Integration for Populations: Organizing the Mesosystem

Eugene C. Nelson, DSc, MPH
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Mollie’s problems

- Homeless
- Unemployed
- Chronic Back Pain
- Depression & Alcohol
- Sole Caregiver for Elderly Mother

New to community ... moved to take care of frail elderly mother
Mollie’s problems addressed

- Homeless
- Unemployed
- Shelter
- Job Assistance
- Chronic Back Pain
- Depression & Alcohol
- Surgery
- Behavioral Health
- Sole Caregiver for Elderly Mother

_Iora Primary Care: Practice Team: MD, Coach, Nurse, Behavioral Health_

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Flow

1. The problem
2. Case examples
3. Integration principles
4. Call to action
1. Problem & Causes

- People are living longer
- Increase in chronic diseases
- Increase in multimorbidity & complexity
- Traditions of siloed services & payment systems that do not reward integration

We are living Longer!

But increase in chronic diseases & in people with multiple chronic diseases
38 million
of the 56 million global deaths in 2012 were due to chronic diseases

45% of patients had more than one chronic condition
Multimorbidity in 24% of population accounts for ....

64% of spending

Basque Country

20% of Medicare (older) patients account for ....

80% of spending

United States
Figure 1. Difference in average of adjusted annual cost (in euros) per patient, by number of coexisting chronic diseases according to the presence of certain selected diseases.

http://127.0.0.1:8081/plosone/article?id=info:doi/10.1371/journal.pone.0089787
Why does the US rank 38th in the world in health status?

US #1 in spending for health care

US #13 in spending for social services & health care

Implication?

Need to mobilize & integrate the assets of individuals & families & friends and formal social, community & health services to improve health and value for individuals & subpopulations
2. Case Examples

- Breast Cancer Center: Navigating
  - Amy’s story
- Iora Health: Primary Care & Coaching
  - Mollie’s story
- Spine Center: Interdisciplinary Team
  - Brian’s story
- Auto Immune Soup: a facilitated network of peer patients
  - Laura’s story

Amy had navigator for integration

6 months, 14 different microsystems, 21 visits
Mollie had a coach

Community Resources
- Mental Health
- Orthopedics
- Homeless Shelter

Primary Care Team
- Physician
- Coach
- Behavioral Health Specialist
- Office Staff

Person and Family
- Mollie

Care Support Tools and Mechanisms:
- Daily Huddle and Review of Worry List Patients
- Custom Built Electronic Health Record for Longitudinal Care
- Systematic and Repeated Health Assessments Using Patient Reported Measures
- Post-visit Patient Experience Survey
- Patient advisory Group Quarterly Meetings

Brian had a solution shop with integrated team & information

Feed Forward

People with healthcare needs

Referral or Visit Request

Orientation & PROMs

Initial Work Up Plan of Care

Acute Care Management

Chronic Care Management

Functional Restoration

Palliative Care

People with healthcare needs met

Feedback

Disease Status

Functional & Risk Status

Expectations For Good Care

Sunk Costs

Disease Status

Experience Against Need

Incremental Costs
Laura X, MD
with auto immune “soup”

“I learned more from my Yahoo chat group than I learned from the doctors at Dartmouth, or Mass General or Johns Hopkins”

Laura had a facilitated network that she started herself

3. Integration Principles

1. Assume: Self-care is the new principal care & align incentives to promote better value
2. Improve: Use co-design to map, mobilize and redesign the mesosystem for & with subpopulations to integrate services
3. Innovate: Leverage and combine all 3 ways to create value: shop, chain, network
4. Communicate: Feed forward data to make and update care plans & track outcomes
Assume: Self-care is the new principal care & align incentives to promote better value

"Assume doctors and hospitals are the last resort." Don Berwick
Upshift in Health Care Payments

Old Cost Stream:
Illness Pays

Patient exits home when sick
Primary Care
Specialty Care
Hospital Care
Quaternary Care

New Value Stream:
Health Pays

Person healthy doing self-care
Primary Care
Specialty Care
Hospital Care
Quaternary Care

Systems Inside Systems

Self-care system
Individual care-giver & patient system
Microsystem
Mesosystem
Macrosystem
Market / Geopolitical system
Improve: Map, mobilize and redesign the mesosystem for and with subpopulations

The individual
- Clinical skills
- Self-management
- Role and reward
- Personal development
- Quality & Personal

Clinical Microsystem
- Synthesis of individual, team and patient
- Enable improvement in everyday functioning
- Building blocks of system

Meso-system
- Mainstream to support the microsystem
- Enables inter mesosystem work
- Interface between micro and macro

Network, district, regional
- Inter microsystem work
- Whole patient journey
- Improvement ‘epidemiology’

National Initiatives and policies
- National Service Frameworks
- Training & education
- Improvement ‘H’
- Resource allocation

Lind Family Mesosystem
Innovate: Leverage and combine all 3 ways to create value

- Solution shop
- Value chain
- Facilitated network

Solution Shops

Mayo Clinic just opened a “cough clinic” bringing together all of the specialties for the first time for this subpopulation
Value Chains

Mission: to eliminate needless blindness

Aravind cataract surgery India & Frenesis renal dialysis centers in the US

Facilitated Networks

Welcome to Wikipedia,
The free encyclopedia that anyone can edit.
4,605,853 articles in English

Cystic Life
“Real. Positive. Community”
7763 members and counting

“PatientsLikeMe Is Building A Self-Learning Healthcare System”
Paul Wicks, Medical Architect 3/1/13
1000+ CF Patients
Value Creation Models & Level of Complexity

1. Solution shops: complex problems
2. Value chains: simple or complicated
3. Facilitated networks: simple or complicated or complex

“In future, in a well designed system, shops and chains may become nodes in the network.”

P. Batalden 9/19/14

Information: Feed forward data to make and update care plans & track outcomes
4. Call to action: Integration

- Start by organizing & activating the mesosystem
- Continuously feed forward information to assess the individual’s health, assets changing needs and preferences
- Identify the resources that can be mobilized
- Develop a personalized care plan that takes advantage of the assets of the person, family & friends, peers, community, social and health services to co-produce health & high value services – “doctors & hospitals are the last resort”
- Integrate shops & chains & networks to support high need populations (e.g., frail elderly, children with special needs, complex multi-morbidity)