serve as a facilitator in a dynamic health care continuum, helping the patient navigate the complexities of the medical care system. We can provide trusted information, increase participation in disease management programs, and improve patient compliance with wellness initiatives. The result should be lower costs, improved patient satisfaction, and better outcomes.

Our medical system needs to become more user friendly and transparent. We harbor no illusions that we are fundamentally fixing the health care system in our role as health advocate. It certainly would be fulfilling if others were to examine the issues that consumers ask us to help them with and address the underlying problems plaguing the care delivery and benefits administration environment. In the meantime, we are just trying to help the average consumer cope.

REFERENCES

1. Frist WH. Health care in the 21st century. *N Engl J Med* 2005;352:267–272.
2. Kaiser Family Foundation. Health poll report (conducted August 5–8, 2004). Available: <www.kff.org/healthpollreport/archive_aug2004/4.cfm>. Accessed January 30, 2005.

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