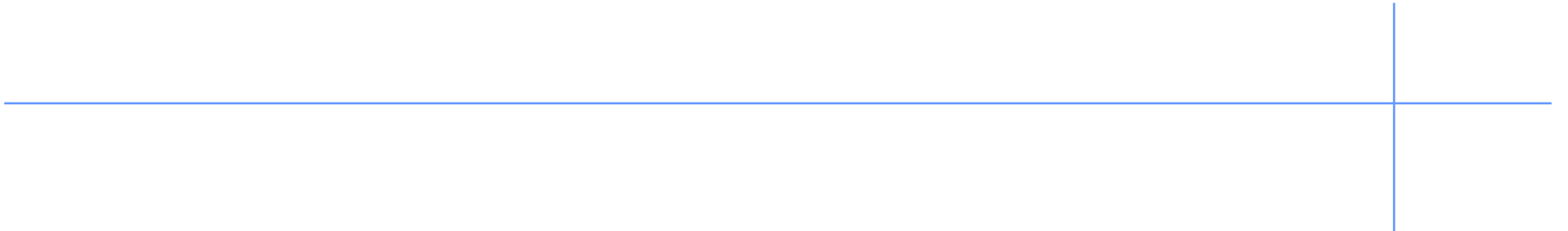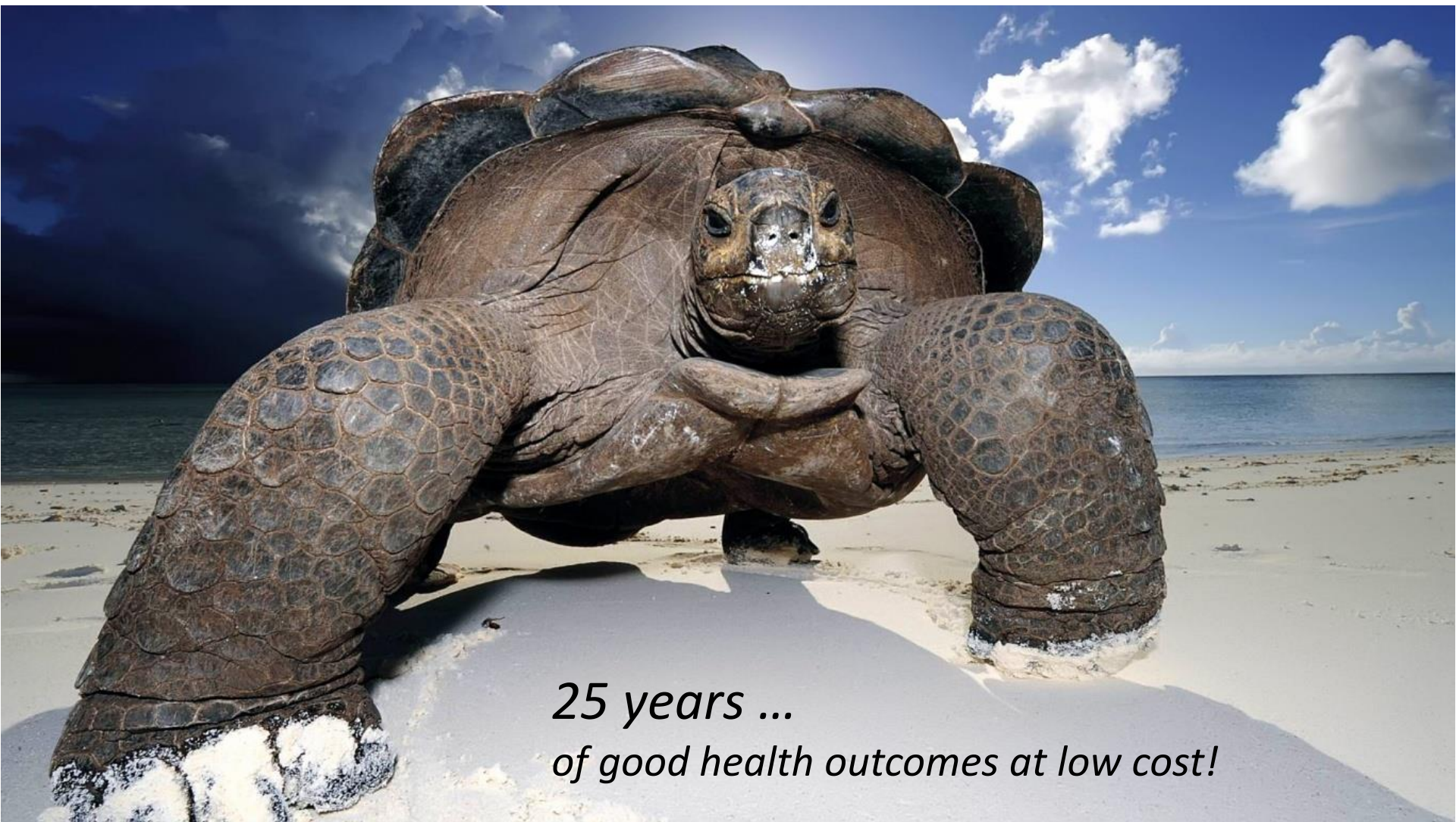# The EHIF - World Bank Collaboration
A Quick History

Tallinn, October 2017
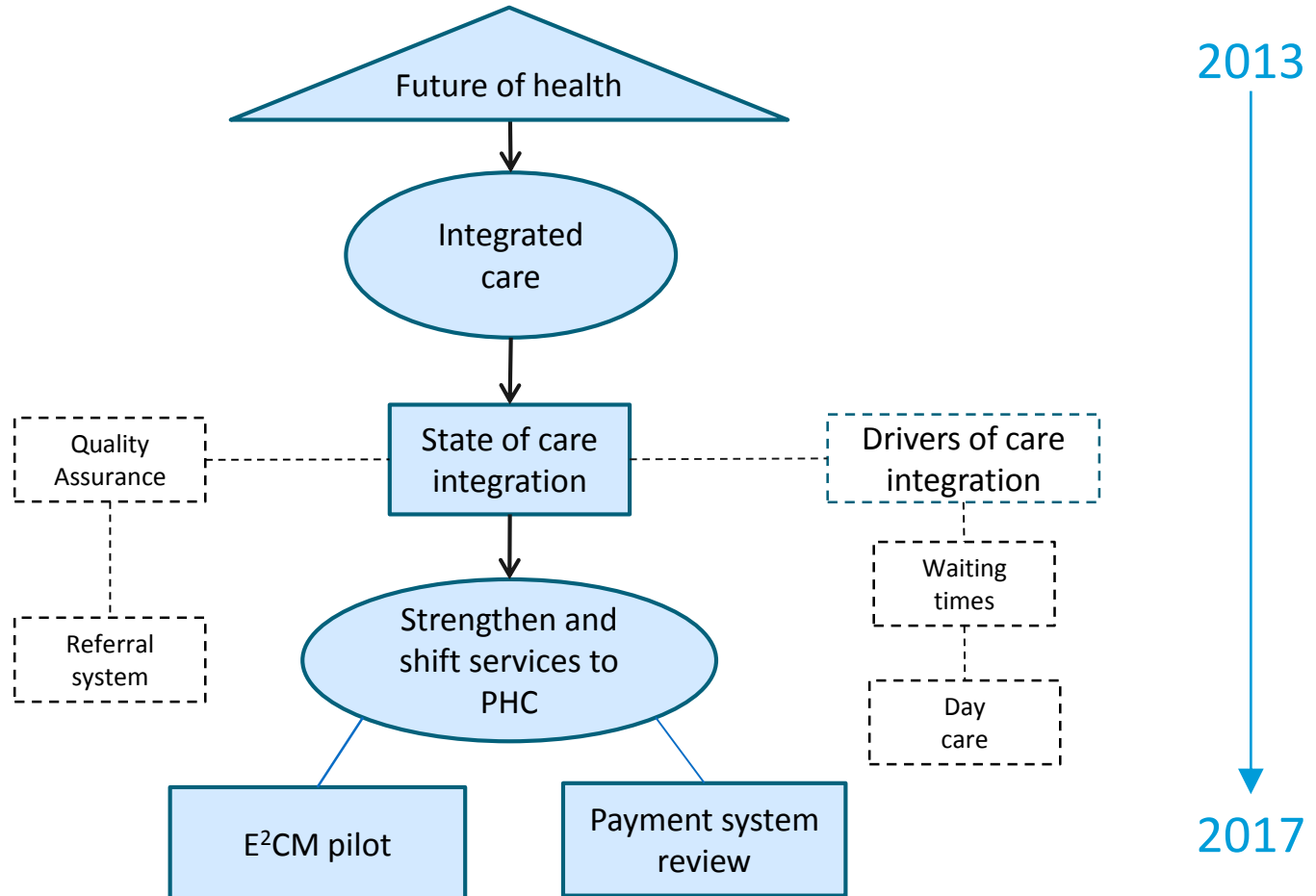
25 years …
of good health outcomes at low cost!

