

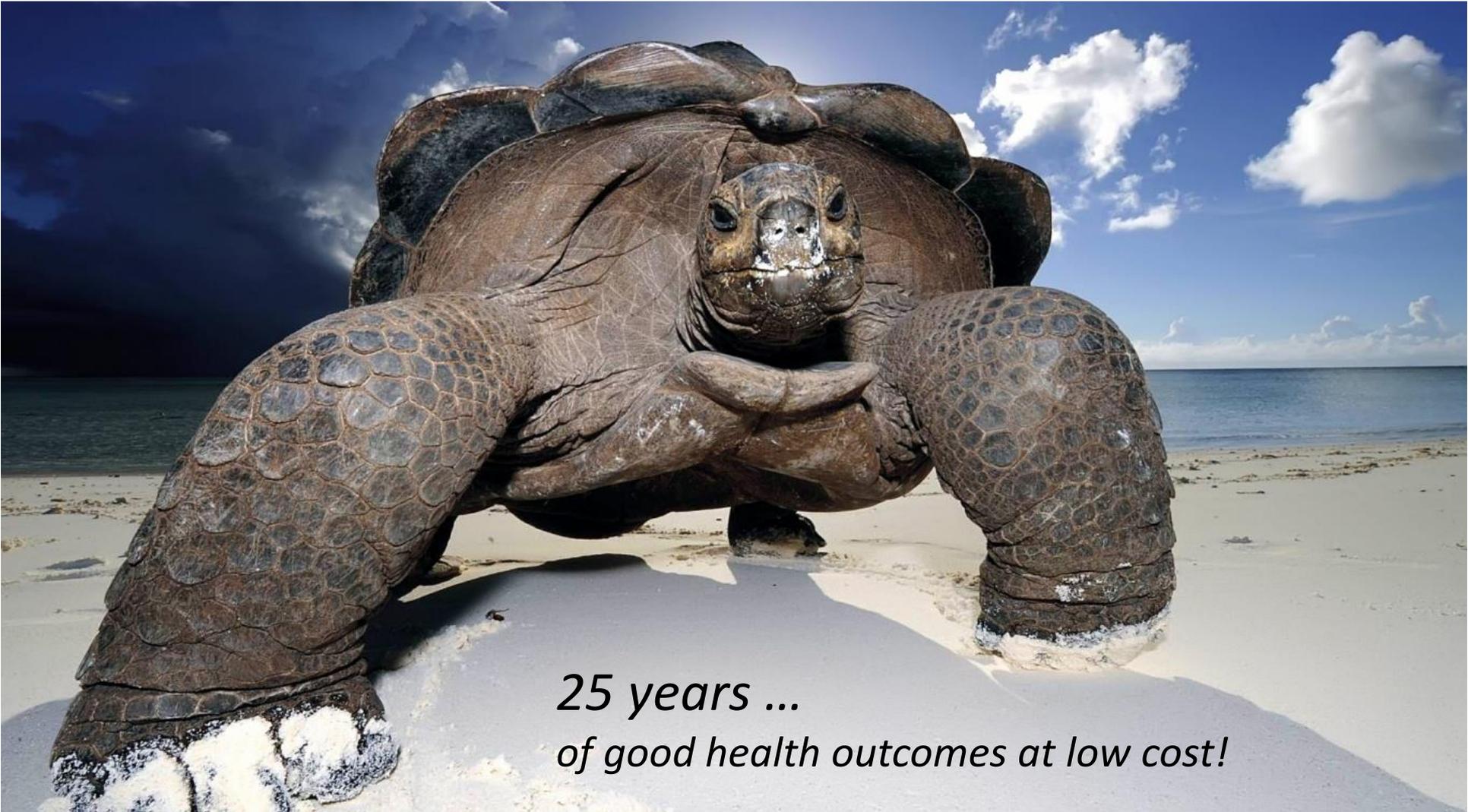


The EHIF - World Bank Collaboration

A Quick History

Tallinn, October 2017

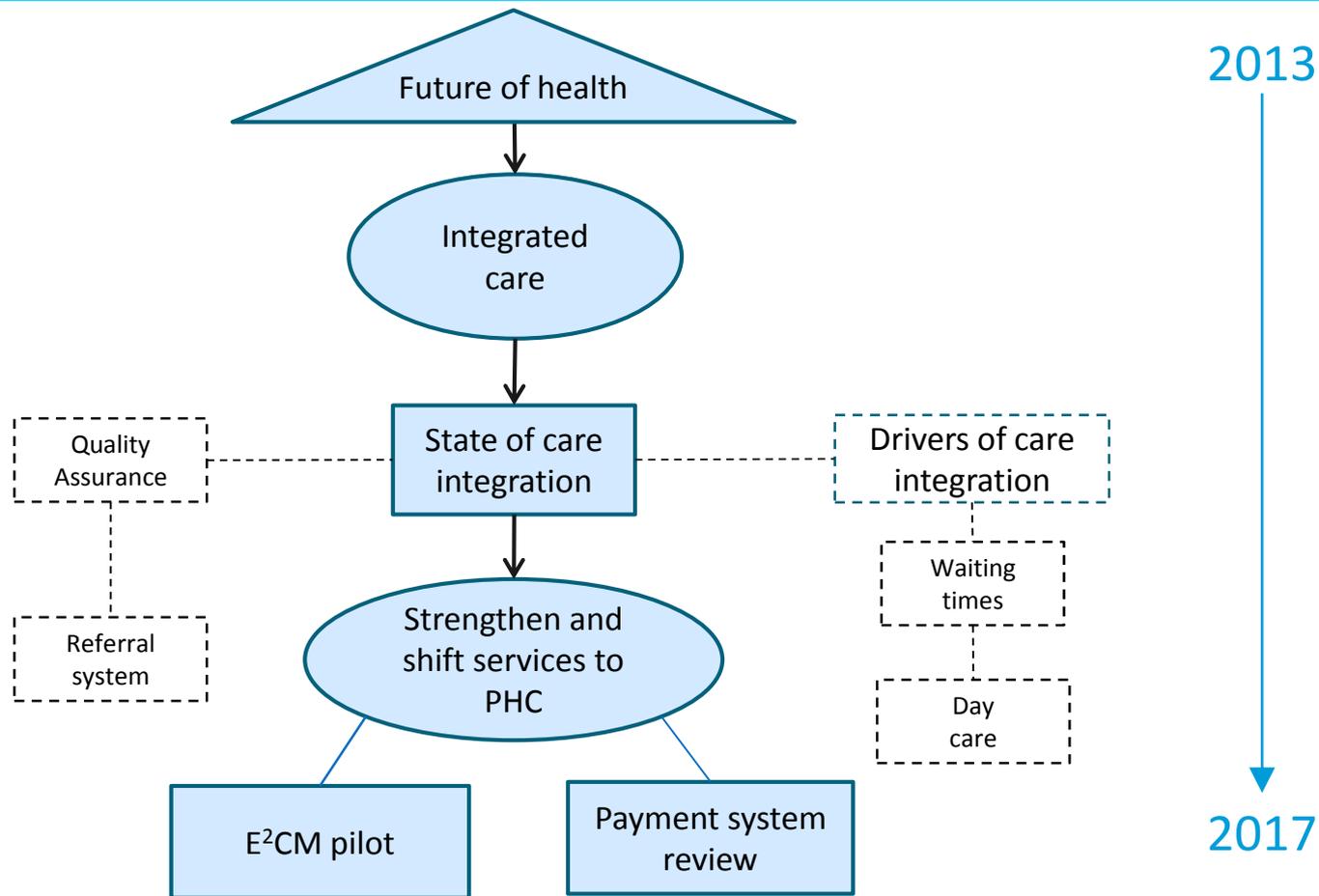




*25 years ...
of good health outcomes at low cost!*



History of EHIF - World Bank Collaboration





Partners



Institute of Health Policy, Management and Evaluation
UNIVERSITY OF TORONTO





Enhanced Care Management: Improving Health for High Need, High Risk Patients in Estonia

