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Institute *for* Healthcare Improvement

Leveraging quality improvement to strengthen primary care systems in the face of NCDs: A Case Study from Ecuador

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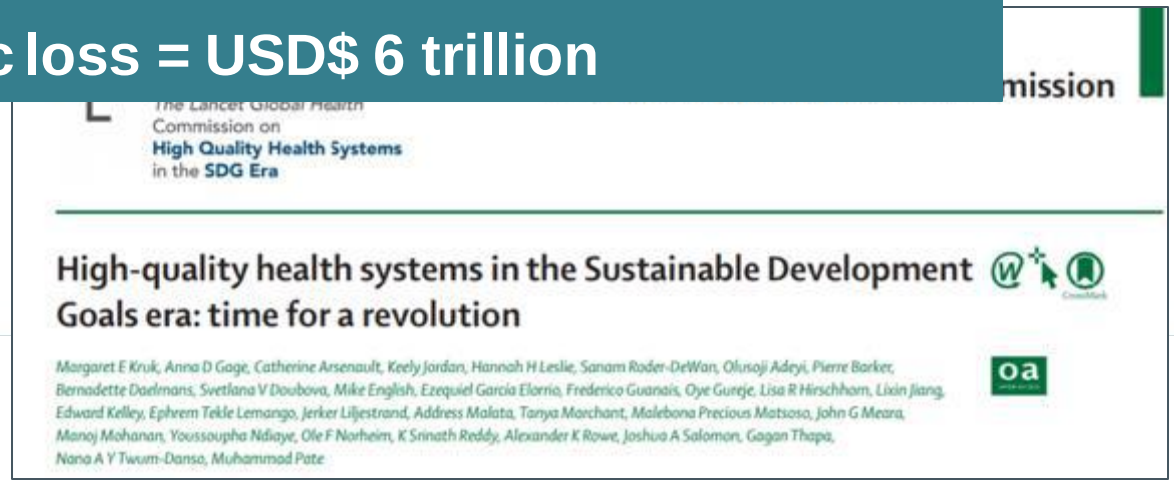
Roadmap

1. Background
2. The problem
3. The opportunity
4. Aim
5. Theory of change
6. Results
7. Lessons learned