History of EHIF - World Bank Collaboration

Partners

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

EHIF-WBG Project

Tallinn, October 2017
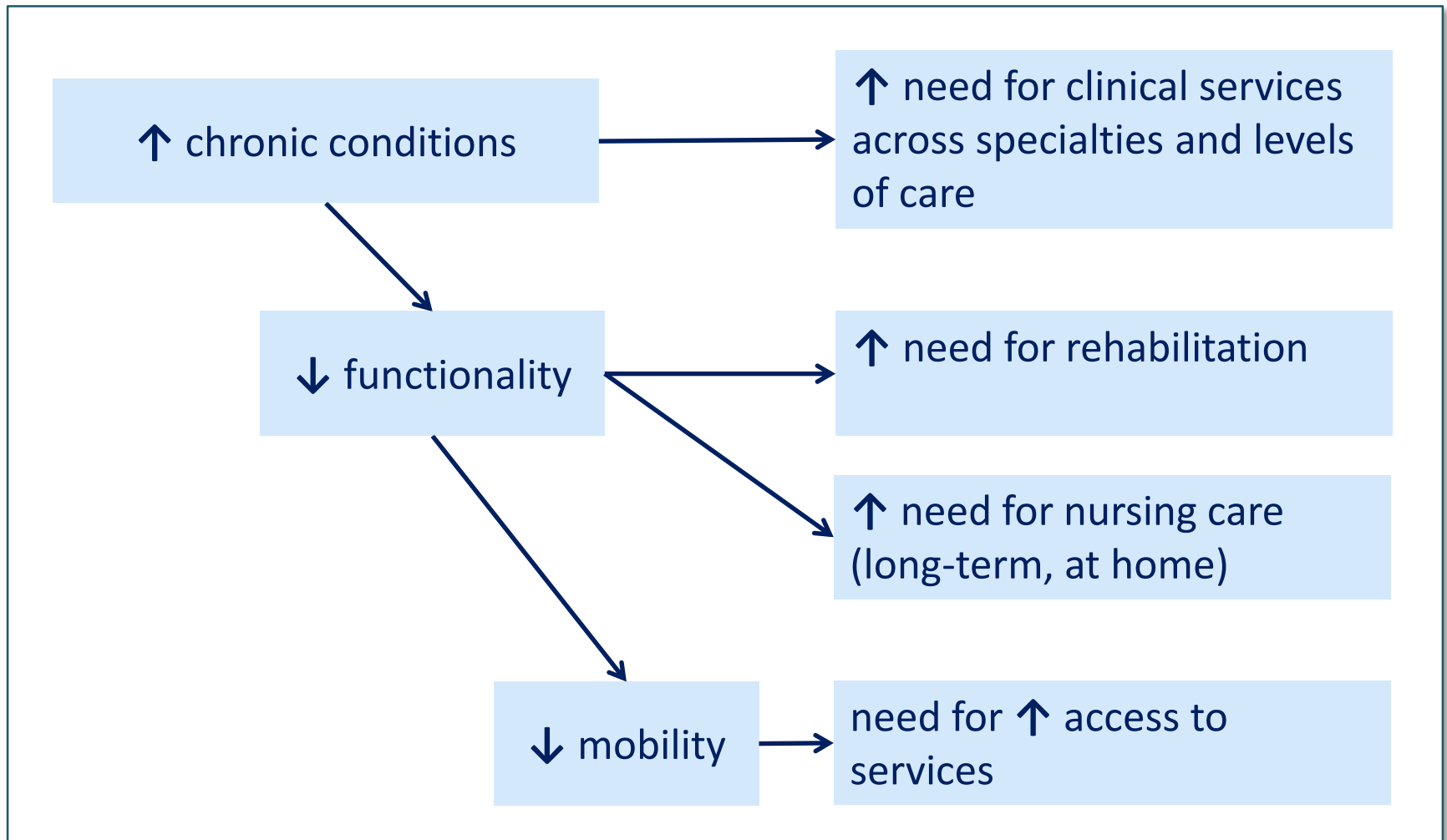
Outline

Care integration challenges in Estonia

Toward enhanced care management
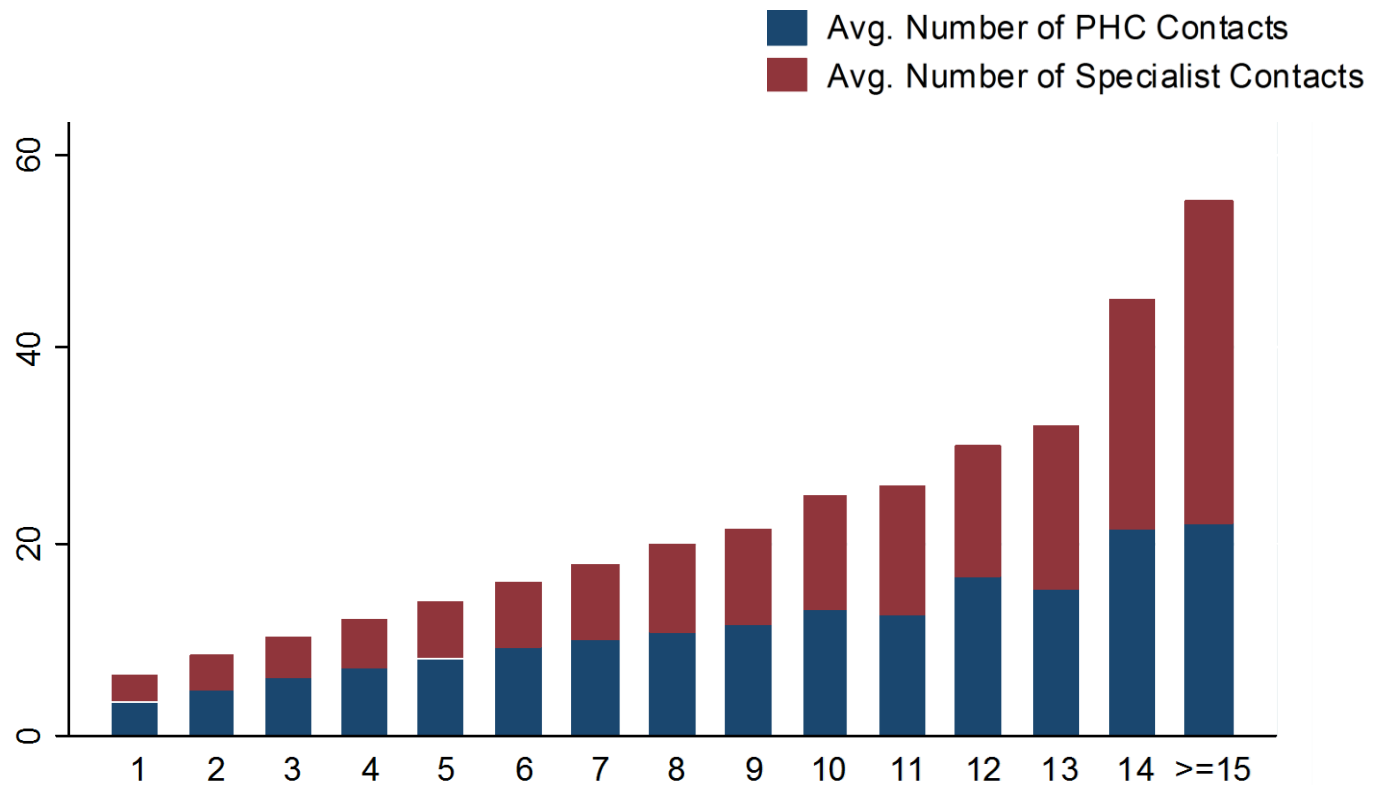
Estonian enhanced care management pilot

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*
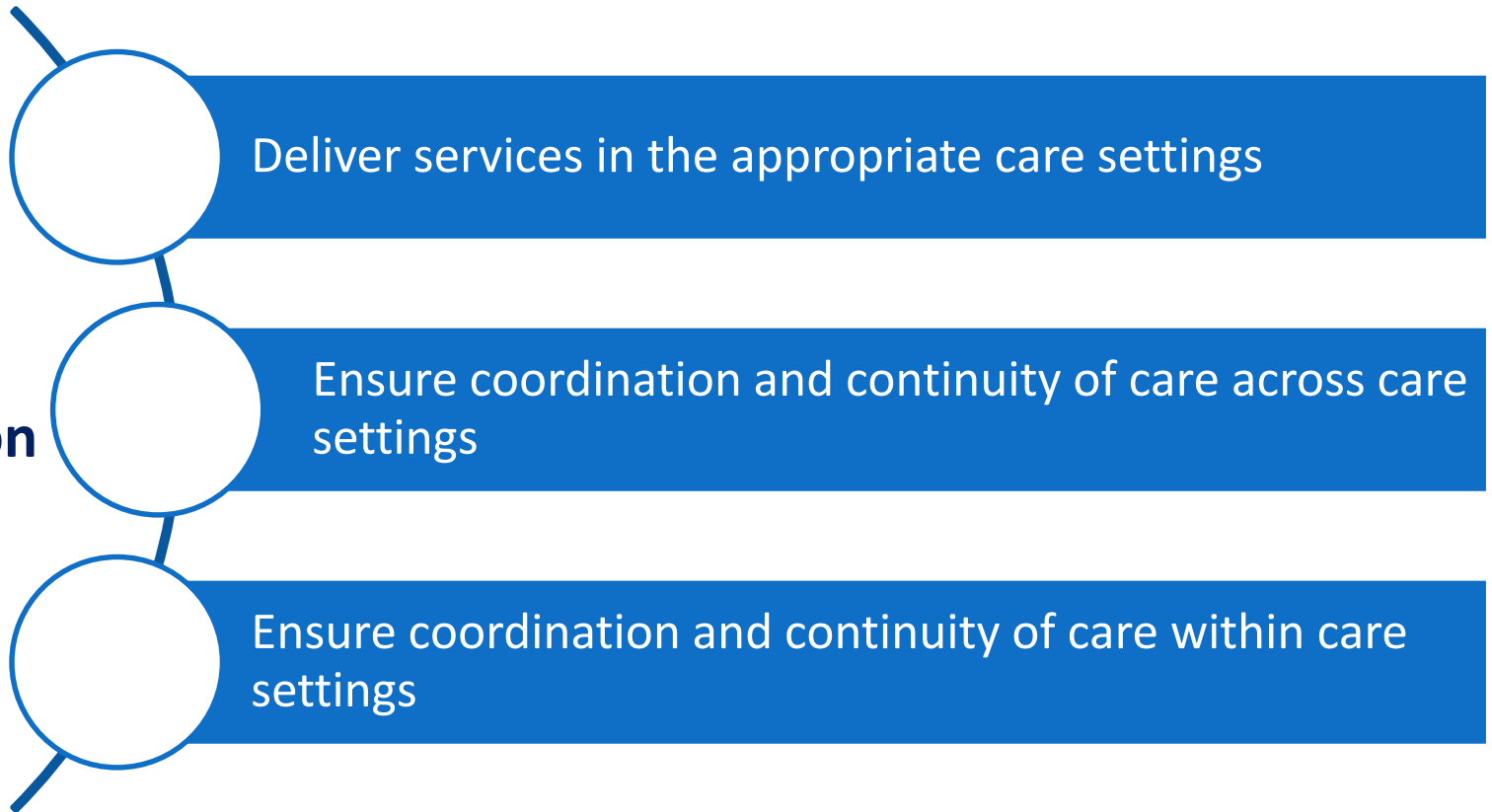
Care integration - key challenges

