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HEALTH CARE
IMPROVEMENT
PROJECT

# USAID Health Care Improvement Project

## CTO Quarterly Review Meeting

Wednesday, February 1, 2012

# GEORGIA

## What Are We Trying to Accomplish and at What Scale?

| Key activities | What are we trying to accomplish? | How will we know? | Geographic scale |
|---|---|---|---|
| Improve Quality, consistency and continuity of medical care | • Improve timeliness, continuity, effectiveness, efficiency , patient-centeredness of provided services and their consistency with clinical guidelines through improvement collaborative approach<br>• Strengthen capacity of medical providers to provide safe, timely, continuous, effective and efficient medical care;<br>• Strengthen capacity of local partners (medical associations, training centers, teaching hospitals and medical schools) to deliver continuous learning opportunities;<br>• Improve awareness on quality improvement experiences countrywide;<br>• Strengthen HIS to support development of evidence-based decisions on improvement quality of medical care;<br>• Ensure equitable access to priority "best-buy" high impact medical services *in IC regions;* | • Number and % of identified QI gaps addressed through improvement collaborative;<br>• Number and % of health care facilities covered with QI activities through ICs in selected region(s);<br>• Indicators of timeliness, continuity, effectiveness, efficiency and patient centeredness of priority "best-buy" high impact medical services;<br>• Indicators of consistency of priority best-buy" high impact services with evidence-based clinical guidelines;<br>• # of learning sessions conducted with support of HCI team in IC region(s), stratified by provider cadre, facility type and geographic location<br>• # of case studies and other improvement experiences posted on MedPortal with support of HCI team;<br>• # of meetings (including IC meetings) and online discussions held to share QI experiences;<br>• # of quality indicators developed to measure progress of QI interventions;<br>• The set of quality indicators is routinely reported by health care facilities, involved in ICs;<br>• Utilization of priority "best-buy" high impact medical services, stratified by self-reported wealth quintiles *in IC regions*; | Dissemination of evidence for priority conditions to all physicians countrywide, Demonstration of QI intervention (CI) to improve quality, consistency and continuity of care in one region<br><br><u>A city (Kutaisi) and district (Samtredia) in Imereti (1 out of 12 Regions of Goergia)</u><br><br>(This region has 699 890 population)<br><br>(Exact number and names of the facilities from preselected list (see table 1 below) of facilities are being finalized and will be agreed with USAID) |
| Improve access and use of evidence based medical information by Georgian physicians and enhanced availability of modern | • Improve access to evidence-based medical literature (guidelines, manuals, pathways, protocols) of Georgian Physicians;<br>• Enhance the use of evidence-based clinical guidelines, protocols and pathways in clinical practice; | • #/% of medical providers having access to evidence based medical information;<br>• # of evidence based medical literature developed/adapted with close support of HCI team;<br>• # of clinical guidelines disseminated through various communication channels;<br>• # of national and regional IC | Dissemination of evidence for priority conditions to all physicians countrywide, Demonstration of QI intervention (CI) to improve |

| | | | |
|---|---|---|---|
| evidence based treatments. | • Strengthen capacity of professional associations in developing and adapting international guidelines and evidence-based literature to Georgian context;<br>• Provide technical assistance to hospital and insurance company executives on planning and introduction of new essential medical technologies; | meetings, learning sessions and supportive supervision visits *at selected IC sites* held to support implementation of approved clinical guidelines;<br>• Indicators, measuring compliance of provided priority "best buy" high impact services with screening and treatment guidelines ;<br>• Document with recommendations on essential inputs (equipment, laboratory capacity, medicines) to provide priority "best-buy" high impact evidence-based services is developed and shared to ambulatory, hospital executives and insurance companies, that own medical facilities; | quality, consistency and continuity of care in one region |

