IQVIA INSTITUTE
FOR HUMAN DATA SCIENCE

Advancing Person-Centric Healthcare

IQVIA Institute Perspectives from Human Data Science Lab 2

The concept of the "patient" is evolving, driven by changes in society, demographics, culture, healthcare, science, and technology. Fundamentally, the term "patient" as an identifyer is too narrow, too passive, and maybe even antiquated as we think about the way we as individual human beings live, manage our health, and interact with the healthcare system today.

The discussion about broadening the concept of the patient to focus more on the person and less on the disease is not new. It was articulated by William Osler in 1899 with his famous edict about caring more for "the individual patient than for the especial features of the disease." [1] And it was taken a step further in 1934 when A.H. Gordon urged the medical community to "treat a patient as a person, not merely as a representation of medical, surgical or pathological material." [2]

The healthcare industry – including providers and the life sciences sector – began to promote this idea a couple of decades ago with the concept of "patient-centered care," which later evolved into "patient-centricity." However, the question is whether industry has been able to fundamentally take this approach beyond a marketing slogan. If we are honest in our self-reflection, such good intentions have not been matched by tangible changes in the behavior of the healthcare industry and in the delivery of services directed at individual people.

The moment is ripe to rethink the concept – and even the terminology - of the patient. Chronic conditions are on the rise, leading to comorbidities and multidisease states that complicate a discrete descriptor; new players among technology companies and consumer retailers are joining the healthcare fray, and bringing with them

new ways of thinking about their audience; and the impact on consumer behavior from digital technologies, and the urgent need to address health inequalities in society run as an ever-present force, creating momentum and shaping ideas.

To discuss this important topic, the IQVIA Institute for Human Data Science convened a multidisciplinary panel representing patient advocacy groups, academic research, life sciences industry, healthcare providers, technology companies, consumer retailers, and healthcare advertising.

This was the second Human Data Science Lab, an interactive, open discussion of game-changing topics in medicine, academic research and health policy designed to advance the understanding of challenging issues and explore new territories for research and solutions in human health.
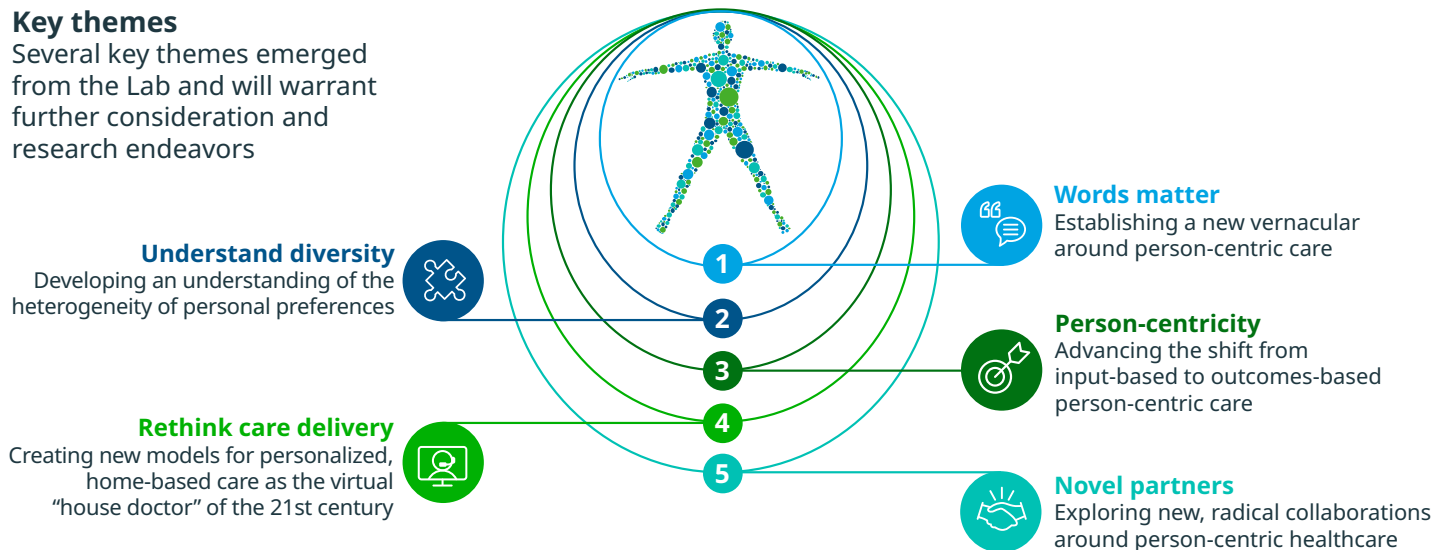
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This second Lab, titled *"Evolving the Understanding of the Patient. Exploring paths from a disease-centric to a human-centric model"* generated a thought-provoking and inspirational discussion around this topic and yielded a number of new thoughts and ideas, as illustrated in the Proceedings from the Lab.

Several key themes emerged from the Lab and will warrant further consideration and research endeavors:

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Understand diversity
Developing an understanding of the heterogeneity of personal preferences

Rethink care delivery
Creating new models for personalized, home-based care as the virtual "house doctor" of the 21st century

Words matter
Establishing a new vernacular around person-centric care

Person-centricity
Advancing the shift from input-based to outcomes-based person-centric care

Novel partners
Exploring new, radical collaborations around person-centric healthcare

1. Establishing a new vernacular around person-centric care

Words matter, words are powerful. Replacing the term "patient" with "person" and building a new vernacular focused on the person is vitally important to express a different approach to the individual human being in the context of health and healthcare.

This is about more than language. **Person-centric healthcare** articulates a new and different perspective about how individuals think about, believe and act when it comes to their health, and how they engage in all aspects of healthcare.