Care integration
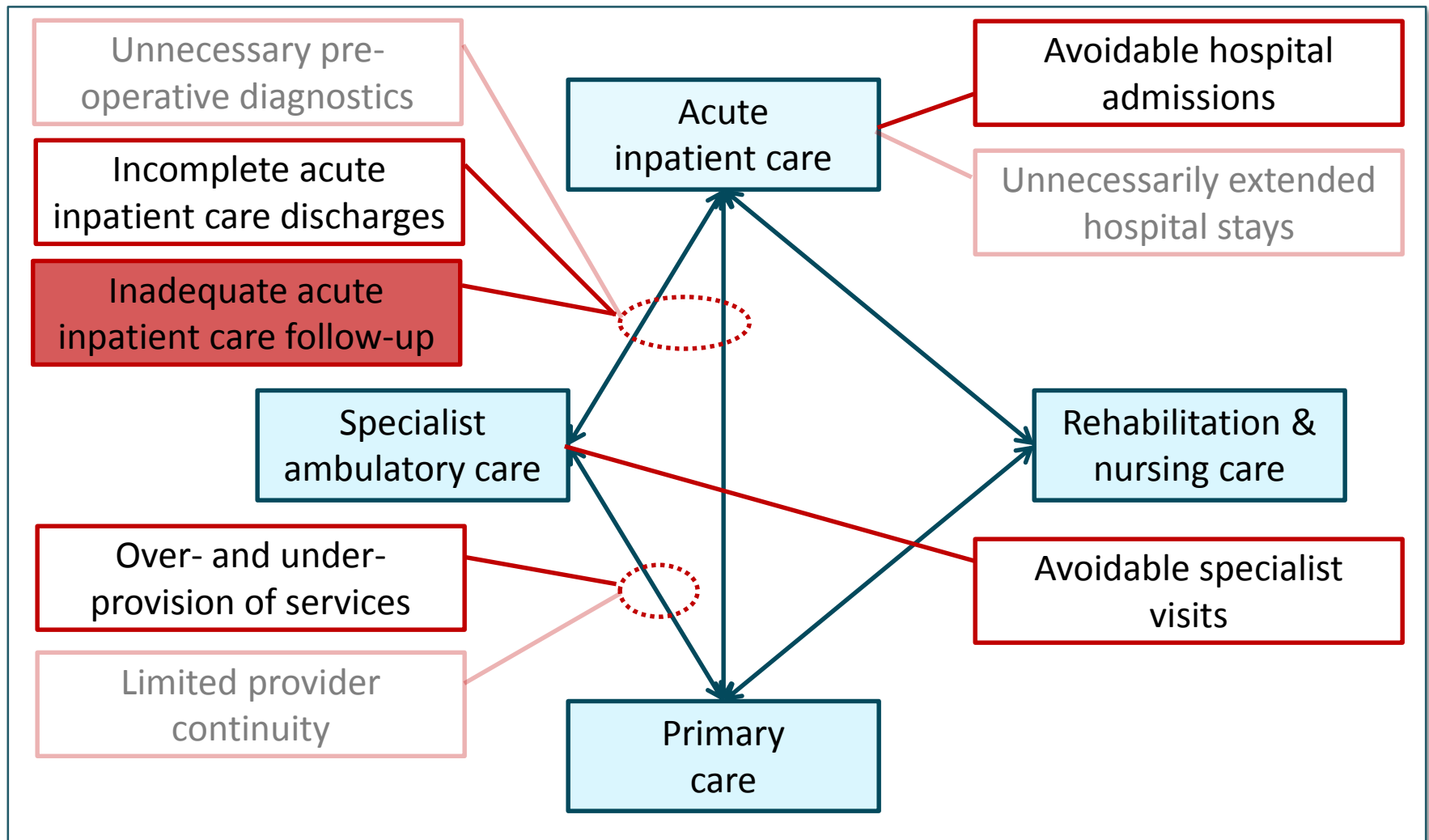
- Deliver services in the appropriate care settings
- Ensure coordination and continuity of care across care settings
- Ensure coordination and continuity of care within care settings

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

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Toward enhanced care management

Estonian enhanced care management pilot

Toward enhanced care management

Work builds off of a large body of evidence

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 years[1], *% of adults age 65 and over*

Country	%
Australia	21%
Canada	32%
France	7%
Germany	41%
Netherlands	21%
New Zealand	20%
Norway	37%
Sweden	24%
Switzerland	29%
United Kingdom	24%
United States	35%
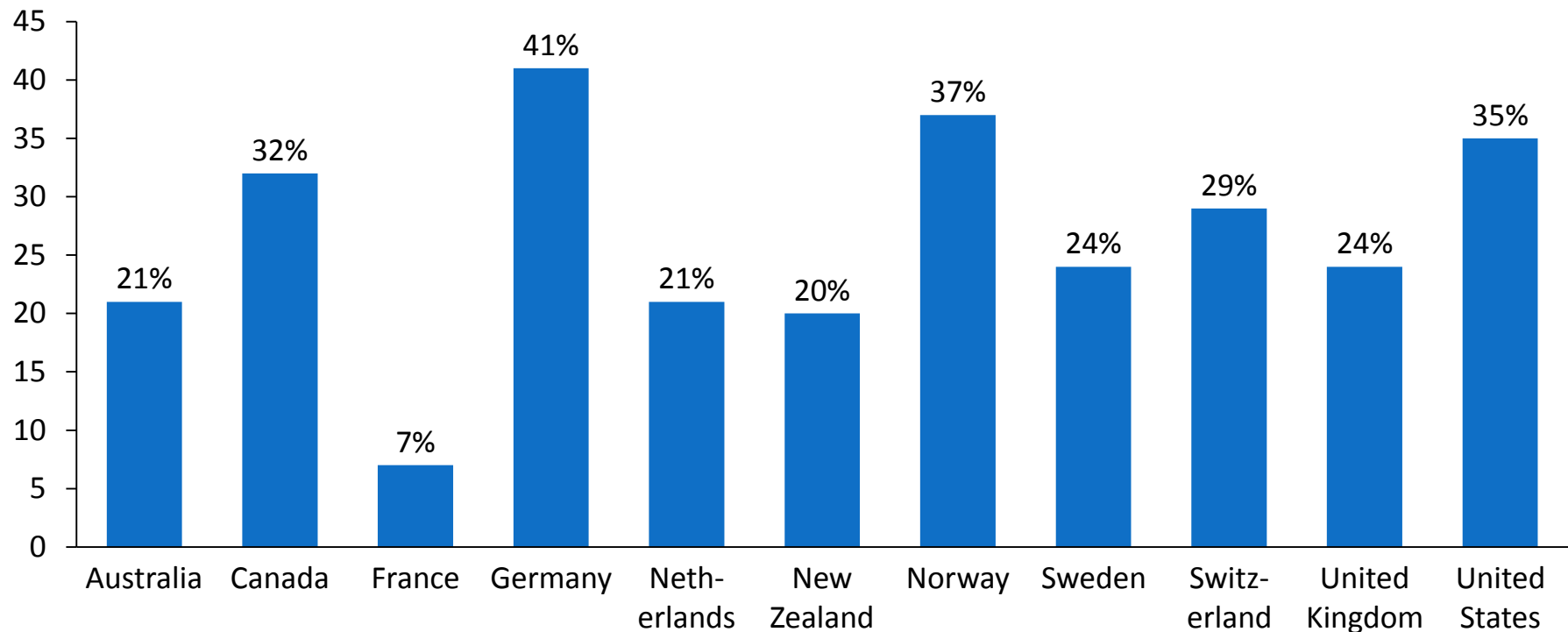
1 Answered yes to at least one: test results/records not available at time of appointment or duplicate test ordered; received conflicting information from different health professionals; or specialist lacked medical history or regular doctor not informed about specialist care

SOURCE: 2014 Commonwealth Fund International Health Policy Survey of Older Adults in 11 Countries

