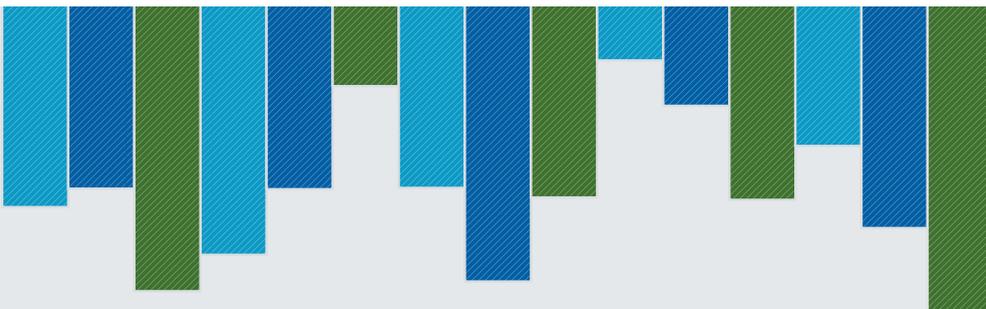# Paving a Path for Better Polychronic Care

How Collaboration, Prioritization, and Engagement Can Improve Outcomes

Heather Cianfrocco
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There are several challenges standing in the way of helping polychronic patients. One of the most significant is the lack of collaboration and interoperability within the health system. Taking it a step further, our health system was largely built to manage single transactional episodes of care. Bridging the gaps for more connected care while championing access to information is the foundation for more effective treatments—whether it's tied to helping individuals navigate the health system or sharing data between care providers, pharmacies, and health plans.

By 2030, an estimated 83.4 million people in the U.S. will have three or more chronic conditions—compared to 30.8 million in 2015.[1] People with polychronic conditions are:[2]

- Less likely to feel like they have control over their health

- More likely to struggle with managing stress

- More likely to feel their health care costs are higher than expected

- Much more likely to worry about the future of their health

In addition, people with polychronic conditions spend significantly more on health care than those without chronic conditions. In fact, spending on individuals with multiple chronic conditions is eight times more than that for healthy people.[3] However, approximately half of people with polychronic conditions do not understand the health care services and benefits available to them.[3]

There are tremendous opportunities to work together and focus on the "whole person"—building a system from the patient's point of view that gets to know their care preferences, how they're managing all their conditions, what struggles they're facing, and what can be done to help support them. By understanding more, we can better treat and engage individuals and put them at the center of their care.

The following white paper examines how health services leaders are working to better understand the polychronic population and bridge gaps in the system for more connectivity. It also examines the need for care prioritization and how having access to the right information allows for a more nimble focus on the patient—all efforts that can lead to improved quality of life and better health outcomes, and help change the trajectory of health care costs.

At Optum, we see not just challenges—we see possibilities. We are constantly growing, developing, and innovating because we believe that the needs of our partners, in service of the patients they serve, will continue to grow, develop, and change just the same. We're working to enable connections between people, health and social systems, and technologies that will ultimately improve delivery and access to care—creating a more agile, responsive, and equitable health care system for everyone. And we won't rest until we do.

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Paving a Path for Better Polychronic Care
How Collaboration, Prioritization, and Engagement Can Improve Outcomes

The United States health ecosystem was originally designed to treat transactional episodes of care, such as illness and injury. Today, however, consumers' needs are more complex, which is placing considerable stress on the health care system.

This stress is in large part due to the rise of polychronic cases—or people with more than one chronic disease. These individuals are diverse both in socioeconomic and cultural backgrounds and in the complexity of their health needs. People with polychronic conditions require extra attention to help them understand their conditions and interdependencies, comply with their care plan, and navigate a complicated health care system.

Today's health care system is not designed to effectively care for polychronic patients, says Rozalina McCoy, primary care physician and researcher at the Mayo Clinic in Rochester, Minn. "Our health care system today is often fragmented, compartmentalized, and disease-centric, which prevents good care," she says. "Patients are triaged to a variety of specialists who each work on a single disease in a silo, and this can result in conflicting, contradictory, or inconsistent messaging to the patient."

