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AIDE MEMOIRE

Quality and governance of primary health care in Georgia

Mission from 24 to 28 July 2017
Tbilisi, Georgia

In the context of the Primary Health Care Strategy 2016–2023, this mission focused on two strategic objectives. In an effort to avoid disruptive reforms, marginal changes that focus on improvements in an iterative, stepwise manner are proposed.

Governance of primary health care

Policy recommendations: Developing an identity for primary health care and, gradually, align system incentives. This can be achieved stepwise by creating virtual primary health care teams that network services and actors; apply connecting tools (e.g. patient pathways, health records, discharge plans) and define a *niche* for primary health care teams (care/case managers, coordinators). A definition of new accountability arrangements based on that identity is then needed to align system regulations, incentives and health workforce competencies.

Primary health care quality assurance, management and improvement

Policy recommendations: Strengthening quality of clinical practice requires focusing on the quality of outcomes. Mechanisms for assuring quality of inputs and processes do exist but need enhancing. Strengthening the quality of clinical practice includes reinforcing the quality of PHC inputs, improving and consistently applying mechanism for quality of the PHC processes, continuing efforts to pilot and standardize mechanisms for quality of the PHC outputs and establishing mechanisms for assuring quality PHC outcomes.

Note: This draft document has been prepared by the Mission Team and will inform a final report following discussions and input of the Ministry of Labour, Health and Social Affairs.

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Mission overview

Policy context

Primary health care (PHC) is a policy priority at present, accelerating earlier policy efforts in Georgia. The current priority weighted to PHC builds upon the First PHC Master Plan 2004–2006 and overcomes the lag in the development of PHC that followed between 2008–2012; a period observing rapid privatization of the services provision and the unsuccessful adoption of a Second Master Plan.

Recent PHC strides are set in the context of the Georgian Health System State Concept 2014–2020 on universal health coverage (UHC), investments in quality control and launch of a UHC Programme in 2013. In 2016 the PHC Development Strategy for the period 2016–2023 was approved by the Health Council. In line with this strategy, a Health System Quality Improvement Strategy elaborating a platform for quality improvement was developed. While not yet approved, it draws upon important regulatory advancements on facility licensing and permits and minimum quality and safety requirements established, predominantly over the past five years.

International policies and partnerships allow for the scale-up of support to Georgia and call for sustaining momentum. This includes the WHO-EU-LUX UHC Partnership (UHCP), prioritizing the operationalization of the current PHC strategy. Importantly, Georgia's policy priorities are in line the WHO European Framework for Action on Integrated Health Services Delivery, Health 2020 and the Sustainable Development Goals – each recognizing the critical role of PHC in making progress to the delivery of quality, essential health services, that are safe and acceptable to all people and communities.

Health status drivers for change

The health and demographic profile of the Georgian population has observed changes towards chronic, noncommunicable diseases (NCDs) that demand an evolution in the services delivery. Georgia's life expectancy has increased slowly over the past years and, in 2015, only 14% of the population was over the age 65 years. At present, NCDs alone account for an estimated 93% of total deaths in Georgia, of which 69% are related to cardiovascular diseases.[1] The period 2005–2015 saw the greatest increase in deaths caused by hypertensive heart disease (145.6% change) and diabetes (66.3% change).[2] Risk factors for NCDs in Georgia draw attention to diet and high systolic blood pressure and persistently high levels of adult smoking. While notable progress has been made on communicable disease control, including malaria and childhood vaccine-preventable illnesses, Georgia faces persisting challenges for tuberculosis, remaining among the 18 high priority countries in the WHO European Region.

In 2016, the STEPS survey of noncommunicable disease (NCD) risk factors in Georgia was carried out. The results point towards some concerning patterns: 52% of males reported

[1] WHO. (2014). NCD Country Profile: Mortality structure, Georgia. http://www.who.int/nmh/countries/geo_en.pdf.
[2] Institute for Health Metrics and Evaluation. (2015). Global burden of disease: Georgia country profile. http://www.healthdata.org/georgia

smoking daily (females, 6%); 35% of men engage in heavy episodic drinking (females, 3%), and 65% of males and females combined are overweight.

Objectives of the mission

This mission set out to support the Ministry of Labour, Health and Social Affairs (MOH) with the operationalization of the PHC Strategic Plan 2016–2023. This focus is in line with the fifth priority area of the UHCP initiative.

In the framework of the umbrella UHC agenda in the country and in the spirit of strategizing those first most pertinent steps for the implementation of the PHC strategy, two specific objectives of the current strategy were prioritised and determined the scope of the mission.

These areas include:

- Objective 1. Improving governance and organizational capacity in primary health care
- Objective 4. Improving the quality of primary health care services

Approach

Modality of work. Over the period of a week, the mission team split into 2 subgroups (Team A: policies and Team B: clinical practice). Through semi-structured interviews, the teams sought out the first-hand experiences from the MOH, national counterparts and providers, professional associations on the status of PHC and what ways quality of care could be improved. The teams then worked to operationalize these options, giving attention to aspects that are feasible, to think to these in different scenarios that are adjustments in a stepwise approach rather than disruptive reforms. The approach to strategizing implementation worked to build on existing good practices, up taking good innovations and systematizing their use.

Outcome oriented-approach. The mission drew focus to the current burden of disease described above. Applying a population health lens, the scoping of the current context and relevant options had view to the capacity of PHC, asking: what is the responsive capacity of PHC at present and in the future? This forward-looking perspective is considered essential to ensure sustainability and to adjust the system gradually, yet accordingly, overtime.

