



USAID
FROM THE AMERICAN PEOPLE

HEALTH CARE
IMPROVEMENT
PROJECT

Quarterly Review Meeting

GEORGIA

January, 2013

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 in Georgia in a demonstration region	<ul style="list-style-type: none"> • Improve timeliness, continuity, effectiveness, efficiency, patient-centeredness of provided services and their consistency with clinical guidelines through improvement collaborative approach • Strengthen capacity of medical providers to provide safe, timely, continuous, effective and efficient medical care • Strengthen capacity of local partners (medical associations, training centers, teaching hospitals and medical schools) to deliver continuous learning opportunities • Improve awareness on quality improvement experiences countrywide • Strengthen HIS to support development of evidence-based decisions on improvement quality of medical care • Ensure equitable access to priority “best-buy” high impact medical services in the demonstration region 	<ul style="list-style-type: none"> • Indicators of timeliness, continuity, effectiveness, efficiency and patient centeredness in project priority clinical conditions in targeted facilities • Improved intermediate short-term health outcomes and reduced complication rates for prioritized adult and pediatric conditions in targeted medical facilities • Number of medical and para-medical practitioners trained in evidence-based clinical guidelines • Number of provider training-hours in evidence-based clinical and QI practices • # of local partners (medical associations, training centers, teaching hospitals and medical schools) involved in development or implementation of different QI tools with HCI support • # of CME modules developed together with professional medical associations • # % of population in target districts (catchment areas) that gains access to higher quality health care services for prioritized high burden conditions 	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 Demonstration phase is taking place in 4 hospitals (out of 40), 4 polyclinics (out of 42) and 13 village doctors (out of 212) in Imereti (1 out of 12 regions of Georgia) This region has 699,890 population
Improve access and use of evidence based medical information by Georgian physicians and enhanced availability of modern evidence based treatments.	<ul style="list-style-type: none"> • Improve access to evidence-based medical literature (guidelines, manuals, pathways, protocols) of Georgian physicians • Enhance the use of evidence-based clinical guidelines, protocols and pathways in clinical practice • Strengthen capacity of professional associations in developing and adapting international guidelines and evidence-based literature to Georgian context • Provide technical assistance to hospital and insurance company executives on planning and introduction of new essential medical technologies 	<ul style="list-style-type: none"> • % of medical providers having access to evidence based medical information; • Documented increase in utilization of clinical care guidelines in priority clinical areas by Georgia physicians in targeted health facilities • # of clinical guidelines (or protocols) disseminated through various communication channels; • # of evidence-based protocols developed in collaboration with professional associations with support of HCI project; • 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; 	Dissemination of evidence for priority conditions to all physicians countrywide, Demonstration intervention to improve quality, consistency and continuity of care in one region with 294 health facilities

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 3.1: Ratios of girls to boys in primary, secondary and tertiary education	<ul style="list-style-type: none"> • Support development of evidence-based gender-sensitive interventions through generating, collecting and analyzing the project specific and improvement collaborative (IC) data, stratified by gender; • Develop recommendations to decision makers to incorporate quality of medical care indicators, stratified by gender, in National Surveillance and Routine Reporting Systems

3.2: Share of women in wage employment in the non-agricultural sector	<ul style="list-style-type: none"> 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 4.1: Under-five mortality rate 4.2: Infant mortality rate 4.3: Proportion of 1 year-old children immunized against measles	<p>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;</p> <p>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;</p> <p>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</p>

Coverage of intervention				
Activity	Region Target population/ Total population	District Target population/ Total population	Total facilities covered/ doctors in district	Total number of facilities/doctors in district
	(in 1/12 regions)	(5 of 11 in the region)		
Demonstration collaborative	Imereti Population: 699,890	Samtredia Population: 60,456	1 hospital, 1 polyclinic, 7 village doctors	2 hospital, 3 polyclinic, 16 village doctors
		Kutaisi (city) Population: 192,500	3 hospitals, 3 polyclinics	12 hospital, 14 polyclinic,
		Tskaltubo Population: 73,889	2 village doctors	32 village doctors
		Terjola Population: 45,496	2 village doctors	21 village doctors
		Tkibuli Population: 31,132	2 village doctors	12 village doctors

Key Results and Program Status during October-December 2012

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

This quarter Georgia HCI team continued support of facility QI teams through integrated clinical, QI and other needs-based training and coaching of providers at CI facilities.

In 1st quarter of FY13 the project team conducted:

- 1 learning session;
- 9 field trips;
- 2028 provider-hour trainings: including 104 provider-hours in QI methodology and practice, 643 provider-hours in CVD risk factor screening & modification, 292 provider-hours 74 provider-hours in Acute Coronary Syndrome management, 861 provider-hours in pediatric pneumonia/acute respiratory tract infections management, 346 provider-hours in Asthma/COPD management;

The project staff tries to diversify training methods, make them interactive and close to clinical practice needs to the extent possible. For example, HCI team supported clinical case discussions at one hospital. The discussion meeting gathered physicians from all departments providing care during this case (cardiologist, dialysis staff, interventionalist, and radiologist), quality manager and HCI team members. The project offered standard format for case presentation and discussions and initiated the process of institutionalization the case presentation, review and feedback process at facility level.

During routine field visits providers of CI facilities continued to ask trainings in broader than project priority clinical areas. To support them in access and use of modern evidence-based medical information,

HCI team proposed providers to search and appraise modern evidence and present it to their colleagues in light with their clinical practice. Within support of Georgia HCI project, ambulatory and hospital teams of CI facilities conducted joint session on management of diarrhea in children, where village doctor Ekaterine Dvalishvili presented modern evidence, followed by discussions of clinical cases in small groups.



To support involvement of patients in day-do-day management of their own conditions and shared decision making, as well as make healthier lifestyle choices the project published patient diaries on:

- 1) Chronic Obstructive Pulmonary Disease (COPD) and
- 2) Smoking cessation.

These materials contain background information about disease, risk-factors, inhaler use and modification of treatment plan according to symptoms or harm of smoking and benefits of stopping and most effective strategies to quit. Some parts of patient diaries are intended to be filled by medical providers (dates and results of the tests, prescription, targets for diet or exercise), the others are for shared completion (plans for lifestyle changes) and for filling by patients (compliance to medications, significant changes of symptoms, questions to discuss with provider, validated tests to assess the influence of disease on daily life of patients). Georgia HCI project collaborated very closely with National Center of Disease Control and Public Health to prepare patient diaries that now are available electronically (on NCDC and the project web-sites).

Pic I. Patient diaries on COPD and Smoking Cessation



The Fourth Learning Session

On December 20-21st Georgia HCI team conducted the fourth Learning Session in Imereti region. Along with facility quality improvement teams of regional improvement collaborative, representatives of Ministry of Labour, Health and Social Affairs (including head of regulatory division Dr. Dea Nizharadze) National Center of Disease Control and Public Health (the director Dr. Eka Kavtaradze and Head of

Non-communicable disease division Dr. Lela Sturua), Medical Corporation Managers, USAID Georgia Senior Health Systems and Financing Advisor, Dr. George Khechinashvili and the president of Georgian-American Medical and Public Health Association Dr. Zurab Guruli attended the event.