EHIF-WBG Project

Tallinn, October 2017



Outline

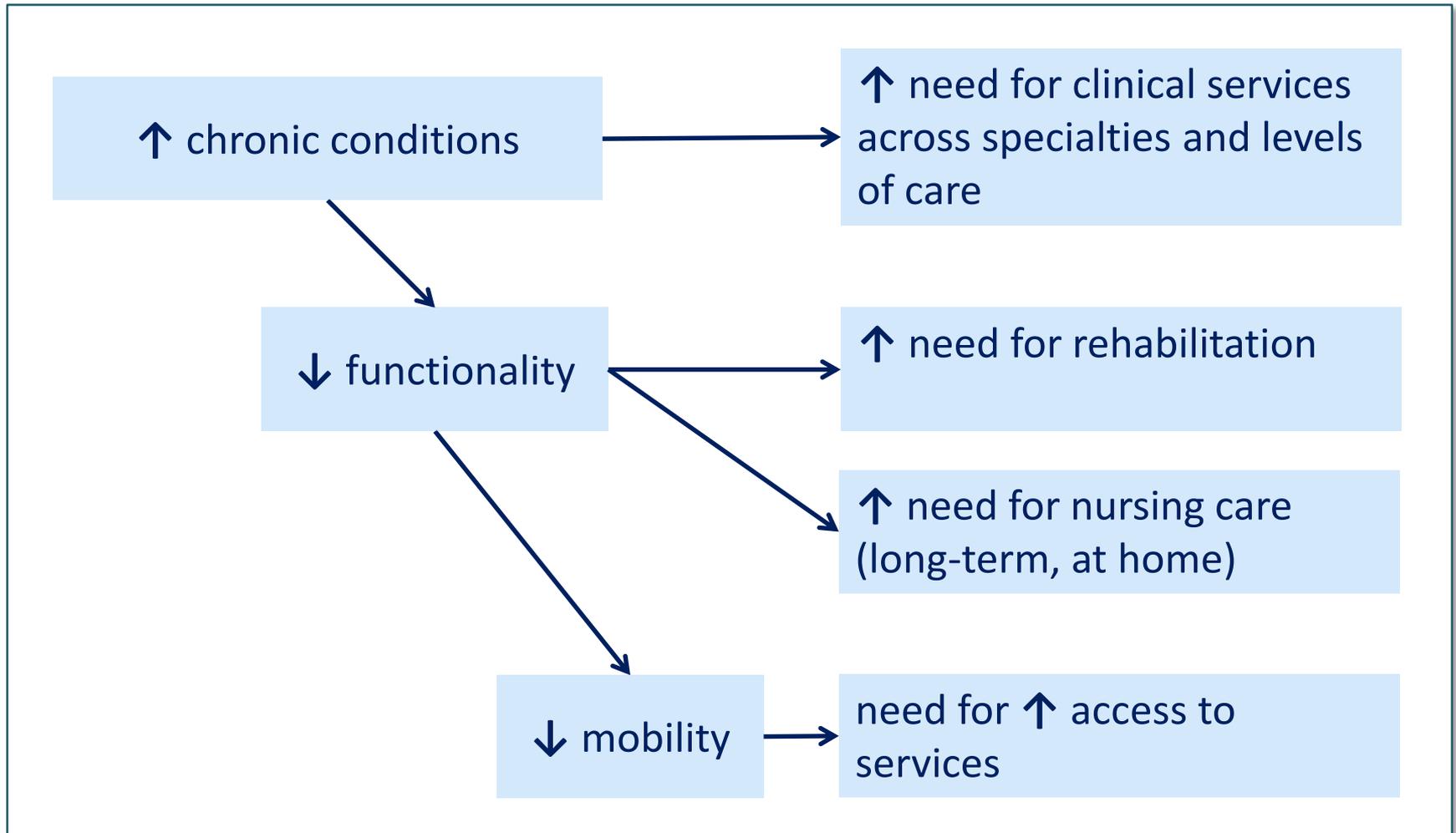
Care integration challenges in Estonia

Toward enhanced care management

Estonian enhanced care management pilot



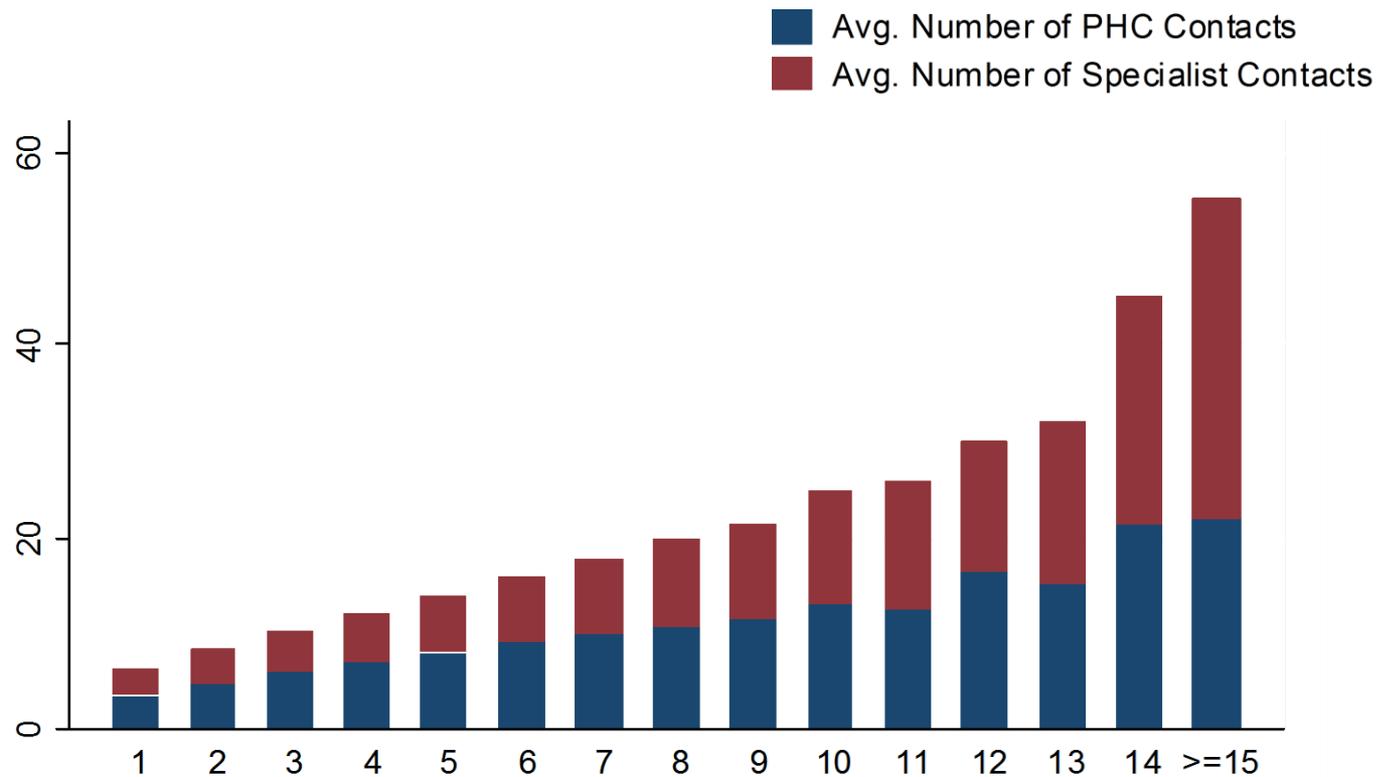
Changes in the demand for health care due to population ageing and rise of non-communicable diseases





The impact of chronic conditions on the demand for health care

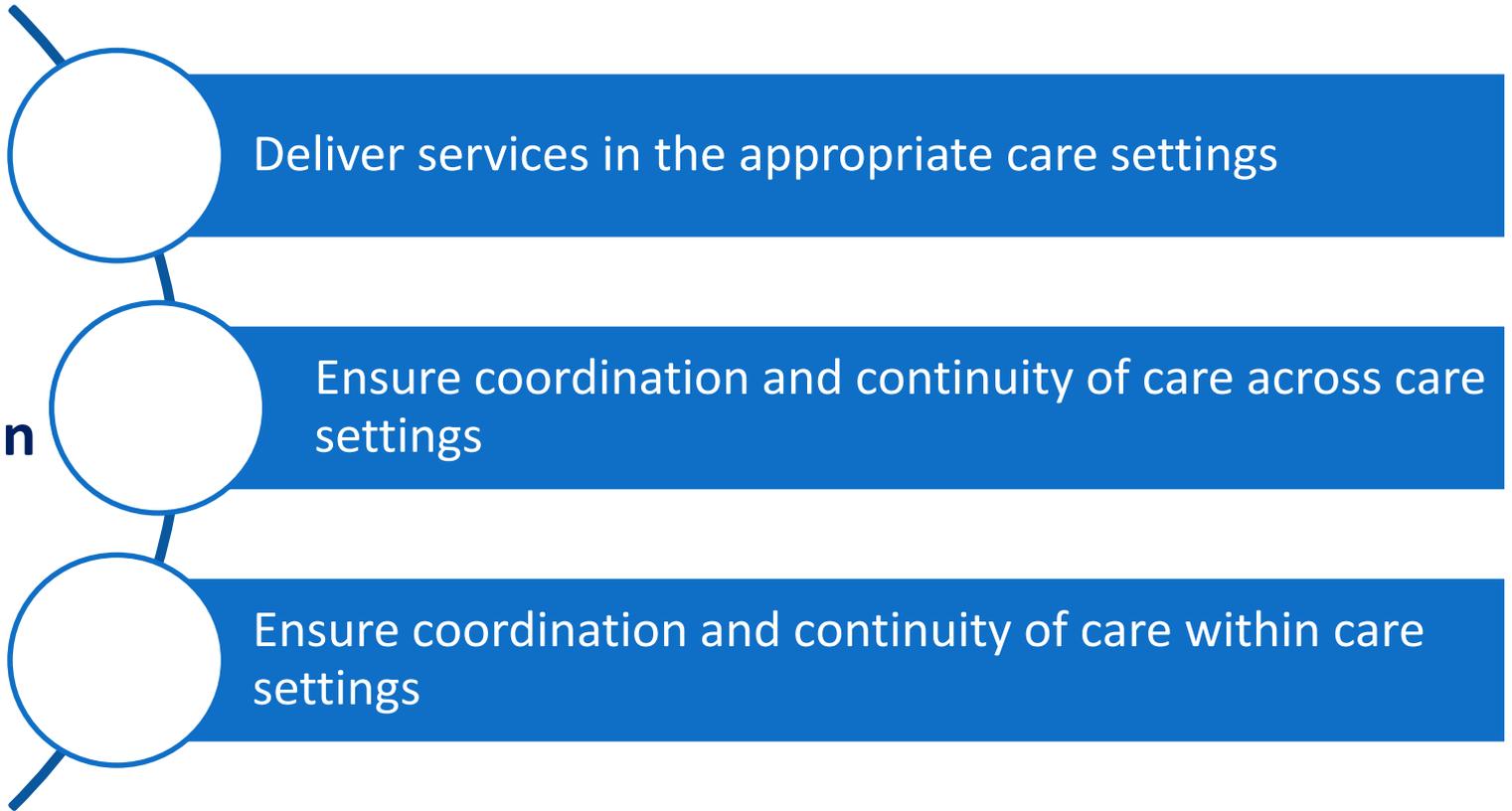
Use of PHC / Specialist Care (2013), # of comorbidities