## Contributing to Attaining the Millennium Development Goals and Indicators

| MDG / Indicators | HCI Activities that contribute to the attainment of the MDG |
|---|---|
| MDG 3 – Promote gender equality and empower women<br>3.1: Ratios of girls to boys in primary, secondary and tertiary education<br>3.2: Share of women in wage employment in the non-agricultural sector | • Support development of evidence-based gender-sensitive interventions through generating, collecting and analyzing the project specific and improvement collaborative (IC) data, stratified by gender;<br>• Develop recommendations to decision makers to incorporate quality of medical care indicators, stratified by gender, in National Surveillance and Routine Reporting Systems<br>• Analyze, develop and deliver Gender-sensitive strategies through the provider learning sessions in target IC region(s) to support treatment compliance; |
| MDG 4 – Reduce child mortality rates<br>4.1: Under-five mortality rate<br>4.2: Infant mortality rate<br>4.3: Proportion of 1 year-old children immunized against measles | Through complex analysis of country-specific mortality, morbidity and disease burden statistics, strengths of evidence and cost-effectiveness of the intervention, identify set of "best-buy" high impact pediatric services;<br>Address the quality of priority "best-buy" high impact pediatric services through project IC interventions, including ensure access to and use of evidence-based clinical guidelines, protocols and pathways, related to priority best-buy" high impact pediatric services;<br>Develop the set of key facility inputs (supplies, medicines, laboratory capacity, equipment) that are essential to deliver priority high impact "best buy" pediatric services in the medical facilities |

## Key Results and Program Status during October-December 2011

### Project Start-up activities:

During the first quarter of project implementation URC HCI team was focused on project start-up activities. As first of URC projects we initiated Completed registration of URC's representative office in Georgia. Now, the company operates as a branch office of the University Research Co. LLC in Georgia. The company is registered as the tax-payer authority, received VAT exempt status and opened bank accounts in Georgia. From December 20th representative office opened office at 57 Shartava St, where HCI project operates together with another URC USAID funded TB prevention project.

From the first days HCI team held series of meeting at the Ministry of Labor, Health and Social Affairs (MoLHSA), (Deputy minister, structural entities of MoLHSA and its affiliated organizations, working groups) to finalize the project design and synchronize project activities with ongoing health reform and Ministry's current priorities.

**Component 1: Improve Quality, consistency and continuity of medical care in demonstration region**

- In collaboration with MoLHSA, Imereti region (specifically its one city _ Kutaisi and one district _ Samtredia) was chosen for CI activities;
- Meeting with Insurance companies responsible for implementing government funded programs in selected regions conducted;
- Corporative directors, managing set of clinics across the Georgia (including health care facilities in demonstration region) contacted and agreed to work collaboratively;
- List of health care facilities and manager's contact information in selected region obtained;
- Questionnaire for initial assessment of health care facilities developed;
- Introductory visit to preselected facilities conducted;
- Data collected from pre-selected CI facilities through managers questionnaire;
- Excel database has been created;
- Collected data entered and primary data analysis completed.

Table 1 below summarizes the number and type of service providers visited during the initial meeting and their catchment population.

**Table 1: Number and type of service providers visited during the initial CI meeting and their catchment population**

| Type of Service Providers | Number | Population Coverage |
|---|---|---|
| Village Doctors | 13 | 34,983 |
| Ambulatory-Polyclinic Centers | 4 (2 training centers) | 119,700 |
| Hospitals | 4 (district, regional, referral, pediatric) | 1,295,000 |

**Results of preliminary assessment of pre-selected CI sites** (Source: provider (village doctors) and manager questionnaires):

1. Low level utilization of primary health care services at village level:

- Number of Visits at Village Doctors Per Catchment Population per Year – 0.35

2. Asymmetric utilization of health services at villages and District/City ambulatories:

- Average Number of Visits per Primary Care Provider Team (Family Doctor & Nurse) per day:
- Village Doctor - 3
- District/City Ambulatory Center- 15

3. Low/Middle Bed Occupancy rate:

- Average Inpatient Hospital Admissions per Bed per Month – 3.5

4. Insufficient laboratory capacity at village level;

- Village ambulatories do not have laboratory capacity. The only diagnostic test conducted at village ambulatories is blood glucose check;
- Despite having glucometers, village doctors encounter problems related to availability of strips to measure blood glucose level.