To better serve this growing population, the health ecosystem must fundamentally change to treat the whole person—not just the disease or a particular health episode. To do this, providers and payers must consider social determinants of health and health equity when coordinating access to health services, and they must make a concerted effort to improve patient engagement. Solutions that address polychronic pain points are necessary too, and they require data sharing among health care partners and patients.

"Doctors need shared information [from health system partners] and better access to it, and patients need to participate in the care plan. A lot of this is impossible unless the system better supports them," says Jonathan Weiner, professor of health policy, management, and health informatics at Johns Hopkins University.

HIGHLIGHTS

Polychronic patients, or people with more than one chronic disease, are a **rapidly growing subset** of the population.

Improving **data sharing and collaboration** within the health ecosystem is key to reimagining health care.

To better serve polychronic people, the health care system must **abandon transactional care and reinvent its processes, priorities, and systems** with whole-person care at the core.

> "Doctors need shared information [from health system partners] and better access to it, and patients need to participate in the care plan," says Jonathan Weiner, professor of health policy, management, and health informatics at Johns Hopkins University.

Through research with leading industry experts, this paper examines polychronic individuals and the challenges they face in today's health ecosystem. It will explore the opportunities for and the limitations of data sharing and interoperability, the ways in which collaboration can both improve the quality of their care and prevent chronic disease in the future, and why a people-centered approach is key.

Understanding the Polychronic Population

Polychronic individuals, or people with multimorbidity, are a rapidly growing subset of the population. According to the Centers for Disease Control and Prevention's National Center for Chronic Disease Prevention and Health Promotion (CDC's NCCDPHP), six out of 10 adults in the United States have been diagnosed with one chronic disease and four out of 10 have been diagnosed with two or more. **FIGURE 1**

Polychronic individuals present differently depending on age and gender. Those over the age of 55, for example, are primarily affected by multiple physical conditions, while younger age groups are more likely to experience mixed physical and mental health conditions. In men, cardiovascular metabolic disorders tend to be more prevalent, while women are more likely to experience psychogeriatric diseases.[1]

Of the 10,000 recognized diseases, the top 10 most common include diabetes, hypertension, obesity, chronic obstructive pulmonary disease, asthma, hyperlipidemia, cancer, cardiovascular disease, depression, and osteoarthritis.

As a result of their complex medical needs, the polychronic population consumes a disproportionate amount of health care resources. According to the CDC's NCCDPHP, 90% of the nation's $3.5 trillion in annual health care expenditures are for people with chronic and mental health conditions. According to Johns Hopkins University, people with five or more chronic conditions comprise about one-fifth of the Medicare population yet consume two-thirds of the program's spending. In addition, care providers are most likely to see polychronic patients, who account for up to 80% of their yearly consultation visits.

These factors place a burden on the health care system, and they're also stressors for clinicians. "Managing all these diseases and different combinations of diseases is very tricky," Weiner of Johns Hopkins says. "It can be overwhelming for both the doctor and the patient."
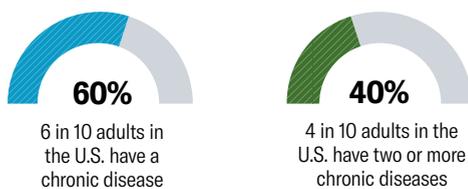
Doctors don't provide care to polychronic patients in the same way they do patients without multiple chronic diseases because polychronic patients' conditions often complicate treatment plans. For example, if a non-polychronic patient presents with cold symptoms, the Mayo Clinic's McCoy explains, a clinician will determine whether the infection is viral or bacterial and prescribe antibiotics, if appropriate. But in diabetic patients—who are frequently polychronic—treating cold symptoms is far more complex. The stress response of the illness can cause the patient's blood sugar to increase, which could cause deterioration in their blood pressure that may ultimately lead to heart failure. These issues can occur if the clinician only treats the acute problem without contextualizing the whole person, she says.

