

## Chapter 8 - Recommendations

### توصيات

The IRTR is now a reality. Most provincial hospitals who care for kidney transplant patients in Iraq have adopted it. What currently exists is a solid base to build on for the future evolution of the registry. Continued investment in the registry will unlock a great potential for practitioners and policymakers.

The next phase of the registry evolution requires a crucial participation by the MOH to issue specific regulatory requirements that will help make using the registry a path that all medical centers and physicians have to adopt. The recommendations in this chapter will address steps to further develop the IRTR, as well as ways to improve services to Iraqi transplant recipients.

#### *Recommendations for further development of the IRTR*

As with the inception of the IRTR, the MOH should play an instrumental role in supporting the integration of the registry technology into transplant patient management practices in Iraq. There are specific regulatory initiatives that the MOH can enact that would advance the IRTR development in that direction:

- i. Require all records for kidney transplant patients become electronic during a three-year deadline.
- ii. After the end of the 3-year deadline, only patients who have records in the registry will benefit from the MOH coverage of immunosuppressive drugs.
- iii. When a recipient is being considered for transplant surgery, a tabulation of matching parameters with all potential donors, should be provided to the MOH prior to the surgery, which can be printed from the electronic record.
- iv. Require surgeons who perform the transplant surgery to submit to the MOH a form containing the surgery parameters, printed from the electronic record, within one month of the

surgery date.

- v. Since the MOH covers patient's medications for free, nephrologists should be required to submit an annual clinical and laboratory summary form, printed from the registry.

All forms indicated above will be programmed into the registry to make downloading and printing them a simple straightforward process, and it would be possible to submit them within the built-in electronic email application into a MOH electronic email box.

Medical institutions and physicians were also integral in supporting the adoption of the registry technology since 2015. However, there is still a need to maintain and expand participation among these stakeholders. The benefit of this investment are extensive:

- i. Physicians can:
  - a. Access patient records from anywhere with internet.
  - b. Enter, save, and print orders and notes into the clinical module.
  - c. Generate longitudinal patient information and statistical summaries of patient population.
  - d. Access patient data entered in registry by other physicians and institutions through intra-registry authorization process.
- ii. Institutions can:
  - a. Eliminate excessive current and archived paper records.
  - b. Gradually eliminate paper thinning and archiving of patient charts in boxes and storage areas. Access to historical patient records becomes easier, faster, and more extensive.
  - c. Maintain accurate records of dated and documented patient traffic at the institution, which help in preparing their administrative reports.
- iii. MOH can:
  - a. Maintain a topline record of patient activity throughout Iraq.
  - b. Obtain an accurate account of utilization of various services, devices, medications, etc. which help to project and estimate future needs.

- c. Identify areas of weakness and shortfalls in patient management, which help in focusing future plans to improve these areas.
- d. Generate performance measures to evaluate improvements in patient services and other provider outcomes.
- e. Identify clinical profile of the disease population to help devise educational material for training of professional staff, as well as produce public health education materials and pieces.

### ***Recommendations to improve transplant services in Iraq***

Clinical practices and services are of good standards, but continue to face significant difficulties related to the health system which suffers organizational issues due to unstable security conditions in the country, budgetary shortfalls, and deficiency in well trained staff caused by displacement and brain drain of qualified professionals from the country. Key recommendations in the services available to the transplant patient population in Iraq are geo-political, sociocultural, and documentational.

#### Geo-political factors

1. Coordination between central MOH authorities in Baghdad and MOH authorities in Kurdistan region can be improved to facilitate better flow of service provision to the region and linkage of information documentation between the two authorities
2. While over half of the transplants in the country are performed in the Kurdistan region, there is little documentation provided to the patient to carry with them into their home province where they have their follow-up. This results in major dissociation between the transplant surgery and clinical follow up that follows.
3. Rural areas have low level of services in all logistical aspects: high turnover of clinical professionals, practically non-existent documentation, deficiency in equipment and support personnel, and lower level of health education and awareness. Special attention to these areas is encouraged as part

of future MOH plans.

### Sociocultural factors

These factors are best addressed through health education programs directed to the public and possibly incorporated into school curriculum.

1. Less than 30% of transplanted patients were females - Increased awareness about chronic kidney disease, especially in media programs directed to females may be helpful.
2. Transplant rates in urban areas maybe five times higher than in rural areas - Improved services and awareness among professionals and the public in rural areas may help bridge the gap.
3. Less than 30% of transplant patients in Iraq are over 50 years old, which is one of the lowest rates worldwide - Improvement in screening among older people and better management of a transplant organ pool, can increase opportunities for older people to access transplant services.

### Documentation factors

In general, documentation of clinical services provided to transplant patients is scant, disorganized, and varies greatly amongst individual professionals and in different institutions across the country. Only a handful of medical centers had a home-grown spreadsheet to keep track of key clinical parameters. Then the thinning of patient charts at 6 or 12 months and archiving of older paperwork in storage, makes it difficult to track longitudinal information and track a patient's medical history except through recollection.

Also, there can be major dissociation between services provided prior to transplant surgery, the transplant procedure, and the post-surgery services, which are generally offered by different physicians at a variety of medical institutions. Information is rarely communicated between various entities with few exceptions when a physician takes the time by personal initiative to inquire with previous care providers.

The IRTR can go a long way towards addressing these documentation issues, as it allows continuity of a patient record to be accessed by different physicians, contingent on the patient's consent or by obtaining an approval from the patient's primary physician via an intra-registry email process.

### ***Conclusion***

In summary, the evolution of the IRTR can provide the tools and information to help address the issues discussed above, provided an environment of collaboration and determination to make it a successful endeavor. As the registry continues to evolve, it will improve patient care, support the organic development of health-care systems, and identify ways to make renal care more efficient and effective.

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