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

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

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

Country	Percentage
Australia	59%
Canada	44%
France[1]	0%
Germany	20%
Netherlands	73%
New Zealand	68%
Norway	51%
Sweden	41%
Switzerland	68%
United Kingdom	78%
United States	43%
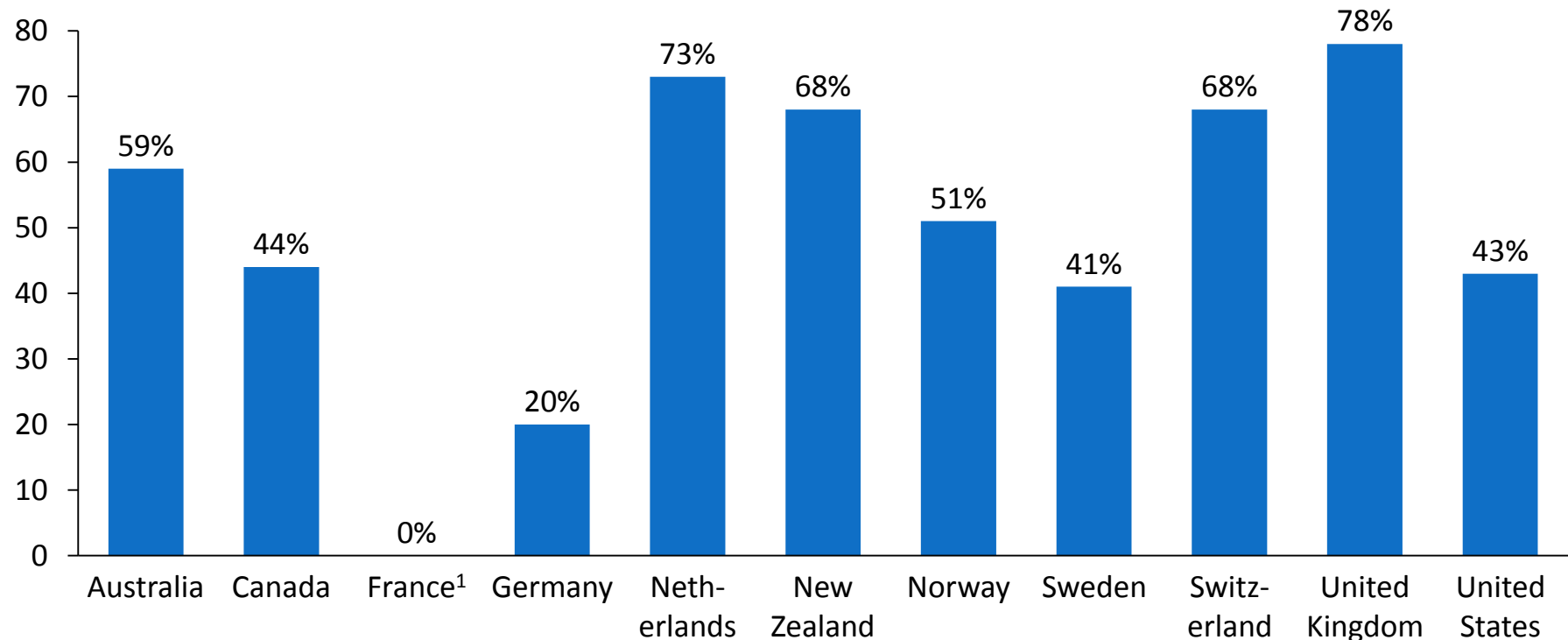
Enhanced Care Management

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
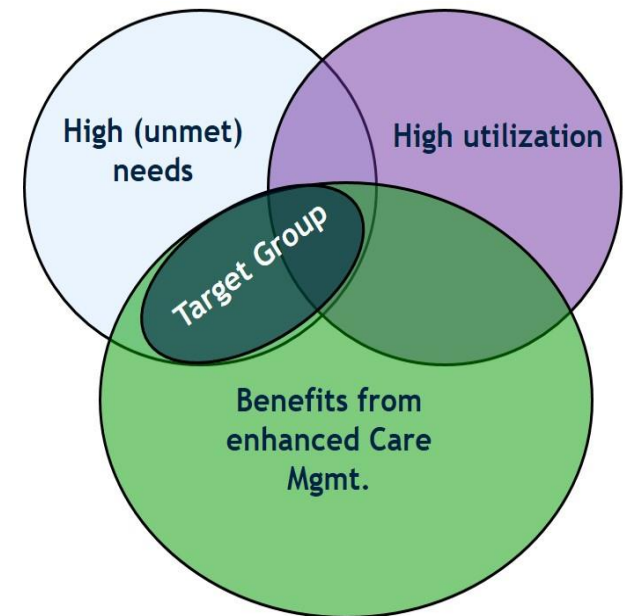
Targeting Patients
(Care Coordination vs. Care Management)
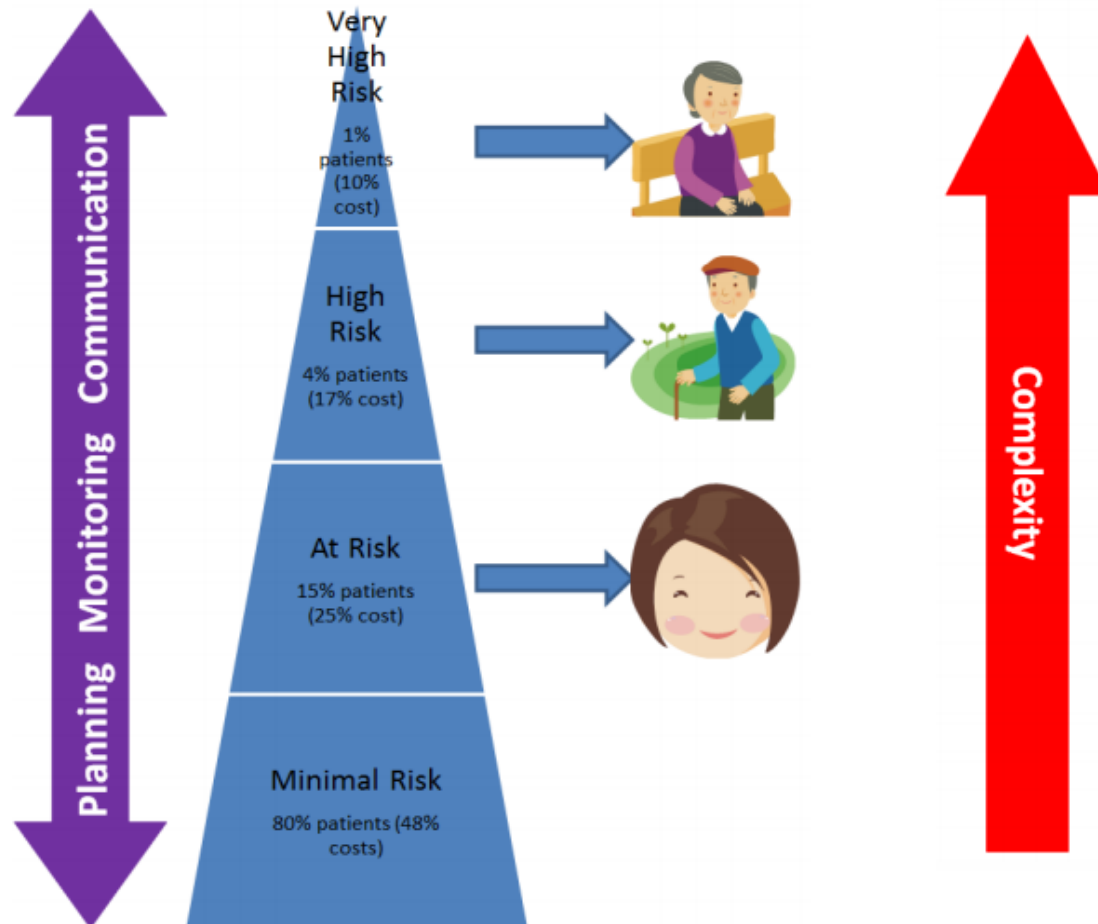
Care Plans

- 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

Information about personal health situation

Self care support

Health literacy

Decision making

Communication skills

Being connected

PASSIVE → ACTIVATED

Know Your Own Health

All faith in our doctor

Passive behaviours

Helplessness

Isolation

Take action

Find information

Organise our questions

Map our options and choices

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

South Huntington Hospital Admissions and ED Visits
(data from South Huntington internal records)
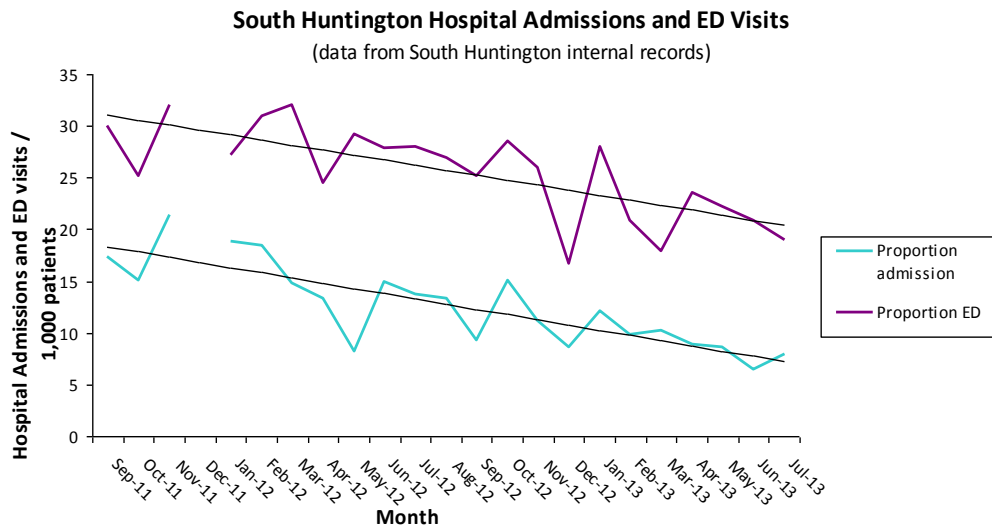
Team Approach and Resource Connections

Building a care team

Iora Health (US)

CARE TEAM WORKING TOGETHER

WARM AND CARING ATMOSPHERE

FORUM TO BE HEARD

HEALTH COACH

Nuka (Alaska natives)