8. Recommendations

Health care quality gaps

In 2016, approx. 8.6 million people died due to causes amenable to healthcare in LMICs (Kruk, Gage, Joseph, et al., 2018):

- 5 million due to poor-quality care
- 3.6 were due to non-utilization of health care services
- **Economic loss = USD$ 6 trillion**



The global healthcare quality chasm

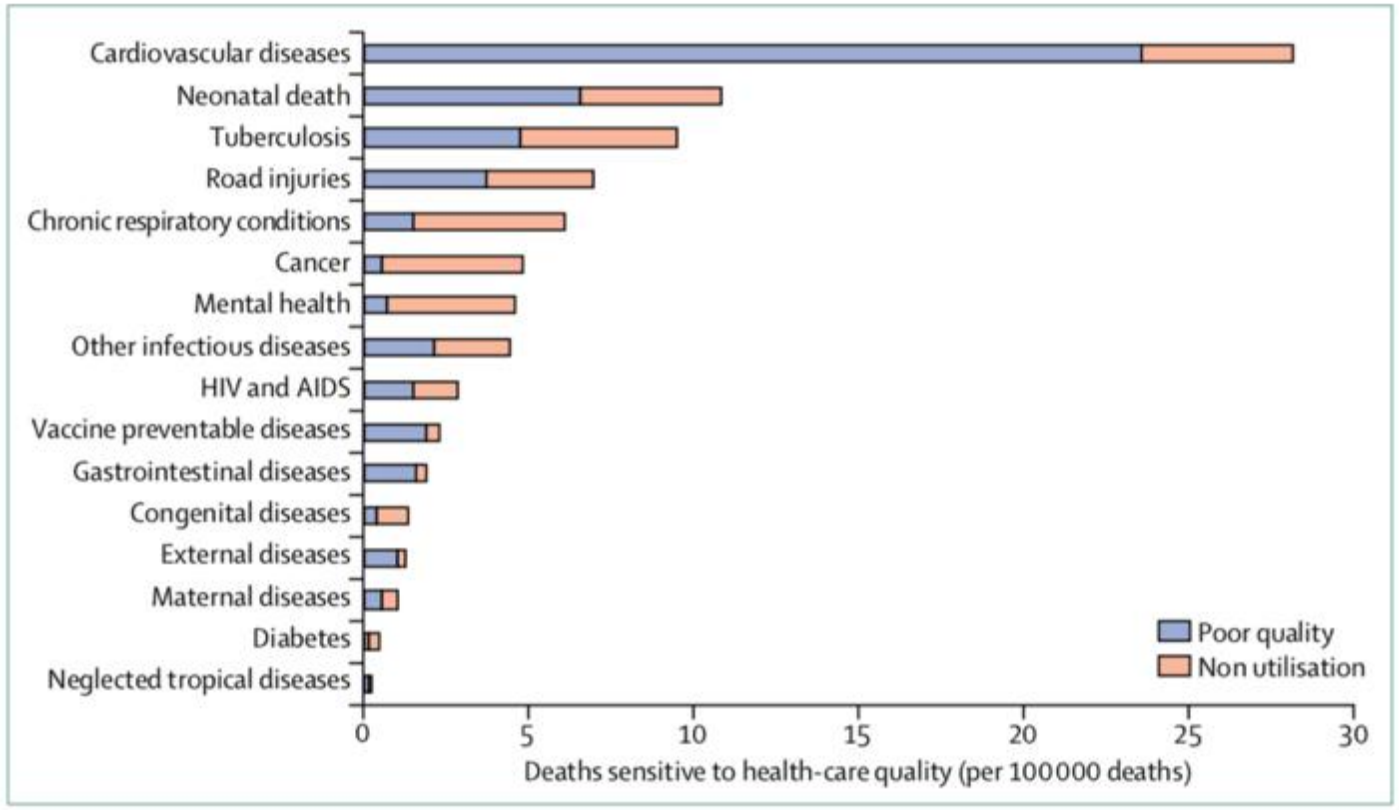
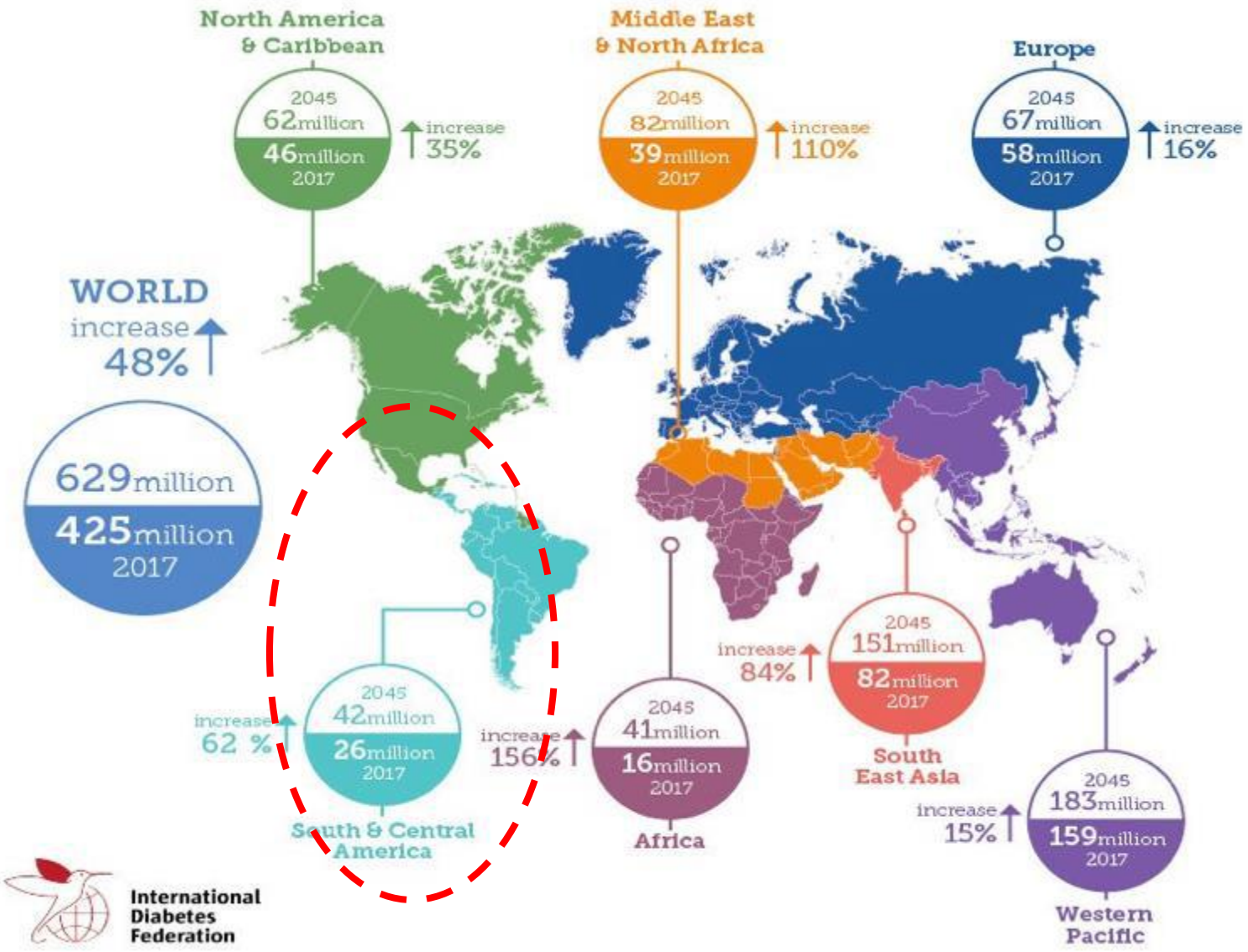


