USAID FROM THE AMERICAN PEOPLE | HEALTH CARE IMPROVEMENT PROJECT

IMPROVING CARE FOR PEOPLE WITH CHRONIC CONDITIONS IN EAST AFRICA

BACKGROUND

Until recently, malaria and other acute infectious diseases were the leading causes of mortality and morbidity in East Africa. The health systems in the region are, therefore, designed to manage acute conditions. Now with the advent of the human immunodeficiency virus (HIV) pandemic and increasing prevalence of non-communicable diseases, these health systems are being forced to manage people with chronic conditions.

The needs of patients with chronic conditions are very different from those with acute conditions, and health systems are struggling to adapt. Patients with acute illnesses come to the clinic when they have a problem. They then require a diagnosis and short-term treatment which is carried out entirely by the provider (e.g., surgery) or involves the patient for a short period of time (e.g., short-term antibiotics); long-term follow-up is usually not required. People with chronic conditions have different needs. After the initial diagnosis and prescription of treatment, the patient becomes the primary care taker and is responsible for managing his or her health at home. Treatment of chronic conditions is often complicated. For instance, a patient with diabetes mellitus will need to adjust insulin dosage based on home glucometer readings, make changes related to diet and exercise, and take precautions to prevent infection.

Helping health systems change from the current model which is designed to make diagnoses and deliver short-term care to one which has structures and processes in place to help people living with chronic conditions manage their condition at home will require transformation at many levels. The USAID Health Care Improvement Project (HCI) is working in Uganda and Tanzania to make these changes. We are promoting the use of the Chronic Care Model, which is an evidence-based set of principles for improving chronic condition care and has been endorsed by the World Health Organization.

Flow chart developed by QI team at Buikwe Hospital in Uganda showing care process for patients with diabetes or hypertension, including triage to decide if they need medical or psychosocial support. *Photo by Martin Muhire, URC.*

DESCRIPTION OF THE PROBLEM

UGANDA

Buikwe District in central Uganda is home to 407,000 people and provided 270,000 outpatient visits in 2010. Last year, 44,000 (17%) visits were for patients with HIV, tuberculosis (TB), hypertension (HTN) or diabetes mellitus (DM)(this proportion was as high as 34% in some of the hospitals in the district). HIV was the most common chronic condition (81% of all chronic care visits), followed by TB (13%), HTN (4%) and DM (1%).

MAY 2011

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Despite chronic conditions making up a large proportion of visits, health workers do not feel skilled in managing HIV, TB, diabetes mellitus or hypertension. In addition, evidence of care being organized along the principles of the Chronic Care Model was weak: the majority of patients with HIV, DM or HTN did not know that treatment is required for life and could not describe common drug side effects; most clinics did not have staff dedicated to educating patients and even fewer had staff responsible for helping patients problem-solve; longitudinal records were available in some clinics for HIV and TB but not for the other conditions; and links with the communities were weak.

TANZANIA

The issue of how well patients with HIV are supported to manage their own health was further investigated in Morogoro Region of Tanzania and found to be poor:

- 25% did not know HIV was treatable
- 70% felt that care was not their responsibility, but rather the responsibility of someone else (either a health worker or a family member)
- 60% did not know that HIV treatment was life long
- Only 25% had worked with health workers to set their own health goals
- Only 10% had worked with health workers to make plans to meet these goals
- Only 40% felt that they have the ability to solve problems related to their own health.

INTERVENTION

UGANDA

HCI is working with clients, providers and managers in Buikwe District and the central Ministry of Health to change how care is provided. Since January 2011, we have trained patients and providers from 14 clinics about the principles of good chronic care and helped form quality improvement teams in each facility to change their systems to be more responsive to the needs of patients with chronic conditions. The teams are focusing on: 1) improving the knowledge, skills and motivation of patients with chronic conditions, 2) re-organizing the clinics to ensure that more provider time is available for supporting patient and 3) improving data systems so that longitudinal patient information is collected and used for patient management and for reviewing quality of care.

I no longer spend a lot of money seeing consultants for my diabetes. Now I know what to do to keep my blood sugar stable.

– A patient with diabetes in Uganda about the changes in her clinic

TANZANIA

HCI is supporting clients, providers and manager in Morogoro to change how they deliver care so that they are better able to support patients to manage their health at home. Since April 2011, we have trained 43 providers and 24 'expert patients' in 14 facilities to help patients manage their health. To support this process, we have helped develop provider job aids and helped clinics reorganize care to ensure that patients receive self-management support.

RESULTS

HIV CARE AND TREATMENT IN UGANDA

Between January and March 2011, all 14 facilities in Uganda have changed how care for patients with chronic conditions is provided. All 14 now have dedicated staff available to educate patients on their condition, and seven have dedicated staff who help patients set management goals and develop plans to meet these goals.