Resource connections to other services

- To meet **patient needs**

- To fill gaps in **care team capacities**

Patient registry – paradigm shift

Directional effect

Patients likely to benefit most

Utilization + Costs

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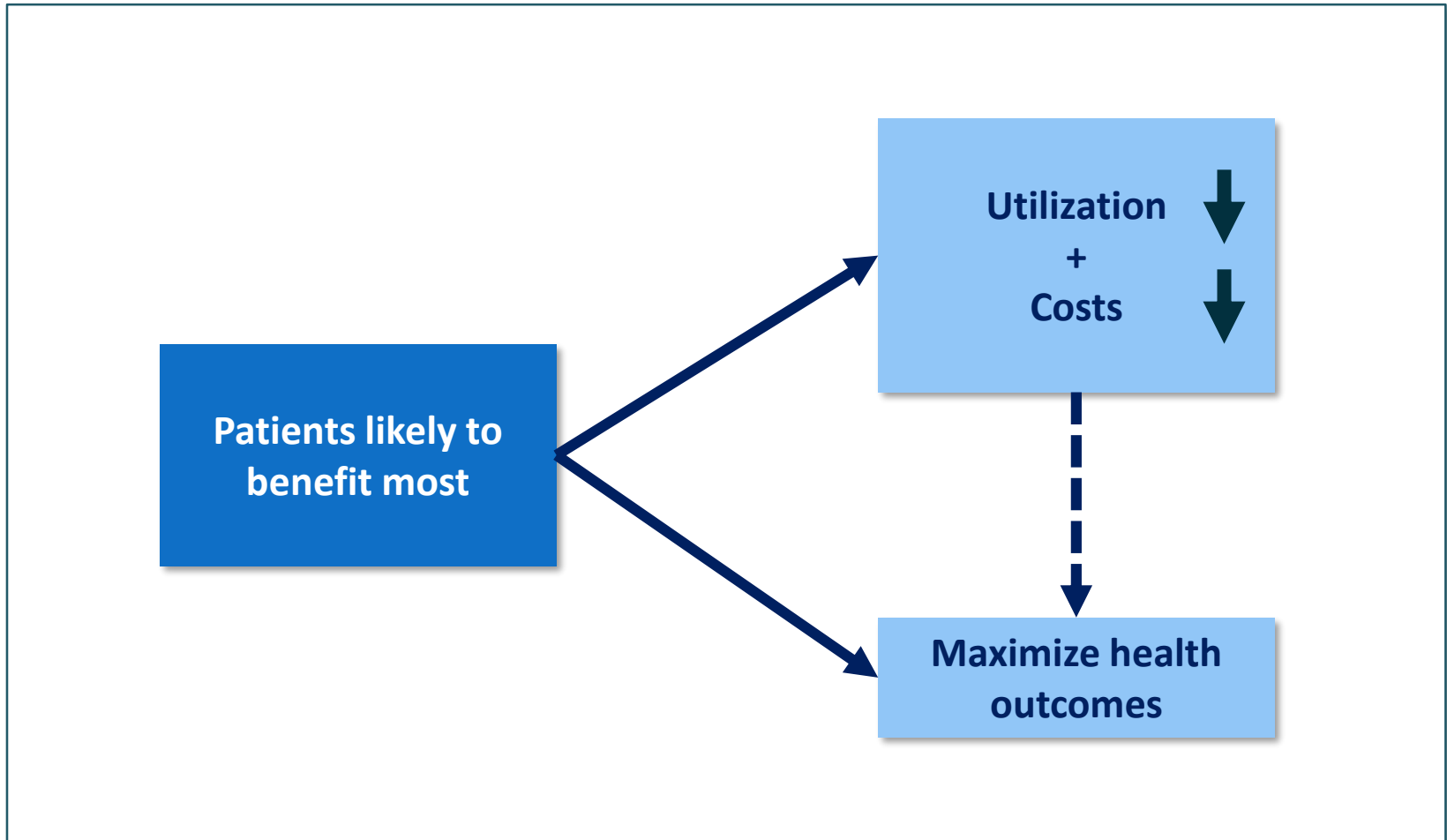
Use of archetypes in health care is helpful to better address unmet patients needs

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

Data

FP intuition

Disease archetypes → Patient characteristics → Patient archetypes → Patient registry

Development of patient registry

Development of patient registry

Data

FP intuition

Disease archetypes → Patient characteristics → Patient archetypes → Patient registry

Potential to benefit
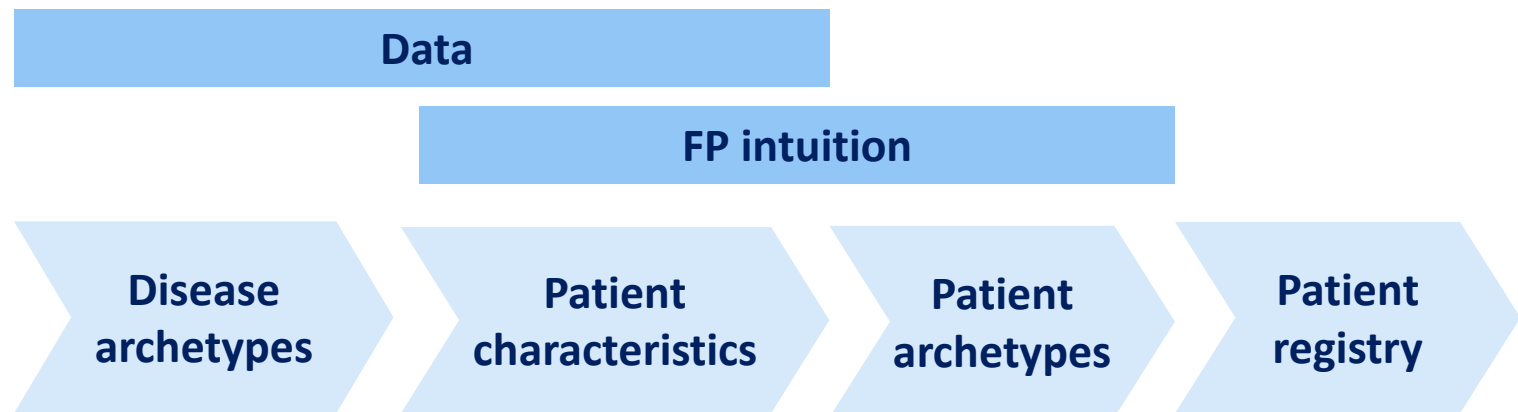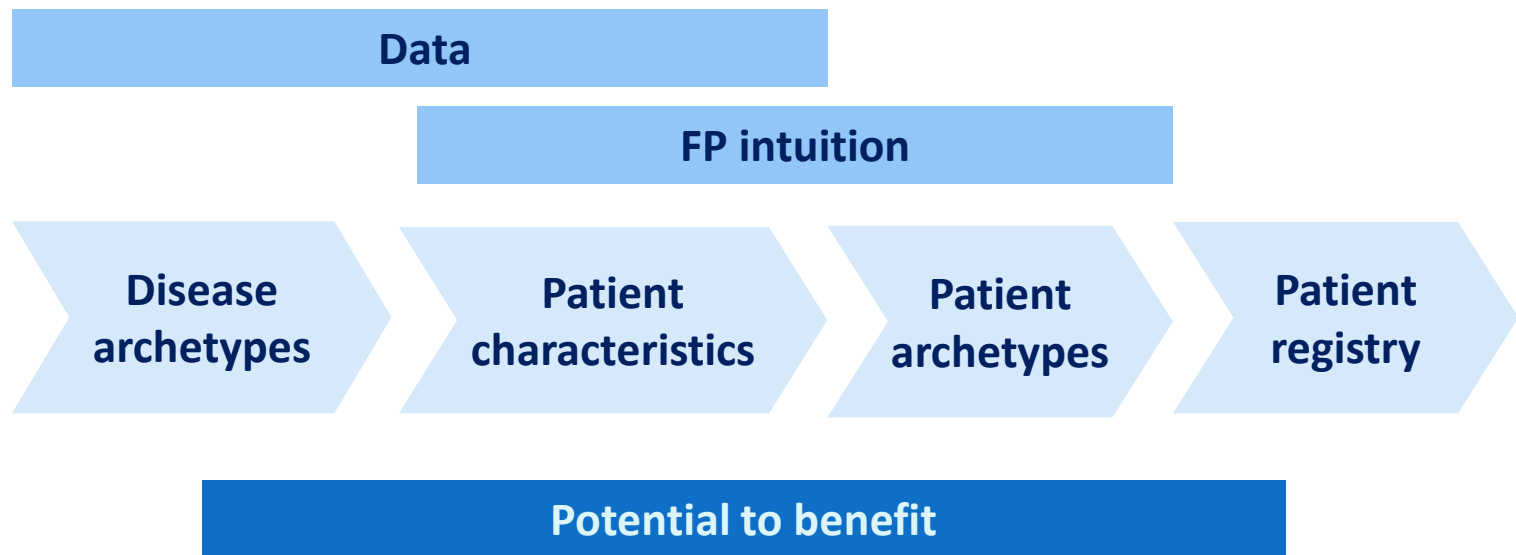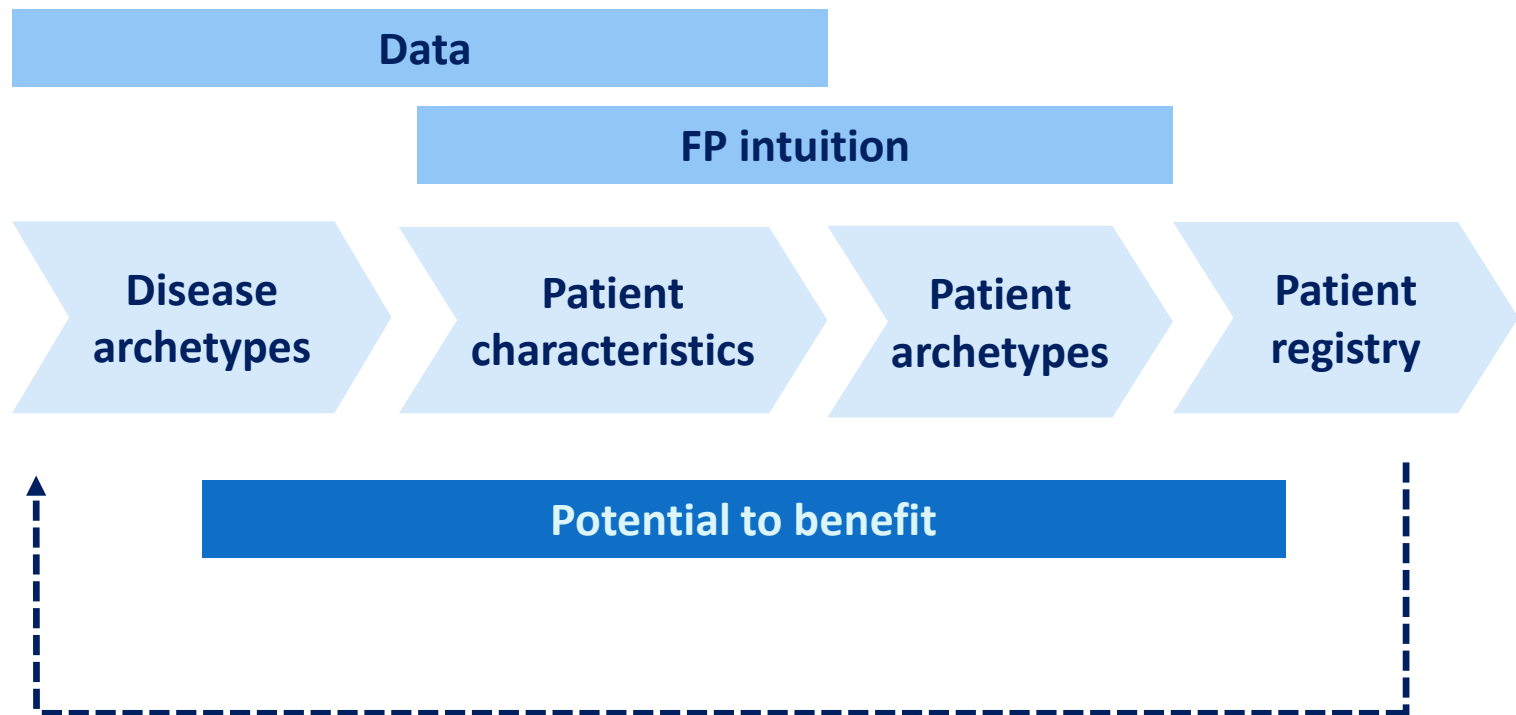
Risk Stratification Model for EECM
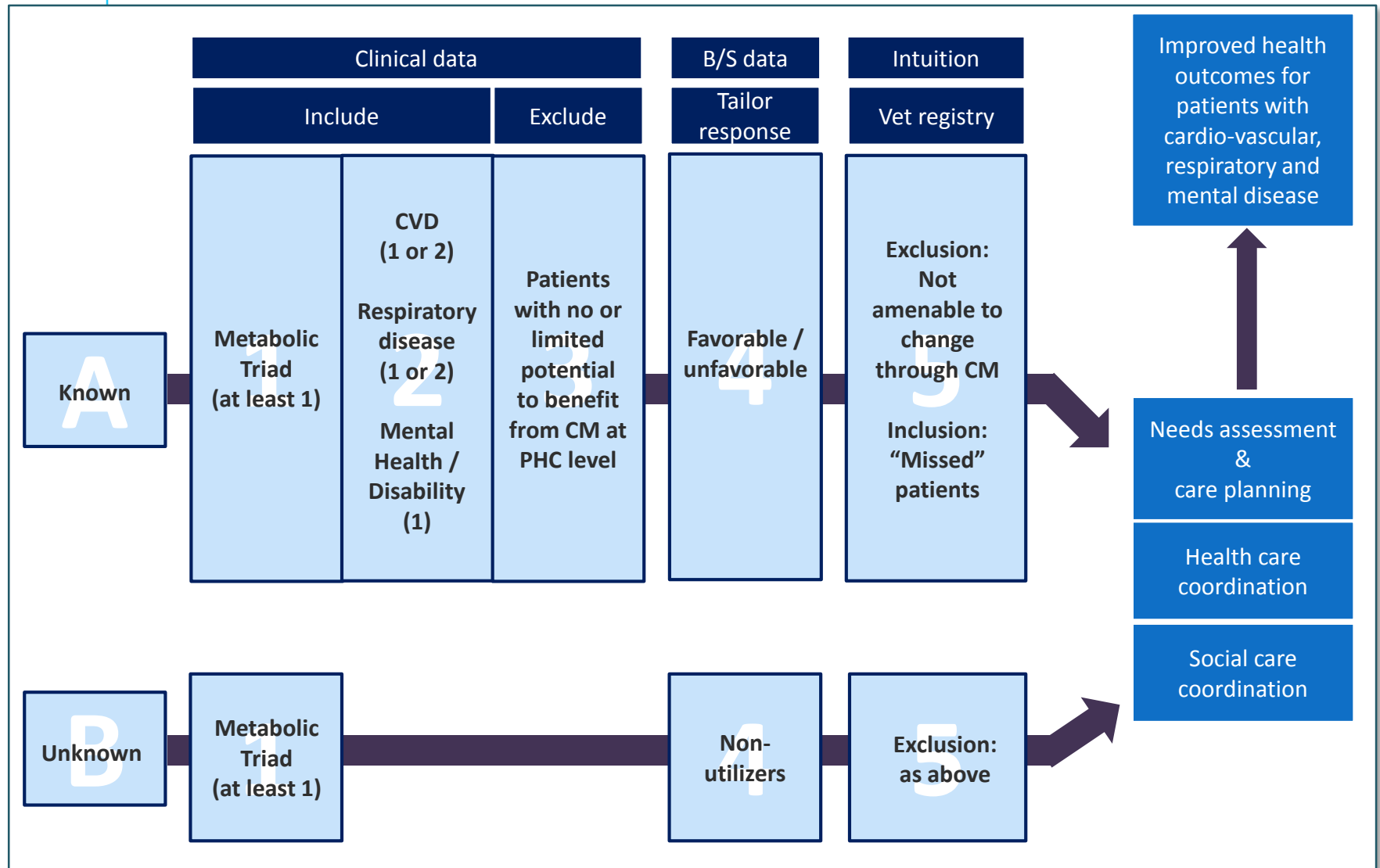
Outline

