KEY CRITERIA FOR QUALITY MANAGEMENT IN CHCs

- **Inputs:**
  - Actual staffing of a site;
  - Availability of staff and actual presence on site;
  - Staff skillset and knowledge.
- **Outputs:**
  - Caseload monitoring with cause of consultation breakdown;
  - Presence of a medical record for each patient, with consistent entries for each consultation;
  - Duration of consultation;
  - Respect of a consultation steps;
  - Evidence of written feedback after referral to a higher-level facility
- **Outcome:**
  - Adequacy of test prescription, medical prescription and referrals through medical records examination;
  - Satisfaction from users;
  - Mortality rate monitoring at communal level.

Designing a quality management system for grassroots facilities

To support the deployment of those tools and to ensure high-quality the EU-HF, in coordination with the Ministry of Health, is also producing the outlines of a quality management system for commune health centres, the first of its kind.

Currently, the Medical Service Administration is already deploying a quality management system for the hospital sector. This comprehensive system will take a few years to be fully implemented. And, in a context of scarce resources and urgent needs, the philosophy of action retained by the EU-HF is to build on already existing proto-mechanisms, and to make the choice to focus in a first phase on medical staff performance assessment, which should be coordinated with already existing staff training mechanisms in provinces.

As such, the EU-HF is proposing a set of indicators following a Donabedian approach to capture, monitor and improve the quality of care delivered at grassroots level. Essentially, the EU-HF proposes to develop a set of simple and measurable criteria, either through routine monitoring, or through yearly quality assessment tours operated by the DoHs.

The European Union Health Facility has been established by the European Union Delegation to Socialist Republic of Vietnam in March 2015 as a part of the actions agreed with the Government of Vietnam within the framework of the EU Health Sector Policy Support Programme phase 2. Its major objective is to support the Ministry of Health and the Ministry of Finance in Vietnam for implementation of the measures foreseen in the Financing Agreement.

With funding of €114 million, this is the largest EU Sector Budget Support Operation in Asia. The Financing Agreement for the EU Health Sector Policy Support Programme phase 2 (EU-HSPSP 2) had been signed between the European Union and the Government of the Socialist Republic of Vietnam in December 2014, with the overall objective "to sustain poverty alleviation and inclusive economic growth in Vietnam through the provision of support for the development of a Vietnamese health care system towards equity, efficiency and improved quality, in line with the country's health sector strategy". The specific emphasis on equity will be given by focusing on 10 provinces considered to be the poorest: Lai Chau, Son La, Dien Bien, Kon Tum, Gia Lai, Ha Giang, Lao Cai, Cao Bang, Yen Bai and Dak Nong. The EU Health Sector Policy Support Programme phase 2 is the largest EU budget support programme in health in Asia.

To achieve these goals the European Union will transfer 100 million Euro directly to the state budget of the country, which will be distributed by the Ministry of Finance and the Ministry of Health as budget transfers to ten targeted provinces.

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EU-HF TECHNICAL SHEET

Supporting high-quality services at grassroots level in Vietnam

Background

Vietnam is facing a rapid epidemiological transition with non-communicable diseases representing now 70% of its burden of disease. To face this challenge, Vietnam, with its vast grass-roots level facilities (12,000 commune health stations alone) needs to operate deep changes in the way it addresses the health of its population. The public health care system has now to move from an infectious diseases control system to a new one designed to deliver diagnosis and high-quality, cost-effective care for chronically ill patients.

In this context, the European Union Health Facility (EU-HF) has been mandated by the Ministry of Health to develop a set of tools to increase early diagnosis capacities for in most common non-communicable conditions, and to produce the outline of a first quality management system for its communal health centres.

Approach

- The EU Health Facility has started its support to the Medical Services Administration (MSA) of Ministry of Health (MoH) since July 2016 and for a period of 18 months towards improvement of its primary health care system for the provision of services to address the increasing burden of NCDs and to improve quality of services at commune health centres level.
- The approach taken by the EU-HF consists in working simultaneously on three components, with each component synergically complementing the others.
- The use of early diagnosis guidelines of common NCDs specially tailored for grassroots professionals will help to improve NCD detection capacities. The introduction of periodic health examination in at-risk patients will guarantee an earlier management of the risk-factors, and when applicable treatment of the conditions. A quality management system to be implemented in commune health stations will improve the monitoring of staff performance, and their ongoing training.

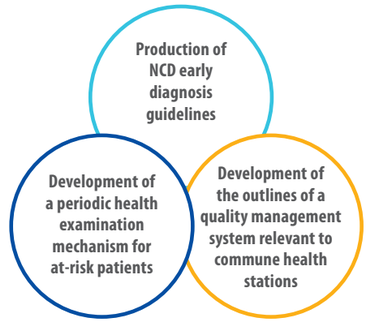

Figure 1: 3 components supporting quality of care at grassroots level

An NCD early diagnosis handbook

Currently, medical personnel receive medical information on diagnosis procedures in a mostly textual fashion through Ministry's issued decisions, which are applicable to any level of the health care pyramid and convey an important amount of highly technical information, which is usually more adapted to a tertiary level hospital.

Besides, in the current system, medical doctors may not always have received a full education in a medical university and may have progressively been "upgraded" to a doctor position by seniority.