Alignment with on-going technical assistance initiatives. The mission team was well-briefed and mindful of other ongoing WHO activities in Georgia. These activities and their related reporting were fully up-taken in advance of the mission to serve as a baseline and platform for coordination. This coordination put focus to harmonization with health financing, NCDs and nutrition, public health services, system response to tuberculosis.

The mission itself included joint meetings with Joao Breda, Head of the Moscow Office for NCD, present in Georgia on a parallel mission related to ongoing nutrition studies and childhood obesity.

Coordination with Development Partners. The mission teams had the opportunity to connect with Development Partners working within the scope of PHC services. This included

the Embassy of the Czech Republic, UNICEF and UNFPA. These meetings allowed for an exchange of activities and an important overview of new and ongoing work.

WHO technical team

Team A – Policies

Name	Perspective
Juan Tello	Team leader, coordination and alignment, quality of care
Erica Barbazza	Overall PHC governance, health system alignments
Paola Abril Campos	Quality assurance, meso-level governance, integration of PC and PHS
Alexandre Lourenco	Strategic purchasing, health financing

Team B – Clinical Practice

Name	Perspective
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Evgeny Zheleznakov	Quality improvement, both PHC and hospitals, patient engagement

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Section one: Governance for primary health care

1. Main findings

Overall, there is a diverse, multi-profile network of actors that are involved in the delivery of PHC services. While the entire continuum from promotion and disease prevention to diagnosis and treatment is in place, services are currently mainly curative, placing emphasis on diagnosis and treatment. Taken together, a range of PHC services that extend along a continuum from disease prevention and health promotion, to diagnosis and treatment are in place. The settings were PHC is provided also vary considerably together with the models of care they have in place. A mapping of services, actors and settings of care identifies the following.

1.1 PHC services

- **Scope of services**. Through a large range of practitioners and varied settings of care, the conventional scope of PHC services is observed. This includes maternal and child services, immunization, reproductive health, screenings including some promotion and prevention activities, both population and individual-based, basic laboratory tests, diagnostics, palliative care, rehabilitation, psychiatric community-based care, health checks, etc. Access to medicine for vulnerable population has recently improved in the context of the UHC Programme.

  The scope of services, however, is not standardized across the population and the quality is not audited, raising equity and safety concerns. Importantly, given the current burden of NCDs, there remain gaps related to tackling NCDs in primary care. This includes, for example, population risk stratification, early detection, diagnosis and management of chronic conditions, lifestyle and behaviour changes counselling services. Access to after-hours primary care services, despite not directly assessed by the mission, was preliminary found very limited.

- **Scope of practice**. The scope of practice of rural family doctors and nurses is based on a standardized job description. However, this is has a narrow scope and is not standardized with the family doctors contracted by private providers raising concerns of equity and quality e.g. rural doctors prescriptions are not covered by the UHC Programme.

  Similarly, the scope of practice of family doctors (FDs) and those of specialists are assumed from recommendations in the clinical guidelines (first time confirmation of diagnosis and periodic check-ups for diabetes mellitus, hypertension) and only partially by competencies and clinical capacity of each FD. For example, there is no clear division of what profile of hypertensive patients should be treated solely by FDs and which should be treated by cardiologists or other secondary care specialists. Role of nurses (that work with FDs) is limited to administrative tasks and drug administration (DOTS) with few anecdotal examples of task delegation that are mostly at discretion of the FDs will to delegate (only Rural Doctors have nurses; private FDs usually not).

- **Patient pathways and continuity of care**. The gatekeeping role of FDs is strengthened by UHC requirement of FD referral for specialist consultations and inpatient treatment. In

recent reforms, it is also strengthened through the requirement that prescriptions for the fully-reimbursed essential medicines is made by FDs.

However, there are no defined patient pathways and aid patient support to navigate the system and communication between providers is missing, e.g. patient records are separate for FDs and separate for specialists and between out/in patient regimes. This poses risks of test duplications and higher administrative burden for patients. Frequently, patients opt to visit secondary care specialists directly, without referral, and pay out of pocket or call an ambulance or go to the hospital emergency department, avoiding out-of-pocket payments. Counter-referral and FD follow-up after acute episode or inpatient treatment is missing. Continuity and coordination of care in chronic patients is problematic, especially in urban areas where patients change their FDs frequently or buy services directly from narrow specialists.

- **Vertical programmes**. The MOH has several vertical programmes that ensure either services and/or medication for specific diseases and health conditions. The Health Services Department defines priorities and annual budget. Minor changes can be made to the programmes during implementation if necessary. Some of current programmes include TB, Hepatitis C, rural doctors, mental health, diabetes, addictions. The SSA unit for vertical programmes procures services and medicine through tender (drugs), voucher and direct contracting of services for pre-qualified providers and reimburse providers. Follow up of the programmes is limited to financial and administrative compliance. There is no evaluation of the quality of the services provided. During the implementation of vertical programmes, there exist some degree of interaction with some local authorities to coordinate complementary assistance to same beneficiaries. For instance, for the programme on dialysis, some municipalities co-finance the transportation of patients. Another example is the programme on Hepatitis C.

1.2 Settings and points of care

Services are provided in different settings with different modalities. It is observed that primary care services are delivered in outpatient services (co)located in hospital and multi-profiled facilities.