***Figure 5*: Deaths from Sustainable Development Goal conditions due to poor-quality care and non-utilisation in 137 low-income and middle-income countries[94]**

Fuente: Kruk et. al, 2018

A growing epidemic of diabetes



International Diabetes Federation

Some numbers…

- 41 million adults are living with DM2 in Latin America
- 25-50% patients remain undiagnosed
- Only 60% of patients receive regular, long-term treatment
- Only 10-25% of patients receiving treatment are under clinical control

The Opportunity

***Figure 9*: Quality of care across health system platforms in low-income and middle-income countries (LMICs)**
DALYs=disability-adjusted life-years. HDI=Human Development Index. References can be found in appendix 1.

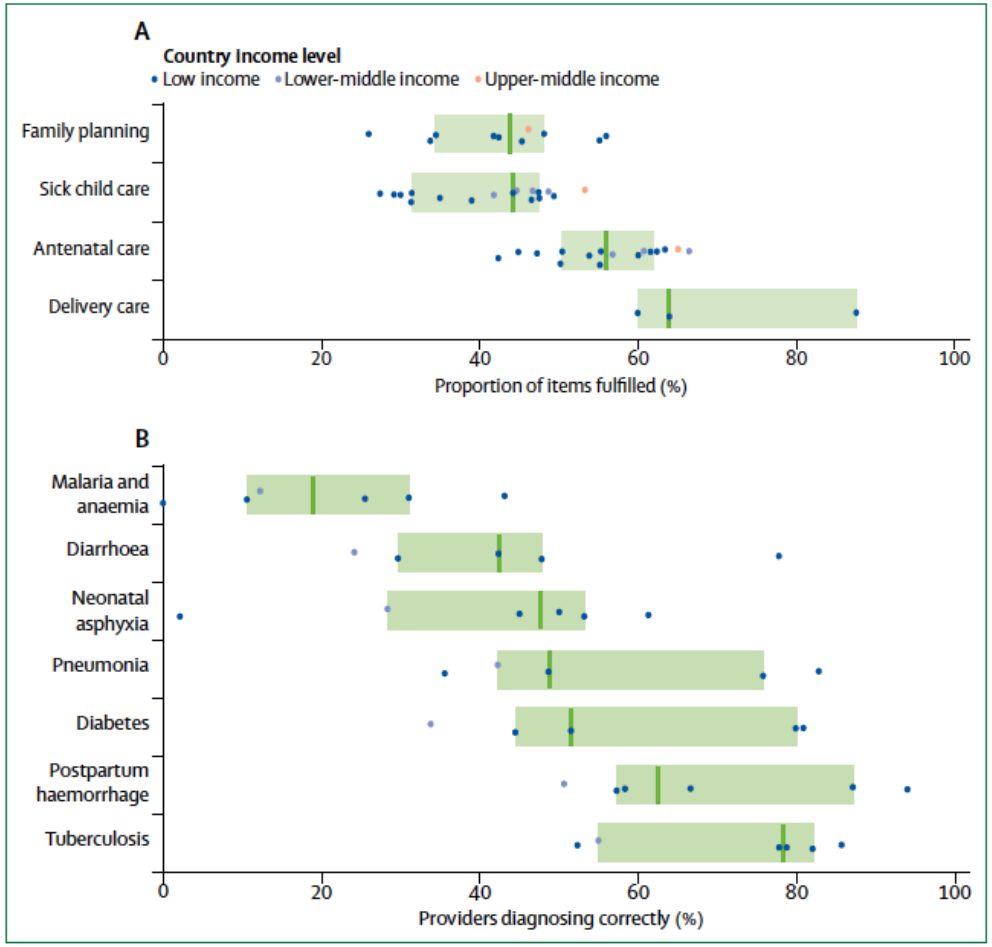


***Figure 2*: Adherence to evidence-based guidelines and diagnostic accuracy**
Dots represent country-specific means, vertical bars indicate median performance across countries, and boxes delineate the IQR. Indicator definitions are shown in appendix 1, and country specific means are shown in appendix 2. (A) Data are from Service Provision Assessment (SPA) surveys done in ten countries (Ethiopia 2014, Haiti 2013, Kenya 2010, Malawi 2013, Namibia 2009, Nepal 2015, Rwanda 2007, Senegal 2015–16, Tanzania 2015, and Uganda 2007) and baseline facility surveys of Results-based Financing impact evaluations (RBF) in eight countries (Burkina Faso 2013, Central African Republic 2012, Cameroon 2011, Republic of the Congo 2014, Democratic Republic of the Congo 2015, Kyrgyzstan 2012–13, Nigeria 2013, and Tajikistan 2014–15). (B) Data are from clinical vignettes from the Service Delivery Indicators surveys done by the World Bank, in cooperation with the African Economic Research Consortium and the African Development Bank in Kenya (2012), Nigeria (2013), Tanzania (2014), Togo (2013), and Uganda (2013) and from the Service Provision Assessment survey in Ethiopia (2014).

SUSTAINABLE DEVELOPMENT GOALS

1 NO POVERTY

2 ZERO HUNGER

3 GOOD HEALTH AND WELL-BEING

4 QUALITY EDUCATION

5 GENDER EQUALITY

6 CLEAN WATER AND SANITATION

7 AFFORDABLE AND CLEAN ENERGY

8 DECENT WORK AND ECONOMIC GROWTH

9 INDUSTRY, INNOVATION AND INFRASTRUCTURE

10 REDUCED INEQUALITIES

11 SUSTAINABLE CITIES AND COMMUNITIES

13 CLIMATE ACTION

14 LIFE BELOW WATER

15 LIFE ON LAND

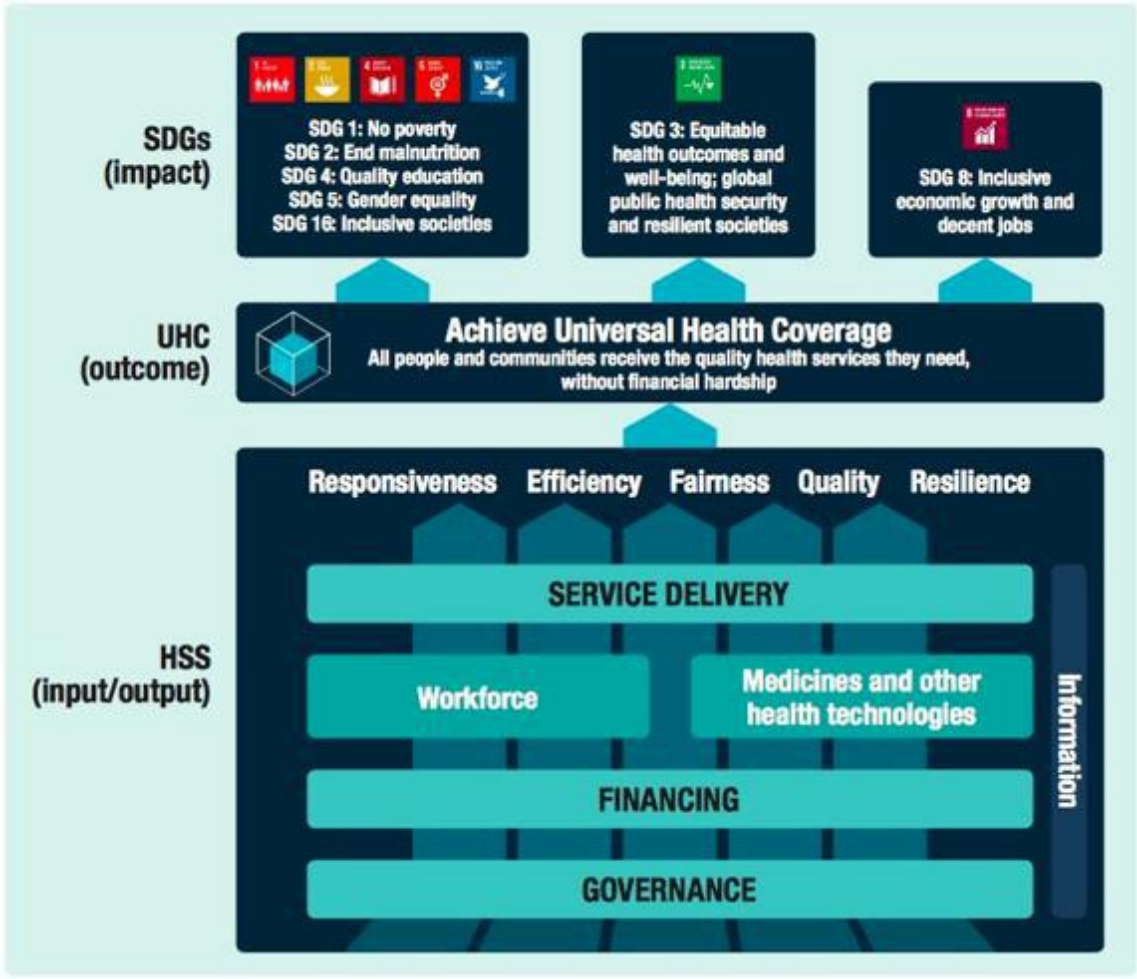
16 PEACE, JUSTICE AND STRONG INSTITUTIONS