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

Patient registry		
A	2 3 4	
	1 5	
B		

Enhanced care management

- Needs assessment & care planning
- Care coordination - health
- Care coordination - social
- Team work / organization

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

Implementation

- Training
- Support
- Monitoring and evaluation
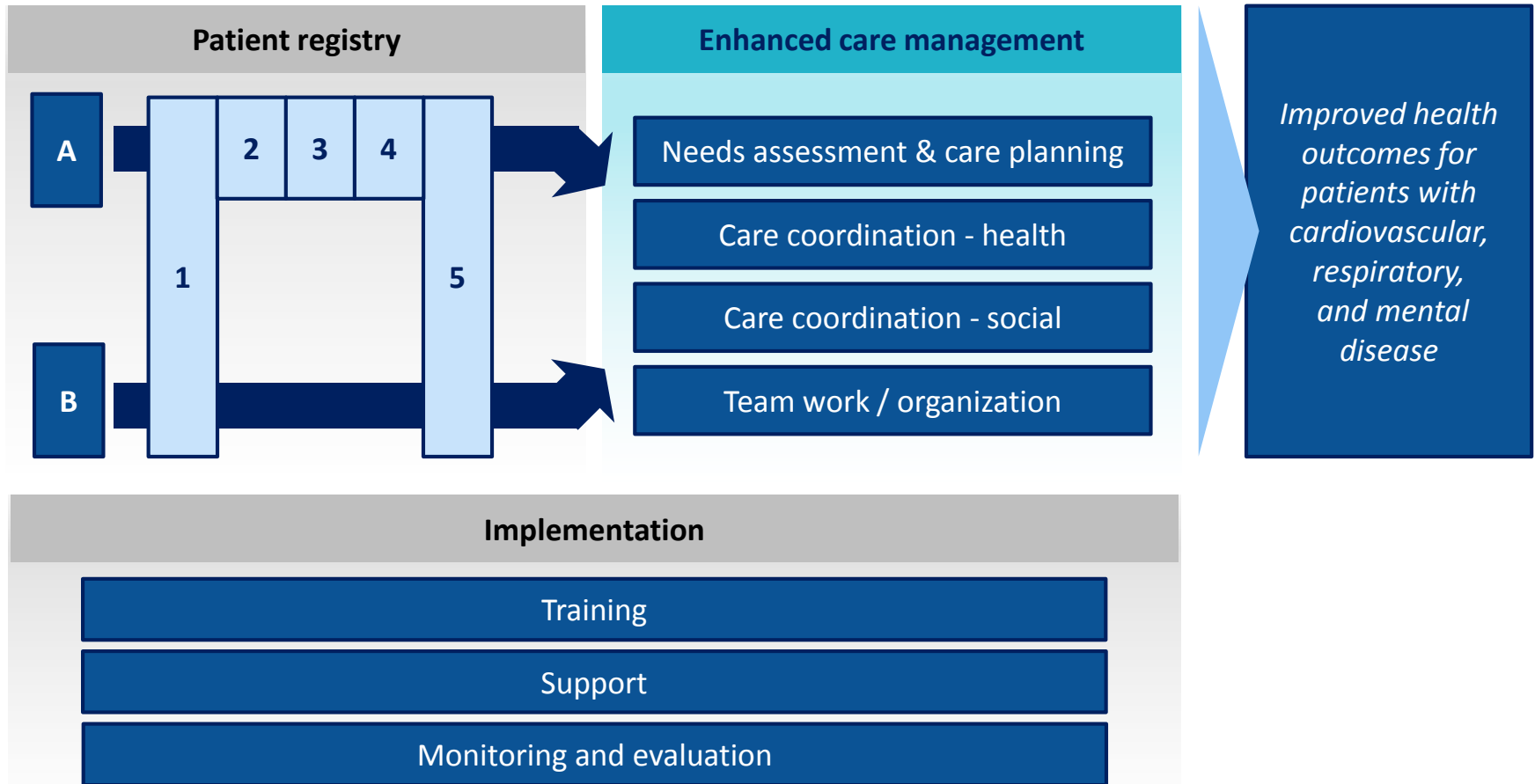
Pilot overview - Estonian enhanced care management
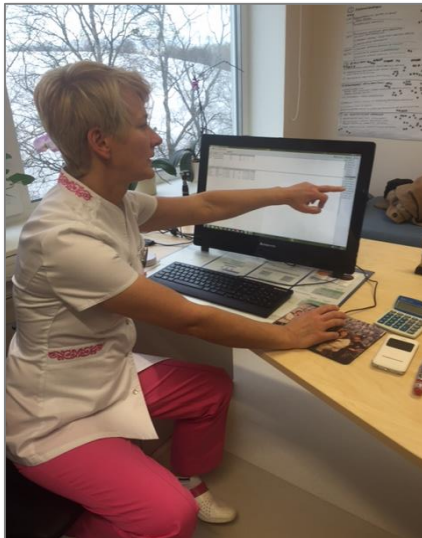
Timeline	Feb 2017 – Aug 2017
Practices	9
Family Physicians	10
Nurses	11
Resident Physicians	1
Total Patients	~500

