

Is a Strategy Focused on Super-Utilizers Equal to the Task of Health Care System Transformation? No.

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Super-utilizers are like a siren song. If we could just heal these people, the reasoning goes, we will save enough money to invest in other important social needs, such as education and housing. For family physicians, the song is particularly seductive. Super-utilizers often combine multiple comorbid conditions with behavioral health challenges and poor living conditions, making them a wonderful fit for broadly trained family physicians who are comfortable working with teams across the continuum of care addressing behavioral and social problems. At last, family physicians become clinical rock stars, practicing heroic medicine like the cardiac surgeons of yesteryear. And it gets better: identifying hotspots can be done with relatively simple data systems, providing a portal for beginning to address the social determinants of disease and social justice.

A nice story—but perhaps too nice. We believe instead that a focus on super-utilizers as a sole strategy for health transformation may in fact distract from the real opportunities of health care reform and possibly harm the evolution of primary care.

A critical first issue is definition: super-utilizer according to whom? It is no accident that insurance companies and their foundations have been major funders of the development of strategies for implementing superutilizer interventions. The story of a patient getting over 150 CT scans in a year sells copy

and fits anyone's definition of a super-utilizer. In practice, however, an insurer desiring to tier physicians according to costliness differs from practices responding to complex patients and their needs. The elasticity of the concept—the top 1%, 5%, or 10% of utilization, denominators that vary by 3 orders of magnitude and vastly different protocols for refreshing and reviewing these populations—makes launching a “super-utilizer” intervention relatively easy. But this variation has huge implications for clinical strategy and makes evaluation and sustainability more difficult. *Caveat emptor!*

Beyond definitions is the question, on which population do we want to focus? An important distinction is between high utilizers and high utilizers we can do something about. Community Care of North Carolina,^{1,2} which has served as a model for Medicaid reform in many states, routinely distinguishes between these 2 populations. A focus on super-utilizers alone misses waste. There are many super-utilizers with conditions that prevent acute intervention, such as cancer patients getting a bone marrow transplant, and many patients who do not reach the threshold to be labelled “superutilizers,” but there are still great opportunities for efficiency. Another important distinction is between the “expensive” and the “about to become expensive:” the decision of when we should intervene varies from population to population. For example, in our regional uninsured initiative,³ the greatest initial savings have not been from a few individuals with dramatic stories—the proverbial burned-out schizophrenic with a coagulopathy living under a bridge—but rather from those patients receiving a primary care home and from simple case management for patients visiting the Emergency Department.

The focus on utilization alone, both by itself and as a proxy of overall cost, is also problematic, allowing the belief to persist that our health care problems boil down to cost only. This belief allows us to ignore our perva-

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sive problems with quality of care^{4,5} and patient experience.⁶ We must keep the Triple Aim in mind. Moreover, for insurers, foundations, and most importantly the clinically integrated systems that now employ the majority of family physicians, super-utilizer interventions seem a quick fix. Such interventions are attractive because they focus on dramatic cases and are amenable to a targeted, strategic initiative. The Advisory Board and several insurance companies are now promoting “extensivist” programs targeted at super-utilizers. In many settings, this is drawing investment away from the hard work of transforming primary care, by adding yet another layer to the multitude of providers serving a patient in a still fragmented delivery system.

Finally, sustainability of improvement projects is challenging, both programmatically and financially. Let us be humble: it is difficult to sustain outcomes over time. Regression to the mean explains the faltering of many reported successful quality improvement projects. There is an increasingly robust literature on sustainability of improvement programs; for example, for chronic care, sustained and committed leadership, culture change, incentives, staff development and job descriptions, and patient engagement are critical for long-term success. Of course, payment mechanisms for super-utilizer interventions will be critical. What else will be necessary for sustaining success?

So what is the role of super-utilizer interventions in the evolution of primary care? Our advice: don't be seduced by the siren song. The danger is in the distraction from the challenging and unsexy work of evolving the patient-centered medical home and improving the medical neighborhood.^{7,8} The key will be building super-utilizer interventions into office systems that can truly support patient populations with their varying levels of care by using an engaged and appropriately resourced care team. New approaches to advanced access scheduling that can address super-utilizer patients (and transitional care), embedded case management, IT systems necessary to drive care management, capacity to intervene outside of the office setting, and community-based infrastructure to coordi-

nate efforts with social services are all requirements of adequate office systems.^{9,10} Targeting a population on cost alone will not get us to where we need to go.

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