Expanding Community-based Services for Noncommunicable Diseases: The Abundant Health Model In Ho Chi Minh City, Vietnam

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• Introduce the service delivery model implemented in the Abundant Health project, phase I and II
• Share results & lessons learned
• Update on city-wide project scale-up, 2018 - 2020
## Setting the Stage for the Abundant Health Project (AH)

### The Problem:
- High NCD burden in Vietnam
  - Estimate 520,000 NCD deaths in 2012
  - Prevalence of hypertension among adults is 20.3% (2015)
  - Diabetes rate among adults is 4.1% (2015)

### Government Priorities:
- GVN has strong political support and commitment to NCDs
  - Current NCD programs based on the National Target Program
  - Challenges to NCDs control (limited financial support, skills, knowledge, community awareness)

### Funder Priorities:
- Support NCD prevention that can improve health services and access for underserved populations in low- and middle-income countries

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AH Model: Community-based Care for Hypertension (HTN) and Diabetes Mellitus (DM)

Goals:
1) To increase the proportion of community members aware of the four shared NCD risk factors
2) To increase the proportion of people screened and treated for DM & HTN by the Commune Health Stations
### AH’s Key Stakeholders for Phase I & II Implementation

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<td><strong>Project owner</strong></td>
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<td>HCMC Department of Health</td>
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| **Implementing agencies** | ▪ HCMC Preventive Medicine Center  
▪ Tan Phu District Hospital  
▪ Tan Phu District Medicine Center  
▪ 5 CHSs with social health insurance (SHI) service in place | ▪ Tan Phu District Hospital  
▪ Tan Phu District Medicine Center  
▪ 11 CHSs: 6 out of them did not have SHI in place |
| **Technical partners** | ▪ Harvard Medical School, Center for Primary Care  
▪ HCMC Medicine & Pharmacy University  
▪ Nguyen Trai Hospital  
▪ HCMC Nutrition Center | ▪ Heart Institute  
▪ Nguyen Tri Phuong Hospital  
▪ Family Medicine Unit, Pham Ngoc Thach University of Medicine |
Collaborative Improvement Framework: Abundant Health Project in Phase I and II

Baseline Assessment

Ongoing Assessment

Endline Assessment

Patient Enrollment

Kickoff meeting

Learning Session 1

Learning Session 2

Learning Session 3

Dissemination Meeting

Project Close-out

Capacity Strengthening
- TBC and QI training
- Clinical training & Competency assessment
- Collaborators training
- Screening equipment provision

Technical Assistance
- Site visits

Data Management
- Data software

Community Engagement
- Mass communication & screening events

Challenges Resolving
- Quarterly Board Meetings

Supporting System

Stakeholders engagement

Month 1

Month 2

Month 3

Month 4

Month 5

Month 6

Month 7

Month 8

Month 9

Month 10

Month 11

Month 12

TBC: Team-based care; QI: Quality improvement; NCD: noncommunicable diseases
The CHSs established a workflow for team-based care, did not conduct the Plan-Do-Study-Act (PDSA) cycle and screening uniformly.

The CHSs shared improvement stories based on the implementation of the PDSA cycle, reflected the Study and Act steps were not well followed.

The CHSs were competent with PDSA cycle, achieved improvement targets and set plan for maintaining success, shared experiences with the district’s six other CHSs.
Screening, Diagnosis, Treatment Data for Phases I and II

**HTN & DM Screening**
- # of HTN screenings:
  - May 2015 to February 2016 (before AH): 3,472
  - May 2016 to March 2017 (Phase I): 8,075
  - July 2017 to May 2018 (Phase II): 15,101
  - Increase: 233%

- # of DM screenings:
  - May 2015 to February 2016 (before AH): 336
  - May 2016 to March 2017 (Phase I): 6,989
  - July 2017 to May 2018 (Phase II): 8,562
  - Increase: 187%

**HTN & DM Cases Treated at CHSs**
- # of HTN treatment:
  - May 2015 to February 2016 (before AH): 66
  - May 2016 to March 2017 (Phase I): 174
  - July 2017 to May 2018 (Phase II): 510
  - Increase: 123%

- # of DM treatment:
  - May 2015 to February 2016 (before AH): 19
  - May 2016 to March 2017 (Phase I): 59
  - July 2017 to May 2018 (Phase II): 167
  - Increase: 208%

**HTN & DM Cases Identified in Phases I & II**
- # of previously diagnosed
  - HTN: 3,465
  - DM: 494
- # of newly diagnosed
  - HTN: 1,049
  - DM: 138

**Insured Visits at CHSs**
- 2015: 225
- 2016: 2,657 (Increase: 1,200%)
- 2017: 5,195 (Increase: 200%)
- 2018 (Jan - May): 3,380 (Already 65% of 2017 total)

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Successfully supported 6 new CHSs to get social health insurance approval (SHI)
Key achievements

1. Enhanced team-based care practice and patient-centered care approach at the CHSs.

2. Improved collaboration and communication between Tan Phu district hospital and the Medicine Center & CHSs for better insured drugs provision and patient referral.

3. Regained trust of community members on HTN&DM care services at the CHSs in Tan Phu district.
Learnings from Phase I and II

Effective Community Engagement Approaches in Disease Prevention & Management

1. Increase awareness of community members about the NCD risk factors

2. Increase HTN&DM identification in the community for early treatment

3. Attract patients to CHS healthcare services
Step 1: Increase Community Awareness using Multiple Forms of Communication

- Integrate communication into screening activities
- Create NCD website
- Conduct NCD club meetings
- Train a network of collaborators
- Integrate communications into quarter meetings
- Leaflets, banners, posters, bulletins
- Loudspeakers at CHSs & Wards
Step 2: Increase HTN & DM Identification through Free Screening

**Passive Approach**
Community members come to CHS for any reason

7,086 (47.0%)

**Active Approach**
Screening in community (ward people’s committees, police stations, supermarkets, clusters, schools, pagodas)

7,024 (46.5%)

**Integrate with other programs** (TB, HV, Disability services, food safety checks, vaccinations, elderly checkups)

992 (6.5%)

**Leverage existing systems**
Step 3: Attract HTN & DM Patients to Use CHS Services through SHI, People Skills, Comprehensive Counseling, and Meeting Patient Needs

- Analyze advantages of using treatment services at CHS
- Enhance comprehensive counseling, prioritizing lifestyle modifications, only treat with drugs if required
- Facilitate convenience for patients (drugs, visit reminders, or home visits)

### Treatment at CHSs
- **Near home**
- **Short waiting time** (<15 mins)
- **No time pressure** for doctors
- **100% free for** insured drugs
- Have treatment capabilities

### Treatment at Hospitals
- **Far from home**
- **Long waiting time** (> 2hrs)
- **Time pressure** for seeing doctors
- **Co-pay of 20%** for insured drugs
- Have treatment capabilities
Abundant Health
Citywide Implementation Timeline

Kickoff implementation at 162 CHSs

Oct. 2018

Dissemination for year 1
July 2019

Kickoff implementation at remaining 157 CHSs
Sept. 2019

Dissemination for year 2 & all of whole Phase III
June 2020

Year 1: October 2018 to June 2019 covers 162 CHSs with SHI already in place

Year 2: September 2019 to May 2020 covers remaining 157 CHSs
Phase III Activity Progress

- First HTN clinical discussion
- Second HTN clinical discussion
- TCB and QI model training
- Onsite technical assistance
- Onsite technical assistance
- Baseline service and clinical competency assessment
- Screening equipment provided
- First learning session
- First board meeting

Achieved 48% of year 1 activities already
Thank you!!