17 PARTNERSHIPS FOR THE GOALS

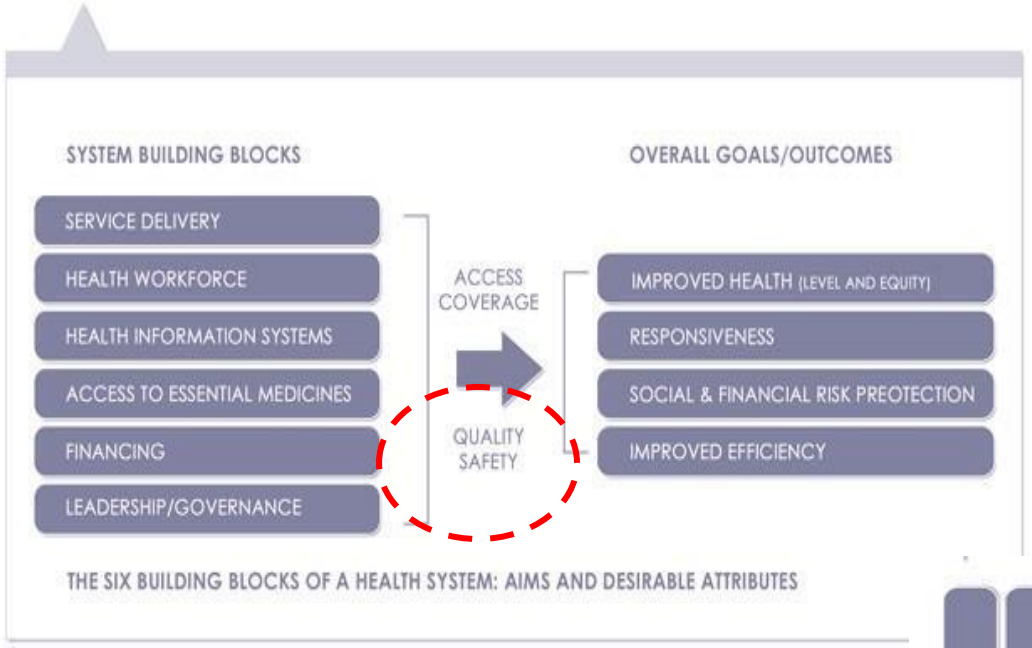
1978 2018

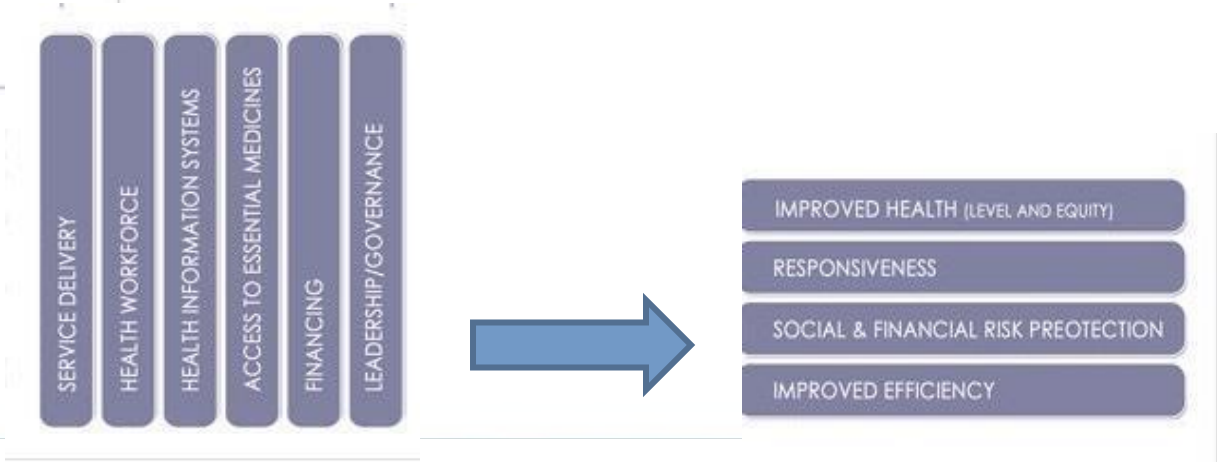
Primary Health Care

Health for All



Quality and Safety as a cross-cutting theme

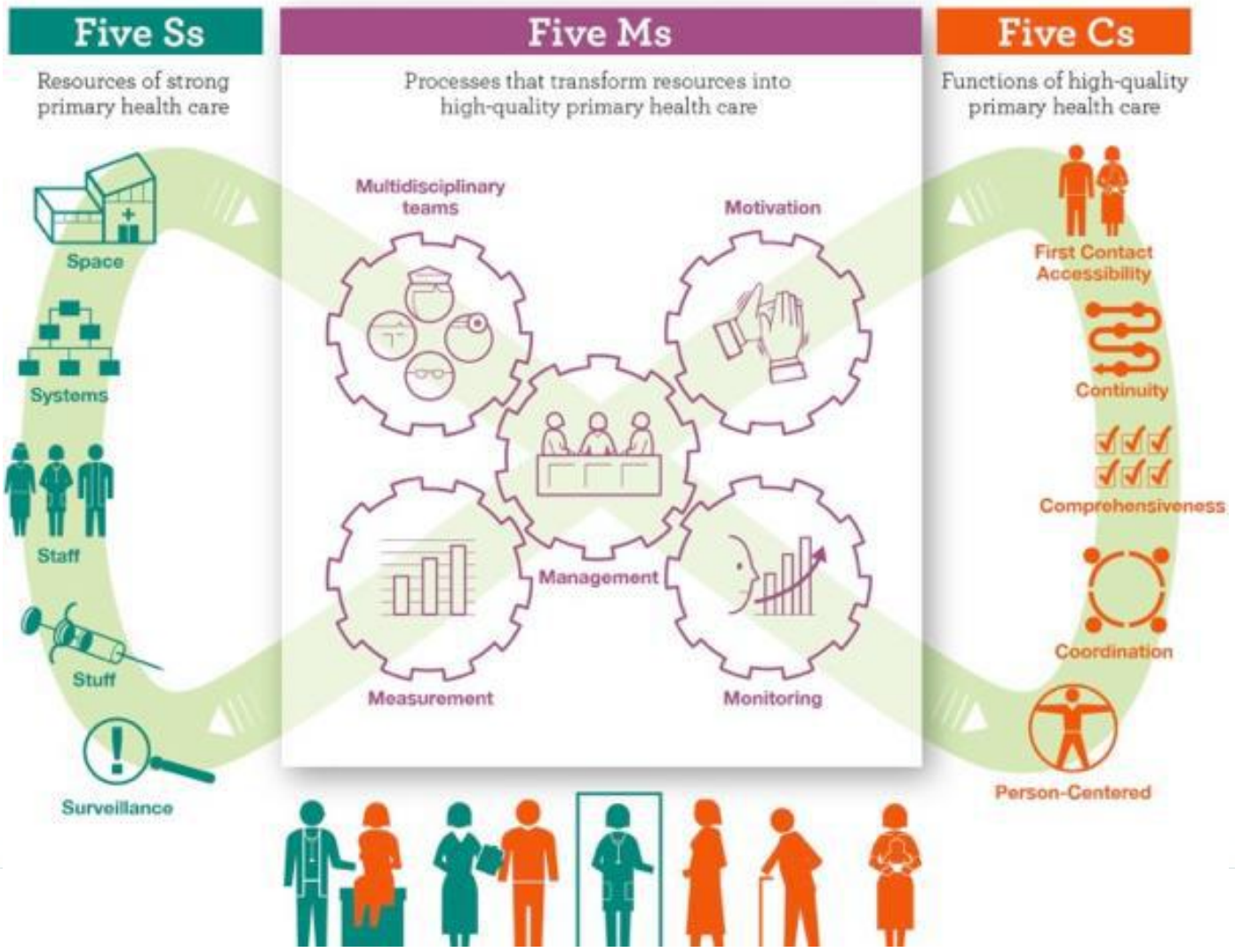




Quality, Safety and Equity

Source: Adapted from OMS, 2007; Kruk et al., 2018

High-Quality Primary Care Framework



Source: BMJ Glob Health. 2018; 3(Suppl 3): e001020.