Patient records and registers created by the QI team at Nyenga Hospital in Uganda to record data for patients with diabetes and hypertension. *Photo by Martin Muhire, URC.*

These staff are also available to help patients problem-solve when they do have trouble sticking to their plans. Ten facilities are involving expert patients in providing peer support to new patients or patients experiencing difficulties, and eight clinics have reorganized care so that patients do not need to see a clinician at every visit. Instead, these clinics have set up triage systems to identify who needs to see the clinician; all other patients see nurses, counselors or peer supporters only. Eleven facilities are now using registers to keep track of all their HIV-positive patients in care. Figure 1 shows the progress since the baseline in January 2011.

These changes have led to dramatic improvements in the ability of patients to manage their health. Buikwe Hospital has 356 patients with HIV in care. Prior to this intervention, there was no documentation of how well patients understood or were able to manage their disease. Now 326 of them have been assessed for their understanding (218 scored 4 or 5 out of 5), and 288 have set themselves management goals relating to their HIV care. Documentation of the new approach has just started, but since none of the clients have yet returned for a follow-up visit since the data has been collected, so there are currently no data on the effect of the improved support on patient outcomes.

NON-COMMUNICABLE DISEASES IN UGANDA

The lessons from HIV have been transferred within the facilities to improve care for HTN and DM. Clinics have started routine screening of hypertension for all adults, having dedicated clinic days for DM and HTN, spreading messages via radio of the importance of HTN screening, and making clinical records to collect, store and analyze patient data. These interventions have led to more than a four-fold increase in the number of patients receiving care for hypertension and diabetes (Figure 2).

Clinics are also supporting clients to better manage their HTN and DM at home. Of the 65 patients with HTN and DM at Buikwe clinic, 25 (38%) have received education on how to better manage their condition and will be developing self-management plans at their next visit.

PATIENT SELF-MANAGEMENT IN TANZANIA

The program was launched in May 2011 with the introduction of 'expert patients' into the region's health facilities to provide the additional labor needed to improve self-management support. Already in the first month, 189 patients in 14 facilities have been assisted to identify health problems which they want to address and to develop action plans to solve these problems. These patients have also been linked to 'expert patients' to continue engaging with them on a regular basis to improve skills and motivation.

Figure 1. Changing systems for chronic care in 14 clinics in rural Uganda, 2011

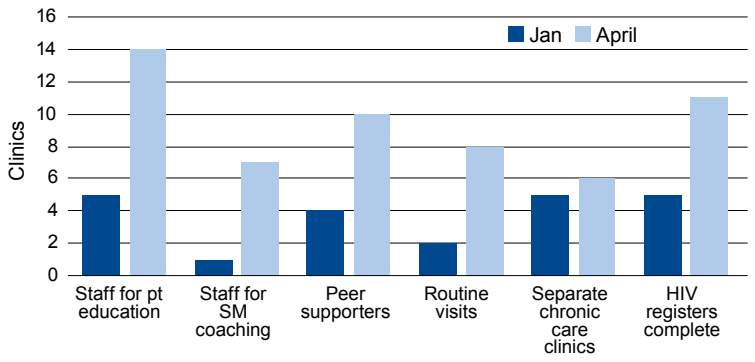
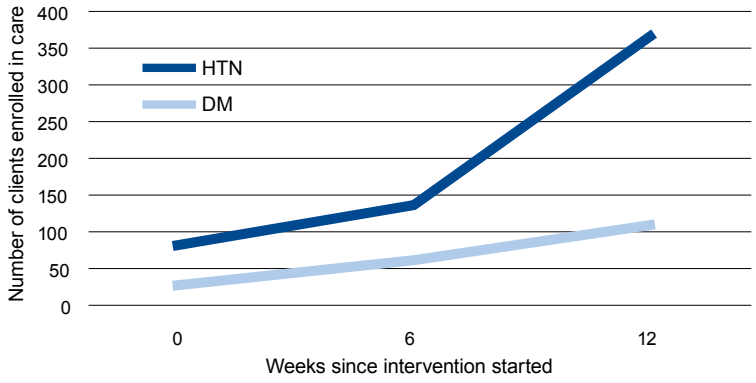


Figure 2. Increase in patient enrollment in hypertension or diabetes care in Buikwe District, Uganda



Self-management support as an approach to improve quality of care was long overdue. There is no better clinician than patients themselves if they are empowered and motivated.

– Regional Medical Officer of Morogoro when officiating stakeholders meeting to endorse patient self-management program

I trust and receive with confidence advice and services provided by other HIV-positive people because they understand where we are coming from.

– A patient at Ngerengere Clinic in Tanzania after meeting with an expert patient on self-management.