The session included:

- ✓ Presentation on key activities and results of Georgia HCI project;
- ✓ 18 poster-presentations on progress and challenges of quality improvement (QI) activities, prepared and presented by QI teams,
- ✓ Group work on summarizing problems and achievements in each project priority clinical area
- ✓ Awards of the Best Performing Teams (with certificates) of the quarter in each project priority clinical content areas;
- ✓ Internal Quality Improvement System in US hospitals;
- ✓ Methods of searching and apprising medical literature;
- ✓ 4 presentations of medical doctors of collaborative improvement facilities on summary evidence updates on their topic of interest;
- ✓ Presentation and distribution of patient education and self-management supporting materials. Patient diaries on:
 - Tobacco cessation;
 - Chronic Obstructive Pulmonary Disease
- ✓ Discharge planning: Current situation in Georgia and International best practice (presentation of chart standardization tool: discharge form);
- ✓ Hospital Management of COPD in 2 regions of Georgia: presentation of the results of Baseline Assessment.

As the results of project CI activities, after 7 months from the start of regional collaborative improvement activities the project witnessed significant improvement **in all project priority clinical areas**:

- Average compliance with evidence-based best practices on screening, prevention and management of CVD and its risk-factors, increased by **59%**,
- Average compliance with Management of Acute Coronary Syndrome best practices improved by **36%**;
- Average compliance with Respiratory Tract Infection management best practices in ambulatories and hospitals of CI facilities improved by **42%**;
- Compliance with Asthma and COPD management best practices in ambulatories improved on average by **50%** and in hospitals _ by **20%** (see Table #1 below).

Table 1. Average compliance to all percentage process indicators per clinical focus area, Regional CI in Imereti, April-November 2012

Clinical focus	April 2012	Nov-12
Screening and Modification of Cardiovascular Disease Risk factors, Primary and Secondary prevention of cardiovascular disease	22%	81%
Management of Acute Coronary Syndrome	27%	63%
Management of Respiratory tract infection in children (ambul & hosp)	44%	86%
Management of Asthma and COPD (ambulatory)	15%	65%
Management of Asthma and COPD (hospital)	20%	40%

The participants expressed satisfaction on the project results as a whole. “Despite many directions and activities the National Center undertakes, this meeting has been considered as one of the most important and I am happy to be part of it. We welcome USAID assistance to prevent and improve care of priority chronic conditions as most pressing public health problem for us. You are doing the job that our country appraises a lot and I hope this will be also adequately reflected in state’s health policy and programs” _ said Eka Kavtaradze, Director of National Center of Disease Control and Public Health.

“I want to thank the project and personally its chief of party for supporting US Georgian Medical Diaspora to share their knowledge and expertise with their countrymen. Without this close collaboration, sometimes heated discussions, it is impossible to work together to strengthen and improve whole health care system of our country” _ said Dr. Zurab Guruli, the president of Georgian-American Medical and Public Health Association

“I am happy to be here today and witness how village doctor updates her colleagues with international medical evidence she searched, read and appraised. This is the most important part of the project that will enable all of you to stay in touch with modern medical information even after the project is over” _ stated Dr. George Khechinashvili, USAID Georgia Senior Health Systems and Financing Advisor.

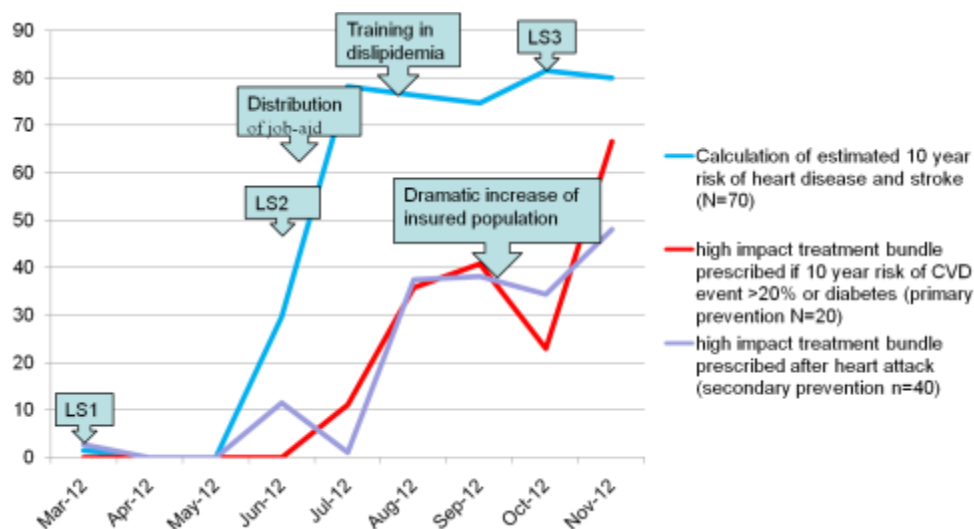
Analyses of status and progress of regional collaborative improvement activities per project priority clinical focus areas:

a) CVD risk factor screening & modification:

By November 2012 6 out of 12 process indicators (blood pressure at last visit, hypertension therapy initiated, continued or adjusted, tobacco status assessed at last visit, tobacco cessation intervention in smokers, Weight classification and nutrition & physical activity counseling within last year) reached or remained above 90% compliance. 3 indicators (current updated list of chronic medications, Cholesterol measurement planned and calculation of estimated 10-year risk of CVD event) reached above 80% compliance. In other words, 75% of CVD routine monitoring indicators reached above 80% compliance.

As indicated from the figure #1 below, primary (estimated risk of 10-year CVD event>20% or diabetes) and secondary (after heart attack) prevention (prescription of high impact treatment bundle) also show significant quality improvements (45-67%).

Fig 1. 10 year cardiovascular disease risk calculation, primary and secondary prevention in 3 polyclinics and 13 village practices, Georgia, March – November, 2012



The only indicator that we can not influence remains cholesterol measurement. Despite dramatically improved planning the indicator remains at 12% level. The project works hard at corporation management and national level to persuade key decision-makers that routine administration of this measurement will help to reduce costs of complicated CVD cases in future.

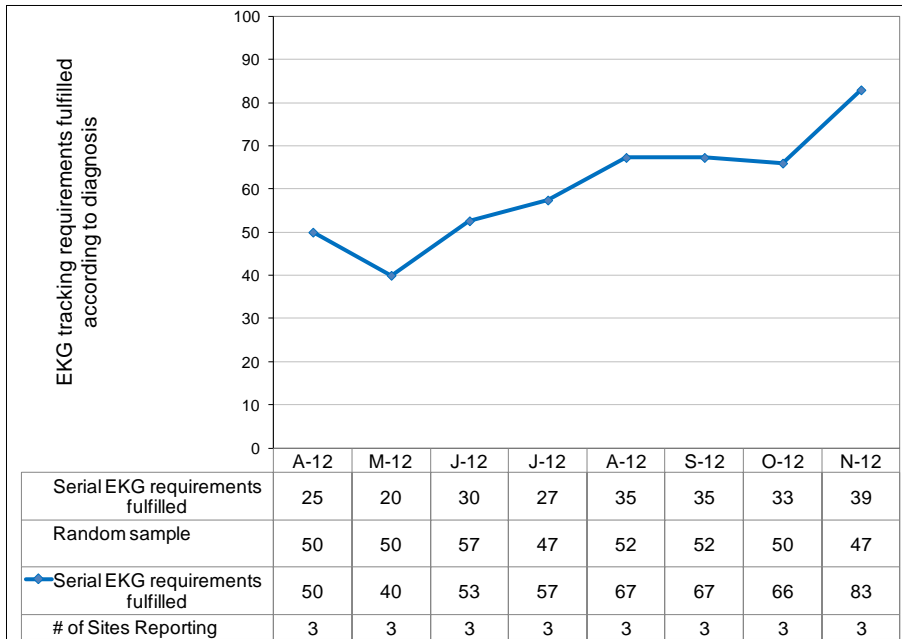
b) Acute coronary Syndrome management:

Significant improvements are reached in management of acute coronary syndrome (ACS), but due to higher resistance to changes and complexity and fragmentariness of service provision systems in hospitals, the progress in quality improvement is slower than at ambulatories.