The Opportunity

Implementing Partners

15
Primary care clinics

Ministerio de Salud Pública

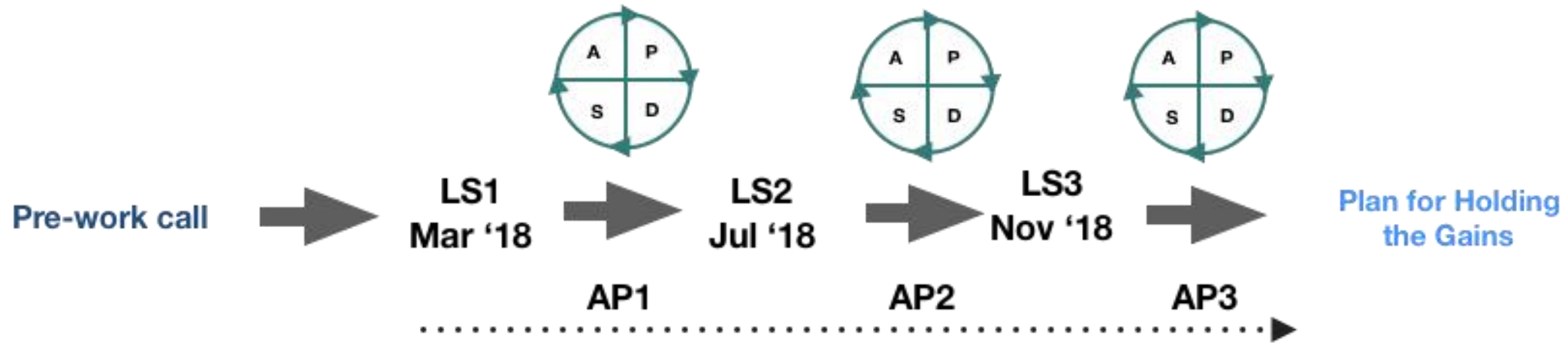
IDB

Institute for Healthcare Improvement

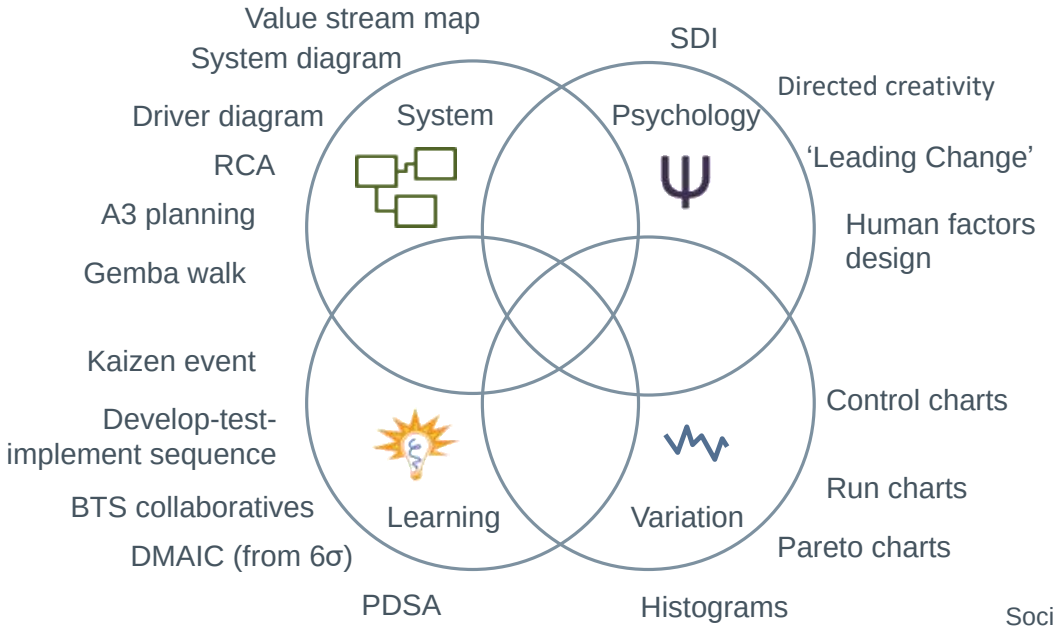
6
Quality Improvement Teams

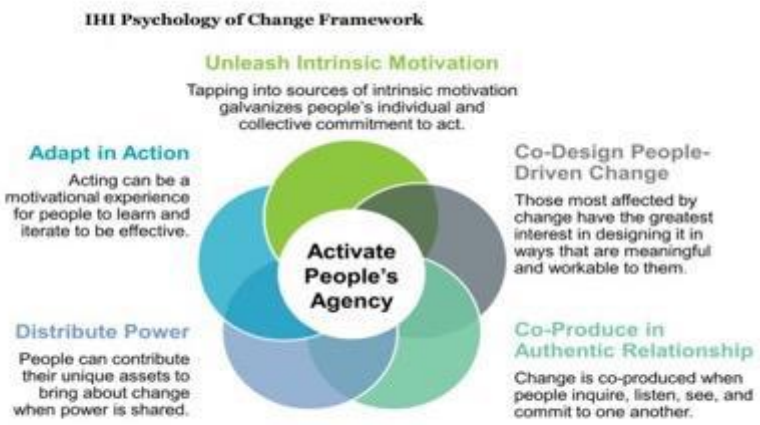
Our approach: Building QI capacity to strengthen systems

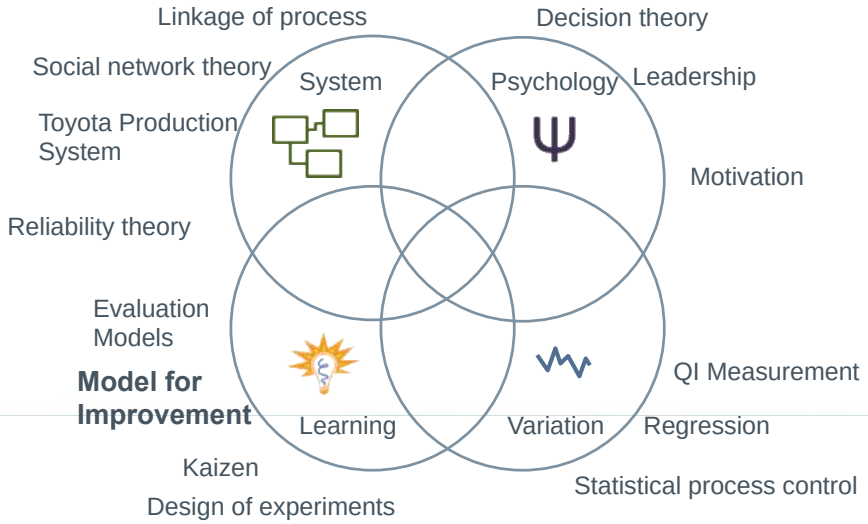
Aim:
- Improve clinical outcomes for patients with DM2 across participating primary care facilities



Enable people to change on ”their own terms”



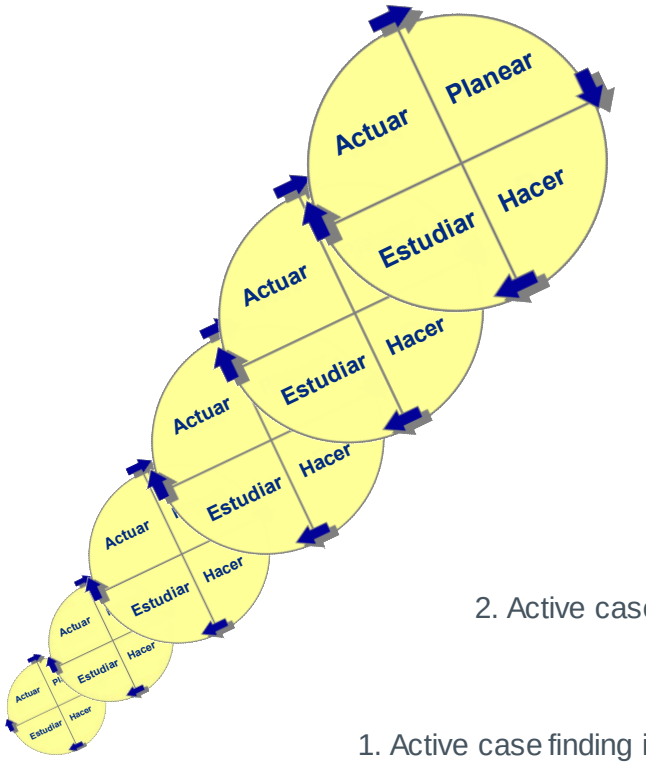





Improve health and wellbeing for ALL
Ensure minimum infrastructure for care delivery (staff, stuff and space)
Supply chain strengthening
Adoption of task-sharing approaches
Improve workflow
Build inter-sectoral collaboration to address SDH
Establish community partnerships
Partner with other Ministries and NGOs
Focus on priority conditions and populations
Identify and prioritize health conditions with the highest burden of disease**
Identify and prioritize health system needs
Build a culture of continuous learning and improvement
Adoption of learning systems and use of data for improvement
Build QI capacity and capability
Promote effective teamwork and communication
Actively communicate with and engage leadership
Ensure clinical process reliability and continuity of care
Standardize clinical processes
Build clinical capacity
Promote adherence to clinical best practices (protocols, guidelines, algorithms)
Provide accompaniment and supervision
Adopt a people-centered approach
Build provider-patient/family partnerships
Co-design and co-produce with patients, families and communities
Promote shared-decision making
Adapt health literacy and education approaches to local context

By December 2018, we will increase the percentage of patients with diabetes in clinical control (HbA1c <7) by 50% across 15 primary care clinics of Ecuador