- **Types of facilities**. Multi-profiled settings of PHC; in hospitals – co-located; flexibility and experience in different arrangements for organizing services. There are also facilities managed by vertical programmes such as Women Consultancy Centres.

- **Facility infrastructure**. There are no basic medical equipment and infrastructure requirements for FDs. E.g. only some FD offices have scales, offices vary in sizes and physical location. First aid kits have reportedly been provided to rural FDs by the MOH. This however, is the limit of supplies provided, leaving rural FDs to equip their practices with medicines, basic office supplies, and other essential resources. Rural FDs were found to take advantage of co-location at municipality or private outpatient clinic premises to minimize these costs.

1.3 Actors in PHC

Taken together, the myriad of actors for PHC have an impressive range of knowledge, skills and capacity in delivery PHC services. These actors showed readiness to fulfil their role in creating a shared PHC approach for Georgia. PHC actors also expressed a common sentiment of respect for the MOH, recognizing the need for the ministry's leadership on services delivery. The welcomed governance of the MOH is highlighted recognizing the significance of this in the particularities of a highly privatized system and is considered positive circumstances for strengthening governance.

This myriad of actors has, overall, increased fragmentation in the service delivery and many actors show a narrow mandate for PHC.

- **National, macro-level**. The main national actor is the MOH with a policy and normative role. Other national actors involved in the provision and purchasing of PHC services, under the control of MOH are the National Centre for Disease Control (NCDC) and the Social Security Agency (SSA), with a network of regional branches.

  Professional associations play a significant role with regards to clinical regulations, developing clinical guidelines (CPs) then approved by the MOH.

- **Regional, meso-level**. Actors at the meso-level include regional departments of health contracting out health programmes for their catchment population and municipal public health centres supporting the implementation of vertical programmes such as immunizations while reporting to the NCDC, funded by municipal and national budget. There are also local Social Services Agencies in charge of purchasing health services for the population covered by UHC.

  These actors, however, appear to be neither trained nor empowered for population health management. The degree of priority setting for public health programmes offered appear limited to financial considerations. Overall coordination between regional and local bodies and the MOH was found to be limited.

- **Facility managers**. The variability of the model of facilities is a testament to the flexibility of the system and capacity of managers. Innovative managerial practices introducing internal quality improvement processes and monitoring of processes are illustrative of this potential.

- **Practitioners**. There is a critical mass of empowered FDs with an understanding of family medicine principles. **Rural family doctors** appear to uphold an approach to services more in line with the traditional notion of PHC, having a sense of responsibility for their practice population, greater resolutive capacity (mainly due to resource constraints of their population) and a greater inclination to manage the needs of their patients rather than referring to specialists. These rural FDs are paid a salary based on individual contractual arrangements in the context of a vertical programme of the MOH. From their salary they cover all practice costs. Their (co-)location varies from working in municipality-owned health facilities to private hospitals where they work side by side with specialists.

In contrast, **urban family doctors** are employed by private providers that are contracted by the SSA and are paid by capitation. Contractual arrangements include urban FDs and other different medical specialties and diagnostics. The monthly capitation is split into 44.6% for FDs and 55.6% for the remaining services. In the case of patients registered with rural FDs, the private provider is also entitled to a monthly capitation for the other specialists and diagnosis. Urban PHC providers are (co-)located at an outpatient clinic or in an acute hospital.

In urban areas, where access to specialists is greater, FDs have a role more closely to a dispatcher rather than a gatekeeper (high referrals for UHC covered consultations and hospitalizations), having a limited scope of practice and accountability to manage diseases. As a result, high volumes of unspecialized cases are reportedly treated by specialists, to the disadvantage of specialist and their expertise to manage highly-specialized services and FDs.

- **Patients**. The UHC Programme has invested in the delivery of services to vulnerable groups and the continued roll-out and expansion of this programme, including the further addition of medicines covered (as of July 1st) as important access gains. However, the quality of services provided is not assessed. The privatized nature of services allows patients the mobility to move between providers every 2 months, creating significant continuity of care constraints.

- **Development Partners**. The network of Development Partners in Georgia share an appreciation for the importance of investing in PHC. These efforts were described to include work of the Embassy of the Czech Republic to pilot quality management indicators, UNCIEF to introduce a scheme for investing in health information management and systematized preventive and health promotive measures for improving maternal and child health and UNFPA to strengthen family planning initiatives. The efforts described adopt a common approach to improvements that minimize disruptions and gradual, stepwise implementation.

2. Drivers for change

- **UHC Programme is a window of opportunity for PHC**. The UHC Programme has called attention to services delivery and presents an opportunity for the alignment and consolidation of vertical efforts into a horizontally integrated platform of services with a higher resolutive and quality capacity. A model of care based on a strengthened PHC approach can facilitate this.