Pilot implementation – timeline

WORLD BANK GROUP

Detail on next slide

Component	2017	2018							
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Registry	████	██							
Needs assessment & care planning			██	██	██	██			
Care coordination - Health			██	██	██	██	██	██	██
Care coordination - Social			██	██	██	██	██	██	██
Team work / organization		██	██	██					
Training	██	██	██	██	██	██			
Support		██	██	██	██	██	██	██	██
Monitoring & evaluation	██	██	██	██	██	██	██	██	██
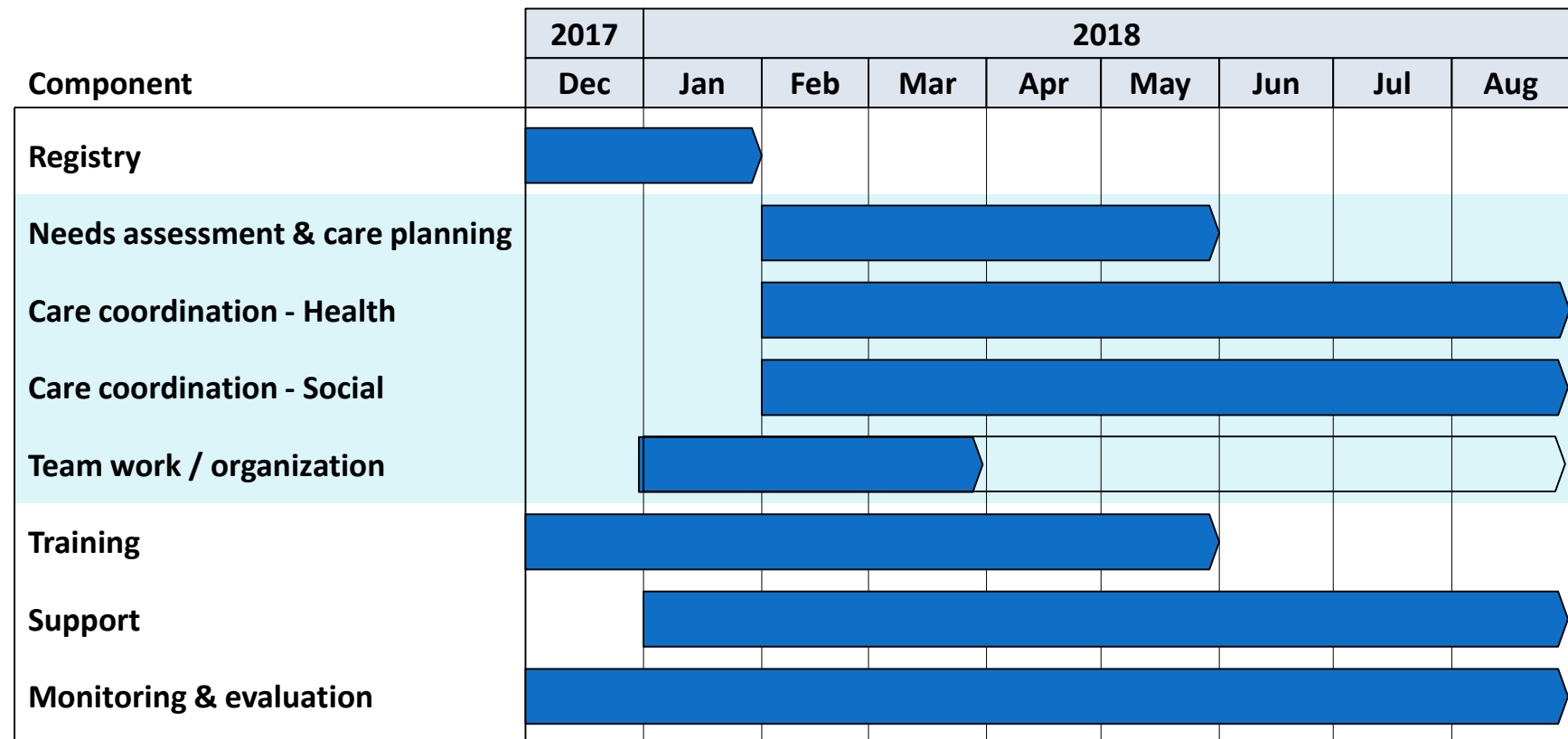
Pilot Implementation – Components, Objectives, and Activities

Component	Activities and objectives
Needs assessment & care planning	■ Elicit patient goals ■ Create care plan
Care coordination - Health	■ 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	■ Improve information flows between care teams and social care ■ Increase coordination with social workers
Team work / organization	■ Promote peer learning ■ Structure and optimize work processes ■ Elevate the role of nurses

Pilot design – Implementation

Patient registry

A

1   2   3   4   5

B

Enhanced care management

Needs assessment & care planning

Care coordination - health

Care coordination - social

Team work / organization

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

Implementation

Training

Support

Monitoring and evaluation
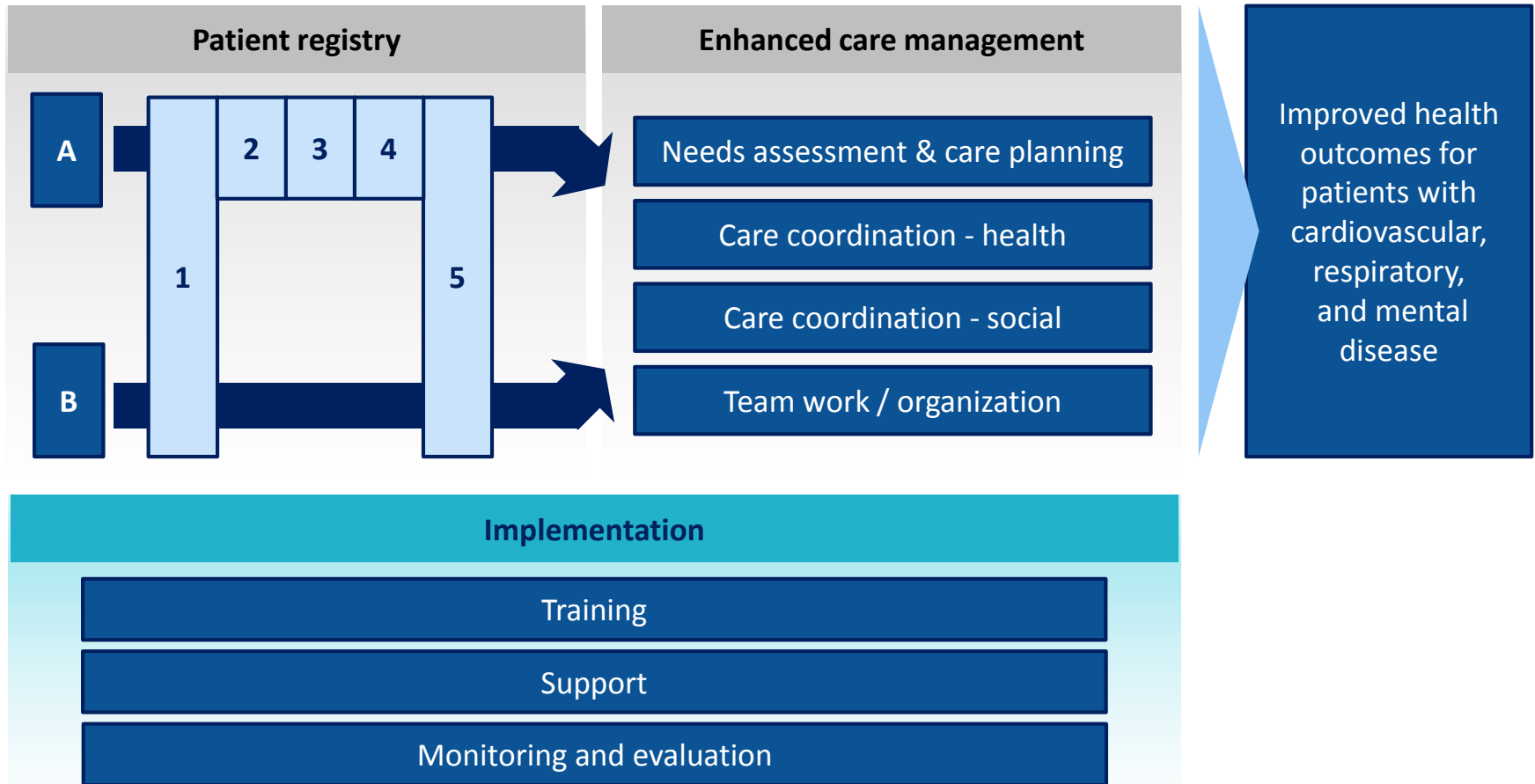
Pilot Implementation

Key components

Implementation		
1 **Training**	■ Webinars
	■ Meetings with FPs to discuss challenges and share practices
	■ Study materials
2 **Support**	■ Monthly coaching
	■ On site visits
	■ Constant feedback on quality progress
3 **Monitoring & evaluation**	■ 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