Timely and convenient access to care	Diabetes screening	Screening of at-risk population groups
	Linkage to care	Access to primary care, specialized care
	Integration and coordination of services	Referral pathways
	Access to medications	Follow-up with patients after clinical visit to review medications
Follow-up	Attendance to follow-up appointment	Call patients 24 hours before next appointment
	Treatment adherence	Medication card, patient information leaflet, adherence aid
		Provide group sessions
Patient self-management	Awareness	Culturally sensitive and linguistically appropriate education programs
	Increase health literacy	Multi-disciplinary teams and support
	Support and accompaniment	Development of self-management plans together with patients and their families
Identifying and addressing social determinants of health	Access to transportation	Linkage to transportation services (i.e. Lyft)
	Access to healthy food	Partnership with local supermarkets
Quality Improvement infrastructure	Leadership buy-in	Active leadership involvement (i.e. regular huddles, meetings)
	Capability building	Quality improvement trainings
		Access to subject-matter experts



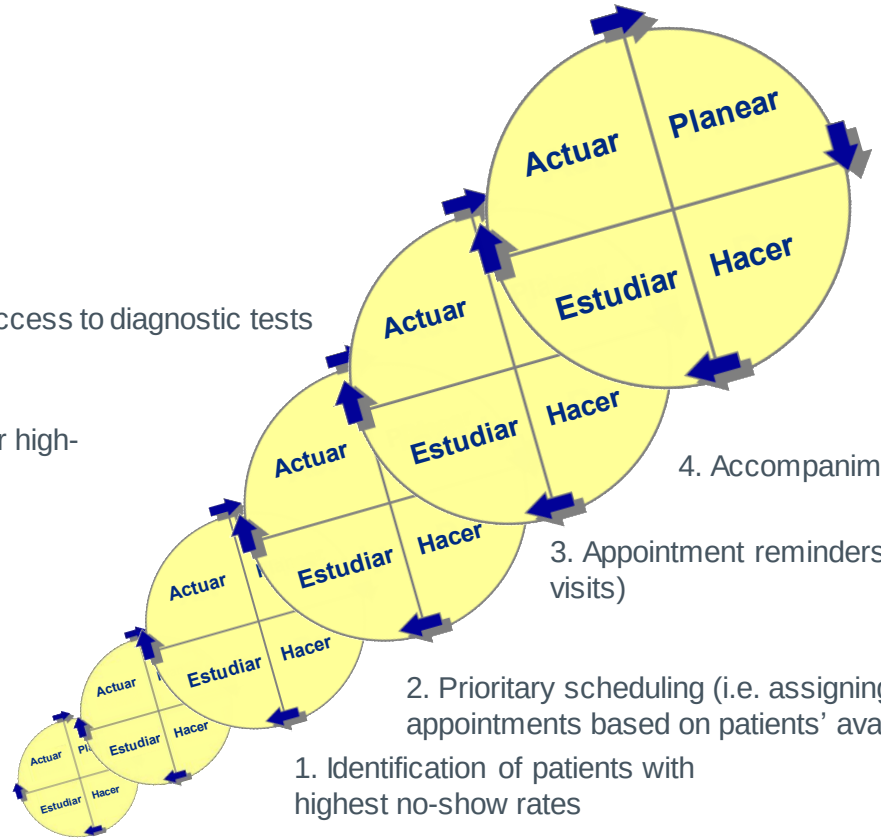
1. Active case finding in clinic