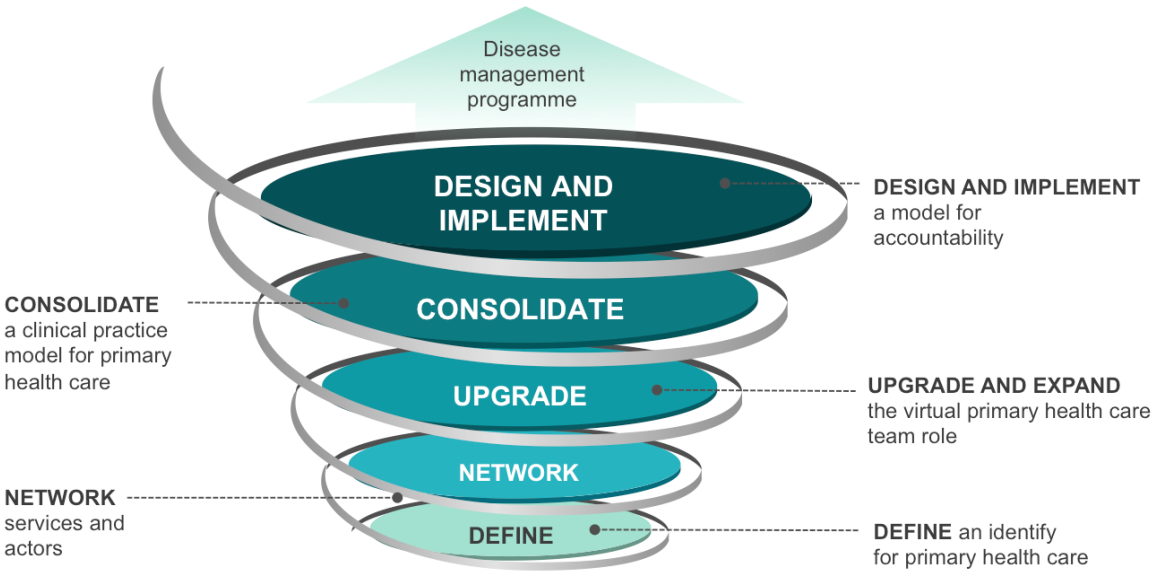
- **Efficiency gains and sustainability are at stake**. Increasing the resolutive capacity of the first level of care will ensure sustainability of the UHC programme efforts, generating internal efficiency gains in the long run.

- **Accelerating the responsive capacity at pace with changing health and social needs**. Health needs and the burden of diseases have drastically changed. There are proven cost-effective interventions both at population and individual levels that call for efforts to invest in developing a PHC approach, also in line with global commitments, e.g. the Sustainable Development Goals.

- **Paradigm shift to put people at the centre of public policy interventions**. A collective understanding and buy-in on a people-centred approach to services delivery is needed to adjust people's perceptions and professional practice. A PHC approach puts people at the centre by design.

3. Policy recommendations: Developing a governance model for primary health care

The main steps are outlined below. These include illustrative actions to be undertaken.



Step one: Define an identity to primary health care

- ✓ Mapping current services, settings and actors.
- ✓ Defining virtual primary health care teams.

Step two: Network services and actors

- ✓ Connect virtual primary health care teams around outputs/outcomes.
- ✓ Define patient pathways.
- ✓ Share information and improve information flows between settings.
- ✓ Establish common/shared health records in outpatient care.

Step three: Upgrade and expand the virtual primary health care team role

- ✓ Introduce new services e.g. NCDs.
- ✓ Upgrade competencies of providers.
- ✓ Develop new standards.
- ✓ Align incentives.

Step four: Consolidate a clinical practice model for primary health care

- ✓ Harmonize basket of services, competencies, scope of practice (rural/urban; private/public), standards.
- ✓ Align system enablers (financial incentives; regulations; licensing; etc.).

Step five: Design and implement a model for accountability

- ✓ Design, establish and implement an accountability framework for performance and outcomes. The accountability framework should improve governance of the providers; also private, around results and health outcomes.
- ✓ Explore relevant models for Georgia: Netherlands (competition; bundle payments), Kaiser Permanente (chronic care/management model, USA), Israel (HMOs with public health perspective); ACOs (organizations accountable for outcomes).

Operative proposal (the how): disease management programmes

Based on one of NCD priorities and building on the existing know-how of vertical programmes, it is suggested to introduce **disease management programmes** to apply the above. This will facilitate the gradual design and development of a PHC model with loops of learning and incentives alignment.

Section two: Primary health care quality assurance, management and improvements

1. Main findings

Taken together, there are a number of mechanisms in place and innovative practices for improving quality of care, in particular the inputs, processes, and outputs of care. Overall, these efforts face constraints to be applied systematically and lack cycles of feedback loops, follow-up or time-based elements for regular updating.

1.1 Quality of inputs

The MOH sets standards for quality assurance mechanisms such as licenses, permits and technical regulations in line with international requirements and the participation of professional associations. There exist standards for professionals, facilities, pharmaceuticals, laboratories, infectious disease control and high-risk services e.g. blood bank, pathology, ophthalmology, clinical practice.

The State Agency for the Regulation of Medical Activities (SARMA) of the MOH is the main implementer of the mechanisms to ensure the quality of inputs to the system. SARMA's current role in PHC quality assurance is overall limited, with undeveloped PHC-related standards. Developing high standards for PHC facilities is recognized as a priority. A Professional Development Council is in charge of professional certification. The MOH Department of Healthcare acts as the secretariat of the Council.

- **Professional certification.** The MOH department of regulations is responsible for the development of standards for health workforce. The Professional Development Council under the MOH is the implementing body in charge of issuing certifications for doctors. This certification is not time-bounded and there is currently no re-certification process in place. Concerns were raised anecdotally on the standards of certification exams. These tests are currently developed as multiple-choice questions (MCQ) and are to the exclusion of practical skills testing. Diplomas and specialization certifications are reported to inform initial contracting and employment of practitioners at health facilities.