QI teams track process quality measures at different phases of care: Initial assessment and treatment, ongoing treatment and discharge processes.

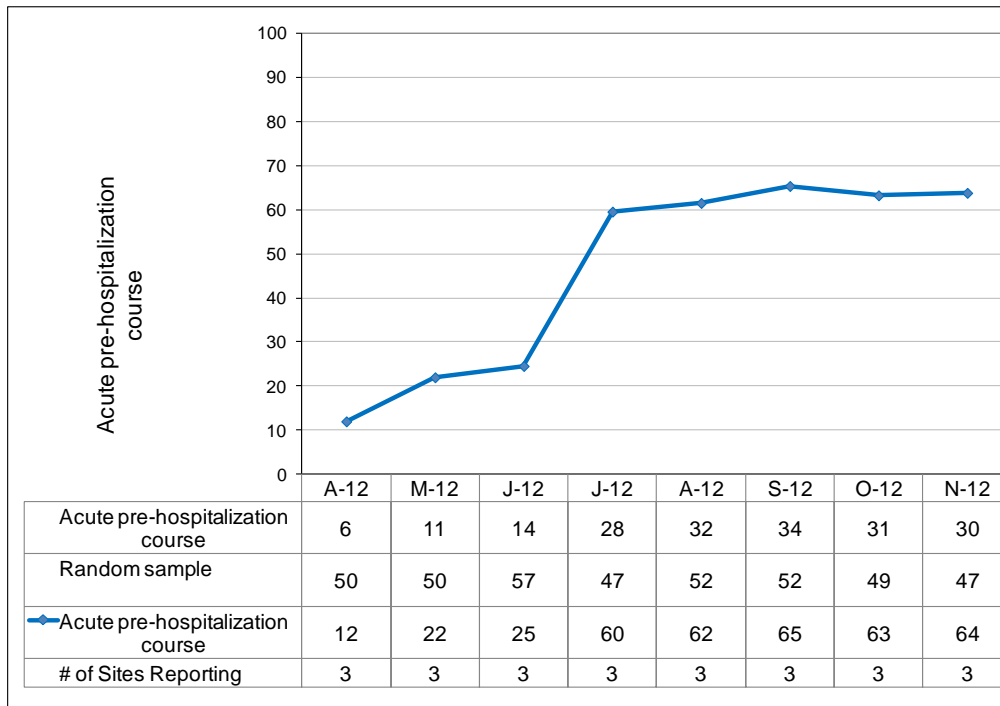
As most important for outcomes we track 7 indicators to assess initial assessment and treatment. For the end of November, 3 of them reached compliance above 80%: vital signs documentation in medical chart within 10 minutes at admission (94%, 68% improvement since April), EKG record and interpretation within 10 minutes at admission (83%, 57% improvement since April), EKG tracking requirements fulfilled according to diagnosis (83%, 33% improvement since April). (Fig. 2).

Fig. 2. EKG tracking requirements fulfilled according to diagnosis in 3 CI hospitals in Acute Coronary Syndrome CI in Imereti region, April – November, 2012



The other indicators also show remarkable improvement. Documentation of acute pre-hospitalization course increased from 12% to 64% from April to November (fig. 3). Measurement of cardiac enzymes according to requirement (if negative repeated 6-8 hours after last ACS symptom) and assessment of severity of early risk also increased from 15% to 56% and from 0 to 60% respectively.

Fig. 3. Acute pre-hospitalization course in 3 CI hospitals in Acute Coronary Syndrome CI in Imereti region, April – November, 2012



QI teams and the project track one complex indicator for initial treatment of ACS: evidence-based pain management (opoids, instead of NSAID), oxygen if needed (pulsioxymetry <95% or not measured), antiischemic therapy (nitrate) and early administration of aspirin (if not contraindicated and not administered during previous phases of care). Even though separate components reached higher

compliance, routine administration of this high impact treatment bundle still remains problematic (fig.4 and 5)

Fig. 4. MONA (morphin, oxygen, nitrate, and aspirin) performed in 3 CI hospitals in Acute Coronary Syndrome CI in Imereti region, April – November, 2012

