Assessment of Integrated Care in Estonia

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Challenges in health care in Estonia

Strenghts of Estonian health care:

- Solidarity based health financing
- Achieving positive outcome at low costs
- EHIF acts as a single purchaser with its strategic partners for providing services, that allows us to control accessibility and quality of care

New challenges in the 21st century:

- Older population continues to grow
- Rising prevalence of chronic deseases
- Requiring increased coordination of care
- Large increases in health care expenditures

Analyzing and developing integrated care in Estonia

- **Cooperation with World Bank Group – study „Towards integrated health care“ 2013 – 2015**
- **EHIF implemented several strategies to improve the care integration**
- **Second World Bank Study 2015 – 2017**
  - Purchasing models to support care continuity and coordination of care
  - Piloting care coordination between different levels of health care and involving social care

Towards integrated care 2013-2015

- **Purpose of the study was to analyze:**
  - Fragmentation of health care services
  - Coordination of services between different health care providers
  - Continuum of care
- **Before the study the ideal situation (hypothesis) was described:**
  - Patients are treated according to evidence based clinical guidelines in primary care (as well as in other care types)
  - Patient with chronical disease is in regular contact with their family doctor or nurse
  - Strong primary care reduces unnecessary visits in ambulatory specialist care and also minimizes inpatient care for chronically ill
  - Primary care, specialist care (both outpatient and inpatient) and social care work together and patient's treatment is coordinated thru different types of services
  - The length of inpatient care in Estonia is on the average level compared to International standards

Qualitative and quantitative measures were used

- **EHIF has comprehensive data of all the health care services used of all the insured people in Estonia (95%)**
  - Primary care visits, diagnostics etc
  - Specialist care, detailed services information both in outpatient and inpatient care
  - All information on prescription pharmaceuticals
- **Data of health care services (years 2008 and 2013) was combined with CENSUS data**
  - Education, income, nationality etc
- **Also qualitative analysis including stakeholder interviews and focus group discussions was concluded**

Key performance indicators were set up

- Avoidable hospital admissions
- Extended hospital stays
- Avoidable ambulatory specialist visits
- Provider continuity
- Under-provision of preventive services
- Incomplete discharges
- Inadequate acute inpatient follow-up care
- Unnecessary pre-operative diagnostic tests

Main findings suggest that there is room for improvement

- **Estonian health care system is inpatient care oriented**
  - There is lack of coordination of care in primary care
  - EHIF's purchasing model motivates outpatient and inpatient specialist care
- **The care is more focused on specialist care**
  - Lack of integration between primary and specialist care
  - Direct access (no referral) to several specialists, also to ER
- **Internationally approved clinical standards are not always followed**
  - Lack of guidelines and standards
  - Lack of incentives to motivate quality of holistic and coordinated care
  - Insufficient flexibility of primary care purchasing model
- **Weak care coordination before and after inpatient care**
  - Lack of communication between hospital and family doctor
  - No common agreement, who coordinates the treatment

One example: **Avoidable ambulatory specialist visits**

Approach

- Internationally, there is no protocol to measure the extent of avoidable specialist visits.
- Internationally, there is a general consensus that a large number of specialist visits is avoidable.
- In consultation with international experts, a protocol was developed that is currently being vetted with the Estonian Association of Family Medicine.

Principles

- Patients with certain diseases (ICD 10) do not require visits with certain medical specialists.

Tracer conditions:

- Diabetes
- Hypertension

Construction of indicator:

Avoidable specialist visits as a share of all specialist visits for a certain disease group

Avoidable specialist visits

	2008		2013		2013
Diagnosis category	Specialist visits	% avoidable	Specialist visits	% avoidable	
Diabetes	39,520	26.03%	42,064	19.91%	>90% of avoid. visits with endocrinologists
Hypertension	60,302	70.81%	63,917	67.49%	>80% of avoid. visits with cardiologists

- The proportions of avoidable visits has decreased marginally since 2008 both, for diabetes and for hypertension
- The relatevily high number of avoidable specialist care visits may be partly attributed to the weaknesses of the primary care

Primary care versus ambulatory specialist visits

Disease / condition*	Average number of visits per year	
	2008	2013
General population seeking care (18 years and older)	6.5	6.4
Diabetes (18 and older)	11.2	10.3
Hypertension (18 and older)	10.2	9.8
CVD (18 and older)	9.7	9.5

*Excluding visits with obstetrician/gynecologists

- In 2013 the general adult population made an average 6.4 outpatient visits and it is remained relatively consistent over time

Primary care versus ambulatory specialist visits

Disease / condition*	Average number of visits per year	
	Primary care	Ambulatory specialist care
General population seeking care (18 years and older)	61%	39%
Diabetes (18 and older)	59,2%	41,8%
Hypertension (18 and older)	60,6%	39,4%
CVD (18 and older)	60,9%	30,1%

- The specialist care provides little added value in terms of increasing coverage with preventive services.