- **Facilities.** There are three main regulatory mechanisms for health facilities: licensing, permits, technical regulations. The MOH regulatory department develops standards for health facilities, these however, are currently to the exclusion of PHC centres. Licensing of facilities and the issuing of permits are conducted by SARMA. The issuing of technical regulations to deliver medical practice requires the submission of information on technical standards and can also include inspections to assess these standards in practice. These mechanisms are currently delivered as one-off tasks, for example, issuing initial licensing without a time-bounded element, permits without check or only reactive inspection due to complains, etc. Facilities that provide services under UHC need to comply with additional standards. There are currently no accreditation programmes for facilities.

- **High-risk services**. There are technical regulations for high-risk services such as ophthalmology, gynaecology. SARMA makes in-person inspections to check compliance on these high-risk services. These inspections do not currently apply to PHC.

- **Clinical practice**. There are about 35 clinical guidelines (CGs) specific for primary care and there is a general awareness on their existence. At present, there are no standardized procedures for developing CGs', periodically updating, distributing and professional training. However, the development of CGs has benefitted from the involvement professional associations, including Family Doctors Association and Physician Association. Some private providers have implemented internal protocols based on national or international standards. Compliance to CGs is not checked, unless there is a complaint and further investigation by the MOH or by the insurer.

- **Pharma**. The mission programme did not allow for discussions on quality mechanisms for pharmaceuticals. Expanding on this will be included in the drafting of the final mission report.

1.2 Quality of processes

- **CME/CPD.** A law mandating CME/CPD was rescinded in 2007. As a result, there is currently no oversight over CME/CPD nationally that ensures these learning systems are in place and, happening on a regular basis.

  The flexibility of this deregulated context has, however, fuelled innovative arrangements that serve to tailor CME/CPD to the priorities of facility managers. Quite a lot of innovation has been observed in terms of the scale, frequency, and modality of these initiatives. The National Family Medicine Training Centre, for example, has designed courses and ad-hoc trainings for FDs and nurses working at the Centre. Professional associations are also active in developing content and implementing CME/CPD. This includes a high-level of activity by the national nursing association in supporting nursing CME/CPD in services.

  In the absence of a regulatory framework, the quality of trainings is not standardized and whether trainings are being informed by practitioner actual needs (to be distinguished from management needs/interests), is unclear. It is also concerning that trainings are being implemented without reported alignment to the Ministry's health priority areas.

  Importantly, there is an understood interest among FDs for trainings on patient counselling with regard to NCD risk factors control, which is a neglected area at the moment. Rural doctors could benefit greatly from learning new approaches on patient counselling to develop this important skill to tackle NCDs at early stages. Expanding skills could also look to improving inter-professional practice, improving prevention and management of disease in the community.

- **Facility quality improvements**[1]. There are a number of internal quality improvement mechanisms in place at national, regional and district hospitals. Each hospital has a designated Quality Committee/Department responsible for implementing regular clinical audit processes that seeks to improve patient care and outcomes through the systematic review of care provided. This is done through checks and reviews of patient case histories for compliance to CGs, protocols and in-hospital standards. In addition, adverse events and outcomes, as well as patient complaints are also reviewed. The results of reviews by specific cases or events are recorded in reports of the meetings and are communicated internally to clinical director/heads of clinical departments and doctors for appraisal/punitive purposes, learning process and implementation of change. There is currently no measurement or monitoring to assess the degree of quality improvement through this mechanism. Nonetheless, according to hospital managers the perceived quality improvement due this mechanism is around 30 percent.

  Other quality improvement mechanisms include routine checks of medical records, reviews of complicated cases and data submission for reporting to the NCDC conducted by heads of departments and randomly by hospital manager and/or clinical directors. Finance departments conduct administrative checks of medical records to assess the amount of delivered services vs. claimed cost. HR departments report checks of doctors' diplomas and specialization certificates to determine their eligibility for practice. Finally, all hospital medical staff participate in regular (weekly) peer review meetings to discuss difficult or complicated cases and adverse events in order to share opinions between colleagues and arrive at well-informed consensus regarding conclusions, lessons learnt and operational decisions. The described quality improvement mechanisms at the hospital level provide a strong platform to build on improving quality of care in PHC.

  Unfortunately, these mechanisms in hospitals are not observed in practice in PHC facilities and rural doctors' practices. Moreover, rural doctors are not integrated into PHC centers and thus, not accountable to facility managers, despite being hosted on PHC premises. There is also a lack of a regulation framework for infrastructure and sanitary conditions at PHC facilities. No routine exchange of patient records/discharge forms exists between hospitals and PHC/Rural doctors.

- **Complaints system for patients**. A national patients' charter in place as well as a, mechanism to capture patient complaints which are received by the MOH. These mechanisms, however, are not yet standardized and are not systematically implemented across facilities (some facilities have complaint boxes but some do not), neither the analyses and follows up with the complaints. Complaints received are described to predominately refer to issues related to coverage of services and disputes of access to services based on aspects of location/registration, for example.

- **Reactive adverse events reporting.** Reporting of adverse events is a key mechanism to ensure patient safety that includes side effects to medicines and vaccines, medical device adverse incidents, defective, counterfeit or fake medicines or medical devices. At present, a mechanism for reporting of adverse events is not in place. Moreover, the 'Yellow Card

[1] Ministry of Labour, Health and Social Affairs Order no. 01-63/N dated September 12, 2012. Requirements towards internal quality improvement and patient safety systems in inpatient medical facilities providing medical services

Scheme'[2] – an international standard vital in helping countries to monitor the safety of all health products to ensure they are acceptably safe for patients and those that use them – is not applied. While there are reports of pharmacovigilance policy being developed, in health facilities visited there is no awareness of known practices of reporting adverse drug reactions, except for internal discussion at health facilities at the level of Quality Committees. Some facilities are only reporting adverse events to pharmaceutical companies.

