



**Georgia – training initiatives
on tackling diabetes**
NCD stories from the field



World Health
Organization

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Introduction

Since 2013, Georgia has been implementing reforms aimed at improving access to publicly funded health services. Barriers remain, however. Funding for primary health care (PHC) is among the lowest in the WHO European Region (0.3% of gross domestic product in 2018) and out-of-pocket payments, especially for outpatient medicines, are significant. Noncommunicable diseases (NCDs) account for 94% of all deaths in the country and there is high probability of death from a major NCD before the age of 70 (36% for men and 15% for women).¹ One way to tackle this situation is to improve the management of diabetes in PHC.

The Georgian Government, supported by the WHO Regional Office for Europe and co-funded by the Government of Denmark, has been working to improve access of people with diabetes to high-quality care from their local PHC clinic. During the first phase of the project in 2019–2020, a team of data collectors was trained to perform an audit review of individual patient records to understand the quality of diabetes care, particularly how people at high risk were being identified, managed and followed up.² The approach was further developed and coverage expanded in the second phase of the project, from 2020 to 2021. The project not only showed how basic medical records could be used to inform the design of services, but also provided insights into gaps in the provision of integrated community care in Georgia, the vital role nurses can play, the importance of scoring heart disease risk and controlling high blood pressure, and the need to avoid complications through regular checks and counselling.

60-second read

Fact: throughout 2021, eight clinics in Georgia took part in the second phase of a project to improve PHC for people with diabetes, training trainers and staff in use of medical audits to assess the quality of diabetes care, developing courses in integrated people-centred management for health-care staff, and establishing clinical pathways, protocols and diabetes registers.

Why it matters: clinical audit and feedback have been shown to be effective in improving professional practice, particularly if feedback is intensive and timely and is combined with educational materials, meetings and incentives.

In practice: the project showed that PHC professionals are keen to use their own data to improve quality of care, working with more standardized procedures and in a more integrated way. The roles of nurses and the education of people with diabetes has become increasingly important for patients managing their condition.

Expected result: an approach has been established for continued quality improvement; this will now be scaled up. The Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs (the Ministry) intends to introduce performance-related payments for better PHC for people with diabetes. The audits, indicators and good practice piloted in the project will form the basis of these performance-related payments for participants.

¹ Probability of dying between the exact ages 30 and 70 years from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases (SDG 3.4.1). In: Global Health Observatory [online database]. Geneva: World Health Organization; 2021 ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/probability-of-dying-between-exact-ages-30-and-70-from-any-of-cardiovascular-disease-cancer-diabetes-or-chronic-respiratory-\(-\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/probability-of-dying-between-exact-ages-30-and-70-from-any-of-cardiovascular-disease-cancer-diabetes-or-chronic-respiratory-(-))), accessed 16 December 2021).

² Georgia: gathering insights to provide better diabetes care. In: World Health Organization [website]. Geneva: World Health Organization; 2020 (<https://www.who.int/news-room/feature-stories/detail/georgia-gathering-insights-to-provide-better-diabetes-care>, accessed 16 December 2021).



The state of diabetes care

In December 2019, the Ministry announced a renewed commitment to comprehensively reforming PHC to better align it with the health needs of the population. Supported by WHO, the Ministry has developed a roadmap for PHC reform. Key components of the reform include: developing an updated PHC benefits package and payment model; strengthening PHC as a first line of contact; increasing the roles of family nurses; assessing individual risk and managing chronic diseases with a people-centred approach involving counselling and education; and expanding the use of digital health-care services.

Managing NCDs in primary care remains a challenge. The existing incentive structure favours inpatient and emergency care and contributes to patients bypassing PHC and going directly to hospital. As an example of this in practice, the number of patients who called for an ambulance doubled in the 10 years between 2008 and 2018.

Care for people with diabetes in Georgia varies widely. In some areas, 87% are seen by family doctors, while in others, all are seen by endocrinologists. There is no standardized documentation, with providers recording information about patients in a variety of ways. This project focused on raising the quality of care within PHC clinics for people with diabetes in an integrated and open manner, adopting standard operational procedures and using information, training materials and data freely shared online between participants.