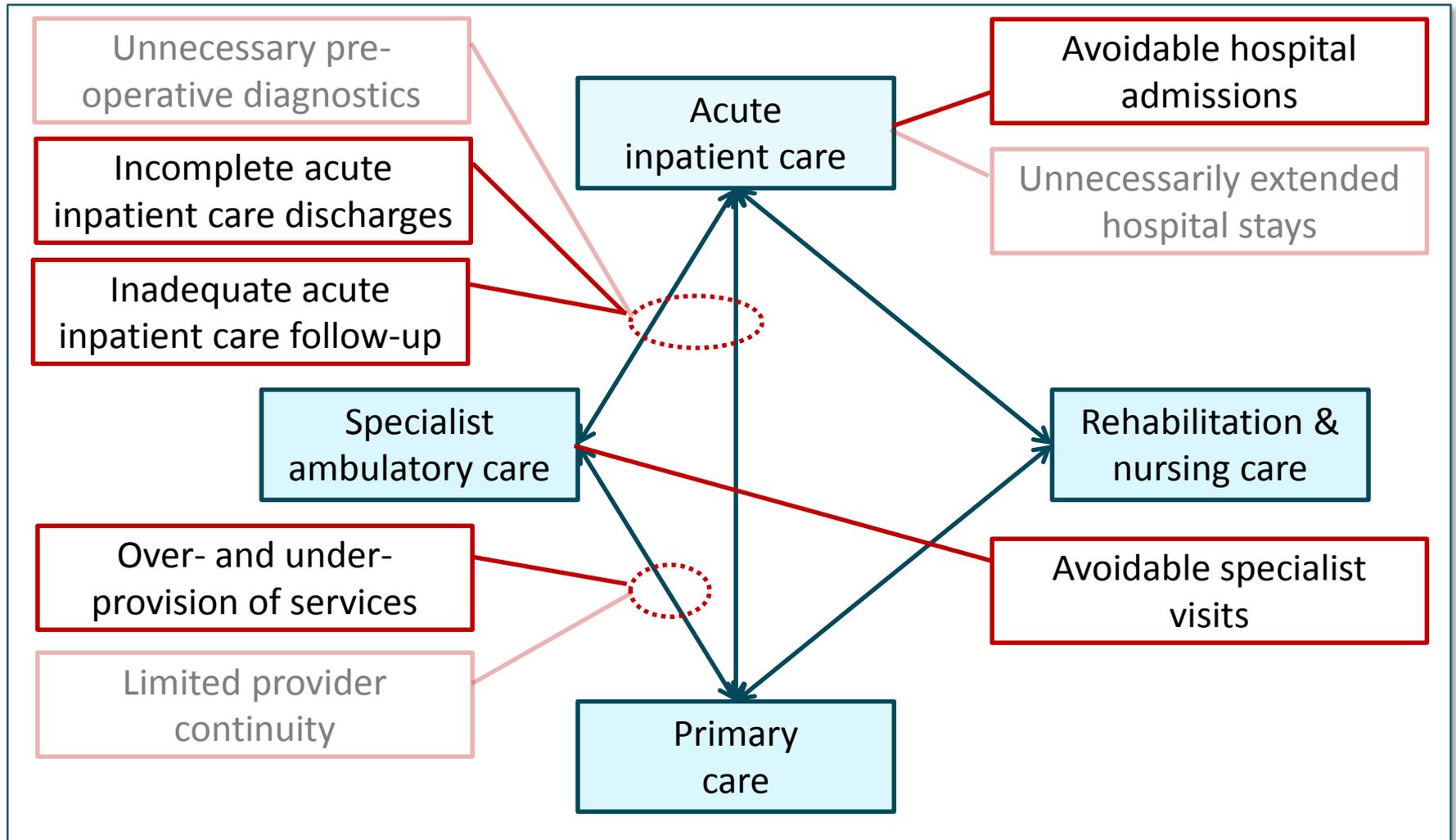
Care integration - key challenges

**Care
integration**



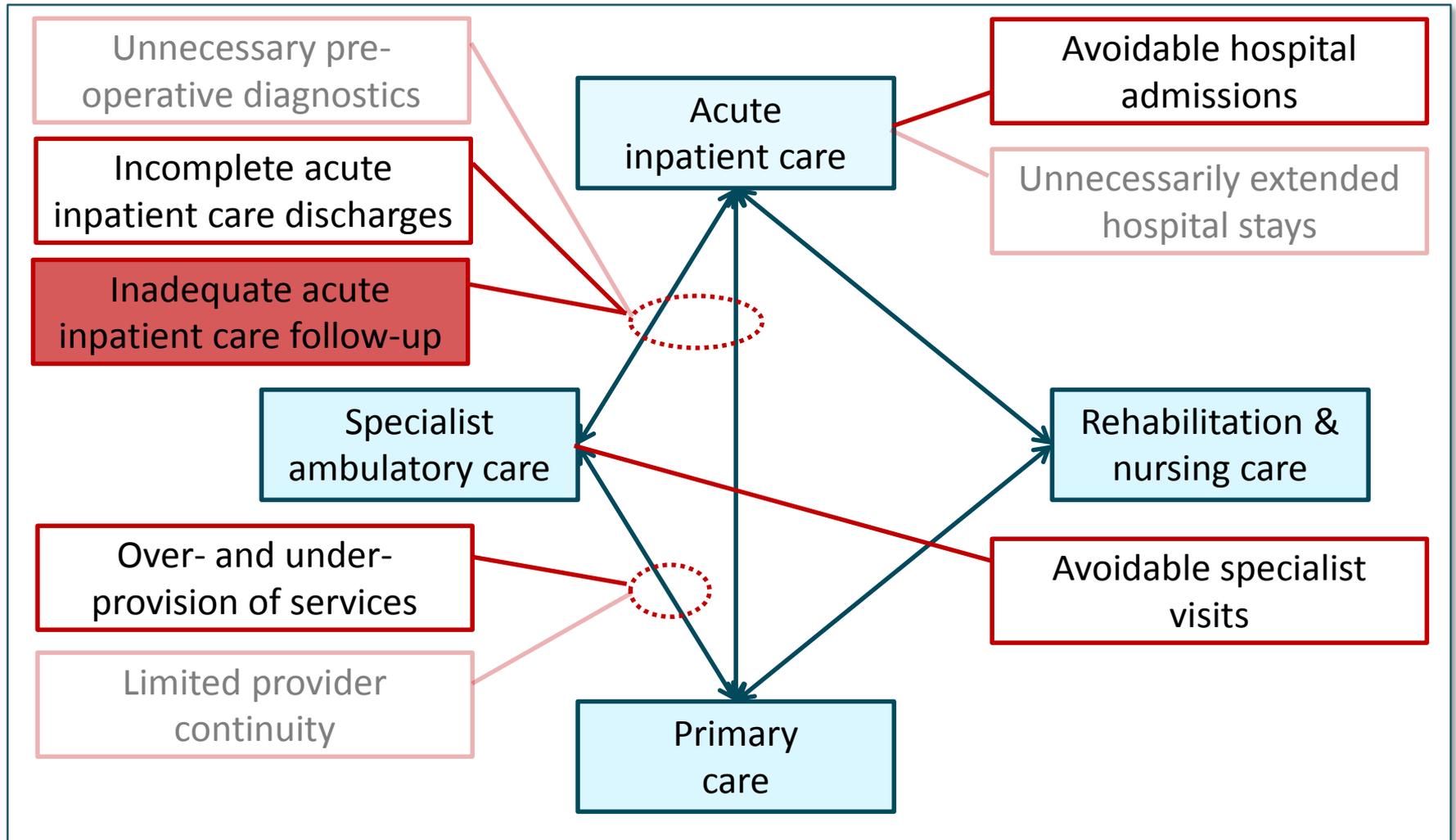


Care integration – key performance issues in Estonia





Care integration – key performance issues in Estonia





Inadequate acute inpatient follow-up care

Tracer	Number of patients	Share with follow-up visit within 30 days after discharge		Share with follow-up visit within 90 days after discharge	
		FP only	FP & S	FP only	FP & S
AMI	4428	30.1%	35.6%	40.9%	49.2%
Stroke	2819	35.8%	38.8%	43.4%	47.5%
Heart Failure	1453	21.8%	25.8%	31.0%	38.1%
Cholecystectomy	2715	31.7%	48.9%	33.5%	51.0%
Hip Fracture	929	21.1%	25.7%	27.0%	36.4%



Outline

Care integration challenges in Estonia

Toward enhanced care management

Estonian enhanced care management pilot



Toward enhanced care management

Work builds off of a large body of evidence

ISSUE BRIEF
OCTOBER 2015



The COMMONWEALTH FUND

Models of Care for High-Need, High-Cost Patients: An Evidence Synthesis

Douglas McCarthy, Jamie Ryan, and Sarah Klein

Abstract This brief analyzes experts' reviews of evidence about care models designed to improve outcomes and reduce costs for patients with complex needs. It finds that successful models have several common attributes: targeting patients likely to benefit from the intervention; comprehensively assessing patients' risks and needs; relying on evidence-based care planning and patient monitoring; promoting patient and family engagement in self-care; coordinating care and communication among patients and providers; facilitating transitions from the hospital and referrals to community resources; and providing appropriate care in accordance with patients' preferences. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

ISSUE BRIEF
AUGUST 2014



The COMMONWEALTH FUND

Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?

Clemens S. Hong, Allison L. Siegel, and Timothy G. Ferris

Abstract Provider groups taking on risk for the overall costs of care in accountable care organizations are developing care management programs to improve care and thereby control costs. Many such programs target "high-need, high-cost" patients: those with multiple or complex conditions, often combined with behavioral health problems or socioeconomic challenges. In this study we compared the operational approaches of 18 successful complex care management programs in order to offer guidance to providers, payers, and policymakers on best practices for complex care management. We found that effective programs customize their approach to their local contexts and caseloads; use a combination of qualitative and quantitative methods to identify patients; consider care coordination one of their key roles; focus on building trusting relationships with patients as well as their primary care providers; match team composition and interventions to patient needs; offer specialized training for team members; and use technology to bolster their efforts.

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.



The COMMONWEALTH FUND

ISSUES IN INTERNATIONAL HEALTH POLICY

JANUARY 2016

How High-Need Patients Experience the Health Care System in Nine Countries

Dana O. Sarnak and Jamie Ryan

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

Abstract U.S. health care costs are disproportionately concentrated among older adults with multiple chronic conditions or functional limitations—a population often referred to as "high-need" patients. This analysis uses data from the Commonwealth Fund 2014 International Health Policy Survey of Older Adults to investigate health care use, quality, and experiences among high-need patients in nine countries compared with other older adults. High-need patients use a greater amount of health care services and also experience more coordination problems and financial barriers to care compared with other older adults. Disparities are particularly pronounced in the United States. The comparative success of other countries, particularly in reducing financial barriers to care, may be a product of policies that specifically target high-need patients. Similarly focusing on these populations in the U.S. and effectively managing their care may improve their health status while reducing overall costs.



Next Steps for Risk Stratification in the NHS



The Value of Primary Health Care

 Focus of following slides



PEOPLE'S FIRST CONTACT

Serves as the entry point into the health care system, and the first source of care for most health needs



PEOPLE-CENTERED

Organized around the health needs and expectations of people rather than diseases



COMPREHENSIVE

Delivers a broad spectrum of preventative, promotive, curative and palliative care



CONTINUOUS

Connects people with trusted providers who address their ongoing health needs throughout their lives



COORDINATED

Manages care across levels of the health system, referring patients to specialists as needed and effectively following up to ensure improvement



ACCESSIBLE

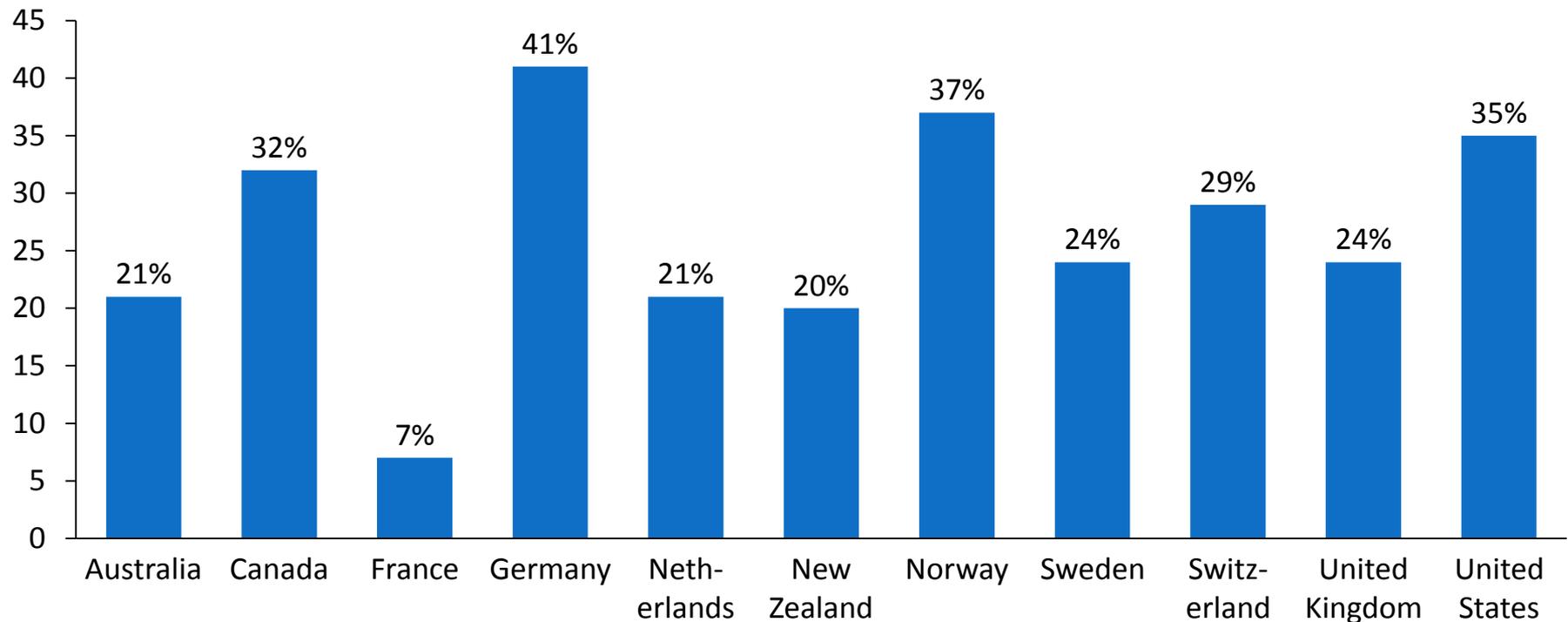
Offered within people's communities, at a price they can afford