1.3 Quality of output

- **Patient satisfaction surveys**. Information about patients' experiences and satisfaction are not systematically collected. For some private facilities, it seems that there is interest in collecting data on patients' satisfaction and experience. Measures at present look predominately to waiting times.

- **Performance-based management and payment**. There are some vertical initiatives monitoring outputs in PHC (e.g. immunizations), however, there is not a comprehensive and standardized monitoring plan. Moreover, the current payment models in place for PHC are based mostly on inputs (e.g. salaries to FDs and nurses, number of patients enrolled with PHC providers). This is to the exclusion of monitoring by factors related to age, burden of disease, care quality, patient experience or population health.

  Under the Global Fund, there are intentions to pilot results based payment for tuberculosis services. Also, the National Primary Care Training Centre has mechanisms that monitor medical practice that are considered to financially reward FDs in a pay for performance programme.

1.4 Quality of outcomes

- Currently, measurement of population health is conducted by the NCDC as part of the organization's population health surveillance. However, this reporting looks primarily to rates of communicable diseases, to the exclusion of NCDs for instance. Findings of this surveillance are published in an annual health statistics yearbook. Other ad-hoc assessments are conducted such as a recent STEPS survey of NCD risk factors and the Childhood Obesity Surveillance Initiative (COSI). Nonetheless, an overall approach or initiatives to report on quality for population health outcomes is absent.

2. Drivers for change

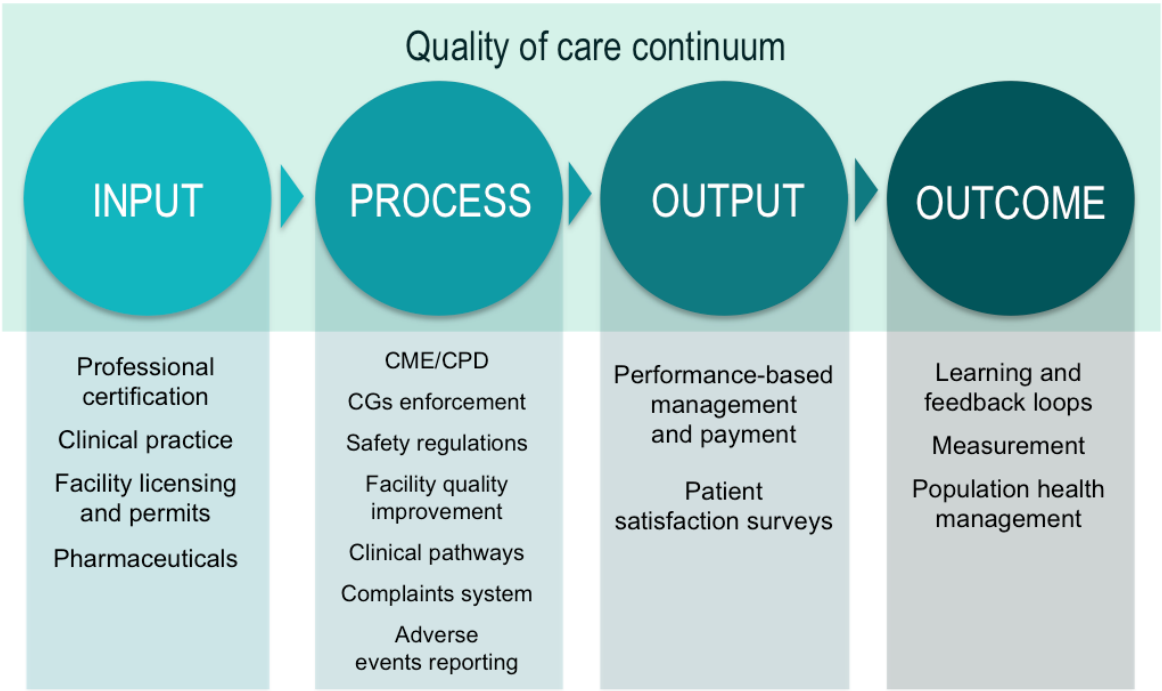
- **Intrinsic motivation to innovative.** The current system has generated space for innovations. Those with entrepreneur skills but also intrinsic motivation to serve patients have developed *niches* of excellence in services delivery. This critical mass of knowledge, skills and critical judgement is a human capital that needs to be nurtured to drive change.

[2] The Yellow Card Scheme is based upon the ICS E2B (R2) international standard and routinely used in EU, USA and many other countries reporting all adverse drug reactions to international database centre and laboratory in Uppsala (Sweden).

- **Need for self-sustaining learning loops.** The development of a culture of performance monitoring and feedback is needed both at the system and provider levels, with special emphasis in analysis, reporting and feedback.

3. Policy recommendations: Strengthening clinical practice towards quality and safety

Strengthening quality of care is viewed to across a continuum extending from the quality assurance of PHC inputs, processes of services delivery, outputs of care and ultimately, health outcomes. This continuum extends the following recommendations and activities. Note, these options are not sequential and can also be activated in parallel. This list is not exhaustive and has been prioritized based on the above findings.



