DMP implementation results in pilots sites

Pavlodar 2015

3 diseases selected:

- ✓ **Hypertension (315 patients)**
- ✓ **II type Diabetes Mellitus (321 patients)**
- ✓ **Chronic Heart Failure (42 patients)**

In pilot program there are following polyclinics participating from Pavlodar (polyclinics #1,2,4,5), following is patient distribution: :

- *Polyclinic # 1* — 129 Diabetes patients
- *Polyclinic # 2* — 200 Hypertension patients & 42 CHF patients
- *Polyclinic # 4* -192 Diabetes patients
- *Polyclinic # 5* — 115 Hypertension patients.

In each polyclinic there are:

- Multidisciplinary teams established (7 people),
- Patient DMP participation agreements made,
- Flow sheets introduced for each patient,
- Personal Care Plan (for one year) and Brief Action Plan (for 10-12 days) made,
- Patient registry introduced,
- Physician and nurse trained to work with registry and risk groups patient segmentation.

Registry benefits:

1. *Contains full information about a patient, so there's no need to take an extra look at the chart.*
2. *There's no need to do additional sorting and any other parameters calculations as everything is calculated automatically.*

Multidisciplinary team members functional responsibilities

Physician: fills out the chart & flow sheet, orders treatment or makes treatment adjustment, refers to psychologist & specialists for counseling

Nurse: does patient recall, enters patient data and examination results into the registry, refers to healthy lifestyle, does BAP in agreement with the patient.

Social worker: does patient recall, calls for planned follow-up in agreement with the patient.

***Psychologist*:** holds patient personal and group classes on troublesome issues, identifies alarm symptoms & provides its adjustment.

Multidisciplinary team consists of: specialists (cardiologist, endocrinologist, nephrologist), dietician, internal audit

Healthy lifestyle school work

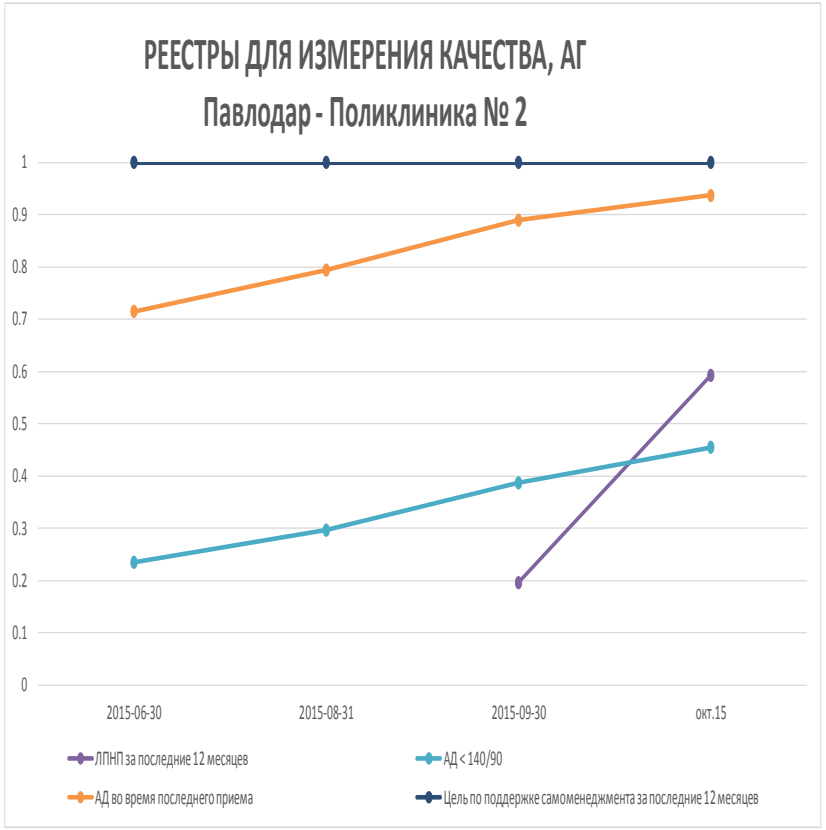
Self-management training

Work with polyclinic multidisciplinary teams

Organizational arrangements:

- Regional Steering Committee meeting with the participation of heads of the polyclinics (4 times).
- Regional Steering Committee meetings (monthly).
- Establishment of the lecturer trainer group (4 people) for conduction of cascade training on Chronic Non-infectious Disease Management Project implementation. 162 health workers & 19 self-management trainers trained.
- Introductory sessions for polyclinics of the small towns (Aksu, Ekibastuz)