5. Laboratory capacity at district/city ambulatories is stronger.
6. Insufficient infrastructure at village level (**Figure 2**)

- About half of the Village ambulatories encounter problems with availability of scale and/or height meters to calculate BMI;
- Only 15% of village doctors have peak-flow meters to monitor asthma, while nebulizers are available in100% of Village ambulatories.

7. Infrastructure is more sufficient at higher level facilities (District/City ambulatories and Hospitals). However, according to the facility managers, the quality of diagnostic tests, sometimes, is questionable (for example, one hospital that serves as referral center for pediatric asthma patients from West Georgia, has the spyrometer and pulsoximeter, but still refers its patients for relevant diagnostic tests to another hospital (**Figure 3**).

**Figure 1: Laboratory capacity at ambulatory level**

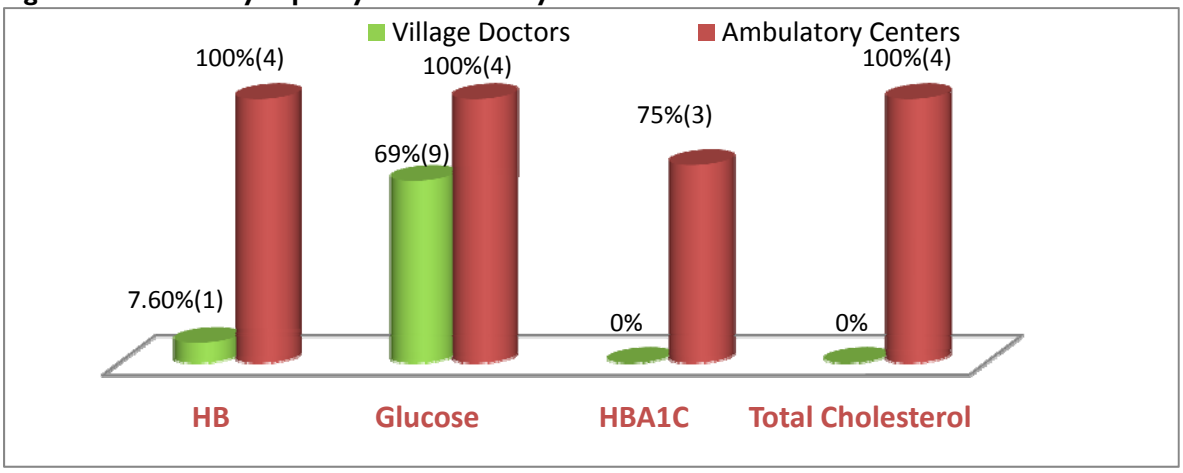



**Figure 2: Key inputs (infrastructure of village ambulatories)**

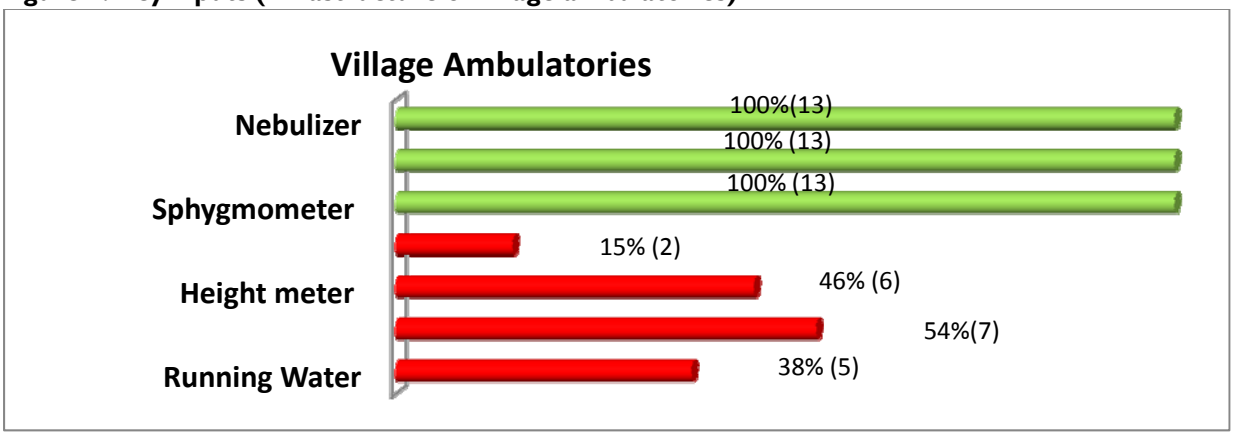
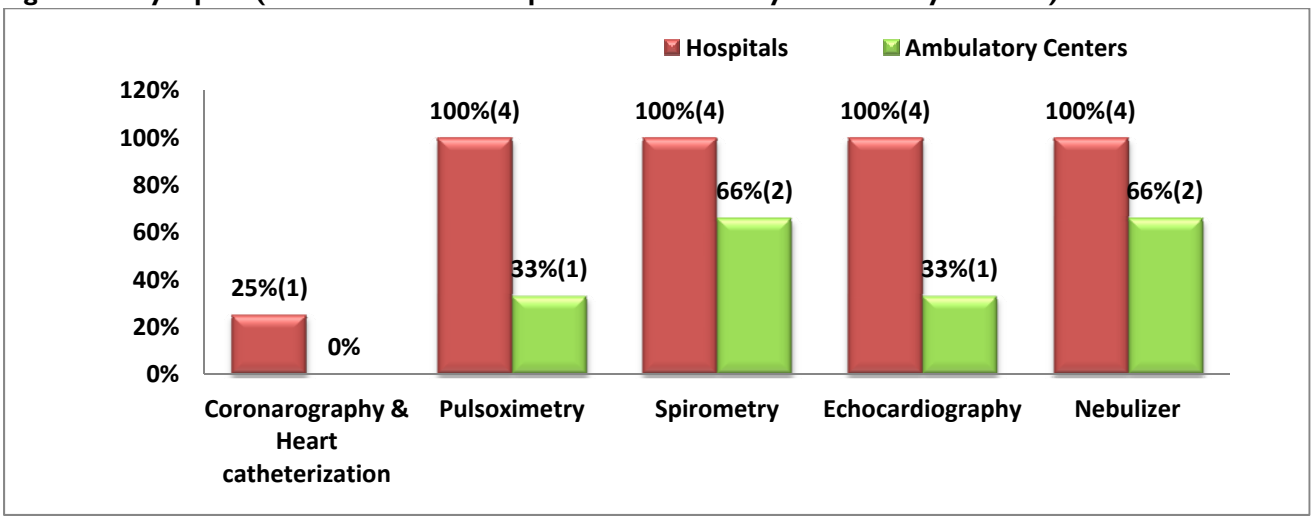