Improved detection capacities for 12 conditions

HBP, DIABETES MELLITUS TYPE II, COPD

MOUTH, THYROID, BREAST, CERVICAL, COLO-RECTAL, AND PROSTATE CANCERS

DEPRESSION, SCHIZOPHRENIA, EPILEPSY

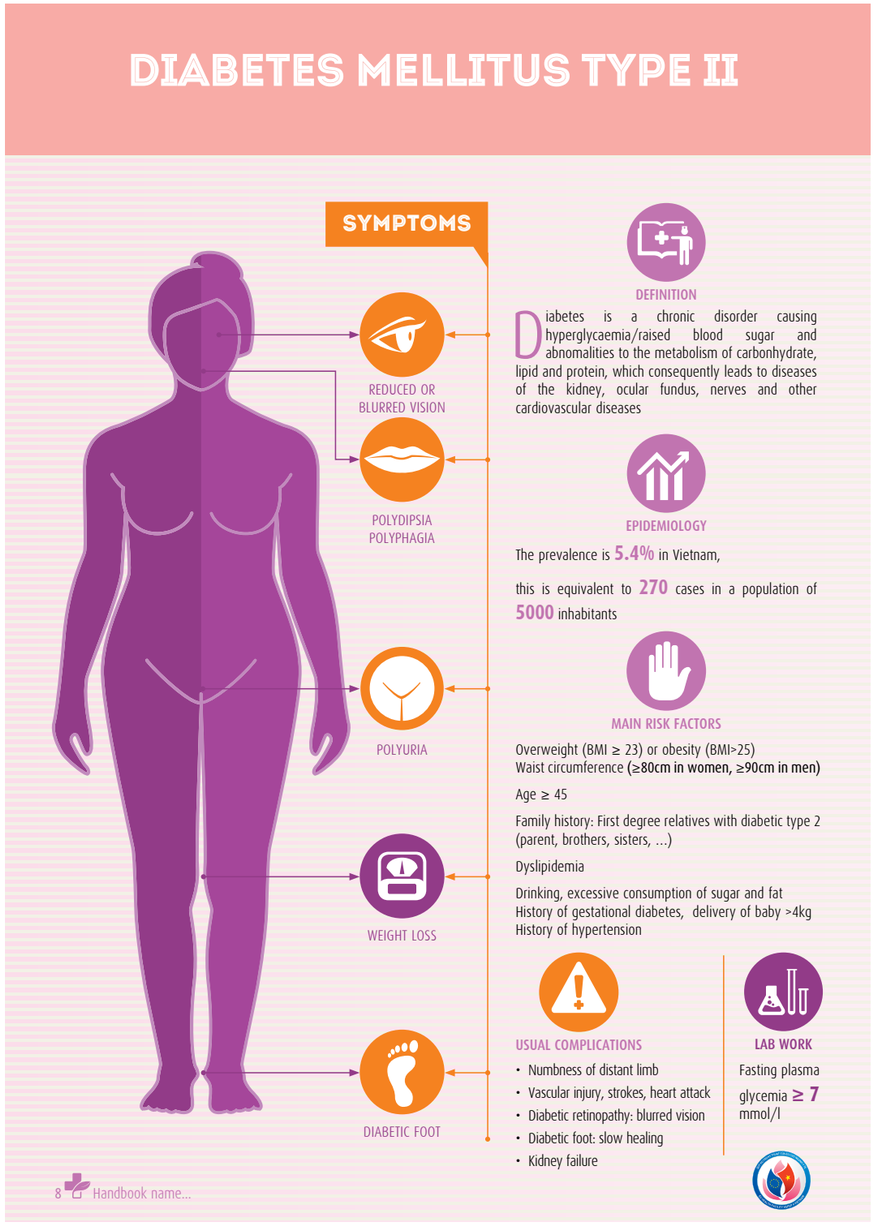

Figure 2: An illustration from the NCD diagnosis handbook

Recently, World Bank survey has shown the actual knowledge and practice of those professionals were a source of concern, and a critical issue in terms of patient safety.

So, in conjunction with the Medical Service Administration of the MoH, the EU-HF, with the support of Vietnamese clinical experts, and in accordance with international best practices, is developing a handbook covering 12 common conditions to offer a visual tool to health care professionals to update their knowledge and guide them in their daily practice.

After approval by MoH, the handbook will be distributed to CHS across the country, but also are available for download at *http://www.euhf.vn/activities/on-going-activities/heath-service/.*

The introduction of periodic health examination

Once dominated by infectious events, the Vietnamese health care system is not yet used to the management of chronic ailments and risks, and to individuals' health management. It is still dominated by mass screening approaches, either through community-based activities, or through labour-related health examination. The emergence of chronic, non-communicable diseases requires the system to adapt and to put long-term patient management at its core.

The EU-HF is currently designing practical mechanisms to support that necessary change in the form of identification of risk factors and recommendations for at-risk patient management which are displayed in the early diagnosis handbook as shown in figure 3 and 4.

The EU-HF is also producing a simple record instrument that the doctor could give to at-risk patients with a summary of their risks and the recommended frequency of health follow-up visits. The record instrument will be doubled by a simple logbook recording when the next visit is due so that commune health stations, which are the nearest to the population, are able to call back patients when necessary.

Main risk factor

- Overweight (BMI ≥ 23) or obesity (BMI>25)
- Age ≥ 45
- Family history: First degree relatives with diabetic type 2 (parent, brothers, sisters, ...)
- Dyslipidemia
- Drinking, consumption of much sugar and fat
- History of gestational diabetes, delivery of baby > 4kg
- History of hypertension
- Physical inactivity

Figure 3: The presentation of risk factors for diabetes mellitus type II

At – risk patient follow-up and management:

Patients who are at-risk should be regularly checked:

- Every 3 years for patient over 45.
- At least once a year for those who are overweight
- Periodic health examination biannually if risk factors are present
- Pre diabetes: re-examination after 3 months

Figure 4: Simple recommendation for risk-based periodic health examination for diabetes mellitus type II