"Unfortunately, it becomes this vicious circle where multimorbidity feeds on itself and causes even more progressive decline," McCoy adds. "We have to think about how [polychronic patients'] chronic health conditions are affecting their functional status incapacity and ability to take care of themselves, too. They need to take care of

FIGURE 1

Polychronic Cases Are Widespread

More than half of U.S. adults have at least one chronic disease

60%
6 in 10 adults in the U.S. have a chronic disease

40%
4 in 10 adults in the U.S. have two or more chronic diseases

U.S. Annual Health Care Costs = $3.5 Trillion
Chronic diseases are the leading causes of death and disability and leading drivers of the nation's $3.5 trillion in annual health care costs.

Source: Centers for Disease Control and Prevention's National Center for Chronic Disease Prevention and Health Promotion, September 2020

themselves to improve their chronic conditions, and their chronic conditions often prevent them from doing so."

The Obstacles and Opportunities of Data Sharing and Collaboration

Reimagining care delivery to better serve polychronic populations hinges on improving data sharing, data interoperability, and collaboration within the health ecosystem.

Patients today generate droves of data on everything from diagnoses and treatments to lab tests, medications, and more. This information is stored in various health information systems using different formats, which creates interoperability challenges. When clinicians and providers need to exchange information on tests, clinical notes, or X-rays, for example, they're left searching for and deciphering data from disparate, siloed systems.

But increasing data sharing among health care organizations is widely supported by the industry, a 2019 Harvard Business Review Analytic Services survey of health care professionals found. Eighty-four percent of respondents agreed on some level that it can have a significant improvement on health care reform efforts, with 51% strongly agreeing and 33% somewhat agreeing.

The survey also asked about top priorities for the health care system now and in five years. Improving patient satisfaction (66%) was the most-cited answer for current top priorities, and increasing communication/collaboration with health care organizations was the second-most-cited (41%). In five years, though, the gap between these two priorities closes: 48% say improving patient satisfaction will be a top priority, and 47% cite increasing communication/collaboration with health care organizations. **FIGURE 2** These results show that many health care professionals see collaboration only growing in importance.

Despite overwhelming support, however, data sharing and collaboration remain some of the most significant obstacles in reimagining care delivery for the polychronic population. If data cannot be easily shared among clinicians, providers, and health plans, collaborating to care for these patients remains problematic.

"A typical doctor that most patients see doesn't know so much about what else is going on with the patient," Weiner says. "The [electronic medical record] can make it better—but it can also make it worse. More often than not the data is dumped in there and doctors have to go searching through it. So, part of [the problem] is interoperability, and part of it is presenting what's relevant."

Improving this lack of data sharing has the potential to positively affect major pain points for polychronic people, including polypharmacy, and even to impact disease prevention.

Polypharmacy, or the concurrent use of five or more chronic medications—has dramatically increased, affecting nearly 40% of adults 65 and older, according to a study published in the *Journal of the American Medical Association*.[2] Weiner says that managing polypharmacy in polychronic people is a challenge not only for the patients, but for clinicians, too.
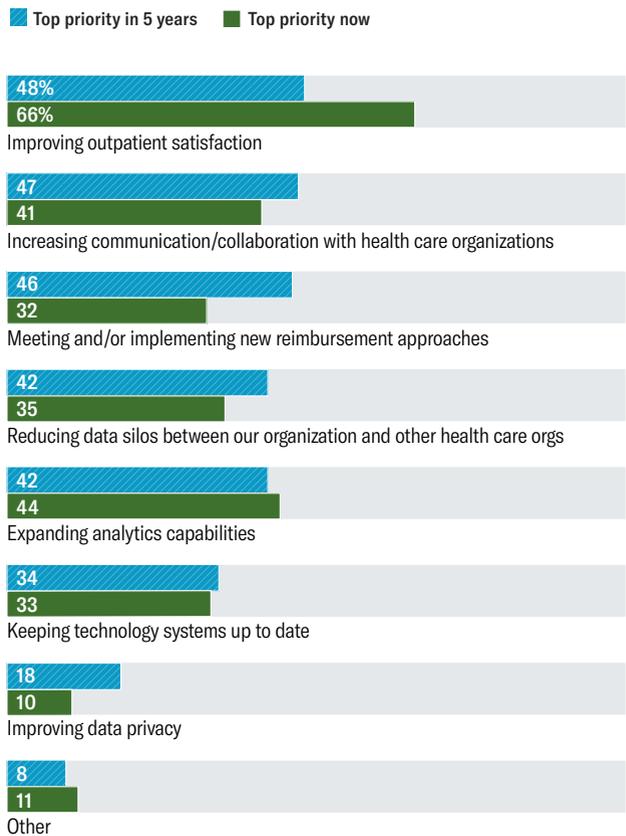
"You have 'doctor one' who orders one drug and 'doctor 10' who orders something else. Because systems don't always speak to each other, doctors don't always know what the other has ordered," Weiner says. "That's obviously dangerous for polychronic [patients], because medications pile up."