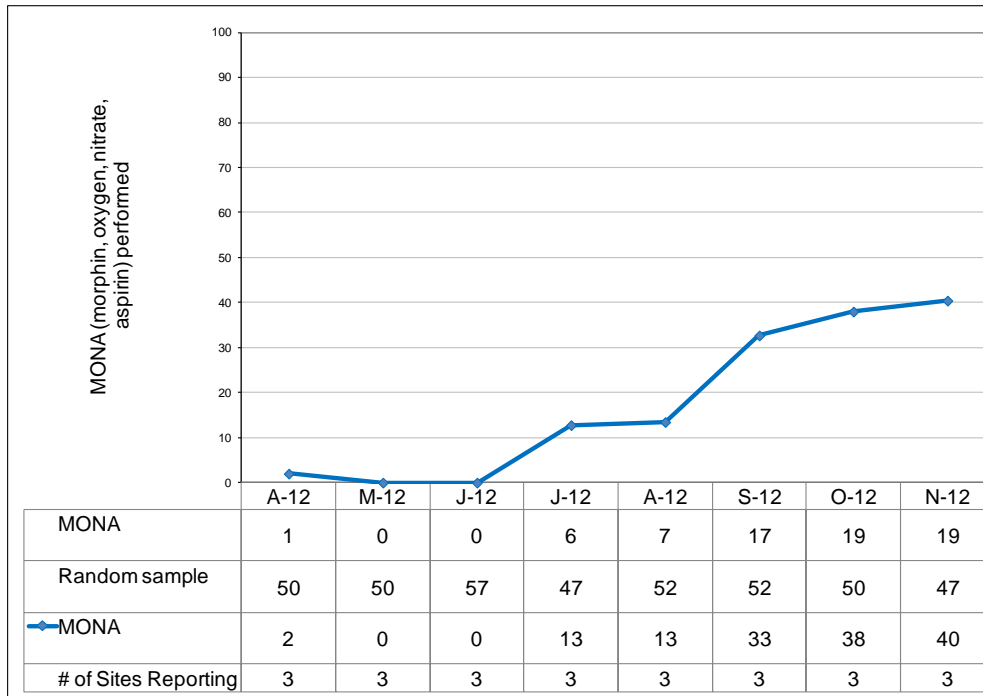
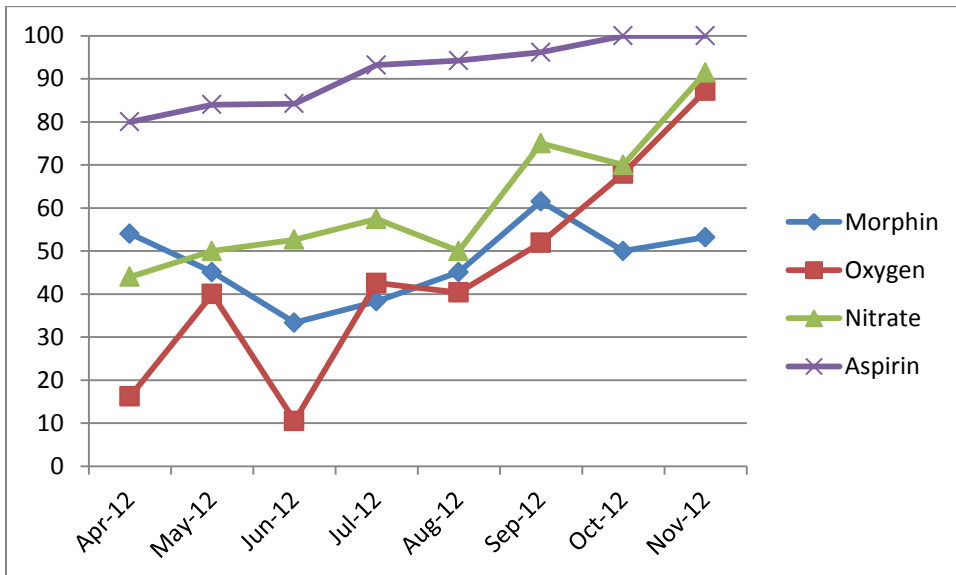
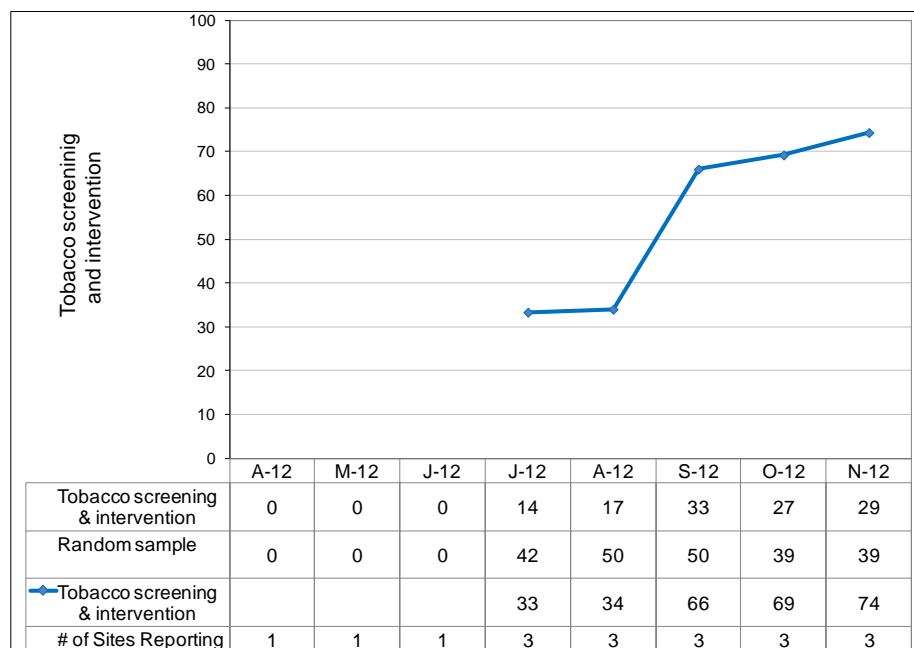


Fig. 5. Separate components of MONA (morphin, oxygen, nitrate, and aspirin) performed in 3 CI hospitals in Acute Coronary Syndrome CI in Imereti region, April – November, 2012



The project as well as international current evidence places high importance for screening CVD behavioral and physiologic risk-factors during hospital stay and start its modification. Unfortunately, particularly when expenses are concerned, this vision is not shared with facility/corporation managers and payers of the service. That is why lipid profile measurement remains low and unchanged. On the other hand, the interventions that do not require additional financial resources, improved significantly. For example, documentation of tobacco status and counseling of smokers showed significant improvement. (fig.6).

Fig. 6 Screened for tobacco and received tobacco cessation intervention if smoker in 3 CI hospitals in Acute Coronary Syndrome CI in Imereti region, July – November, 2012



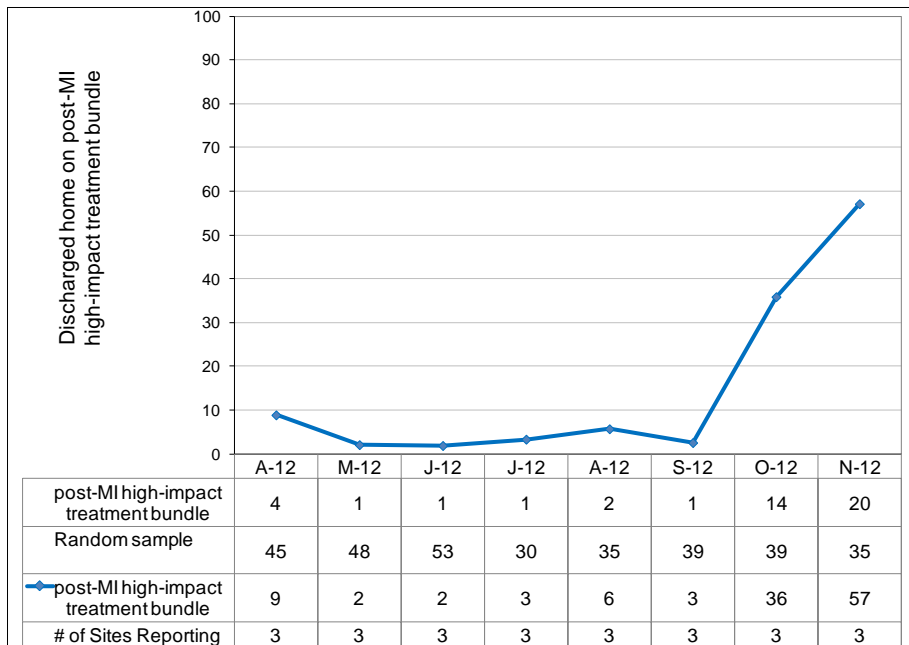
The most weak point in ACS management from the beginning CI in all hospital interventions has remained discharge and continuity of care between different levels of care. At the same time, evidence-based discharge processes are essential for better outcomes. Full completion of standard discharge form (diagnosis, prescribed medications and their regimen, individual plan/targets for at least one lifestyle changes, follow-up time & place), despite significant increase of partial fulfillment of the form still remains at zero level. Completion of standard discharge form and transmission of important clinical information from secondary level to primary care is essential for:

- patient self-management support,
- continuity of medical services and
- prevent disease complications and premature death,

The project developed discharge form for patients with ACS and instructions for providers to use the form. The form will serve as checklist reminding providers to fill and transmit all necessary information to the patient and his/her primary healthcare doctor. HCI team started implementation of the form within CI hospitals and advocated its wider use at national level.

Despite abovementioned difficulties in discharging patients with MI, prescription of high-impact cost-effective treatment bundle for secondary prevention of disease and premature death has been by 48% (fig. 7).