Pilot Implementation – Support

Monthly monitoring and support

1. Understanding the pilot

2. Creating an action plan

3. Applying intuition

4. Operating as a team

5. Enrolling patients

6. Establishing care plans, quality of care plans

7. Establishing connection and regular communication with hospitals

8. Establishing connection and regular communication with social services

9. Coordinating patient care
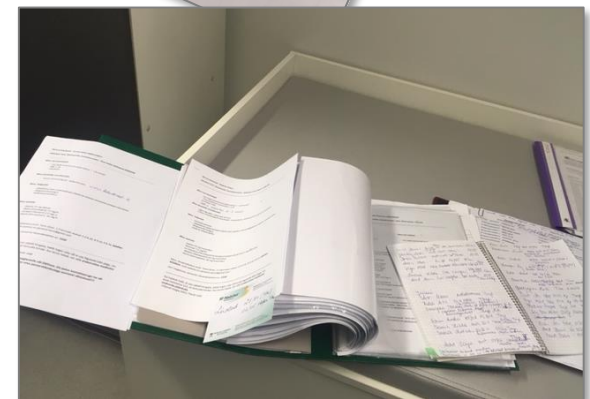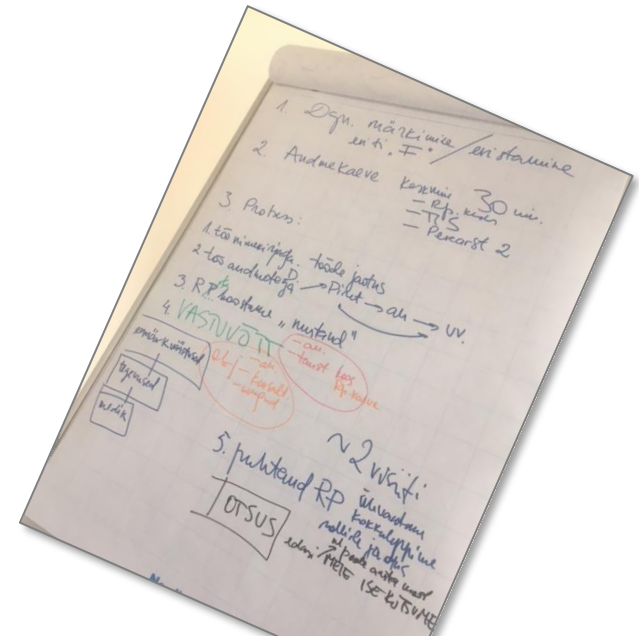
Adherence to pilot implementation plan, *average score* — March / August

SOURCE: Monthly monitoring reports
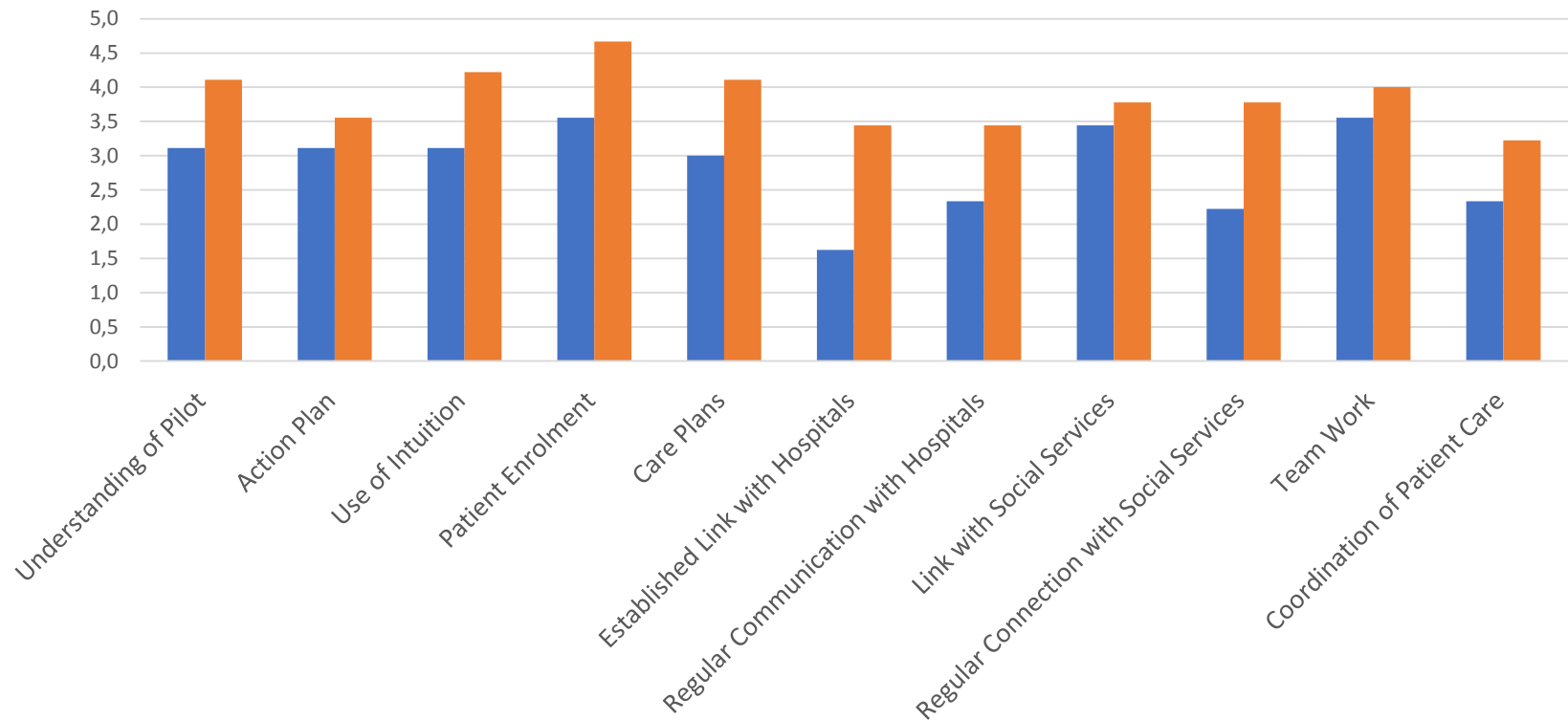
③ Pilot Implementation – Monitoring

	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%**

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 (-)

Dimensions of Evaluation

- Feasibility

- Acceptability

- Process

- Outcomes

Feasibility

- Met all of its implementation targets.

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Feasibility

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Total	**1.004**	**578**	**426**	**53**	**479**	**458**	**96%**

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

SOURCE: Provider surveys, patient interviews, key informant interviews.

Process

SOURCE: Provider surveys.
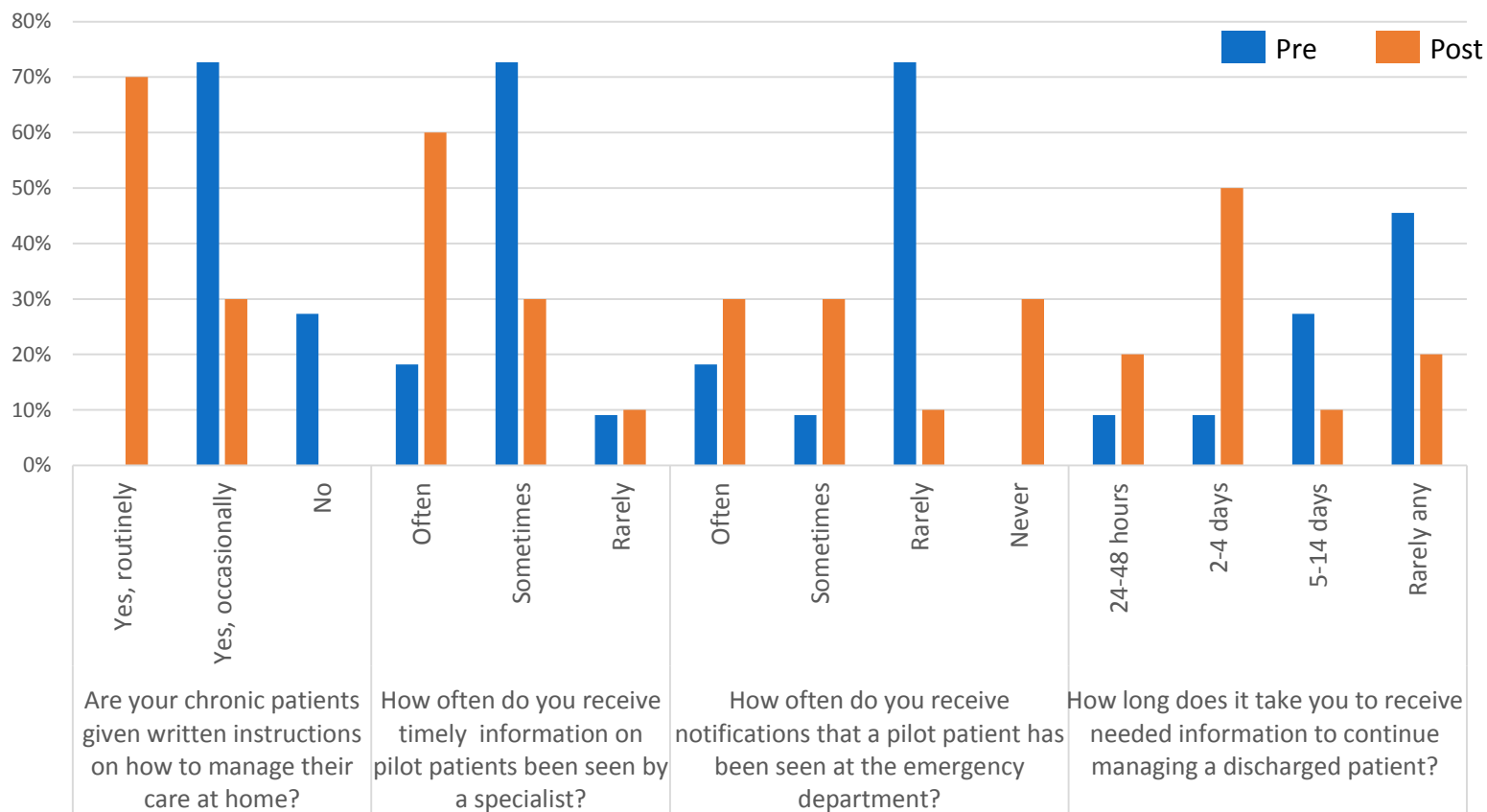
Process

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%**

SOURCE: EHIF claims data.

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

SOURCE: EHIF claims data.

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

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%**

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.