One of those dangers includes adverse drug events (ADEs), or injuries resulting from medical interventions related to a drug. These include medication errors, adverse drug reactions, allergic reactions, and overdoses. In one population-based study, outpatients taking five or more medications had an 88% increased risk of experiencing an ADE compared to those who were taking fewer medications.[3]

FIGURE 2

Priorities for Health Care

Improving user/patient satisfaction tops the list

■ Top priority in 5 years ■ Top priority now

	Top priority in 5 years	Top priority now
Improving outpatient satisfaction	48%	66%
Increasing communication/collaboration with health care organizations	47	41
Meeting and/or implementing new reimbursement approaches	46	32
Reducing data silos between our organization and other health care orgs	42	35
Expanding analytics capabilities	42	44
Keeping technology systems up to date	34	33
Improving data privacy	18	10
Other	8	11

Source: Harvard Business Review Analytic Services Survey, November 2019

"Before all of this technology really becomes useful, the data needs to be accessible and it needs to be interpretable," says Rozalina McCoy, primary care physician and researcher at the Mayo Clinic in Rochester, Minn.

Data sharing could also improve medication adherence—a common problem among polychronic populations, says Thomas Lundquist, senior vice president and chief medical officer of Sentara Health Plans. Polychronic individuals may struggle to adhere to their medication regimen for any number of reasons, he says. Sometimes they simply forget to pick up a prescription or they're unclear about dosing. In some cases, people stop taking a medication because they've experienced negative side effects or because they feel better. Often, these deviations aren't reported to their physicians, compounding problems later.

"I think there's a big opportunity to take the pharmacy data that comes in through a variety of sources to a health plan and share that with the provider organizations, where we're allowed and able to," Lundquist says. "This would give providers real-time data around people fulfilling and adhering to medications. It could also help providers see if their patients are taking their medication properly and encourage the provider's office to ask about side effects, concerns, or questions."

In addition to alleviating polypharmacy management issues, data sharing also has the potential to impact research on multimorbidity. Today, data sharing is helping providers better understand disease trajectory and its connection to prevention, says Thomas Wan, former associate dean for research at the University of Central Florida.

"By studying epidemiological profiles, we're able to estimate the trajectory or likelihood of a condition and how it will emerge into polychronic conditions. The question is how to use this information in a clinical decision support system," Wan says. "A patient has type 2 diabetes, then a heart condition, then a kidney condition. But what's the process? And what are the interventions? The industry needs to spend time and resources on understanding the trajectory pattern." Predictive analytics that facilitate early intervention and prevention is still in its infancy, Wan adds.

In many instances, clinicians and health systems are actively using data to prevent conditions from progressing or deteriorating, McCoy says. In diabetes patients, for example, data is generated from continuous glucose monitors, insulin pumps, and Bluetooth-enabled glucose meters. This data can be uploaded into a patient portal where clinicians review it to identify whether doses should be altered or whether numbers outside predefined parameters should be explored further. Spotting these problems early can prevent conditions from progressing, reducing health care expenditures and the burden on the patients; they don't need to call their doctor with a health problem or wait months to discuss it at their next appointment.