Patients experiencing coordination problems in past 2 years



Patients experiencing ≥ 1 care coordination problem in past 2 years¹, % of adults age 65 and over



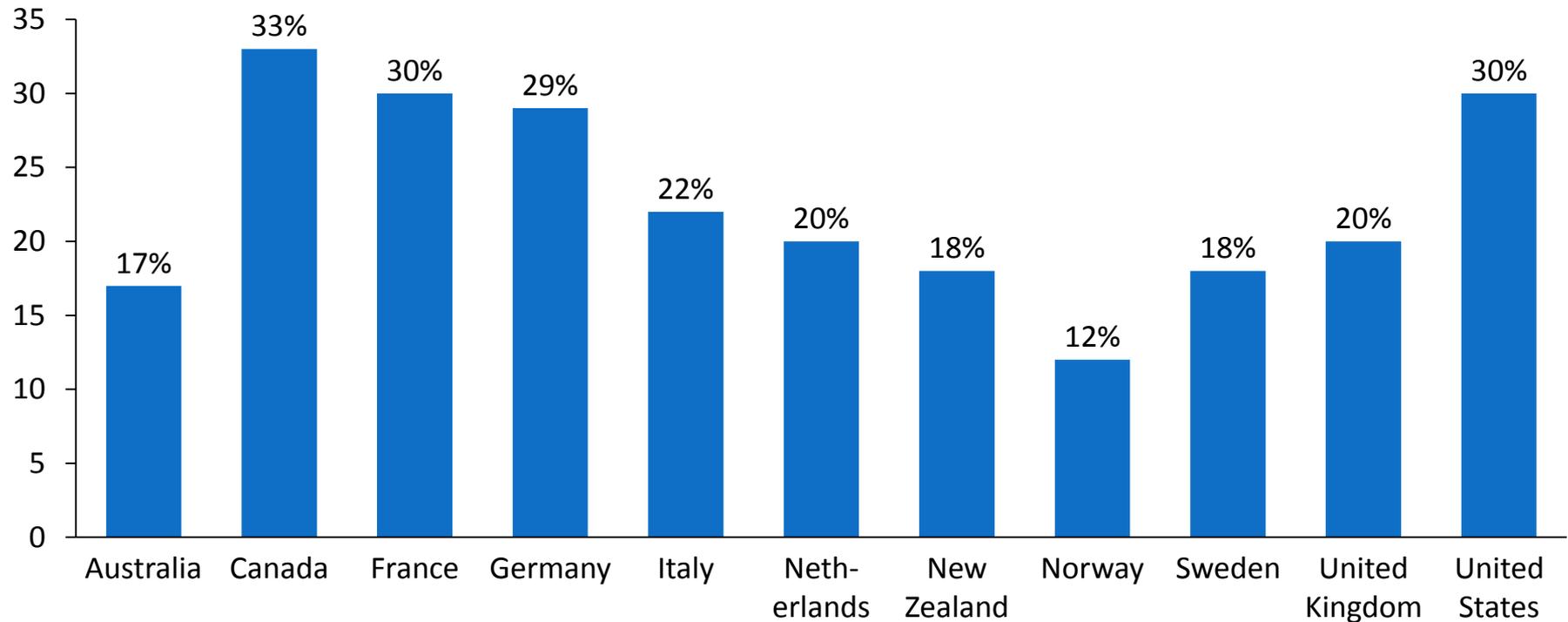
¹ Answered yes to at least one: test results/records not available at time of appointment or duplicate test ordered; received conflicting information from different health professionals; or specialist lacked medical history or regular doctor not informed about specialist care



Primary care doctors reporting time spent coordinating patient care is a major problem



Primary care physicians reporting time spent on coordination of patient care, %



SOURCE: The Commonwealth Fund 2009 International Health Policy Survey of Primary Care Physicians in Eleven Countries; C. Schoen et al., "A Survey of Primary Care Physicians in Eleven Countries: Perspectives on Care, Costs, and Experiences, 2009." Health Affairs Web Exclusive, Nov. 5, 2009, w1171-w1183

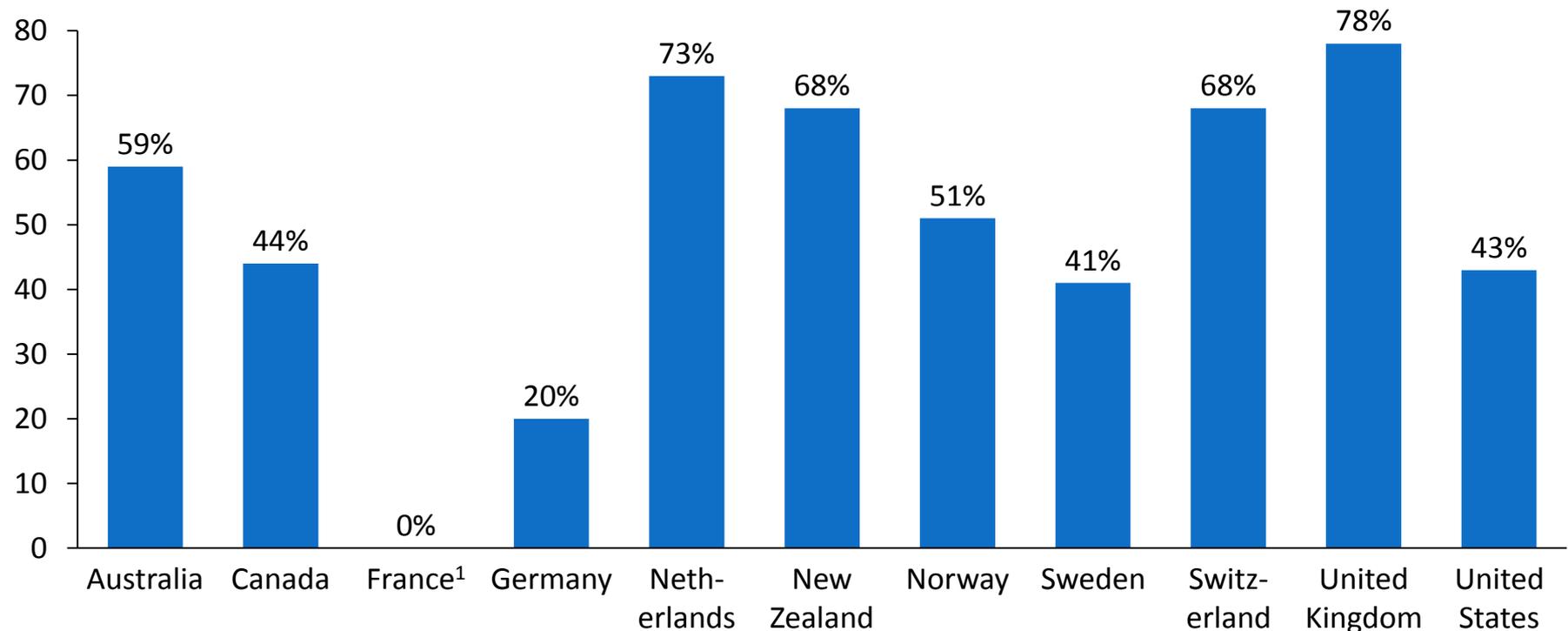


Practice uses nurse case managers or navigators for patients with serious chronic conditions



The Commonwealth Fund

Practices using nurse case managers or navigators for patients with serious chronic conditions, % of primary care physicians