3.1 Strengthen mechanisms to assure quality of PHC inputs

- **Professional certification**. Invest in the licensing examination for health professionals to ensure testing of request core competencies. Introduce a time-bounded element for health professional licencing, including recertification.

- **Clinical practice**. Develop a regulatory framework that details the processes for the timely development, adoption, dissemination, implementation, monitoring and updating of CPGs.

- **Facility licensing and permits**. Extend standards and regulations for health facilities to include PHC facilities. Introduce a time-bounded element to licensing and facility permits. Introduce a scheme of ad-hoc inspections of facilities through the existing implementing agency (SARMA) for surveillance of standards overtime, including mandate to revoke licenses based on findings.

- **Pharma**. To be developed in the final report.

3.2 Improve and consistently apply mechanisms for quality of PHC processes

- **CME/CPD**. Develop a mandatory CME system for PHC with designated point person in the MOH to oversee implementation and take stock of existing practice, resources and training centres. Ensure stakeholder involvement, including associations and universities in the development improvement and implementation of PHC trainings. Engage with regional authorities to facilitate and organize regular (annual) in-person trainings for PHC professionals on ministry identified national priority areas in PHC. Diversify options for courses, trainings and resources including online e-learning and decision aids. Introduce facility accreditation criteria that require on-site PHC specific learning opportunities, such as journal clubs, developing primary care learning plans, lunchtime lectures, peer teaching on topics related to practice, peer-to-peer reviews of cases and inter-professional role playing. Finance these new initiatives using funds from facility accreditation fees.

- **Clinical guideline enforcement**. Introduce internal and external mechanisms for monitoring compliance to clinical guidelines and recommendations, including appropriateness of referrals and hospitalizations. Develop and disseminate a clinical guideline checklist to all facilities to attest that national guidelines are being used to ensure implementation. The checklist should address four elements of effective guideline implementation: facility governance structures supporting clinical guidelines, awareness and dissemination, clinical education and quality and safety. Facilities should be requested to report on the use of any other guidelines.

- **Safety regulations**. Introduce international standards for facility safety measures. Invest in systems for monitoring administrative errors, diagnostic errors, medication errors and transitions of care.

- **Facility quality improvements**. Ensure the consistent use of quality committees in facilities. Align the work of quality committees with regular peer review meetings by hospital staff to ensure quality improvement is based on the systematic examination of clinical priorities, assessment of clinical outcomes and resulting not only in control but in clinical learning.

- **Clinical pathways and continuity of care**. Improve processes for counter-referral and patient follow-up in primary care, including transfer of discharge letters.

- **Complaints system for patients**. Introduce a systematic approach to patient complaints with formal mechanisms in local facilities to gather patient complaints and patient experience data. Introduce a national toll-free number to the population as a platform for

the public to report issues. Strengthen capacity for follow-up by the MOH on issues raised.

- **Adverse events reporting**. Establish a system to stimulate adverse event reporting through incentives for anonymous reporting. Ensure an adverse drug reaction (ADR) monitoring programme is introduced in line with international monitoring programme. The interested parties collaborating on the implementation of an ADR monitoring programme in Georgia should include all medical establishments, Pharmacological Committee of MOH, professional medical organizations and Uppsala Monitoring Centre (the WHO Collaborating Centre of the WHO Program for International Drug Monitoring).

3.3 Continue piloting and standardize mechanisms for assuring PHC quality outputs

- **Performance-based management and payment**. Continue and extend piloting of results-based financing in PHC, including planned application to tuberculosis services. Continue piloting of total quality management in PHC facilities of indicators on the safety, access to services, responsiveness and effectiveness of PHC.

- **Patient satisfaction surveys**. Standardize mechanisms for collecting and analysing patient reported experiences on measures such as patient-centredness of care, coordination, comprehensiveness and continuity of services.

3.4 Establish mechanisms for assuring quality of PHC outcomes

- **Learning and feedback loops**. Introduce mechanisms for quality of care feedback and learning, driving the health workforce to focus on health outcomes. Build upon existing practices such as the model for clinical care coordinators for improving maternal and child health in pilot facilities coordinated by UNFPA.

- **Measurement**. Standardize the coding requirements and harmonize the use of ICD-10 coding for patient records at both PHC and hospitals and for data reporting to the NCDC. Enable data aggregation regionally and feed into regional health strategies at the municipal level.

- **Population health management.** Strengthen accountability of PHC facilities monitor and improve upon population health outcomes for their practice population.

Next steps

A. Drafting final mission report

- Elaborate mission findings in final report, expanding on innovative practices as illustrative examples aligned to policy recommendations.
- Seek feedback from MOH.
- Finalize and disseminate final report.

Timing: August–November 2017

B. Proposed areas for technical support

1. **Technical support to develop virtual PHC teams**
   - Operationalize a proposal for virtual PHC teams, connecting PHC services, PHC providers, and settings of care in a concept note on PHC.

   Timing: end-2017

2. **Ambulatory care sensitive conditions hospitalizations (ACSHs) assessment**
   - Revisit ACSH assessment building on 2016-scoping mission and additional data available at present.
   - Conduct study as part of the evidence base for strengthen PHC efficiency and effectiveness and overall quality.