Theoretically, the integration between diabetes equipment and patient portals should be seamless, McCoy says, but it's not. "In order for me to see my patient's blood sugar data without them coming into the office to see me, they either have to give me their individual passwords to their accounts, or they need to push that data to my provider-level account," she says. "There's no seamless integration with their electronic health record or the data being generated on my end."

McCoy says that the industry needs to come together to focus on how to enable data sharing among constituents. This task involves breaking down silos and synthesizing data into a manageable framework to make it usable. "Otherwise, it's just a stream of data that's not useful—and we're already overwhelmed with information as primary care clinicians having to take care of every aspect of our patients' health," she says. "Before all of this technology really becomes useful, the data needs to be accessible and it needs to be interpretable."

Engaging Polychronic Patients in Their Care

Polychronic individuals play an important role in improving the management of their diseases. When engaged, they actively participate in activities that promote physical and psychological health, interact with health care providers, adhere to treatment recommendations, monitor their health status, participate in decision making, and manage the impact of the illness on their physical, psychological, and social functioning, according to a study in the *Annals of Family Medicine*.

Historically, however, engaging this population has been difficult, Sentara's Lundquist says. Polychronic individuals often suffer a mental burden of managing multiple chronic conditions, experience health care literacy limitations, and are affected by disparities in health. These barriers to engagement jeopardize successful disease management.
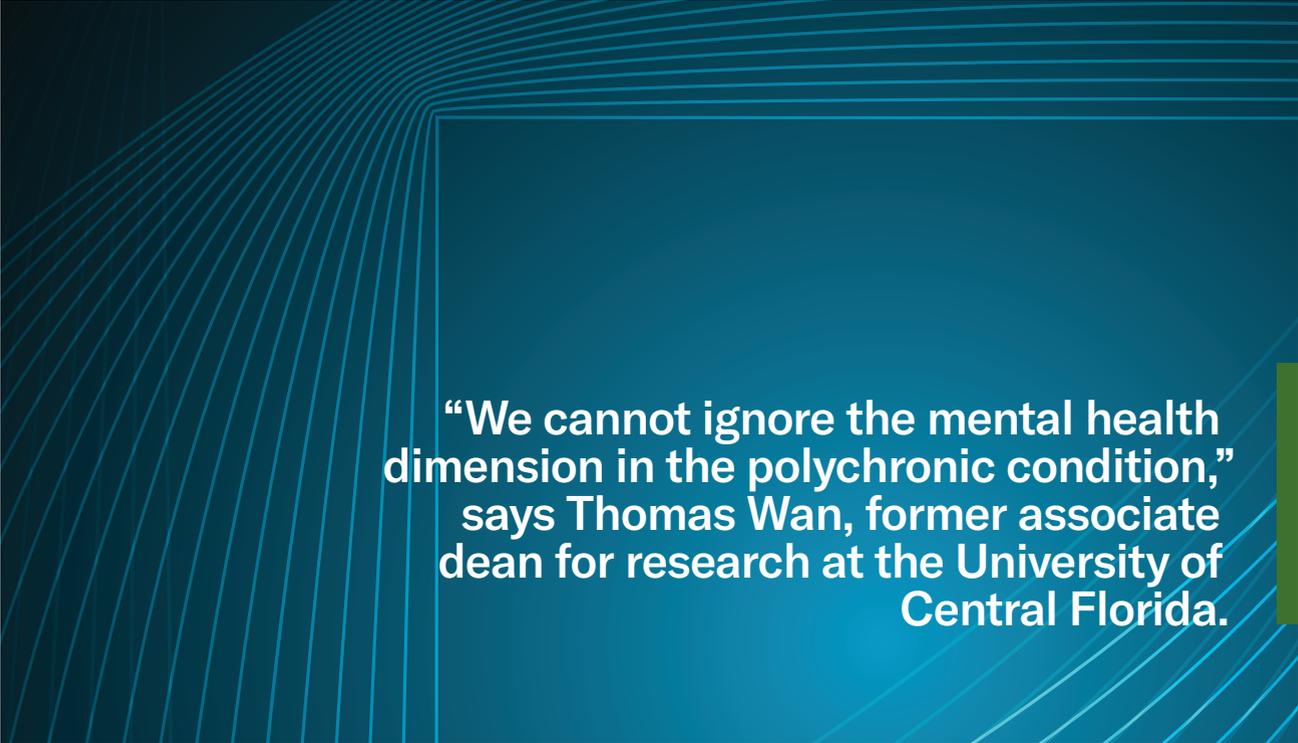
> "We cannot ignore the mental health dimension in the polychronic condition," says Thomas Wan, former associate dean for research at the University of Central Florida.