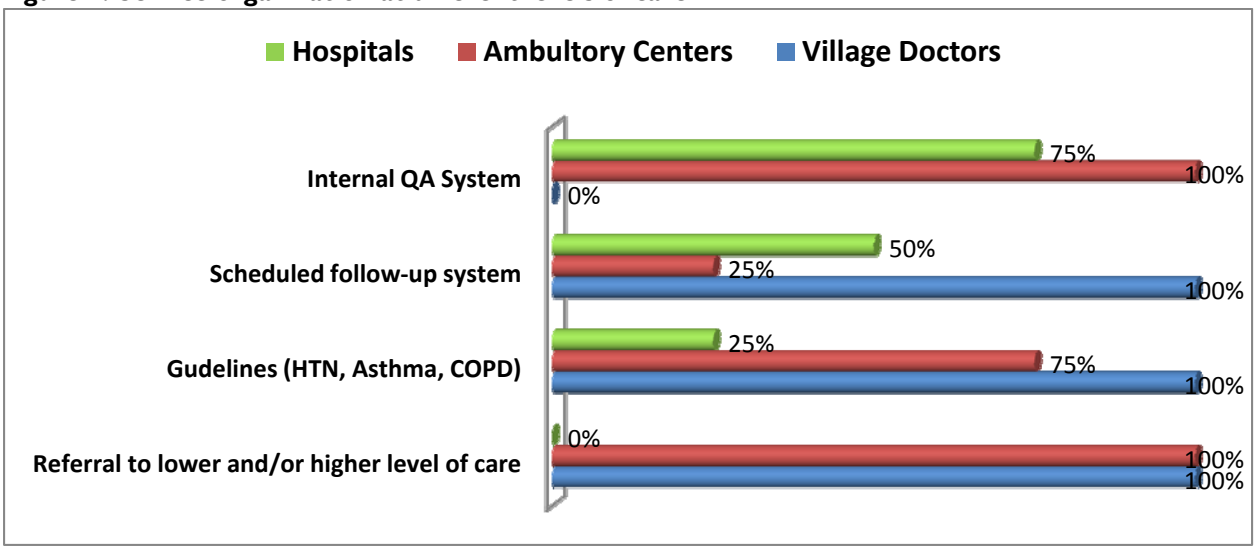

**Figure 3: Key inputs (Infrastructure of Hospitals & District/City Ambulatory Centers)**



8. Organization of services manifests several problems preventing delivery of high quality chronic care services in pre-selected CI facilities. Specifically:

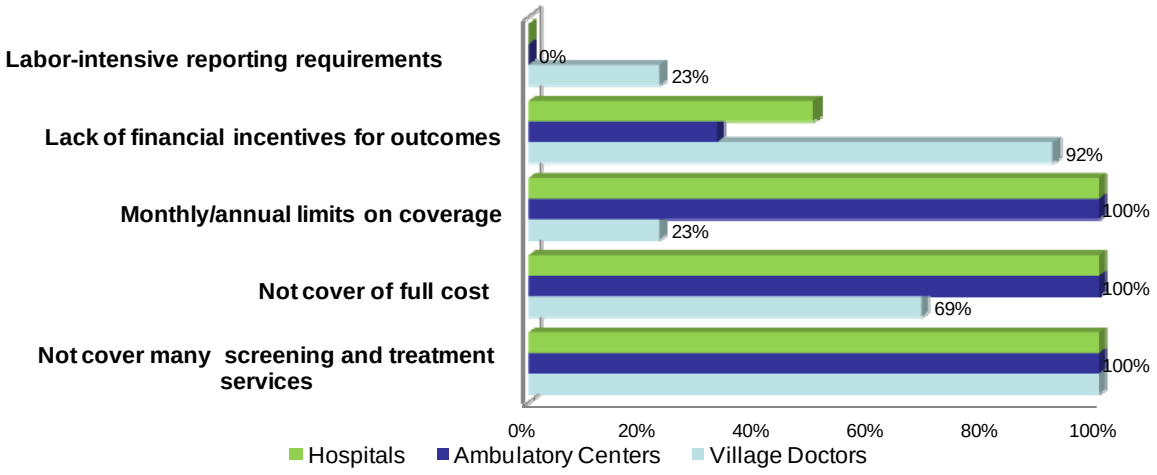
- 75% of ambulatory centers and 50% of hospitals do not have system in place to track patient follow-up;
- In all (100%) pre-selected hospitals, referrals to lower level facilities is not functioning well, _ chronic diseases either are managed in hospital ambulatory unit by specialists or are lost for follow-up (according to hospital managers, primary health care providers are not informed in many cases).
- 75% of pre-selected hospitals lack availability of clinical practice guidelines on screening and management of priority high burden diseases (Hypertension, Asthma and Chronic Obstructive Pulmonary Disease) while all (100% ) interviewed village doctors have relevant guidelines (**Figure 4**);

**Figure 4: Service organization at different levels of care**




9. Other barriers to implement chronic care programs were related to funding the chronic care services; almost all pre-selected providers identified financial access and government/private insurance coverage of many chronic care screening and treatment services as a barrier to ensure higher utilization of ambulatory services and treatment compliance (**Figure 5**).