   Timing: end-2017

3. **Piloting WHO PHC Performance and Capacity Tool (PHC-PACT)**
   - Seek nomination of a Country Coordinator (CC) to support the application of the PHC–PACT – the proposed tool for monitoring the WHO European Framework for Action on Integrated Health Services Delivery to be applied throughout the Region towards a PHC baseline.
   - Consolidate data from existing reporting and address gaps with CC through key informant input.

   Timing: October–December 2017

4. **Joint mission of the design of disease management programme**
   - Coordinated mission with NCD colleagues to explore the design of a disease management programme for a priority area.
   - Develop a proposal for piloting disease management programme.

   Timing: early 2018

5. **Field visit to explore relevant models (e.g. Israel, Netherlands)**
   - Select 5-10 PHC actors (national, meso, clinical) to participate in a field visit to a relevant model of PHC in practice.

   Timing: 2018

Annex one: Mission programme

		Team A	Team B
Monday 24 July	AM	Team briefing and meeting with WHO Country Office	
	PM	Meeting with Dr Nino Berdzuli, Deputy Minister of Health for the Ministry of Labour, Health and Social Affairs	
Tuesday 25 July	AM	Meeting with Dr Amiran Gamkrelidze, Head of National Centre for Disease Control and Public Health	
	PM	Meeting with Natia Nogaideli at Regulatory Division, Ministry of Labour, Health and Social Affairs	Meeting with Medical Director Dr Ivane Chkaidze and team of Iashvili Central Children Hospital
		Meeting with Keti Goginashvili at Policy Division, at Ministry of Labour, Health and Social Affairs	Meeting with Medical Director, Chief Nursing Officer and Human Resources Department at Gudushauri Multiprofile Hospital
		Meeting with Medical Director Dr Irina Karosanidze and team of Tbilisi Family Medicine Training Centre	
		Meeting with Medical Director Dr Nino Kinadze and team of Curatio private PHC centre	
Wednesday 26 July	AM	Meeting with Dr. Givi Javashvili Head of Family Medicine Department of Tbilisi State Medical University	Clinicians at Sartichala Rural Ambulatory Centre
		Meeting with Third Secretary Jan Cernik of the Development Cooperation for the Czech Republic to Georgia	Medical Director and team at Sagaredjo Regional Multiprofile Hospital
	PM	Meeting with Head of Department Gela Chiviashvili at the Department of Health Care and Social Services at Tbilisi Municipality City Hall	Regional Public Health Centre of the Sagaredjo Region

Mission programme – cnt'd.

		Team A	Team B
Thursday 27 July	AM	Meeting with President of the Georgian Society of Hypertension/Director of Cardiology Institute, Professor Bejan Tsinamdzgvrishvili and the Head of research Working Group of the Georgian Society of Hypertension, Dr Dali Trapaidze	
	PM	Meeting with Tako Ugulava of UNICEF- Georgia Meeting with George Mataradze of UNFPA - Georgia	
		Meeting with representatives of the Social Service Agency and Vertical Disease programmes Ministry of Labour, Health and Social Affairs	
Friday 28 July	AM	Meeting with president of the Georgian National Nursing Association, Ms Ketevan Garsevanishvili	
	PM	Meeting with representatives of the Cancer Patients' Association "Winner Women Club"	
		Debriefing with Dr Nino Berdzuli, Deputy Minister of Health for the Ministry of Labour, Health and Social Affairs	

Annex two: Persons met

Ministry of Labour, Health and Social Affairs

Nino Berdzuli
Deputy Minister of Health

Marina Darakhvelidze
Head of Health Services Department

Natia Nogaideli
Regulatory Division

Ketevan Goginashvili
Head of Policy Division

National Centre for Disease Control and Public Health

Amiran Gamkrelidze
Head of the Centre

Maia Kereselidze
Head of the Department of Health Statistics

Ramaz Urushadze
Head of Public Health Department

Lela Sturua
Head of NCD Department

Nana Kavtaradze
Head of International department

Tbilisi Municipality

Gela Chiviashvili
Head of Department
Department of Health Care and Social Services

Iashvili Central Children Hospital

Ivane Chkaidze
Medical Director
President of the Georgian Respiratory Association

Head of the Outpatient Clinic

Nurse Outpatient Clinic

Persons met – cnt'd

Gudushauri Multiprofile Hospital

Medical Director

Chief Nursing Officer

Head, Human Resources Department

Tbilisi Family Medicine Training Centre

Irina Karosanidze
Medical Director

Marina Shikashvili
Director on Quality Assurance

Curatio private PHC centre

Nino Kinadze
Clinical Director

Tbilisi State Medical University

Givi Javashvili
Head of Family Medicine Department

Sartichala Rural Ambulatory Centre

Manager of the ambulatory centre

Rural family doctor

Regional Public Health Centre of the Sagarejo Region

Head of Office

Regional multi-profile medical centre in Sagarejo

Bacho Maghradze
Director

Medical Director

Georgian Society of Hypertension

Professor Bejan Tsinamdzgvrishvili
President of Georgian Society of Hypertension
Director of Cardiology Institute

Persons met – cnt'd

Dali Trapaidze
Head, Research Working Group
Georgian Society of Hypertension

Georgian National Nursing Association

Ketevan Garsevanishvili
President

Cancer Patients' Association "Winner Women Club"

Representatives

Development partners

Jan Cernik
Third Secretary
Development Cooperation for the Czech Republic to Georgia

Tako Ugulava
UNICEF- Georgia

George Mataradze
UNFPA - Georgia