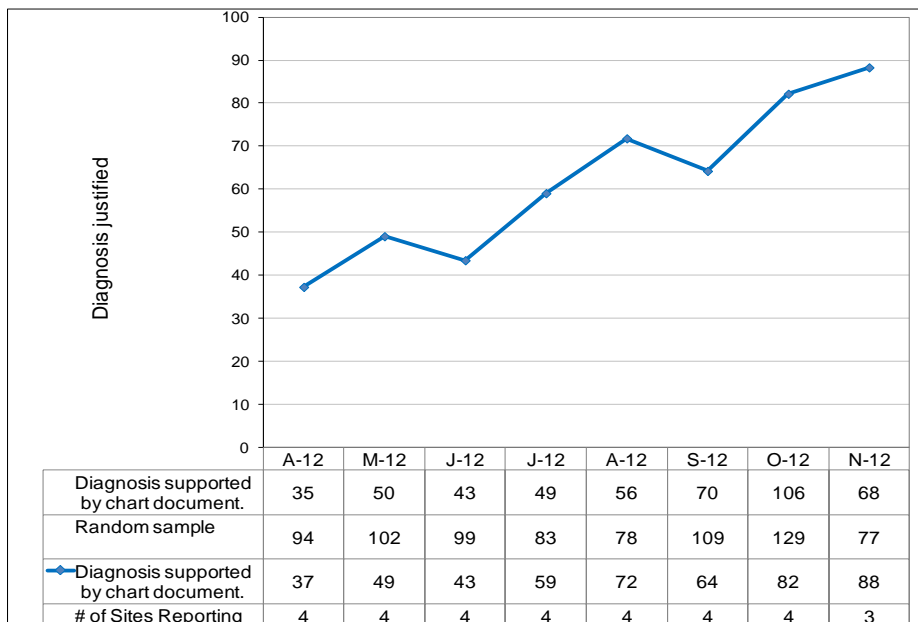
Fig. 7. Discharged home on post-MI high-impact treatment bundle in 3 CI hospitals in Acute Coronary Syndrome CI in Imereti region, July – November, 2012



c) Pediatric respiratory tract infections (RTI) at ambulatory level and pediatric pneumonia management at hospital level:

After intensive group and individual trainings of all relevant providers in CI facilities, supportive supervision through medical record review and case study discussions, data collection, monitoring and analysis of progress through routine measurement criteria Georgia HCI team witnessed remarkable improvement of RTI management, especially at ambulatory level. Particularly important are changes in accurate diagnosis (51% improvement, from 37% to 88% (see fig. 8) and antibiotic use.

Fig. 8. % children diagnosed with acute RTI for whom diagnosis is supported by medical chart documentation (at least one symptom-criterion with duration and at least one objective finding) in 3 polyclinics and 13 village practices in Imereti, Georgia, April – November, 2012



As indicated above, justification of antibiotics prescription (fig. 9) and use of evidence based 1st line antibiotic (fig. 10) also improved by 74% and 65% respectively.

Fig. 9. % children diagnosed with acute RTI for whom diagnosis chart documentation supports antibiotic use in 3 polyclinics and 13 village practices in Imereti, Georgia, April – November, 2012

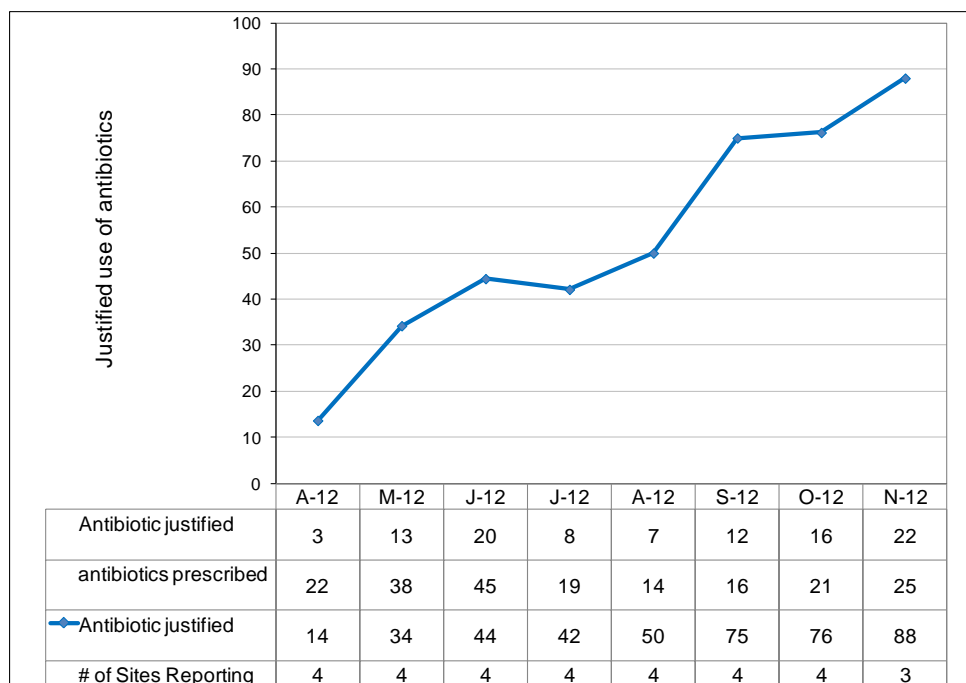
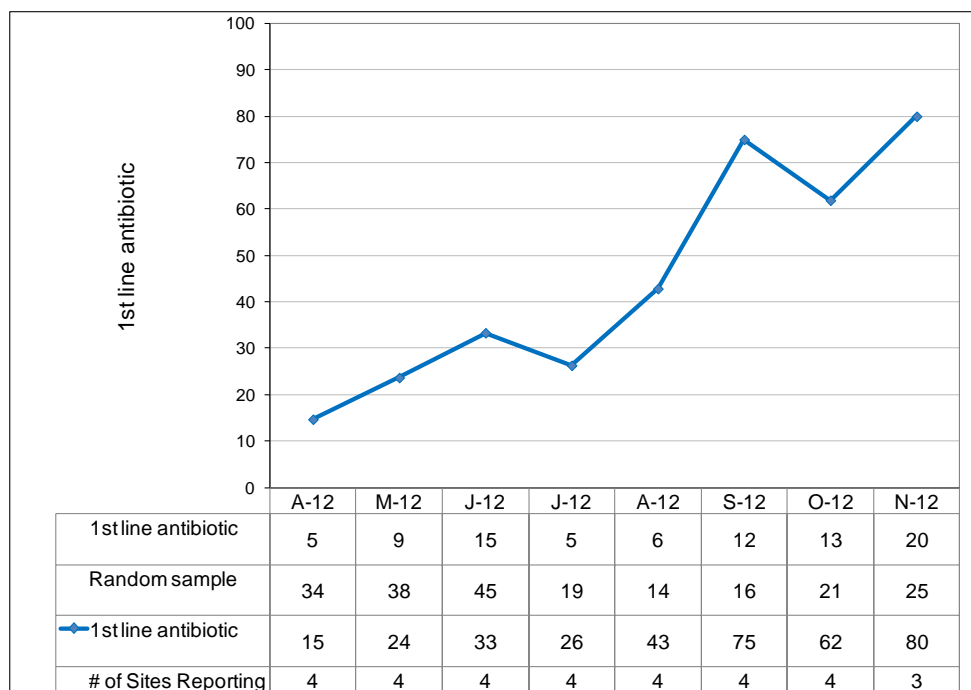


Fig. 10. % children diagnosed with acute RTI for whom diagnosis for whom 1st line antibiotic is used in 3 polyclinics and 13 village practices in Imereti, Georgia, April – November, 2012



As mentioned above making and sustaining changes **at hospital level** turned out to be more difficult. At the same time, HCI team witnessed very low numbers of pneumonia cases at secondary level. In order to increase the project impact on evidence-based hospital treatment of most frequent childhood diseases and spread the successful changes reached at ambulatory level, HCI team has decided to broaden clinical focus area at hospital level from solely pneumonia to pediatric respiratory infections.

