How big data, predictive analytics and strong relationships can improve patient outcomes and lower healthcare costs
By Vivek Garipalli

When it comes to healthcare for seniors, no one would argue that the managed care system is broken. Those that fall into the 65-plus demographic have a higher risk for chronic conditions like type-2 diabetes, congestive heart failure, dementia and arthritis.

They're more likely to be admitted and re-admitted into hospitals and nursing homes to recover which also drives up costs. In fact, in 2011, 93 percent of all Medicare spending was a result of patients with two or more chronic health conditions.

Although Medicare Advantage Plans and medical providers have technology and access to data, they lag decades behind when it comes to understanding and using that data, which leads to gaps in care, worse patient outcomes and rising costs.

Effectively leveraging big data and predictive analytics while also building strong relationships with providers is the only way to fix the system. In fact, a report by McKinsey & Company found that when various pathways enabled through big data are used, it can account for an estimated $300 billion to $450 billion reduction in healthcare spending.

Before we look at these solutions, however, let's delve deeper into the challenges facing managed care for seniors today.

An accountable entity doesn't exist
One of the biggest problems is a lack of an accountable entity for seniors' care. Although providers, caregivers and patients themselves may want to improve their health, how that care is delivered is rarely seamless or effective.

Here's a common scenario that plays out everyday in this country.

John has COPD, the third leading cause of death in the U.S. When John visits his primary care physician, they talk for just 8 minutes, maybe 15 if he's lucky.

During that visit, his doctor discovers that John also has high blood pressure and is depressed. When John leaves, he has a prescription for a steroid and an SSRI, as well as a referral to a cardiologist who prescribes a statin.

Since John is depressed, he neglects to take his medications on a regular basis. So it's no surprise that when he suddenly has chest pains, he's admitted into the hospital.

Yet because the hospital can't easily access John's EHR and his doctor doesn't even know he's there, he's discharged and prescribed medication this time for anxiety, which they suspect was actually the cause of his chest pain.

Now that John is back at home, who will be responsible for his care?

He might have a daughter who will research his condition, schedule follow-up appointments and make sure he takes his medication. But let's face it, most seniors will not have someone who can make caregiving their part-time gig.

Improving patient outcomes is not a priority
Health insurance companies are not clinical organizations. They're financial institutions: they collect cash and then pay it out. What's more, Medicare Advantage Plans are paid premiums on a risk-adjusted basis, meaning they assess and price that risk and use marketing to enroll their members.

Another problem is that most of their current strategies to lower costs include identifying the 5 percent of members who are the most expensive and then focusing their resources on trying to improve their conditions.

True, they may have technology platforms, but they're not using it for the purpose of improving patient outcomes.

Weak provider-payer relationships
Providers and payers are also notorious for being at odds. In fact, a recent survey by HealthLeaders Media found that more than a third of providers say that trust with payers needs to improve.

One of the reasons for this lack of trust is that Medicare providers are not adequately reimbursed and are paid only 80 percent of what private insurance companies do. As a result, providers have large patient panels, are forced to see too many patients in a day and lack the time to give each one of them the care they deserve.

What's more, although providers are experts in transactional care, they fall short when it comes to population health management.

How to fix a broken healthcare system
Although coordination of care is always a good thing, quarterbacking that care by taking the lead to ensure that not only all the pieces are in place, but that they work together too.

It's crucial that patients, providers and caregivers have every last bit of relevant information at the point of care so better decisions can be made which will lead to better outcomes.

For patients who are pre-diabetic for example, big data and predictive analytics can help to identify those who are at risk for developing type-2 diabetes and its associated complications.

Machine learning to build predictive models is another tool. By using a continuous aggregation of lab results, radiology reports, prescription data, call logs, information from

EHR's and physicians, the data can be abstracted and centralized. Natural language processing can take text and structure it and both structured and unstructured data can be pulled together for continuous, real-time monitoring.

Using a multi-touch approach, which includes phone calls and home visits, data can be pulled for additional insights, physicians can make better decisions about a member's health and workflow and collaboration can be improved to lower costs.

For John's, this model would mean that all of his providers know exactly what medications he takes, the hospital's discharge instructions and what he needs to do once he is home.

This is what true accountability looks like. It's not just data, it's understanding and leveraging that data to prevent adverse outcomes, close gaps in care and lower costs. This is the future of healthcare.

About Vivek Garipalli
Vivek Garipalli is a serial healthcare entrepreneur and turnaround expert focused on innovating to increase quality healthcare access and improving patient outcomes. In 2008, Vivek founded CarePoint Health, a fully integrated healthcare system in New Jersey. Through his role at CarePoint–whose mission is to serve uninsured and underinsured patient populations–Vivek experienced the misalignment of providers and insurance companies first-hand.

Prior to CarePoint, Vivek owned and operated various outpatient facilities. He began his career in finance, holding roles at Credit Suisse First Boston, J.P. Morgan Partners and Blackstone Group.

Vivek is active in health tech, serving as a board member of Flatiron Health and Doctor Evidence. He earned an undergraduate degree in business administration at Emory University with a concentration in entrepreneurship.

About Clover Health
Clover Health is reinventing the health insurance model by using its data and analytics platform to identify at-risk members and intervene with its care management team to proactively improve health outcomes, fill gaps in care and reduce avoidable costs. Built with technology at its core, Clover aggregates and structures data from a wide range of sources – from primary care providers and lab results, to customer service interactions and home visits – for continuous, real-time monitoring. Clover is headquartered in San Francisco. For more information, visit www.cloverhealth.com.