¹ Question asked differently in France



Enhanced Care Management

Key elements of Enhanced Care Management

Risk Stratified
Patient Registry



Care Plans



Proactive
Outreach and
Transitions
Follow-Up



Team Approach
and Resource
Connections

Factors that promote a ready environment

Patient
Panels

Universal
Health
Coverage

Supportive
Payment
Environment

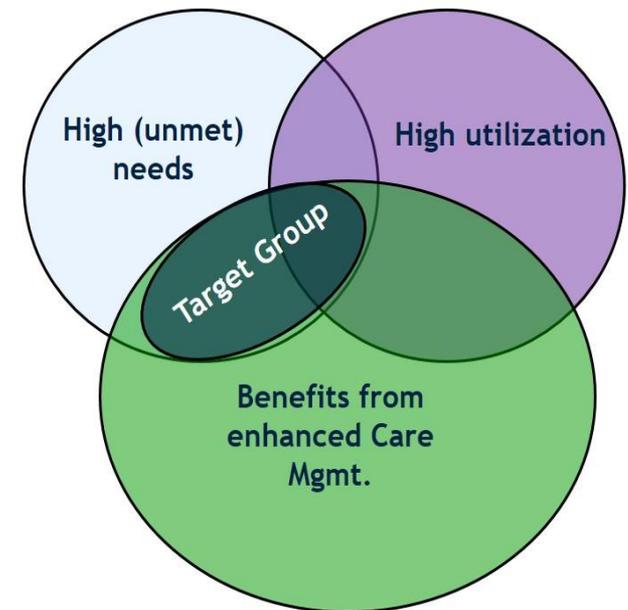
Motivated
Multi-
disciplinary
Teams

EHRs with
Quality
Reporting
System



Risk Stratified Patient Registry

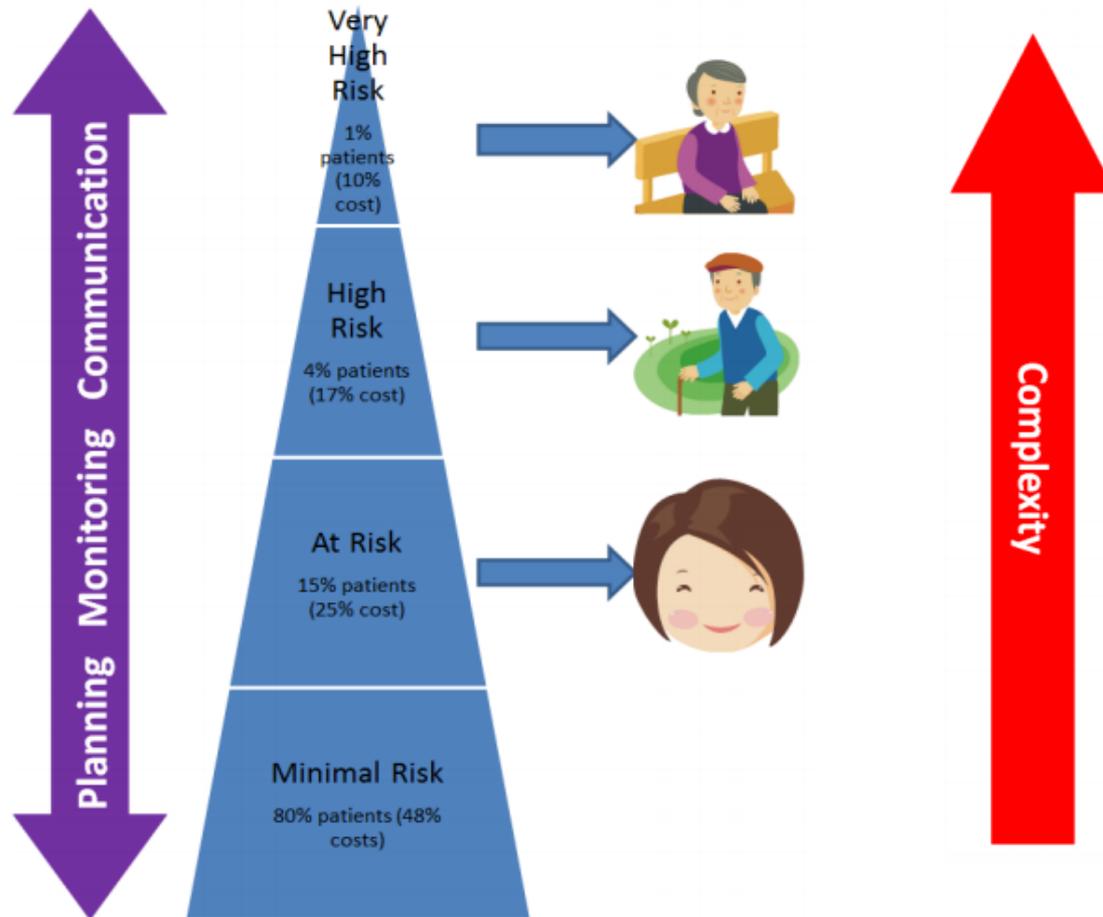
- **Targeting patients** — Who will benefit from enhanced care management?
- Start by **defining “risk”** the program intends to mitigate
 - Chronic disease management?
 - High utilization frequency/costs? Avoidable hospitalizations? Avoidable morbidity or mortality?
- Consider different **types of complexity**: disease, social, behavioral
- Different **models for risk stratification**:
- Clinical algorithm + provider intuition most effective at identifying patients likely to benefit





Targeting Patients (Care Coordination vs. Care Management)

New South Wales, Australia (2014)





Care Plans

- Care plans are often used to coordinate a **patient's health needs** and **treatment goals** between multiple providers
- Goal is to *increase patient activation*
- Using care plans has been shown to improve patient **health outcomes**, increase patient **self-care**, and reduce **healthcare utilization**
- Start by completing a comprehensive evaluation to determine patient's **care needs** — medically, socially, and behaviorally



Care Plans and Self-Management Support

Self management support





Proactive Outreach and Transitions Follow-Up

- **Coordinate care**, inside and outside of clinical systems
- **Primary care** as central point of integration
- **Regular updates** and transfer of information especially during **transitions**

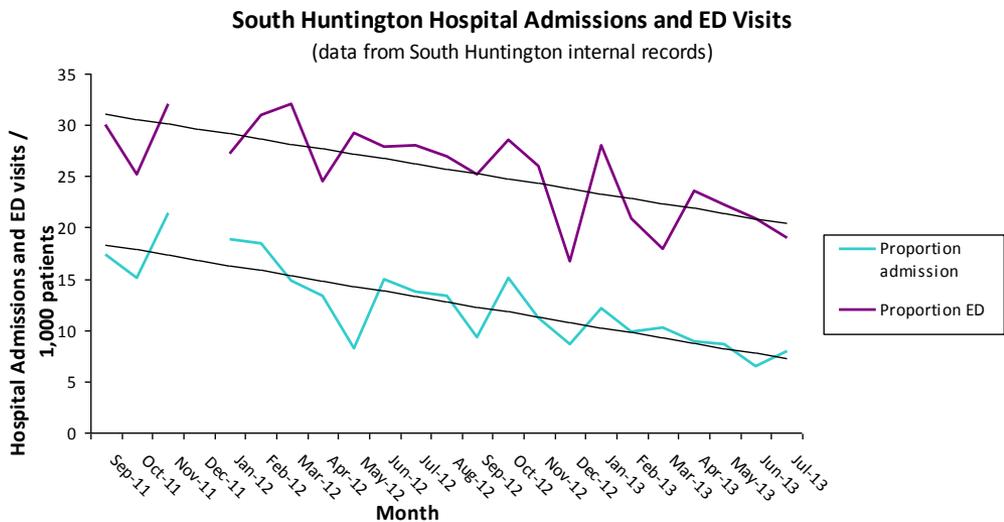




Proactive Outreach and Transitions Follow-Up

Care Management, *South Huntington, Boston, USA*

- Track changes in clinical status
- Updates the care team
- Proactively communicates with patient





Team Approach and Resource Connections

Building a care team

Iora Health (US)



Nuka (Alaska natives)



Resource connections to other services

- To meet **patient needs**
- To fill gaps in **care team capacities**



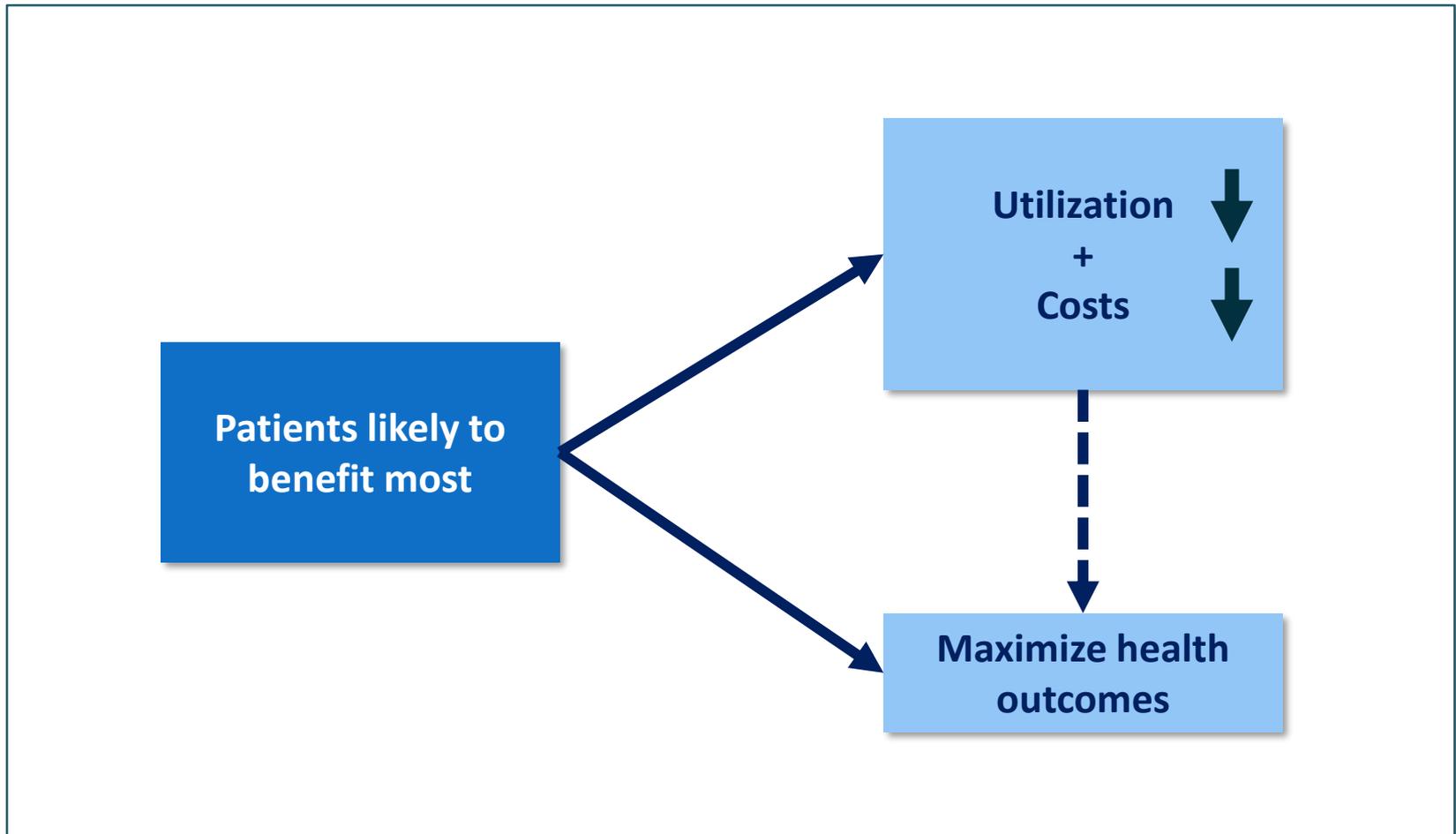
Planning the Pilot: March-December 2016





Patient registry – paradigm shift

↓ Directional effect





Use of archetypes in health care is helpful to better address unmet patients needs

Description

What are patient archetypes?

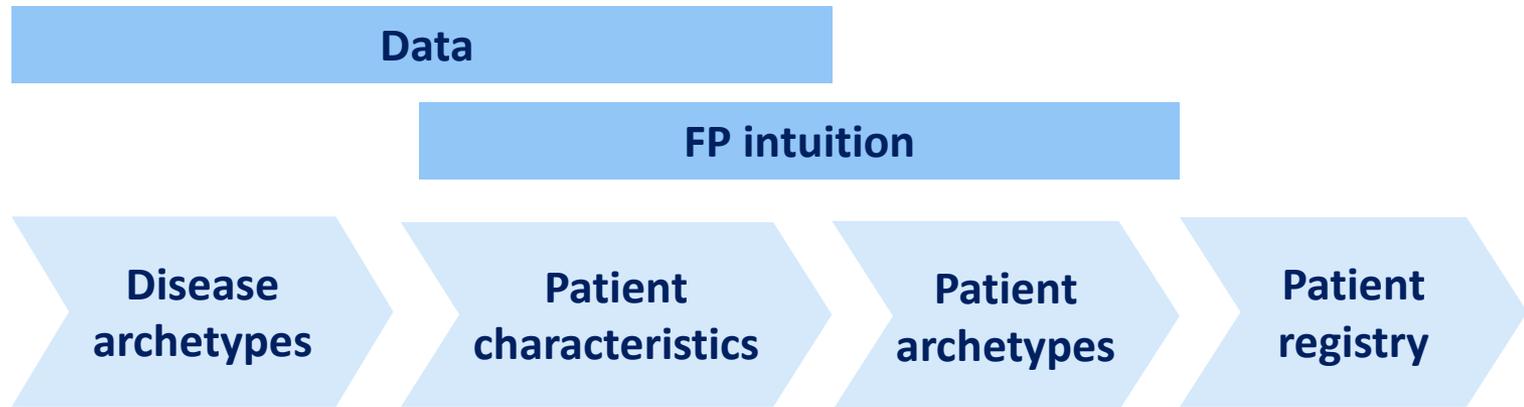
- Common classifications based on people's behaviors and needs
- Defined by a combination of disease, social and behavioral factors