For polychronic patients, managing multiple doctor appointments, new diagnoses, care plans, and medications is stressful and overwhelming, McCoy says. As a result, there's a strong correlation between physical and mental health disorders. Diabetics, for example, can experience "diabetes distress," she says. This circumstance is an emotional state in which people feel stress, guilt, or denial from living with diabetes and the burden of self-management.

"We cannot ignore the mental health dimension in the polychronic condition," Wan says. "We focus a great deal on physical medicine—but without really understanding the underlying reasons why there's such resistance to follow the medical advice or self-care."

Clinicians, McCoy adds, have limited time to spend with patients, making it difficult for them to truly understand the impact that a patient's conditions or the treatment plans for these conditions are having on them. "If a patient can't tell us that they're struggling because the clinicians are really stressed for time, and there are no other ways for us to elicit their struggles from them, it's difficult to help," she says.

Relieving this mental burden starts with developing a system in which the health care team places the patient at the center of the experience, McCoy says. "We need to understand from the patient's perspective what they're able and not able to do, what struggles they're facing, and what we can help them address in terms of providing additional resources or support," she says.

Alongside the emotional burden that halts engagement is the difficulty members often have in understanding their health care benefits, Lundquist says. Engagement is complicated by a misunderstanding of what's covered by their benefits and how their plan can advocate for them, he explains. "They're not sure what to ask, when to ask it, who they can turn to for help to understand and clarify treatment goals, or what to expect of their ongoing care and their benefit coverage. We need to get much better at delivering meaningful health care education to our patients and members."

At Sentara Health Plans, there's an effort to improve engagement and health care literacy that includes the use of artificial intelligence (AI), Lundquist says. The company hopes to use data from members—such as a lab value from a physician's office, a new diagnosis code, or someone engaging in health care services—to provide individuals with helpful information at a time they might need it most. If a polychronic person develops a new condition, for example, that diagnosis would flow through the system, triggering AI to push to the user any information about a diet that might help better manage that condition or other relevant information, he explains. While this relay system is close to happening at Sentara, there are obstacles, including whether to build the capabilities in-house or partner with a vendor, as well as the challenge of evaluating cost versus benefit.

Looking through the patient's eyes means payers and providers need to understand challenges around access to health care services—another issue that's prevalent in polychronic people and one that impacts engagement.

"I think the challenge in improving engagement is making sure that we get this information in front of the [individual] when they need it. The next big jump we all need to make to improve this is making that information available in the right way, to the right patient, when they and their care team is most able to receive it," Lundquist says.

For Sachin Jain, MD, president and CEO of SCAN Group and SCAN Health Plan, improving engagement in polychronic people starts with a focus on simplification. "Health plans need to partner much more closely with provider organizations to create a higher degree of seamlessness and integration than presently exists," he says. "Instead, we send [patients] bills and coverage determinations that don't necessarily make sense and provider directories that are hard to decipher. We need to look more through the lens of the patient."

Looking through the patient's eyes means payers and providers need to understand challenges around access to health care services—another issue that's prevalent in polychronic people and one that impacts engagement. These patients, for example, attend nearly 16 clinician appointments per year—about four times the number attended by non-polychronic patients, according to a 2015 observational study on multimorbidity and health care costs in elderly people, published in *BMC Health Services Research*. This appointment load requires a great deal of planning, time, and coordination of personal schedules and transportation, Weiner says, ultimately hindering their motivation to engage. "These people would simply rather not spend all this time [with doctors]. It's not easy for them to constantly see themselves in sick roles. They'd rather do what they enjoy most."