Working towards integrated care

- Report of care integration indicators is published annually and thoroughly discussed in all the hospitals by initiative of EHIF
- Integrated care indicators report is published in EHIF's web page and announced via press release
- Analyzing specialist care referral system – enforcing primary care, treatment guidelines, e-consultation
- Preparations for clinical decision support system development for primary care – clinical guidelines for family doctor
- Interaction registry for pharmaceuticals – launched in 2016
- Monitoring World Bank integrated care indicators through sampling of medical documents
- Developing effective purchasing models for primary care and specialist care (2nd phase of WB Project)
- Developing geographical access criteria

EHIF & WBG cooperation – Phase II – Strategic objectives

Phase II

- Advance policy measures to improve care integration

Enhanced care management pilot

- Improve health outcomes for patients with cardio-vascular, respiratory, and mental disease

- 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

Care management pilot program

- Care management a tool to improve care coordination of complex, high-need patients across different providers and levels of the health and social care systems.
- EHIF and the World Bank have used international research and experience together with Estonia-based research to develop an evidence-based care management program designed specifically for the use of primary care practitioners in Estonia.
- There are amount patients around the world, with complex socio-medical conditions that typically comprise a small percentage of overall patients in primary care, but account for a disproportionate burden of illness, healthcare utilization, and cost (often 5% of patients account for 50% of costs).
- Care management programs are widely acknowledged as having great potential for improving care coordination and patient outcomes and are increasingly being offered in healthcare systems in many countries.

Objectives of the care management pilot program

- to assess feasibility of undertaking implementing enhanced care management in the primary care setting in Estonia.
- to understand impact of the pilot on care management processes and selected patient outcomes.
- to learn from experiences to inform possible scale-up throughout Estonia

The ultimate objective of the care management program is:

- to improve the health outcomes of complex patients and reduce their need for healthcare utilization.

- The duration of the pilot is 6 months (February-August 2017).
- Amount of 11 FP, 11 nurses and 9 patients´ lists involved into the pilot.
- The care management patient identification algorithm uses criteria developed and agreed by the World Bank and EHIF together with participating primary care practitioners in Estonia to identify suitable patients to participate in the care management pilot.
- FP received list of candidate patients identified by the care management selection algorithm, and submitted the final 50-75 patient names to be included in the Patient Registry for the pilot.
- As part of enrolment of patients´ in this pilot, a member of the care management team must meet with each individual patient (and potentially their family) and co-create a care plan (for engaging patients in their care and increasing their activation).

Main facilitators of implementation

- Monitoring visits seems to be beneficial.
- The FP-s also have raised the need to have regular meetings between themselves to discuss pilot related issues.
- Webinars have been helpful and provided additional information.

Main barriers and obstacles to implementation

- Lack of time to test the dashboard.
- FP experience barrier in making the contact with the hospitals. There also seems to be a mentality among the FD-s that some responsibilities should be left to patients.
- Some of the FD-s still doubt in the need of the enhanced care management. The main argument has been that they already provide all the necessary care the patients need and they do not have anything extra to offer.

Objectives of the primary care reform based on health centers (HC)

- Extended primary health care services, in addition to midwifery, physiotherapy, home and school health care nursing to ensure quality of clinical work, work organization, professional development, availability and sustainability.
- Primary health care team cooperation is primarily based on contractual relations, ie. prefer to be working in primary and basic services in so-called single enterprise services (instead of outsourcing).
- Includes prevention activities with a considerably greater appreciation for both the primary (immunization, individual counseling, if necessary, preventive testing), secondary (preventive health examinations and screening tests) as well as tertiary level (integrated case management, and social and health cooperation organization).
- Will ensure the availability of primary care services in a particular area of FPs principal place of business and, if necessary, through the branches of the HC. HC operates in one of its principal place of infrastructure (in the same building or in nearby buildings in the complex). Service provision is guaranteed even during non-working hours.
- Introduction of more systematic risk patient management with commensurate increase in QBS.
- More coordination between social and health care services.

Multi-professional integrated primary care

- Reimbursement model on health centers from july 2017.
- Health centers requirements: minimum 3 FP´s required working with at least 4500 persons. There are room requirements, as well as extended services providing home care nursing, independent midwifery services and physiotherapy.
- Amount of centers meet the requirements of primary health care centers.
- Group- and single practice´s cost model, for providing and maintaining equilibrium among primary health care providers.
- Changing attitudes and habits of the population when using primary care services.
- Services provided in the health centers will ensure the inclusion of sustainability and development of primary health care system, as it allows a more flexible organization of work, co-operation/collaboration and exchange of experience within health care teams, thus contributing to ensuring the quality of treatment.

Pay-for-Performance

- The main purpose is to increase the quality and effectiveness of preventive services, as well as to improve monitoring of chronic diseases.
- Performance pay introduced in 2006. Participation in QBS is mandatory since 2016.
- Complementary practice based quality management system introduced since 2016.
- Focus shifted from awarding bonus points for single activities to a “full package” approach.
- 18 quality indicators in PHC (related activities, required target)

Patients´ with Diabetes II (indicator)

*The average **target** + 10 % but not more than 90% .*

In 2014 target was 54%, in 2015 70%.

***Target group**: All insured patients´ with type II Diabetes (ICD10 dgn E11), who are in the list of chronically ill patients during current/evaluable year. Those individuals who lost their insurance or died, but received related service (described activities) before the calculation of the results, are taken into account.*

***Related activities**: examination of glycated hemoglobin (1 x year), creatinine (1 x year), general cholesterol (1 x year), cholesterol fractions (at least 1 x during 3 years); visit to family nurse (1 x year).*

Thank you!

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