CONCLUSIONS

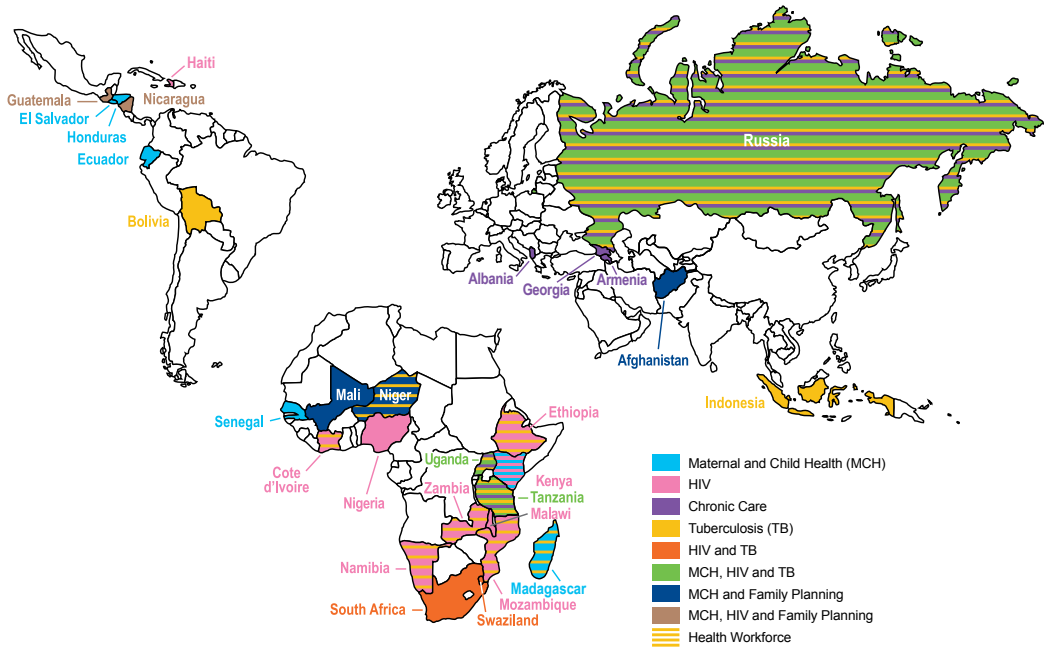
Uganda and Tanzania, as with many other low-income countries, have health systems designed for acute illnesses but have an increasing number of citizens with chronic conditions. There is currently a concerted global effort to respond to this growing epidemic, but much of the focus is on prevention through tobacco control, salt reduction, improved diet, and exercise. Priorities for treatment focus on increasing the availability of essential drugs and technologies. Prevention is likely to be the most cost-effective response to the epidemic but is not going to be 100% effective. Likewise, the provision of drugs is essential but without systems in place which can help patients take the medications properly and make lifestyle changes to prevent or ameliorate health problems, these efforts are not going to be completely successful.

Our findings suggest that patients and providers working together can make some of the changes necessary to develop systems better suited for supporting patients with chronic conditions. The changes made to date in Uganda and Tanzania include re-allocating staff to provide education and support to patients to improve their ability to manage their health, using expert clients to provide peer support to patients, and improving data systems. Preliminary evidence suggests that these efforts are improving patient health but further work is necessary to quantify the effects of these changes on patient-level outcomes. These data will continue to be collected in the HCI-supported facilities.

Further work will also be necessary to tie advocacy for chronic conditions with ongoing efforts to strengthen health systems. The change in spectrum of disease will present a significant challenge to health system strengthening efforts as they require that systems not only become stronger but also be transformed from their current focus on diagnosis to a focus on longitudinal management.

The **Health Care Improvement Project** (HCI) is USAID's global mechanism to provide technical leadership and assistance for improving health care delivery and health workforce management in USAID-assisted countries. The project is managed by University Research Co., LLC (URC) through task orders issued under the Health Care Improvement Indefinite Quantity Contract (IQC). HCI seeks to develop the capacity of health systems to apply modern quality improvement (QI) approaches to make essential services better meet the needs of underserved populations; improve efficiency and reduce costs from poor quality; and improve health worker capacity, engagement, and performance. The project builds on 20 years of USAID-supported experience and innovation to adapt QI approaches that have been highly successful in industrial countries—such as continuous quality improvement, collaborative improvement, job aids and other reminders, self-assessment, and performance-based incentives—to the needs of USAID-assisted countries. HCI helps country programs apply QI to scale up evidence-based interventions and improve outcomes in maternal and newborn care, child health, family planning, HIV/AIDS and other chronic conditions, tuberculosis, and other infectious diseases.

Current HCI Country Presence



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TEL 301-654-8338 • FAX 301-941-8427 • www.hciproject.org