Pavlodar #2 HTN

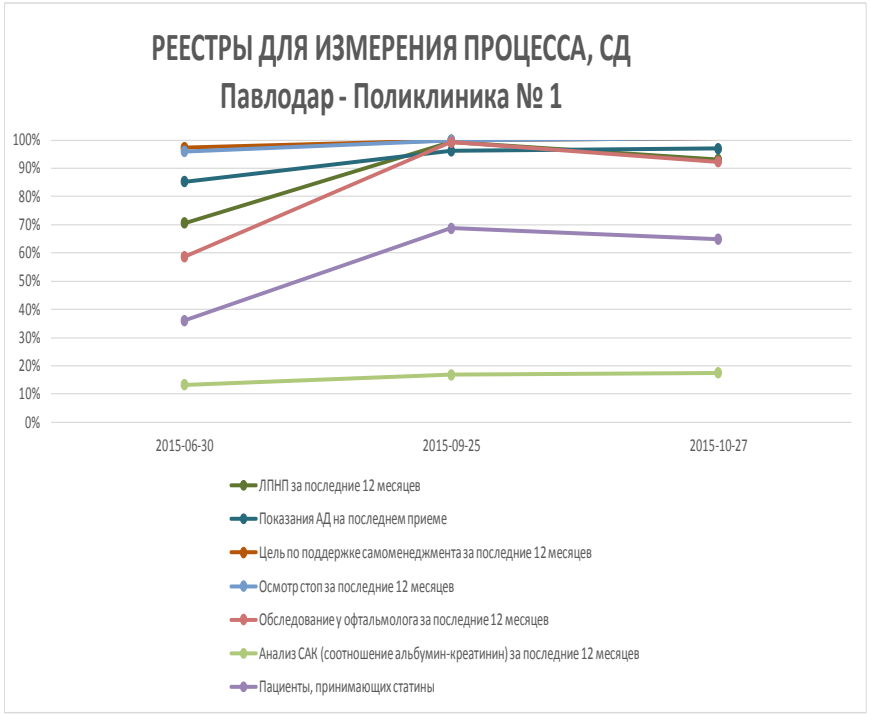


Pavlodar #5 HTN

HYPERTENSION
More patients with BP<140/90
Clinic#2: 24% → 46%
Clinic#5: 10% → 62%

Pavlodar #4 DM

Pavlodar #1 DM



DIABETES

Clinic#1:

A1c test 83%→92%

Statin use 37%→65%

Eye check 59%→92%

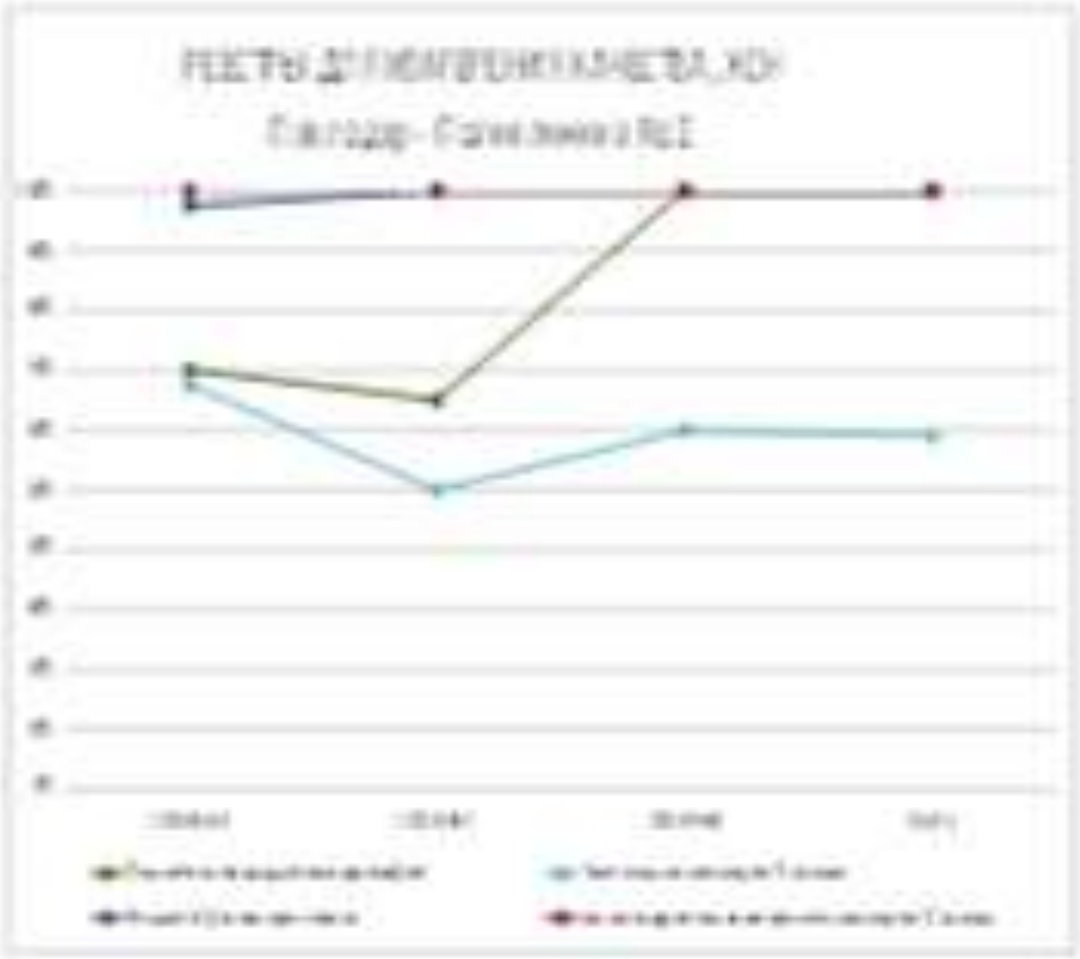
Clinic#4:

LDL check 36%→74%

Eye check 20%→84%

ACR check 20%→84%

Pavlodar #2 CHF



CHF

Clinic#2: % of patients with previous echocardiography

65% →100%

Major issues:

- Low percentage of the patients examined for the HbA1C (4 times a year according to the protocol);
- Low percentage of the patients examined for LDL (2 times a year according to the protocol);
- Funding the laboratory tests (amount of financial means for 678 patients equals to KZT 2.9 million);
- For health workers motivation we're suggesting to include DMP indicator, i.e. hospitalization rate with diabetes complications into the SKPN indicator;
- Patient motivation:
  - provision of self-control means;
  - provision of drugs in full range;
- No software licensed version

Expected outcomes:

- Patient life quality improvement;
- Self-management use;
- Reduction in number of exacerbations and complications (annual reduction in DM disability primary onset for 15% or 17 people; circulatory diseases – for 9% or 35 people);
- Reduction of in-patient and emergency care use – achieving the Memorandum results;
- Raise of patient shared responsibility;

Only with whole team patient collaborative efforts it's possible to achieve good results!