2. Active case finding in the community

3. Prioritary scheduling for high-risk/uncontrolled patient

4. Improved access to diagnostic tests

Active screening and early detection



1. Identification of patients with highest no-show rates

2. Prioritary scheduling (i.e. assigning appointments based on patients' availability)

3. Appointment reminders (calls, texts, home visits)

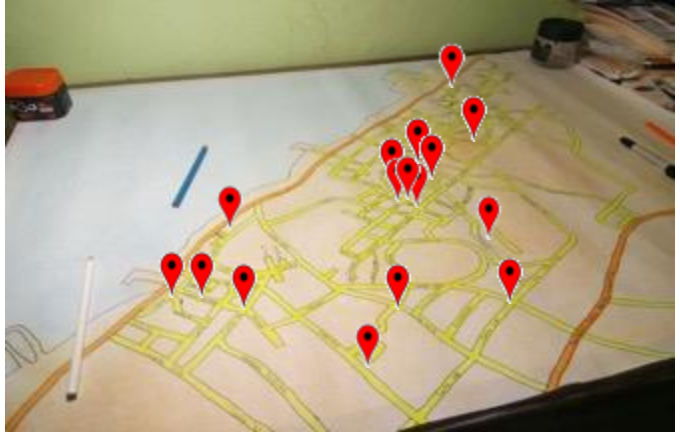
4. Accompaniment through CHWs

Attendance to follow up visits










Cartelera


Centro de Salud
PUERTO DE CHANDUY

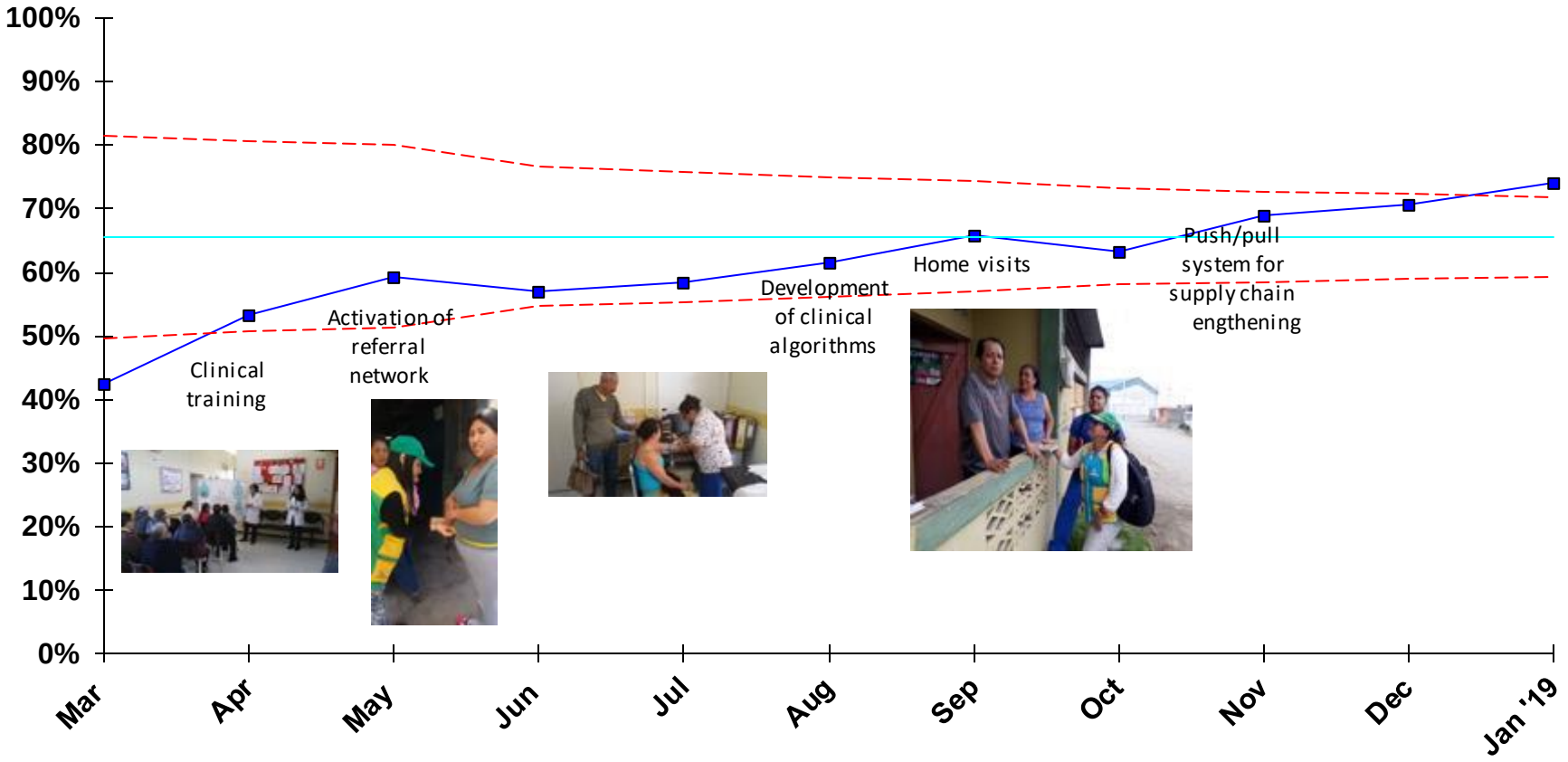

RECCIÓN DISTRITAL DE SALUD N

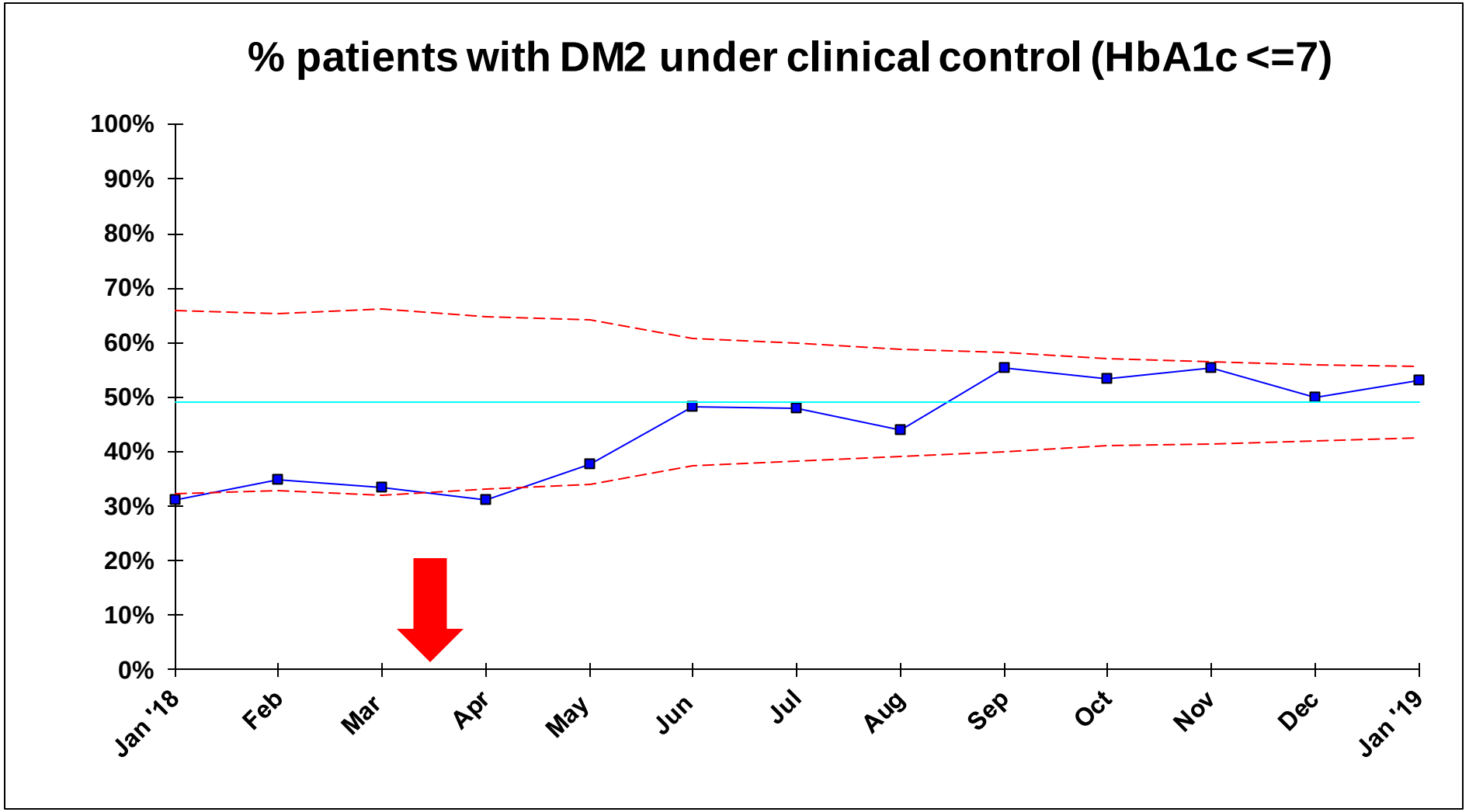

Camnito
de
Esperanza
CNN


Cartelera


Cartelera

% patients with DM2 who receive effective* care




% patients with DM2 under clinical control (HbA1c <=7)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jan '18
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan '19

Building QI capacity within systems provides an opportunity to help re-orient processes and to enable the effective use and optimization of limited resources to unlock the untapped potential of systems to achieve better care and better health for ALL.

Q&A

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