The Covid-19 pandemic has highlighted opportunities to reduce the number of in-person appointments for all patients through telehealth and remote monitoring, Jain says. Applying the lessons learned during this period can greatly improve patient access for polychronic people, too.

"We need to meet people where they are. If you can get somebody who's never used a tablet to use one, that's an extraordinary success," he says. "At the same time, sometimes we tend to overcomplicate things. Through [the pandemic], we're seeing that many things that required an in-patient visit can be dealt with by tablet or telephone."

McCoy's practice, for example, is working to improve patient engagement through telehealth. The practice appointed "health navigators" who call patients prior to their appointments to teach them how to set up their portal and help them practice using the tools for video visits. For polychronic patients, this personal attention has been tremendously useful during the pandemic and will continue to help patients attend multiple doctors' appointments with ease, she says. Nurses embedded in primary care teams have also been working closely with patients by telephone and portal, both before and during the pandemic, to support their diabetes management and overall health. "We need to think creatively as a health system about how to engage patients, be more innovative, and be willing to do the work to get our patients connected."

Although technology has great potential to improve the engagement of polychronic individuals in their own care, providers and payers must consider the wide range of disparities that limit access to care in this population.

Health disparities—or the particular differences in health that are closely linked to social, economic, and environmental disadvantages—adversely affect people who have systemically experienced greater obstacles to health based on ethnicity, religion, socioeconomic status, gender, age, and geography, according to the Office of Disease Prevention and Health Promotion.

Studies have shown that older patients and people from lower social classes are more likely to be affected by multiple chronic conditions. The latter are also found to develop multiple conditions earlier in life—up to 15 years sooner—compared to more affluent counterparts.[4]

People with health disparities from socially diverse populations face unique health-related problems, which add to the complexity of polychronic care, research shows. Individuals from marginalized groups, for example, face challenges related to low language proficiency, poor health literacy, and care from culturally and ethnically discordant providers, all of which present challenges in engaging in their care.[5]

For polychronic individuals from low socioeconomic populations, significant financial barriers exist in accessing care. Limited accessibility increases out-of-pocket spending while discordant treatment plans from multiple providers overwhelm them.[6]

"Disparities in health care access are a huge problem," McCoy says. "Some people are homebound due to their age or

"If a patient has created a trusting relationship with their doctor, the patient is going to share more than they otherwise would, like what's most important to them and what's affecting their ability to cope with their illness," says Thomas Hutchinson, professor of medicine and director of the McGill Programs in Whole Person Care at McGill University.

chronic illnesses, or they may not live close enough to a large medical center or a specialist they need, or even a primary care physician." Telehealth offers the ability to engage with these patients, but there are barriers to this approach, as well. Older patients may not feel comfortable using technology to communicate, while others may not have access to a smartphone, tablet, or computer due to costs. Other patients, especially those in rural areas or without stable housing, may not have reliable broadband internet.

During the pandemic, McCoy's practice implemented remote patient monitoring for people diagnosed with Covid-19 who are at increased risk for experiencing complications or are symptomatic. Patients received a kit with an iPad and sensors to monitor their vital signs and symptoms. To address connectivity disparities, the iPads were cellular-enabled, McCoy explains. Remote patient monitoring reduced the number of unnecessary appointments, provided a seamless connection with a clinical team that was available around the clock, and improved patient access for those without reliable transportation.

Prioritizing Whole-Person Care

Polychronic individuals are complex, with needs that extend beyond the confines of traditional, transactional care. In order to better serve this growing population, the health ecosystem needs to rethink its health care delivery by embracing a people-centered approach. This strategy is called whole-person care—a deliberate focus from clinicians on the whole person, not just the condition they're treating.

A people-centered approach reduces the friction and shortcomings that polychronic individuals experience in managing their diseases. Rather than treating only the condition and physical symptoms, for example, whole-person care aligns individual care preferences with mental and behavioral solutions while also understanding socioeconomic and environmental factors. Whole-person care provides individuals with experiences that place them at the center of their care and enables doctors to better understand individuals, their concerns, and their problems. It also eases emotional

burdens, boosts engagement, and improves adherence to their treatment—ultimately driving better health.