Benefits of using patient archetypes

- Improve quality of care and health outcomes
- Reduce medically futile care
- Align services with patient preference
- Improve system responsiveness to patients needs

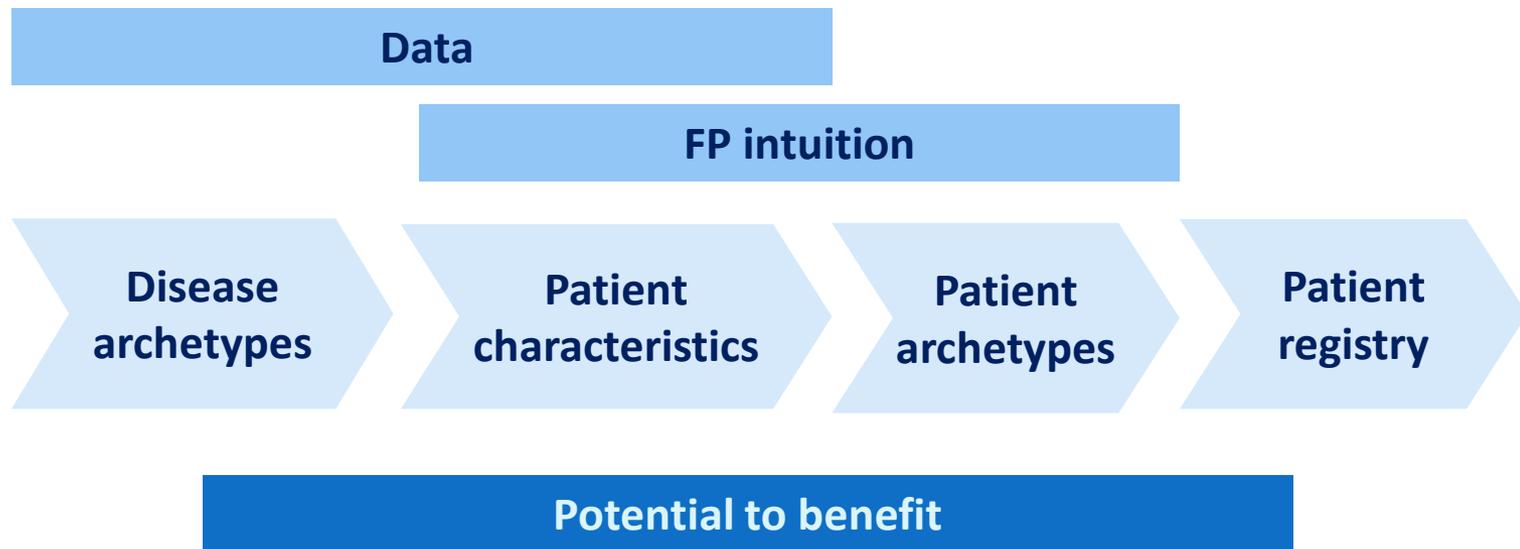


Development of patient registry



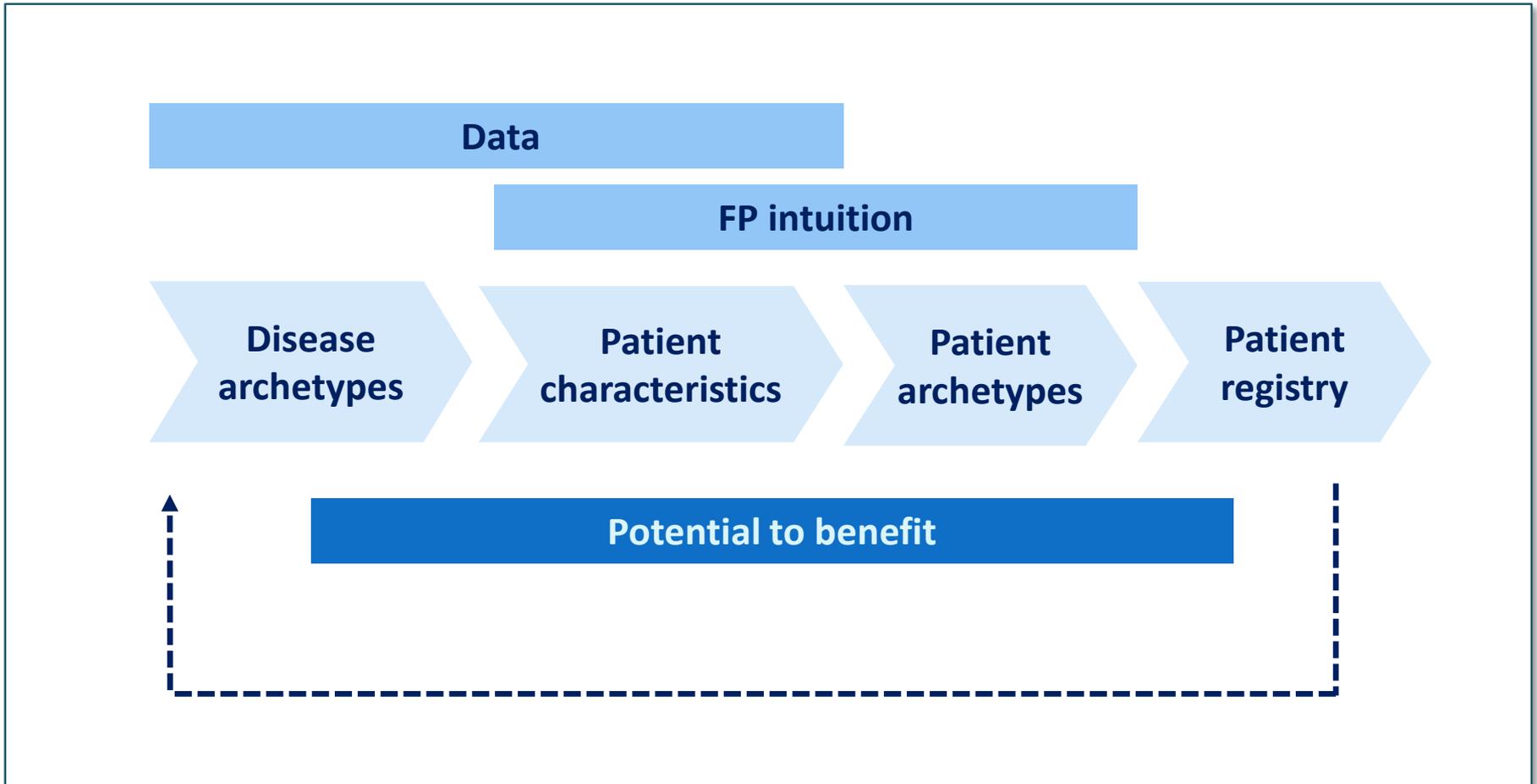


Development of patient registry



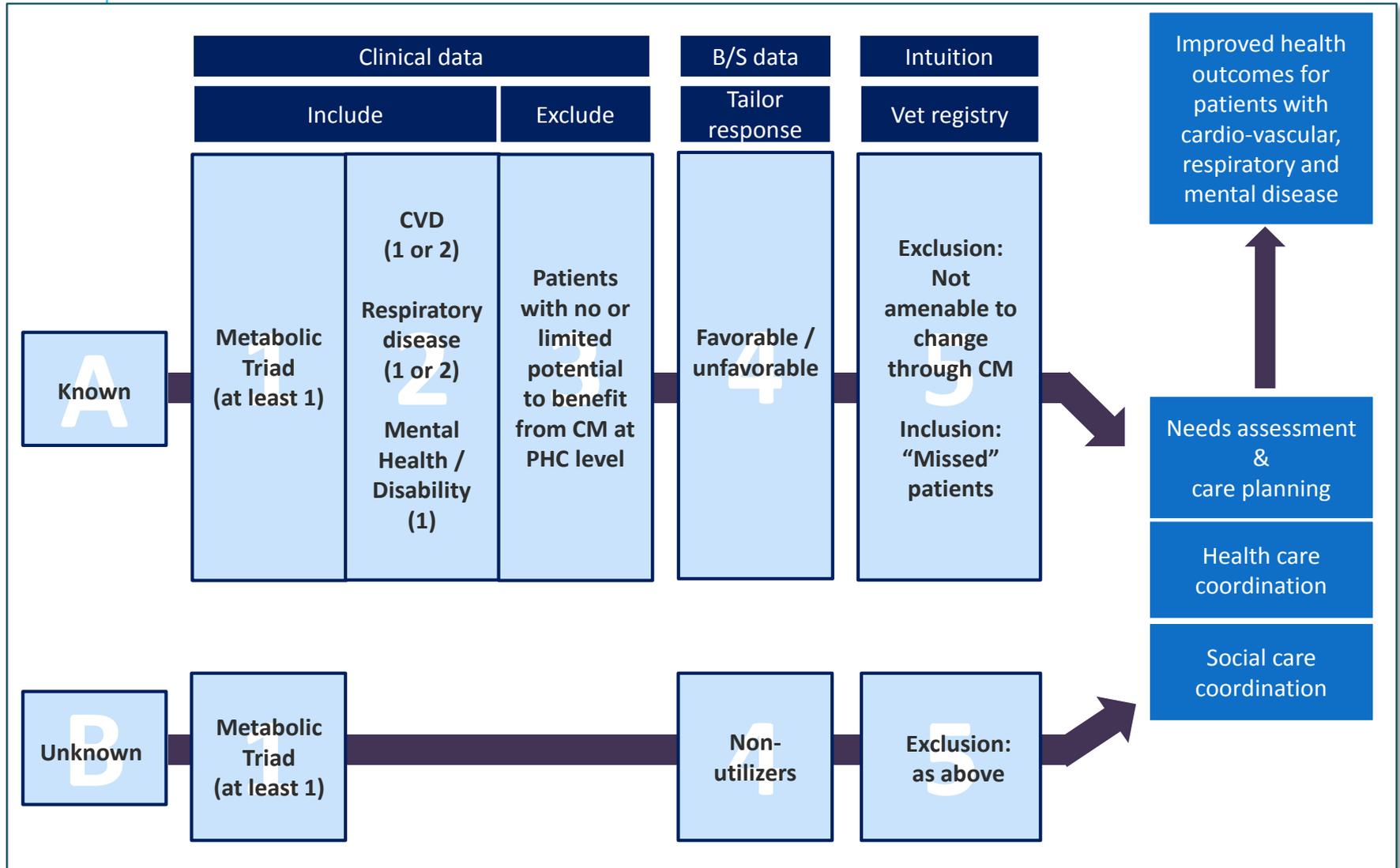


Development of patient registry





Risk Stratification Model for EECM





Outline

Care integration challenges in Estonia

Toward enhanced care management

Estonian enhanced care management pilot



The Estonian enhanced care management pilot

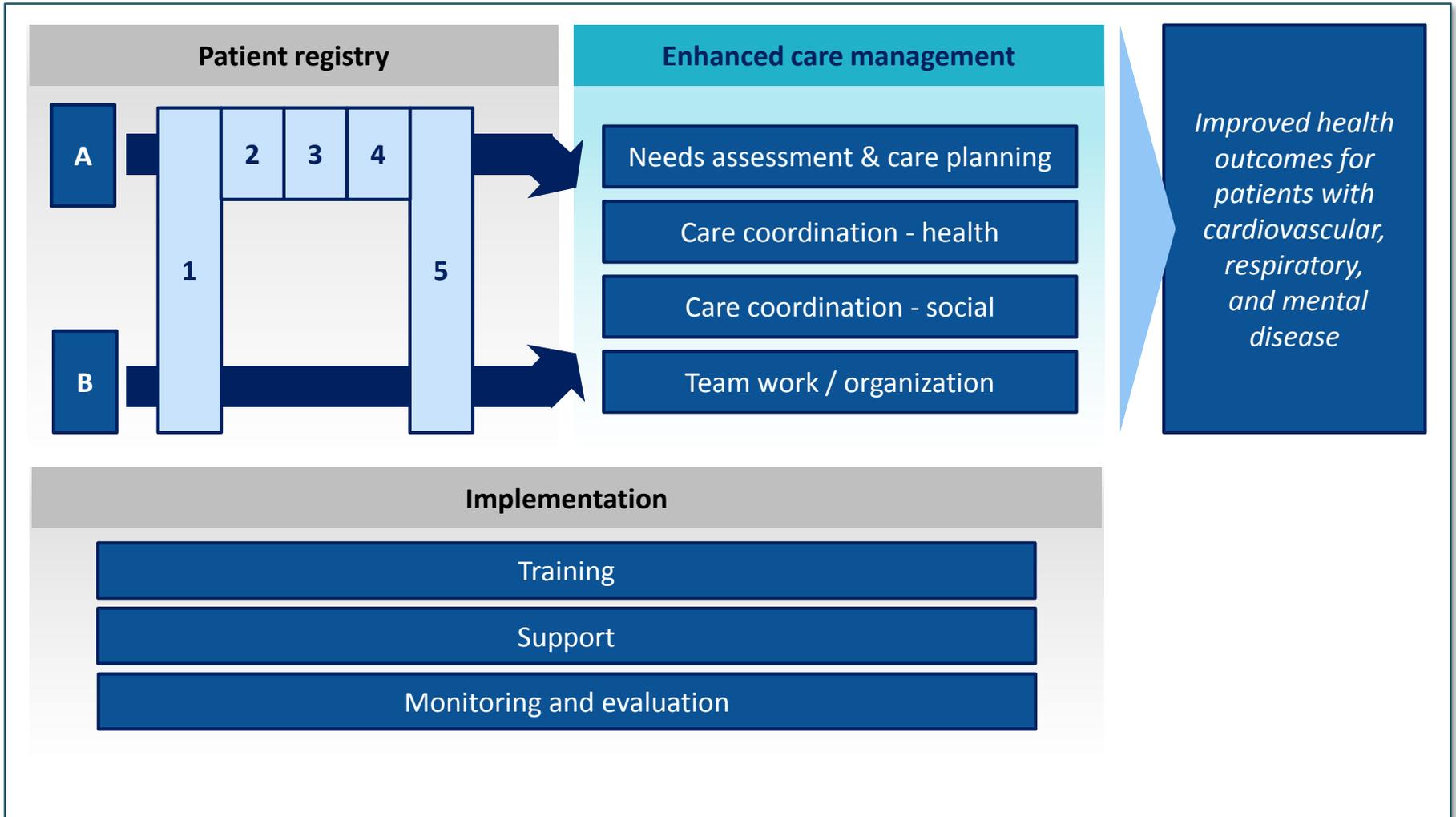
Pilot and strategic objectives

- **Assess the feasibility and acceptability of enhanced care management**
- Understand the impact of enhanced care on selected care quality
- Identify potential constraints and opportunities for scaling-up
- *Ultimately improve health outcomes for patients with cardio-vascular, respiratory, and mental disease*



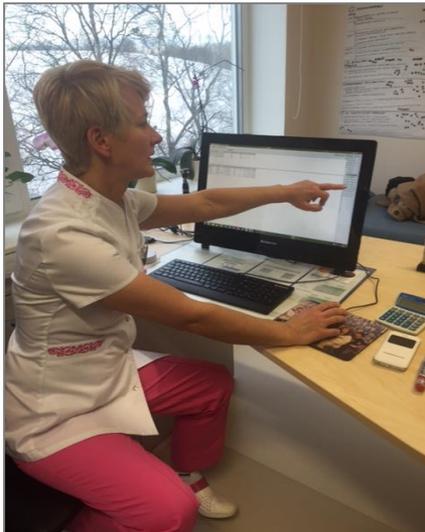
Pilot design - Estonian enhanced care management

Focus of following slides





Pilot overview - Estonian enhanced care management



Timeline	Feb 2017 – Aug 2017
Practices	9
Family Physicians	10
Nurses	11
Resident Physicians	1
Total Patients	~500



Pilot implementation – timeline



Detail on next slide





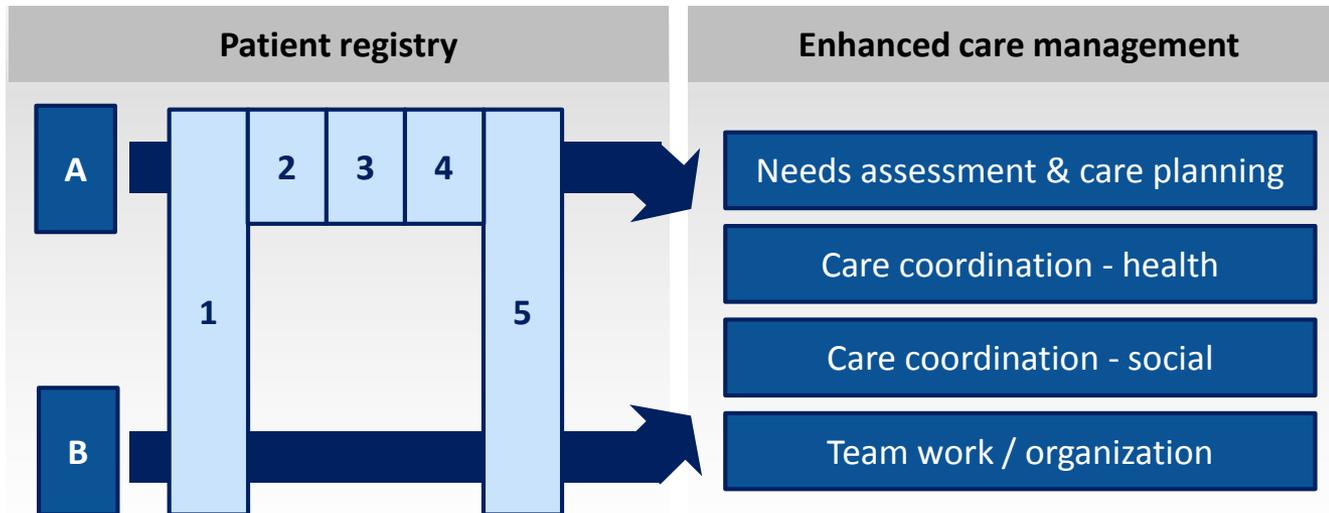
Pilot Implementation – Components, Objectives, and Activities

Component	Activities and objectives
Needs assessment & care planning	<ul style="list-style-type: none">▪ Elicit patient goals▪ Create care plan
Care coordination - Health	<ul style="list-style-type: none">▪ Ensure compliance with guidelines (QBS)▪ Reconcile medication plans and improve adherence▪ Follow-up during care transitions (e.g. follow-up calls, visits after hospital discharges etc.)▪ Track lab tests and referrals▪ Outreach to and monitor patients between scheduled visits
