11-2016

A Partnership to Improve Health Care in Kosovo: Dartmouth Medical School and Kosovar nurses worked together on a two-year project to rebuild primary health care in the postconflict city of Gjilan

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A Partnership to Improve Health Care in Kosovo

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In 2001 the Gjilan Health Municipality in Kosovo partnered with the Dartmouth Medical School to improve primary health care in Gjilan, Kosovo.

Located in Eastern Europe in the former Republic of Yugoslavia, Gjilan faces the challenges of postconflict reconstruction in an emerging democracy.[1] The U.S. Agency for International Development (USAID) has funded numerous projects, including this health improvement project in Gjilan. The American International Health Alliance (AIHA) administered it as a bilateral professional exchange to promote and sustain better health care.

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Courtesy of A. Laurie Harding

Kosovar nurses Lirije Isufi (left) and Syzana Rexhepi practicing their skills on coauthor Cristina Hammond at the Gjilan Main Family Medical Center, Gjilan, Kosovo, in March of 2003.

NEW PRACTICE MODEL

As a cornerstone of building Kosovo's health services, the World Health Organization recommended a "family medicine" approach to primary care, focusing on prevention, management of chronic diseases, and continuity of care. Family medicine was a new concept for this region. Most patients received their care

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from specialists, consistent with the Soviet model of care delivery prior to 2000. Kosovo's Department of Health and Social Welfare wrote, "The referral system does not work. Many patients refer themselves directly to specialist care at health houses or hospitals. The result is an inefficient use of resources at all levels and crowding in hospitals."[2]

STATE OF NURSING PRACTICE

When this project began in 2001, medical secondary schools in Kosovo provided minimal clinical experience to nurses. In clinics the nursing role consisted of giving injections, carrying out basic registration procedures, and general office administration. Nurses, frustrated with their limited role, expressed a strong desire to learn new skills and interact more with patients. They were especially eager to start teaching patients about lifestyle changes associated with controlling hypertension.

USAID and the AIHA, in recognition of the strong leadership at Gjilan's newly named Main Family Medicine Center, selected its 62 physicians and 152 nurses serving 23,079 patients to participate in the partnership. The Dartmouth team's primary investigator, a physician, and two lead nurses, considered themselves to be mentors and coaches of their Kosovar counterparts.

The center was highly disorganized; there were no appointments, no medical records, no systematic patient flow. Patients arrived at the clinic, were registered in a logbook, and made a nominal copayment. They crowded around examination room doors (there were no waiting room chairs), jostling to be seen next and sometimes even rushing through the door, interrupting the patient before them. Nurses did not assess or prepare patients before the physicians' examinations. Little teaching occurred, and there were no patient education materials. This was the starting point for the project.

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PROJECT OVERVIEW

The main goal of the project, established by our Gjilan partners, was to improve the quality of family medicine practice in the Gjilan Health Municipality. Our first steps included an assessment of the family medicine center, using patient demographics and staff satisfaction data. Using a "clinical microsystems" approach, teams were developed to plan, implement, and evaluate changes that would eventually improve the clinic's work processes and the satisfaction of those giving and receiving care. (A clinical microsystem is a small group of clinicians, administrators, information technologists, and patients working together for a common purpose or aim.[3] For more information, see www.clinicalmicrosystem.org.) Our partners in Kosovo chose a common condition, hypertension, as a benchmark to evaluate our objectives, which included the following:

- improving interdisciplinary collaboration and teamwork
- enhancing clinical knowledge
- developing and implementing practice guidelines
- promoting positive patient interactions
- providing patient education
- promoting continuity of care
- establishing a system to assess and improve the quality of care

During the course of the project, both nurses and physicians were required to deal with documentation. Fundamental questions arose, such as how and where medical records would be stored, how they could be made available to providers, and how paperwork would move through the family medicine center in tandem with the patient.

THE UNITED STATES AND KOSOVO: ROLES AND CULTURES

U.S. nurses in Gjilan led groups to design and implement changes. Kosovar nurses struggled in a culture in which nurses deferred to physicians. With coaching from their U.S. counterparts, the Kosovar nurses learned to assert themselves around physicians. Ramize Ibrahimi, a nurse in the Gjilan family medicine center, became the head nurse for patient education during the project. "By the time the partnership entered its second year," she said, "I had the self-confidence, courage, and power to feel free to express my opinions and share my ideas during training courses and other meetings. I am no longer scared to raise my voice."