Detailed plan and relevant tools were developed to collect data for previous months from hospital and implement expanded change package to the providers.

The most visible improvement in hospital management of pediatric pneumonia was decrease in use of non-evidence based medications (vitamins, short-acting methylxanthines, so called “metabolics”, expectorants, cough depressors etc. without any corresponding condition/symptom recorded in the chart). In addition to rational use of antibiotics, decreased use of non-evidence based medications are associated with reduced pneumonia treatment costs for facilities and payers (patients’ families, insurance companies etc.). As shown on the graphs below average number of unnecessary medications administered/prescribed for children with pneumonia at hospital decreased from 10 to 5 (fig. 11) and at ambulatories, _ from 0.76 to 0.05(fig. 12)

Fig. 11. Average # of non-evidence-based medications prescribed per child treated for RTI in 3 polyclinics and 13 village practices in Imereti, Georgia, April – August, 2012

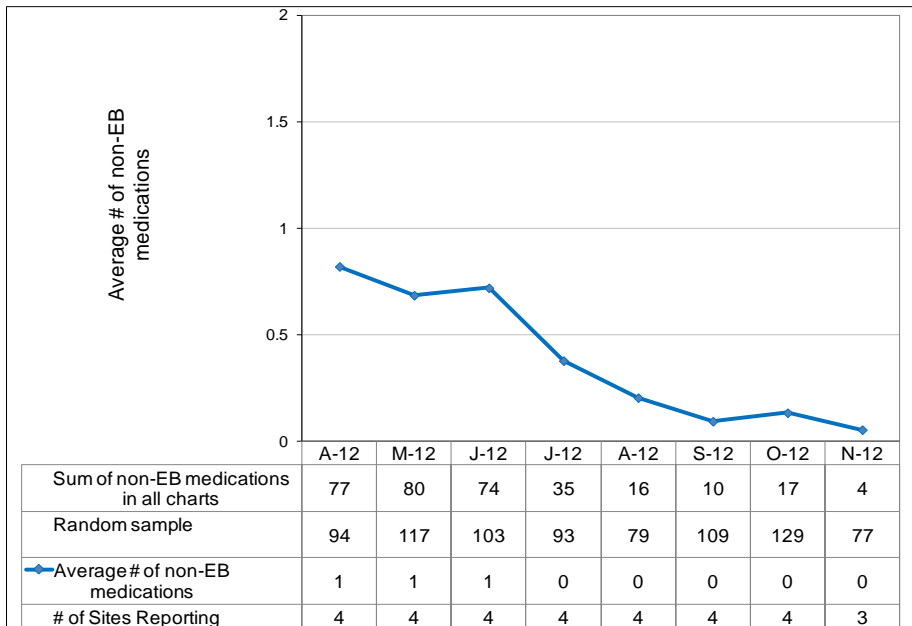
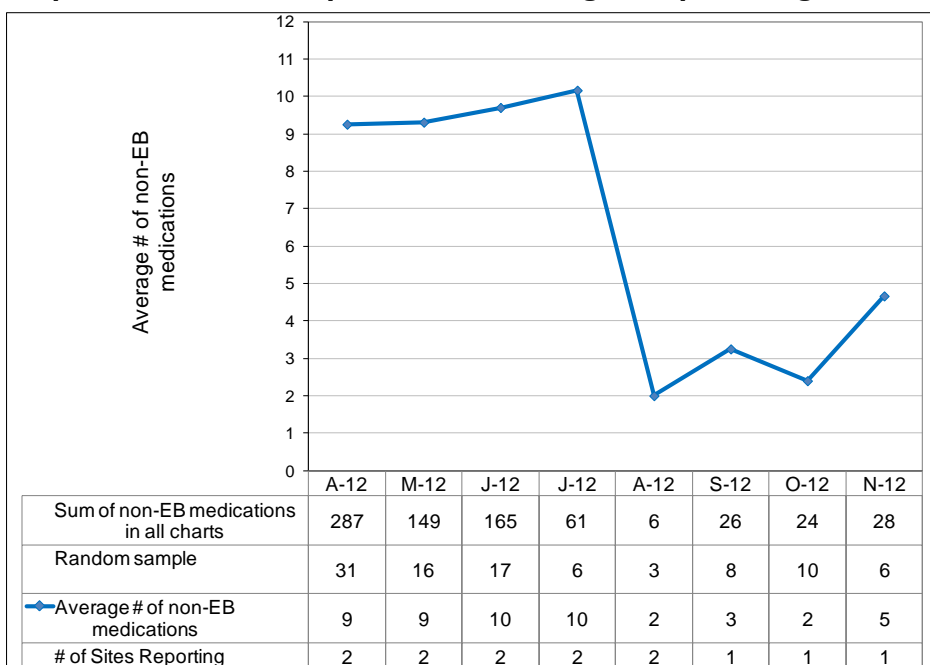


Fig. 12. Average # of non-evidence-based medications prescribed per pneumonia hospitalization in 2 hospitals in Imereti region, April – August, 2012



d) Asthma/Chronic Obstructive Pulmonary disease (COPD):

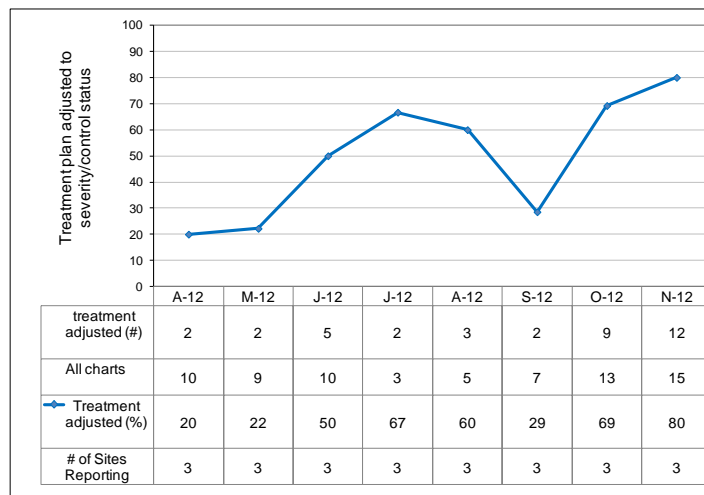
The project continued intensive training and support of CI facilities in evidence-based diagnosis and management of Asthma and COPD. The number of patient visits for COPD and Asthma at all levels of care remain low. This is partly due to problems related to diagnosis of these life threatening diseases: several studies confirm that disease prevalence 5 times exceeds official data. To increase patient and population awareness and provider confidence/comfort in diagnosis and management of the disease, Georgia HCI team organized event of World COPD Day on November 14th together with representatives of MoLHSA and National CDC. Through this activity, Georgia HCI team emphasized the problem in diagnosis of COPD coupled with high risk of the disease prevalence in the country given high rate of smoking among Georgia population. At World COPD day, two collaborative improvements facilities (Nasarishvili Family Medicine Center at Kutaisi and Samtredia Ambulatory branch of Geo-hospitals) offered free spirometry test to the smokers having symptoms and being referred by family physician to the test (Currently this test is not covered by state insurance programs). The project collaborated with the president of Georgian Respiratory Association to provide free examination and pulseoxymetry testing to the patients diagnosed with COPD. In total 10 new cases of COPD were diagnosed and 21 patients directly benefited from this activity. To improve patient awareness, Georgia HCI project team also developed patient information flyer on COPD in collaboration with MoLHSA and NCDC and distributed 1000 copies to patients and collaborative improvement facilities as a patient informational materials. To address the main risk factor of the disease HCI team also developed and distributed 200 copies of posters on smoking cessation counseling and treatment support. The event was featured in the news of 2 regional TV channels several times a day:

<http://www.myvideo.ge/?act=dvr&chan=rioni&seekTime=14-11-2012+16%3A40>



As the result of CI interventions to improve diagnosis and management of asthma and COPD, average compliance with EB Asthma and COPD treatment improved significantly, For example, percentage of ambulatory charts for patients with asthma/COPD with treatment plan adjusted to severity/control status improved from 20% to 80% (fig13).

Fig. 13. % of charts of patients seen for asthma/COPD last month, with treatment plan adjusted ot severity/control status in 3 ambulatories in Asthma/COPD ambulatory treatment CI, Imereti, Georgia, April – November, 2012



At the same time, QI teams witnessed decreased use of non-evidence based medications during asthma/COPD treatment (short-acting methylxanthines as first line treatment, so called “metabolic”, vitamins, expectorants, cough depressors without any corresponding condition/symptom recorded in the chart), resulting more rational use of medications and associated cost-savings for medical facilities and/or payers (patient/families, state, insurance company). As shown on the graphs below average number of unnecessary medications used to treat Asthma/COPD decreased from 10 to 5 (fig. 14) at hospital level and from 0.76 to 0.05 at ambulatory level (fig. 15)

Fig. 14. Average # of non-evidence-based medications prescribed in patients treated for Asthma/COPD in 3 polyclinics and 13 village practices in Imereti, Georgia, April – August, 2012

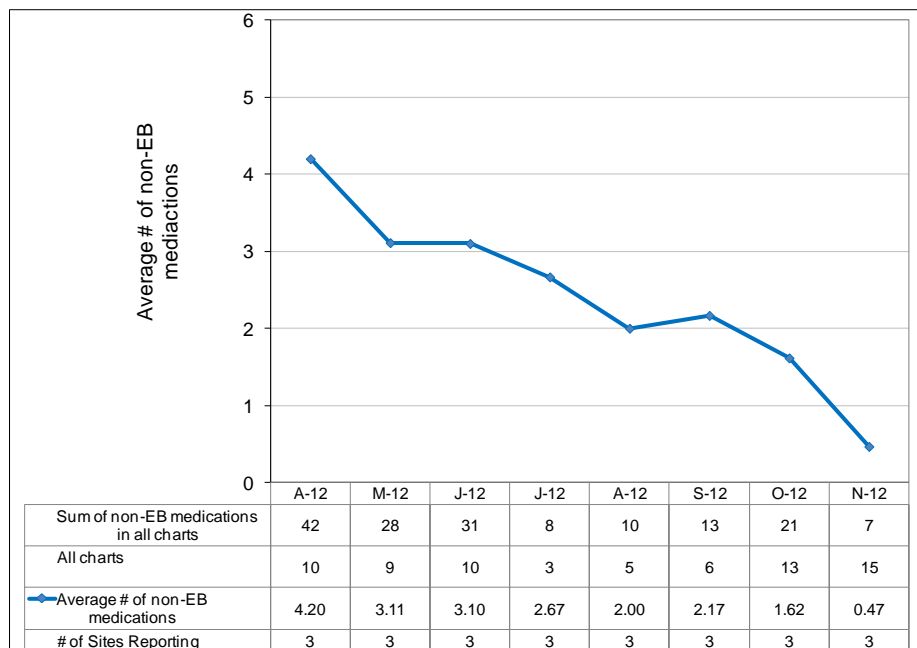
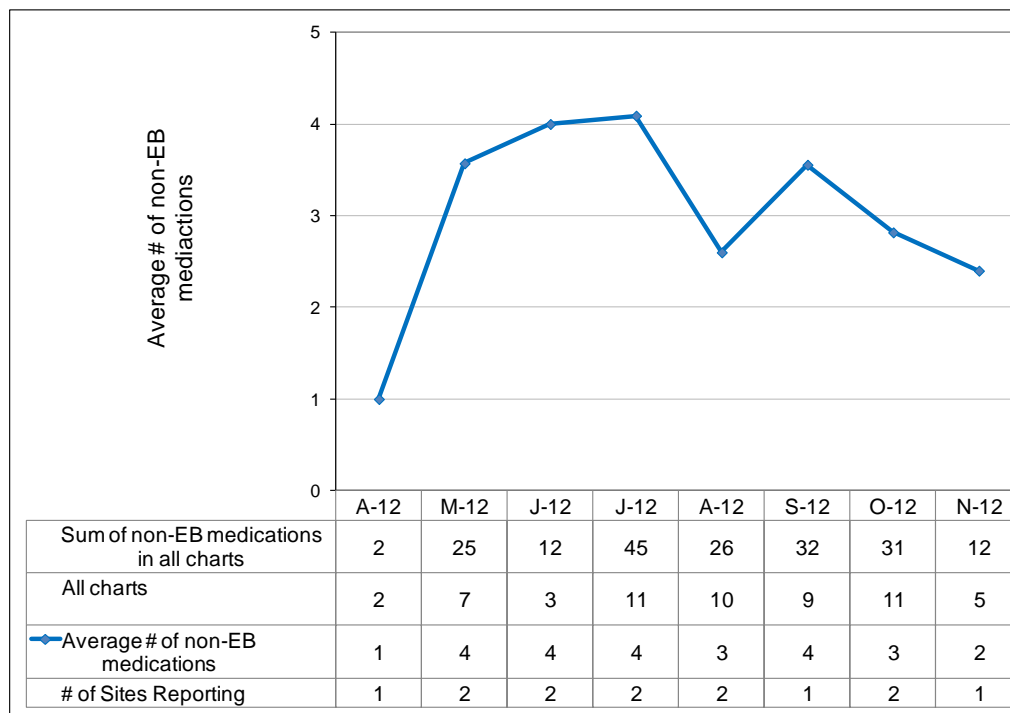


Fig. 15. Average # of non-evidence-based medications administered in patients treated for Asthma/COPD in 2 hospitals in Imereti region, April – August, 2012



Component II: Improve access and use of evidence based medical information by Georgian physicians and enhanced availability of modern evidence based treatments

Collaboration with US Georgian Medical Diaspora

To support participation of Georgian Medical Diaspora in the US to the project activities, vice-president of HCI project Dr, Rashad Massoud and Senior Quality Advisor of the HCI project Dr. Kathleen Hill had meeting with Dr. Tamar Chelidze, Health Care Attache of the Embassy of Georgia to the United States and Canada at URC Office in Bethesda. HCI project HQ team highlighted their honor to support the Georgia Government's ongoing commitment to improve health care for all Georgians and know that many other countries will continue to learn from Georgia's example. On behalf of Georgian Government Dr. Chelidze expressed gratitude on URC's contribution in improving health care system and expressed that this assistance is most needed for overall success.