Person-centric healthcare aligns with several important trends and realities:

- Evolution of personalized medicine and precision medicine, concepts that are based on individual people's unique genetic profiles.

- Rising understanding of comorbidities and multidisease states that impact the personal health and course of disease over time.

- Deepening science and discovery regarding the early onset of pathologies or asymptomatic predisease before symptoms occur and diagnoses are made.

- Expanding understanding of the impact of non-clinical

factors on health outcomes, such as economic, social, cultural factors, and personal belief systems.

- Explosion of new personal digital health technologies that enable and empower the individual to make decisions about and manage their own health and healthcare.

- Proliferation of new players in the traditional healthcare field – whether it is technology companies that provide smart, personalized tools for people or consumer retailers that offer new disruptive healthcare models and provider services.

- Broadening understanding of individual consumer attitudes and actions derived from behavioral economics and psychology.

The approach to person-centric healthcare is also reflected in the evolution of patient engagement at IQVIA from initially approaching the patient as a data source to the patient as a stakeholder and then ultimately for the future as a partner.

However, simply replacing the term *patient* with *person*, or *patient-centric healthcare* with *person-centric healthcare*, will have limited impact if not underpinned by actual changes in behaviors by multiple stakeholders across the healthcare eco-system pertaining to research, clinical development and care delivery.

2. Developing an understanding of the heterogeneity of personal preferences

Digital technologies, real world evidence and advanced analytics, such as artificial intelligence (AI), machine learning (ML) and natural language processing (NPL), provide sophisticated opportunities for understanding the diversity of populations and the heterogeneity of preferences.

These methodologies will help replace traditional outdated segmentation models that are limited to attributes such as gender, age and race, and embrace psychographic, behavioral, attitudinal, and emotional preferences and variations. It will also mean a departure from the "fog of averages" where clinicians are making decisions about treatments based on the "average patient" rather than the individual person.

This will help foster the development of new models for researching, analyzing and predicting the heterogeneity of preferences when developing an understanding of the natural history of disease, designing clinical trials to capture more diverse endpoints, and developing new therapeutic strategies that target both clinical and non-clinical health outcomes.

One possibility is the development of an **index for personal health preferences** that enables mapping of the heterogeneous nature of individualized likings and alternative choices across diverse dimensions, including rational aspects such as biology, genetics, gender, age, race, clinical health, economics, education, geography, demography, as well as emotional aspects such as psychographics, social and cultural attitudes and behaviors, personal beliefs, and spirituality.

The index should be based on evidence from social, behavioral and ethnographic data lined to advanced analytics, and should be tested through application in clinical trials, real world evidence studies and population health research.

3. Advancing the shift from input-based to outcomes-based person-centric care

Taking a person-centric approach when applying clinical trials data, real world evidence and advanced analytics in combination will help facilitate the shift from input-based to outcomes-based measurement of healthcare solutions.

Today, measuring the quality of prevention and therapeutic interventions is predominantly based on input, i.e., the type of drug or the type of therapeutic or surgical intervention, making it difficult, if not impossible, to determine whether the right care is delivered to the right person at the right time. It may also lead to overdiagnosis, underdiagnosis, undertreatment, or overtreatment.

Person-centric healthcare will help foster a transformation from input-based to outcomes-based assessment of preventative care and therapeutic interventions through a **personal health outcomes index** that measures improvement of targeted endpoints based on the individual person's unique clinical and non-clinical profile.

More research should be conducted to explore the development of outcomes-based measurement linked to improving outcomes of person-centric care.

4. Creating new models for personalized, home-based care as the virtual "house doctor" of the 21st century

Fully embracing the impact of multidisease and person-centric health, health systems and healthcare providers have the opportunity to rethink models for personalized healthcare.

Today, the delivery of healthcare services is largely following an old-fashioned model that typecasts the individual based on a single disease and delivers care in a provider-centric model.

More than ever, there are opportunities for shifting the healthcare delivery model from the institutionalized, anonymized approach to a new personalized model based on the person's home.

Due to the ubiquitous nature of digital technology – using virtual care, telemedicine, and remote monitoring – coupled with in-home, 24/7 care services, this can be the dawn of a new era shaping the personal home as the hospital of the future. In other words, enabling complex, simulantaneous care that rises to the holistic needs of the person, rather than the "lowest common denominator" of the provider.

In many ways, installing technology in people's home can bring back the power of the family physician of the 19th century in the shape of the smart, **data-enabled house doctor of the 21st century**.

There are already movements in this direction with the design of new, high-tech, health ready homes for seniors that combine digital technology systems, and 24/7 call systems with the foundations for in-home, long-term care facilities and support-systems to be activated when needed.

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5. Exploring new, radical collaborations around person-centric healthcare

Enabling the novel directions outlined above will require the building of new, radical collaborations that bring together traditional partners – life sciences companies, providers, patient advocacy groups, academic researchers, and payers – with non-traditional partners – technology companies, behavioral scientists, design experts, personal trainers, life coaches, and futurists – to experiment with novel models for person-centric health, healthcare and well-being. We envision building an **Radical Collaborations Around Person-Centric Healthcare** that convenes non-traditional and traditional parties to explore new territories for patient-centered discovery and research.

The nucleus of such collaborations has already started to emerge through collaborations between traditional healthcare companies, researchers, technology companies, and human design experts.

In the future, this may also lead to the creation of new business models and the emergence of new companies that completely integrate classical industry verticals, combining capabilities across health science, therapeutic innovation, healthcare delivery, technology, social care, and human design approaches.

REFERENCES

[1] Osler William, Speech to the Albany Medical Society, 1899.
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[2] Gordon AH. The patient as a person. The Canadian Medical Association Journal. August 1934.

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