Care coordination - Social	<ul style="list-style-type: none">▪ Improve information flows between care teams and social care▪ Increase coordination with social workers
Team work / organization	<ul style="list-style-type: none">▪ Promote peer learning▪ Structure and optimize work processes▪ Elevate the role of nurses



Pilot design – Implementation

Focus of following slides



Improved health outcomes for patients with cardiovascular, respiratory, and mental disease

Implementation

Training

Support

Monitoring and evaluation



Pilot Implementation

Key components



- Webinars
 - Meetings with FPs to discuss challenges and share practices
 - Study materials
-
- Monthly coaching
 - On site visits
 - Constant feedback on quality progress
-
- Constant feedback on patients included
 - Feedback from the dashboard



1 Pilot Implementation – Training

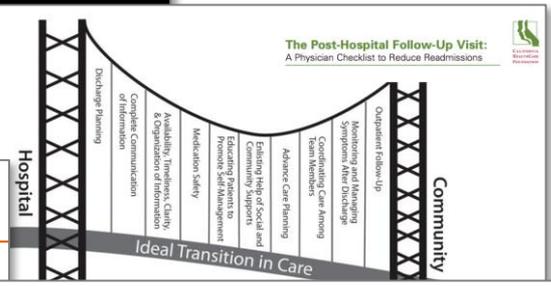
Webinars from January to May

1. Reflections on Building Teams in Primary Care
2. Coordinating patient care after hospitalization
3. Review of provider intuition and care plans
4. Eliciting Patient Goals and Promoting Patient Activation
5. Social Needs Assessment and Resource Connections
6. Statins and Medication Reconciliation

Putting Teams in Action

- Setting and tracking goals together as a team
- Adjusting schedules to meet a work as a team
- Letting the patients know they

Care plan

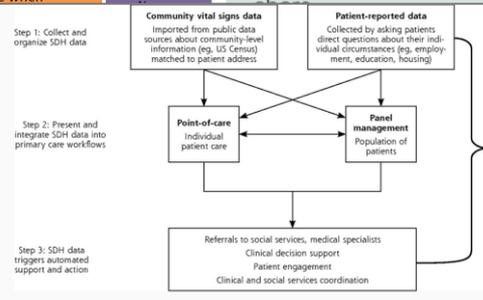


Co-Development

- Co-develop with patient, care provider, and family
- Ensure patient's goals and priorities are reflected and establishes dual ownership
- Identify any additional parties with whom to

Keep it Simple

- Focus on most important information for the patient
- Use patient-friendly language so that care plan feels accessible for patients
- Not too text heavy