“Initially, we professionals thought that we provided the highest-quality services – evidence-based and people-centred – on prevention, treatment and management for patients with this long-term condition. But the reality was different! We were surprised how enthusiastic the staff were about this project, particularly as it took place during the pandemic. We revitalized the audit and now we will have the capacity to support colleagues right across Georgia to improve the lives of people with diabetes.”

Irina Karosanidze, Director of the Family Medicine Training Centre, Georgia



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Stage 2 of the project

Following initial training and a feasibility study in 2020, the second phase of the project was launched in the same year in eight participating clinics in Tbilisi, Kutaisi, Mtskheta and Batumi. The focus was on working with PHC staff on: establishing pathways, protocols and guidelines; developing curricula; identifying and monitoring indicators of progress; and creating multidisciplinary courses on patient education using a people-centred approach. Participation was not as high as was hoped due to the COVID-19 pandemic, but enthusiasm was plainly evident.

Results

- Twenty data collectors from PHC facilities were trained in data-collection in two two-hour remote and face-to-face courses by four medical audit advisers. A total of 766 clinical records were randomly reviewed, covering a 12-month period. Remote meetings were held with staff from 100 PHC facilities, with feedback given on calculating cardiovascular disease risk or annual screening. This was a valuable opportunity, particularly for doctors who had qualified years earlier, to use real-time data to improve their own systems and practice in collaboration with their teams and peers.
- Training modules on the management of diabetes for family doctors, nurses and managers, and for master trainers to train others, were developed and accredited. The modules support the integration of a common chronic disease management model.
- Seventy-three PHC trainers and clinical leads (including family doctors and nurses) were trained in using the new algorithms, protocols and newly approved guidelines for the management of diabetes/hypertension and to evaluate and monitor their implementation.
- WHO convened two webinars on diabetes management tools – diabetic retinopathy screening and patient education.
- Twenty patient referral pathways for the management of patients with hypertension or type 2 diabetes in local facilities were developed, based on updated and approved national protocols.
- Stakeholder mapping was conducted to identify existing activities relating to hypertension and diabetes programmes and training for clinical and patient education.
- Diabetes registries for people with type 2 diabetes were established in all participating clinics. An audit advisory board of previously trained trainers was established and research skills were improved. This has contributed to benchmarking of prevalence, incidence and coverage rates.

“This project’s main target is the quality and performance of primary health care for people with diabetes. I can see that this will expand to be used for patients with other chronic conditions.”

Nana Asatiani, Head of the Association of Development of Primary Health Care, Georgia

“Under the existing system, reporting requirements for providers are intensive and burdensome, yet there is no audit and providers do not receive feedback. Thanks to this programme, providers are now able to conduct internal audits and to continuously assess and adjust their own performance. The enthusiasm this has generated is a very positive development. In addition, it is feeding into other projects on health information and digital health.”

Allison Ekberg, Health Policy Advisor, WHO Country Office in Georgia

- The Regional Office retinopathy screening guide was translated into Georgian and disseminated.
- Key performance indicators were identified for diabetes and other priority NCDs.
- An online webinar was held for 85 PHC providers on the forthcoming PHC reforms of chronic disease management and quality assurance and other issues regarding current practice of diabetes and hypertension management.

What happens now?

Importantly, under the reforms, the indicators and audits that have been created will form the basis for performance-based payments to be made to participating clinics.

The project is likely to continue and build further as the PHC reforms are implemented during 2022.

There has been much clinical evaluation, performance appraisal and promotion of multidisciplinary teams in Georgia. This project will continue to expand the roles of nurses and promote support and education for patients in managing their lives.

“People with diabetes are already motivated to look after their own care. There are some who are very used to a passive acceptance of what the doctor says, but most patients like working in partnership, measuring and monitoring and being involved in different health promotion activities too. They welcome clear guidance, backed by the Ministry. A more patient-centred approach is new, of course, but people want to be involved and take responsibility for their own care. I think this will work and will be implemented countrywide.”

Nato Shengelia, Family Medicine Doctor and
Project Expert, Support to Primary Health
Care Strengthening in Georgia