U.S. nurses encouraged and commended the work of Ibrahimi and all the nurses

Here's How You Can Get Involved

Doctors Without Borders
www.doctorswithoutborders.org

International Medical Corps
www.imcworldwide.org

International Medical Volunteers Association
www.imva.org

American International Health Alliance
www.aiha.com

Global Health Council
www.globalhealth.org

International Council of Nurses
www.icn.ch

The U.S. Agency for International Development
www.usaid.gov/our_work/global_health

World Health Organization
www.who.int/en

involved in the project. This affirmation changed the roles and responsibilities of the nursing staff, encouraging them to pursue new opportunities to improve patient care. Nurses took on the dissemination of patient education and triage guidelines for patients with hypertension. Blood pressure competency testing was established to assure physicians that nurses were capable of taking blood pressure accurately. U.S. nurses introduced the concept of community blood pressure screening, which was promoted by community leaders, on posters, and through word of mouth.

Community members and patients started to compliment the staff on their care. Six visits to the United States exposed the Kosovar nurses to a more evolved family medicine practice. They observed patient education and staff interactions in the community. These visits inspired them to make changes at home such as establishing medical records, infection control, continuing education, and evaluating patient satisfaction.

SURPRISES

Over the project's two-year period, the Kosovar nurses impressed our team with their professionalism and commitment. Although skeptical initially, they responded with enthusiasm and willingness to make changes necessary for better health care. Together, the nursing partners created a vision for the future. During one of the U.S. visits, a trip to Colby–Sawyer College in New London, New Hampshire, introduced our colleagues to the notion of a college education for nurses in Kosovo.

Some unanticipated outcomes of this project delighted us. Nurses established an ongoing nursing education series which was previously unheard of in primary care in Kosovo. Kosovar physicians started attending some of the sessions and offered positive feedback regarding program content. The family medical center became smoke-free, in part because of nurses. Educational posters and soap for handwashing appeared in bathrooms. Finally, we celebrated the first class of university nursing students in Kosovo; there were eight.

LESSONS LEARNED

One of the major challenges for the partnership was long-term sustainability of the changes that had been implemented. To achieve continuity, it was necessary to focus on three levels of intervention: the individual, the microsystem, and the "macrosystem." We focused on fostering within each individual nurse a vision of her work in family practice. We shared nursing and patient education materials and encouraged ideas and participation. Most important, we respected what each person brought to the work.

Professional development for nurses was nonexistent when we started the project in 2002. But to verify the sustainability of the project, an audit was conducted in 2005. It demonstrated that nurses at the municipal level were still attending continuing education classes. They continued educating patients in the screening room and were now teaching patient care for diabetes. A new registry of patients with diabetes had been added, and documentation of patients with hypertension continued. When a leadership change forced the temporary closing of the screening room, physicians and nurses insisted it reopen so patient care could resume; they realized the team approach was an efficient way to organize care and that the assessment data being collected were valuable. On the microsystem level, we focused on work processes within the family medicine center. Data collected before and after interventions helped to measure improvements. It was especially important that nursing roles and responsibilities be examined, revised, and formalized with expectations of daily responsibilities. For example, clinical practice guidelines on hypertension outlined evaluation and treatment responsibilities for physicians and nurses.

Nursing leaders emerged. The concept of supervision was discussed and incorporated into job descriptions in an effort to increase professional accountability, especially on the second shift.

In December 2003, a conference was held in the capital, Pristina, where the work in Gjilan was discussed with all the health care municipalities of the region. Presentations discussed the changing role of nurses, clinical practice guidelines on hypertension for physicians and nurses, competency and training guidelines, and documentation forms. Sphygmomanometers, stethoscopes, and training stethoscopes were distributed to encourage routine blood pressure measurement in family medicine centers.

On the macrosystem level, the Kosovar Ministry of Health's subsequent support enabled the growth of nursing roles throughout the 31 health municipalities of Kosovo. Treatment guidelines on hypertension, explicitly including nurses as part of a team working with physicians and patients, were distributed to family medicine centers in the municipalities. The audit process revealed sustained expansion and understanding of the nurse's role. For the first time in Kosovo's history, nurses would earn master's degrees (in spring 2006).

One nurse said, 'I am no longer scared to raise my voice.'

The use of the clinical microsystem approach worked well in this international collaborative project. It provided the framework necessary for us to focus on our mutual goal of improving the health of the people of Gjilan. System changes were far-reaching, and involved new concepts, such as the development of the nurse–physician team approach to patient care, the addition of waiting rooms with educational materials for patients, and the enhanced role of the nurse as patient educator.

The nurses at the Gjilan Main Family Medicine Center have continued to champion the changes initiated during this project. Safete, one of our nursing colleagues in Gjilan, said, "We will never go back." ▼

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