As mentioned above, the president of Georgian-American Medical and Public Health Association Dr. Zurab Guruli participated in the Fourth Learning Session and updated to countrymen colleagues with the methods of searching/appraising evidence-based medical information and discharge planning practice in the US.

Translation/adoption of evidence-based medical information

To increase capacity of CI facility providers in searching, obtaining and apprising evidence-based medical information the project encouraged and assisted their representatives to prepare evidence summaries on clinical topics/questions of their interest. These reports were presented on the 4th Learning Session and uploaded on project web-page www.hciproject.org/georgiahealthquality.

Web-resource and Facebook page

The project received final approval from USAID mission to create and administer the web-site with tentative name and domain "National Quality Forum" (with tentative website address: www.healthquality.ge). This website is intended to become a platform to facilitate dialogue and collaboration between all interested parties including Ministry of Labour Health and Social Affairs, National Center for Disease Control and Public Health, professional medical associations, academics, Georgian US medical Diaspora, health care facilities, providers and patients to introduce and build culture of quality in health care. Currently we contracted web-developer, signed PO, developed detailed schedule and are working on content and design.

To increase awareness about the project, concept and methods of improving healthcare quality and access to evidence-based medical information, the project runs Facebook page <http://www.facebook.com/USAIDGeorgiaHealthCareImprovementProject>. After its creation, Georgia HCI team posted about 120 links to the up-to-date resources on best clinical and QI practice.

Cross-cutting Activities

Documentation/Knowledge management

To spread information about the initial results of project interventions on cardiovascular disease screening and management, Georgia HCI team developed brochure. It emphasizes changes brought by the project at individual, facility, regional and national levels. The brochure was distributed at official launch of ASSIST project at USAID Central Office in Washington, DC and at several events in Georgia (<http://www.hciproject.org/publications/improving-health-care-and-averting-deaths-cardiovascular-disease-georgia>).

Georgia HCI project interventions and initial results aiming to improve screening and management of major chronic non-communicable diseases (NCDs) will be presented at the International Quality Forum 2013 in London. In addition, the abstract “Improving Quality of Prevention, Screening and Treatment Services of Cardiovascular Diseases in Georgia” submitted by the project has been selected for poster display within the theme “Call for Abstracts (Clinical Improvement)”.

Together with headquarters communication team HCI field team prepared and shared web-story on the project interventions to improve COPD diagnoses and management, including World COPD Day event (available at <http://www.unc-chs.com/news?newsItemID=303>). These activities have been also shared to the Global Initiative for Chronic Obstructive Lung Disease at <http://www.goldcopd.org>.

Research and Evaluation

With the support of headquarters research and evaluation team, the project conducts the quantitative study to assess the effectiveness (cost-effectiveness, efficiency) of the quality improvement intervention in ambulatory and hospital facilities. Currently 1800 questionnaires are filled and entered and patient survey on phone is in progress. Georgia HCI team also completed reports on:

- Hospital Management of Asthma in Imereti and Ajara Regions;
- Hospital Management of COPD in Imereti and Ajara Regions.

The results of COPD hospital Management have been shared to key national and regional stakeholders during the 4th learning session. HCI team continues working on analyses plan and preliminary reports in other project priority clinical areas.

Institutionalization

At national level

Advocacy of NCD-s at policy level

As acknowledgement of importance of collaboration with the project the Deputy Minister of MoLHSA Dr. Mariam Jashi visited URC Headquarters and met with the Vice-president Dr. Rashad Massoud and Deputy Director of ASSIST project Dr. Kathleen Hill. They expressed mutual understanding of importance to address the quality of screening and management practices of major NCDs at the policy level and issue of quality in Health Care in general.

CoP of Georgia HCI project actively participates (often as a facilitator of working groups) in discussions with MoLHSA high level officials (minister, deputy minister, head of the departments), members of National Parliament and other key stakeholders on evaluation of Georgia health policy and planned changes in Health System of Georgia. Within her advocacy several quality measures (such as MI and pneumonia rehospitalization rates, calculation of 10 year risk of CVD event, primary and secondary prevention of CVD with high impact medication bundle), including WHO indicators from Global Monitoring for the Prevention and Control of NCDs, were incorporated in “Georgia Health System Performance Appraisal 2011” as recommended indicators to be routinely collected and analyzed by MoLHSA in upcoming years to assess Georgia Health System Performance at National Level

As Invited Member of the Primary Health Care Council at MoLHSA, created in January 3, 2013 by ministerial decree, Dr. T. Chitashvili also worked on development of basic benefit package that will universally cover 5-65 years old Georgia population. Dr. Tamar recommended incorporation of WHO “Best-buy” high impact screening and management services and more cost-effective diagnostic tests for high burden diseases, instead of covering specialist services at ambulatory level, abdominal ultrasound, universal use of whole blood count and other multi-purpose lab tests. All these recommendations have been strengthened with evidence on:

- Disease or risk-factor prevalence/incidence and mortality data in Georgia;

- Proposed screening and management services/including diagnostic tests that were considered best-buy high impact essential services/diagnostic tests by WHO for resource-limited settings;
- Evidence of effectiveness/cost-effectiveness of proposed services/diagnostic tests in low- and lower middle income countries.

The written recommendations from HCI project have been fully accepted and incorporated in the document developed by PHC Working Group of Primary Health Care Council under MoLHSA.

Development of National Protocols:

The project developed and submitted to MoLHSA final versions of following national protocols:

- Management of Bronchial Asthma in General Practice
- Management of Asthma Exacerbation (in general practice and hospital)
- Management of COPD in General Practice
- Management of COPD Exacerbation (in general practice and hospital)
- Spirometry in Clinical practice.

Development of Continuous Professional Development modules:

To support sustainability and institutionalization of training modules, together with Georgian Respiratory Association, Georgia HCI team submitted to professional development board of Tbilisi State Medical University (TSMU) several Continuous Professional Development (CPD) modules. Currently, 4 CPD modules have been approved and registered under TSMU: within:

- a) smoking status screening and tobacco cessation interventions
- b) Theoretical and practical aspects of Spirometry,
- c) Modern recommendations on assessment and treatment of Asthma,
- d) Modern recommendations on assessment and treatment of Chronic Obstructive Pulmonary disease

According to the agreement with professional medical associations and the University, after completion of HCI project, they will continue to implement abovementioned CPD modules together: professional associations will conduct the CPD modules while TSMU will organize trainings and provide administrative support.

Planned Activities for January-March 2013

- Continue to provide intensive support to facility personnel of quality improvement teams in Imereti to test and implement changes in their care processes for CVD, asthma, COPD and RTI;
- Support translation and spread of current clinical evidence-based medical information among Georgian physicians;
- Finish patient survey for cost-effectiveness study, continue data analysis and report writing;
- Develop pilot version of web-resource and facilitate dialogue between all relevant parties to form National Quality Forum.