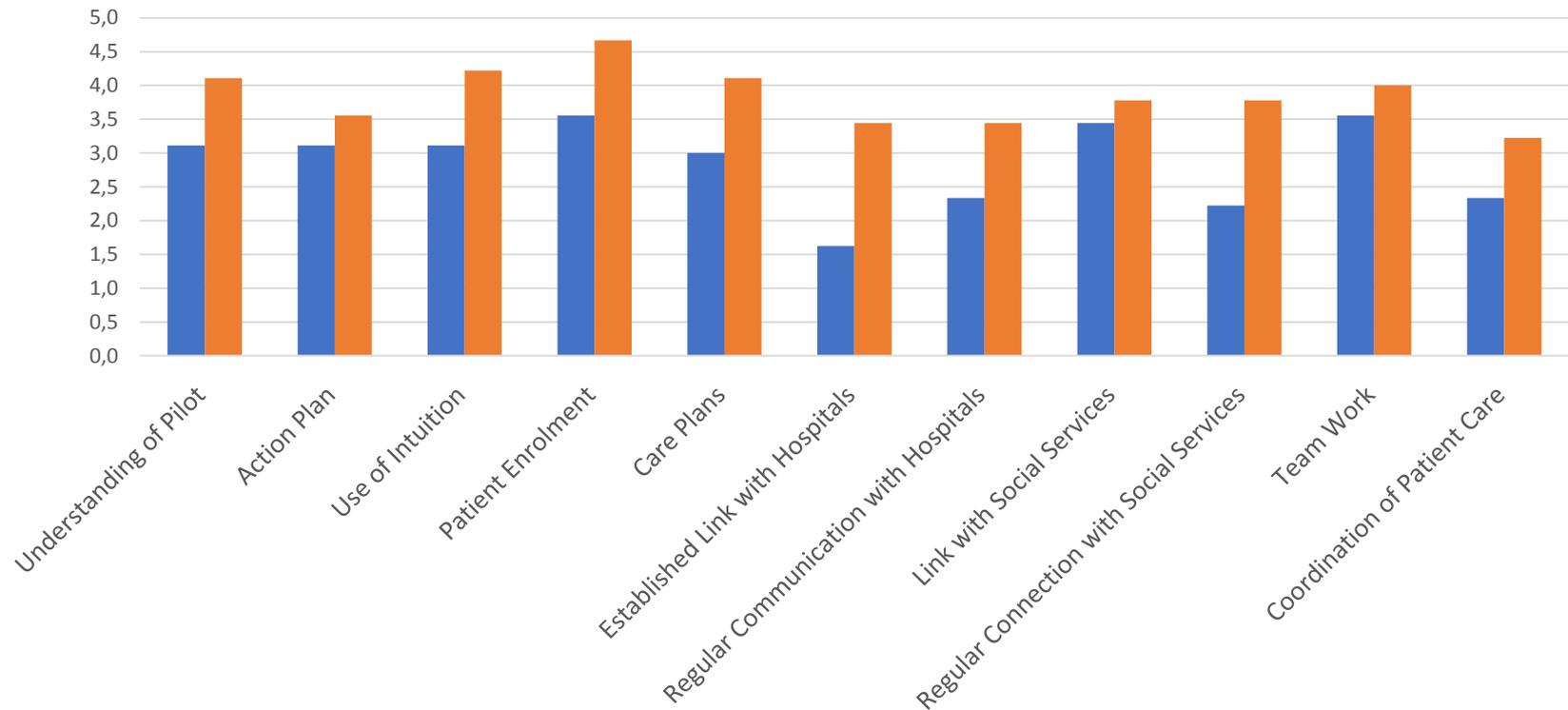
<http://www.amfammed.org/content/142/104.html>



2 Pilot Implementation – Support

Adherence to pilot implementation plan, *average score*

■ March ■ August





3

Pilot Implementation – Monitoring

https://testdmisp2.digilugu.ee/misp2/forms-query.action?idv1354

Eesti keeles Abi Välja

Test - TTO portaal

Roll Tavakasutaja (Haigekassa)

Teenused Teenuste ajalugu Minu seaded

Riskipatsientide mudel

Nimistu N0591

[Kuva väljastatud](#)

Isiku andmed	Triaad	Arhetüüp	Kaasuvad	Haiglaravi	PA visiit	Nõustus	Järgm. PA visiit	Tel kontakt	
	hüpertensioon diabeet hüperlipideemia								Detailandmed Kuva raviplaan
	hüpertensioon hüperlipideemia diabeet								Detailandmed Kuva raviplaan
	hüpertensioon diabeet								Detailandmed Kuva raviplaan
	hüpertensioon								Detailandmed

19:24 10.02.2017



3

Pilot Implementation – Monitoring

	Patients in registry	Patients excluded	Remaining patients	Patients included	Total patients final	Enrolled + care plan	% patients enrolled + care plan
FP 1	134	85	49	2	51	47	92%
FP 2	70	12	58	0	58	52	90%
FP 3	100	57	43	5	48	48	100%
FP 4	57	15	42	7	49	49	100%
FP 5	39	9	30	20	50	50	100%
FP 6	184	125	59	0	59	59	100%
FP 7	246	194	52	1	53	50	94%
FP 8	64	31	33	17	50	49	98%
FP 9	110	50	60	1	61	54	89%
Total	1.004	578	426	53	479	458	96%



3

Pilot Implementation – Monitoring

Facilitators and Barriers

- Participatory design of the pilot (+)
- Elevation of family nurses (+)
- Ongoing implementation support (+)
- Inclusion of entire teams (-/+)
- Dashboard readiness and technical difficulties (-)
- Language barriers (-)
- Time burden (-)



3

Pilot Implementation – Evaluation

Dimensions of Evaluation

- Feasibility
- Acceptability
- Process
- Outcomes



3

Pilot Implementation – Evaluation

Feasibility

- Met all of its implementation targets.

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Pilot Implementation – Evaluation

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Total	1.004	578	426	53	479	458	96%



3

Pilot Implementation – Evaluation

Acceptability

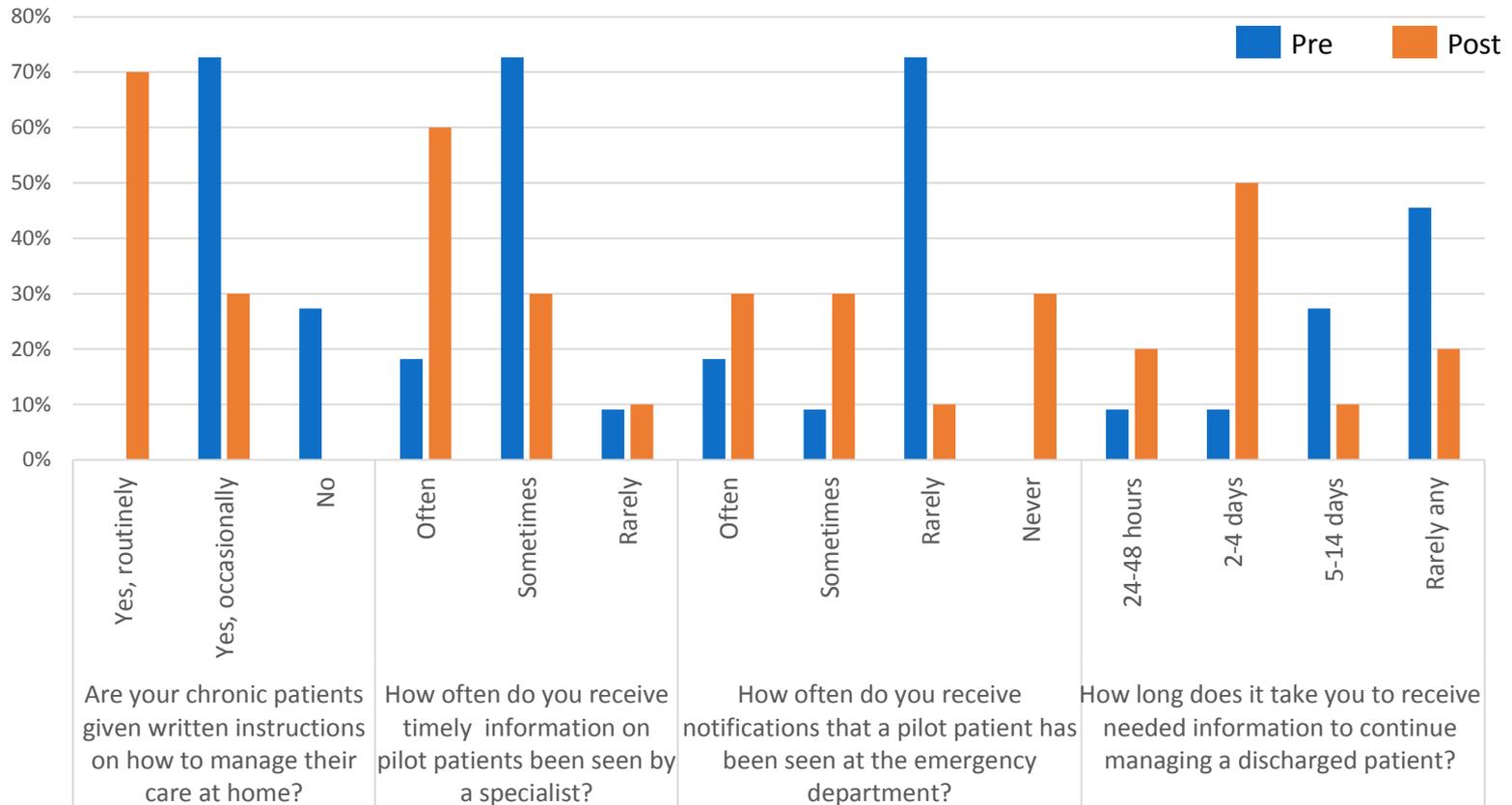
- EECM has not made the job of family physicians more stressful
- High patient acceptance rates
- Unanimous stakeholder acceptance of EECM
- Willingness of most providers to continue with EECM and to invite colleagues to join



3

Pilot Implementation – Evaluation

Process





3

Pilot Implementation – Evaluation

Process

PHC services % Change 2017 vs. 2016	Pilot	Comparison Group	Difference
Visit with FP	-20%	-29%	10%
Preventive visit with FP	67%	14%	53%
Home visit by FP	50%	-2%	52%
Phone call with FP	258%	139%	118%
Consultation with nurse	14%	-2%	16%
Home visit by nurse	300%	4%	296%
Phone call with nurse	256%	20%	237%



3

Pilot Implementation – Evaluation

Process

% of Patients with Post-Acute Care Follow up Call/Visit	Pilot	Comparison Group	Difference
2016	52.4%	57.7%	5.3%
2017	71.7%	56.4%	-15.3%
Change	19.3%	-1.3%	20.6%
Average Time (in Days) between Discharge and Follow up Call/Visit	Pilot	Comparison Group	Difference
2016	8.77	10.90	2.13
2017	8.32	10.46	2.14
Change	-0.45	-0.44	-0.01



3

Pilot Implementation – Evaluation

Process

Diagnostic Lab Tests/Procedures % Change 2017 vs. 2016	Pilot	Comparison Group	Difference
Albuminuria***	-77.4%	-88.1%	10.7%
Cholesterol	38.5%	-6.1%	44.7%
Cholesterol fractions	42.9%	-6.0%	48.9%
Creatinine	32.5%	-10.3%	42.9%
EKG	80.4%	-4.5%	84.9%
Glucose	44.4%	-4.3%	48.7%
Glycated Hemoglobin	33.1%	-2.2%	35.3%
Potassium	25.0%	-6.6%	31.6%

***The microalbuminuria test was part of the QBS in 2016, but not in 2017



3 Pilot Implementation – Evaluation

Outcomes

% of Patients with Statin Prescriptions	Pilot	Comparison Group	Difference
2016	38.6%	31.5%	-7.1%
2017	50.6%	31.8%	-18.8%
Change	12.0%	0.3%	11.7%



3

Pilot Implementation – Evaluation

Outcomes

Avoidable Specialist Visits (DM/HTN)	Pilot	Comparison Group	Difference**
% Change 2017 vs. 2016**	-39.6%	-12.6%	-27.0%
Acute Hospital Admissions Endocrine/Mental/ Circulatory./Resp.	Pilot	Comparison Group	Difference**
% Change 2017 vs. 2016**	-16.7%	-2.9%	-13.8%

**Not statistically different due to pilot size.