**Figure 5: Main Barriers to Implement Government-funded Chronic care Programs**



## Cross-cutting Activities

### Documentation/Knowledge Management

- HCI standard for learning system shared between the HCI Georgia Team;
- Adaptation and translation of site level documentation started.

### Research and Evaluation

In collaboration with headquarters research and evaluation team, HCI Georgia team started working on following studies:

- Quantitative study will assess the effectiveness (cost-effectiveness, efficiency) of the quality improvement intervention in selected facilities;
- Qualitative research activity will focus to understand how involvement in improvement activities can enhance health worker engagement and their approach to QI;

For both studies, concept notes are prepared. HCI HQ and local team currently is working on preparation of protocols and methodologies for both studies.

### Human Resources

- Formation of administrative and technical teams started;
- Training for newly hired finance and administrative team conducted;
- Field Manuals reviewed, the local procedures and policies defined, office paper and electronic files established;
- Knowledge Management & Communication Expert and a QI advisor hired;

### Institutionalization

- Quality Assurance director of Geo-hospital (Private Corporation that owns multiple ambulatory and hospital facilities in Georgia in different regions, including Samtredia Branch of Geo-Hospitals) participated in our first visit to Samtredia Branch of Geo-Hospitals. During the meeting, parties agreed to work collaboratively aiming to address quality gaps in the facility from one hand and replicate/disseminate the quality improvement best practices to other facilities of Geo-Hospitals in different regions of Georgia.
- As part of the regional collaborative, Georgia HCI team chose two ambulatory facilities and referral hospitals that serve as training centers for family medicine and a clinical base for residency programs. Such approach provides further opportunity to strengthen capacity of existing teaching institutions and support institutionalization of best QI practices.

### Coordination with Other Implementing Partners and Agencies

- From the initial days of the project start, URC team has contacted representatives of USAID funded projects (SUSTAIN, HSSP and HIV Prevention Project) to coordinate efforts and build upon the synergies of different partners. In order to use the USAID support more efficiently and effectively, among many other cross-cutting issues, partners, implementing USAID Georgia HCI Project, together with SUSTAIN, HSSP and TB Prevention Projects, have decided to join effort and collaboratively support development and implementation of the voluntary Hospital Accreditation/Certification system in Georgia. For this purposes, HCI team conducted regular (weekly) meetings with partners and jointly identified the key focus areas/interventions for each project and their implementation timelines. The partners have jointly developed MoU between and among the Ministry of Labour, Health and Social Affairs of Georgia, the Georgian Hospital Association (GHA) and the USAID Quality Accreditation and Certification Partners in Georgia (JSI_SUSTAIN Project, Abt Associates _ Health System Strengthening Project, University Research Co., LLC _Health Care Improvement and TB Prevention Projects), where the type of assistance and the roles of each partners are clearly described. Specifically USAID HCI project will lead the development of clinical standards for a subset of high-burden adult and pediatric diseases of HCI project clinical focus areas; support MoLHSA in identification of the needed indicators for a subset

of high-burden adult and pediatric diseases and work collaboratively with HSSP to incorporate them in national health information and management system where possible.

- Georgia HCI project CoP conducted also the meeting with WHO country representatives, shared the information on the Georgia HCI Project scope, approaches and expressed the willingness to collaborate with WHO country office. The parties identified and agreed on the priority areas of collaboration (including but not limited with Non-communicable diseases screening and management as well as knowledge management practices) to support improvement of quality, consistency and continuity of medical care in Georgia in project priority clinical conditions.

## Planned Activities for January-March 2012

- Develop final version of Scope of Work;
- Start Formation of Regional Improvement Collaborative (IC) and Facility QI teams in selected region;
- Start improvement collaborative activities in ambulatory and hospital facilities in demonstration region;
- Conduct rapid assessment of key quality challenges in selected CI facilities;
- Chose and measure simple quality indicators at CI sites;
- Track the progress and share results on generated quality indicators at regional IC meetings;
- Support implementation of approved guidelines through regional IC meetings, learning sessions and supportive supervision at selected CI sites
- Support collaboration between Georgian key stakeholders and Georgian Medical Diaspora in the US