"Medicine starts with trying to fix what can be fixed. But for people with multiple chronic diseases, not everything can be fixed," says Thomas Hutchinson, professor of medicine and director of the McGill Programs in Whole Person Care at McGill University. "That's when people need support in coming to terms with, being able to live with, and seeing possibilities in their lives in the presence of, a diagnosis—a process we call healing."

He shares an example of an individual with diabetes who is later diagnosed with kidney disease. After beginning her dialysis treatment, the patient mentions to her doctor that she's overwhelmed by the frequency of the treatments, which last four hours a day, three days a week. The patient relies on public transportation to get to and from the clinic, Hutchinson says, which is also a financial burden and increases her weekly time commitment.

Hutchinson says it's important that her doctor doesn't neglect or dismiss these feelings; instead, the physician should explore them and incorporate them into her treatment and management plan.

"If a patient has created a trusting relationship with their doctor, the patient is going to share more than they otherwise would, like what's most important to them and what's affecting their ability to cope with their illness," he says. "Not only is it important that [the patient] is heard, but it also might make a difference in what [the doctor] does. [The doctor] needs to think about an arrangement that presents the smallest imposition while still being effective."

That's why relationships between doctors and patients are key, Wan says, and should be cultivated through increasing the standard allotted time with clinicians. "We focus a great deal on physical medicine, but without really understanding why a patient might be resistant to or have trouble following medical advice," he says. "It's very important that we don't ignore the mental health dimension to improve care management and achieve better outcomes."

According to the *New England Journal of Medicine*, whole-person care should be collaborative, coordinated, and

According to the *New England Journal of Medicine*, whole-person care should be collaborative, coordinated, and accessible.

accessible. In treating patients, care providers should take into consideration patient and family preferences, values, cultural traditions, and socioeconomic conditions. Patients and their families should play an active role in decision making, with physical comfort and emotional well-being as the top priorities.

"It's important to stress the value of listening," Hutchinson says. "If you ask patients what they want from a doctor, the first thing they will usually say is they want someone who listens, empathizes with their situation, and supports them in living with and growing with the disease."

While this relationship goal is the gold standard for treating polychronic individuals, it's not yet the norm, Hutchinson says. "Medicine has become busier and we have become a little more mechanized. We need to establish more of a balance between curing and healing." To facilitate a stronger focus on whole-person care, doctors need to be trained to be more mindful and present, he explains.

"It's true that time is an issue for physicians, but it doesn't actually take that long to make a connection with someone," Hutchinson adds. "For these people, it's just important that someone sincerely cares about them. We need to be relating to them and interested in them as a whole person."

Conclusion

To better serve the growing polychronic population, the health ecosystem must abandon the outdated model based on transactional care and reinvent its processes, priorities, and systems with whole-person care at its core.

"Whole-person care really needs to be our main focus," McCoy says. "Unless we can care for the whole person, nothing we do is really going to work in the end."

Reimagining care delivery for this population is largely dependent on creating a better-connected and intelligent environment that's fueled by improved data sharing within the health ecosystem. Not only can reimagining care delivery reduce common polychronic pain points and identify individuals at risk of developing additional diseases, but it also enables better collaboration among all people who empower the patient—from the doctors to the health plan administrators to the providers.

Addressing the mental burden of managing care, boosting health care literacy, and improving access to health services are factors that will improve engagement in the polychronic population. Engagement, in turn, improves outcomes in chronic care management. While systemic changes are necessary in order for clinicians to spend more time with patients, technology also plays an important role. Health disparities must be considered when designing, implementing, and evaluating new and existing programs.

"The health care system today is really good at treating the body part or condition, but each of us is more than that. We're an entire person," Weiner says. "People need a support system. They need better primary care. Data helps to achieve these goals—but it's not only about the latest technology. It's about using data efficiently and effectively as one piece of caring for the whole person."

Endnotes

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