COMMUNITIES FOR HEALTHY HEARTS

MAKING DIGITAL TECHNOLOGY AND DATA WORK FOR BETTER HYPERTENSION MANAGEMENT IN VIETNAM

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1 HYPERTENSION IN VIETNAM

One in four Vietnamese adults have hypertension

Over 50% of cases are not detected

one third are untreated

86.4% of hypertension cases are not managed

The lack of a case management system to track patients over time and **across health facilities leads to loss to follow-up between screening, diagnosis, and care. This is a key barrier to the control and management of chronic diseases in Vietnam.**

2 THE COMMUNITIES FOR HEALTHY HEARTS PROJECT

The Communities for Healthy Hearts project, led by PATH, the Ho Chi Minh City (HCMC) Provincial Health Department and Preventive Medicine Center (PMC), and the Novartis Foundation, aims to test ways to improve hypertension case management and retain people with hypertension in care.

Launched in 2016, Communities for Healthy Hearts is being piloted in four districts of HCMC.

The project uses a multi-sector approach that engages the government, public and private health care providers, pharmacies, social enterprises, and community members, in efforts to improve hypertension management and control.

3 THE eHTN.Tracker

An electronic patient tracker, known as the 'eHTN.Tracker, is an online searchable database was developed, that contains data of hypertension service delivery between hypertension screening, diagnosis, care and treatment.

At present, clients' data is collected by community outreach workers on paper forms at a first hypertension screening at a free blood pressure checkpoint or community event, or by health workers at a primary healthcare center. The data is then entered into the eHTN.Tracker by local health workers. In the future, data could be entered directly into the system via computers or mobile devices.

The eHTN.tracker:

Enables health workers in public and private health facilities to log patient data throughout their hypertension journey, track their clients over time, and provide prompt hypertension diagnosis, treatment, and management. Clinicians can use the data to provide more accurate cardiovascular disease risk assessments, and appropriate medication prescriptions and counselling.

automatically generates a unique identifier and barcode for each person, which in the future can be printed out and kept by patients or linked to other patient records to ensure accurate records

Helps reduce the workload of health staff by automating time consuming tasks such as manually collating data, generating client lists for treatment and follow-up, and developing monthly service delivery reports

Provides aggregate data that can be viewed by public health managers to understand the hypertension burden in their area and improve performance across the hypertension cascade. This promotes better data use for service planning, budgeting, and advocacy, in order to target hypertension services to those that need them most

Includes population census data of those living in pilot areas in HCMC; this data can be cross-referenced with service delivery data to enable health workers to target those who have not yet received a first hypertension screening.

The system also offers clients automated SMS reminders that reinforce adherence to treatment and follow-up appointments, and promote key behavioral changes for hypertension control.

4 INITIAL HIGHLIGHTS

241,873 Census data for project 241,873 district residents aged 40 and above has formed the foundation of the database.

106,922 106,922 of these people have received an initial blood pressure measurement that has been registered in the eHTN.Tracker, and are now bring tracked by primary health care workers.

11,000+ Over 11,000 people presented with elevated blood pressure, and have been linked to hypertension services and are now being tracked and supported by local health workers.

3,500+ Over 3,500 people with hypertension have received weekly SMS messages that promote healthy lifestyle changes, treatment and appointment adherence, through a pilot initiative. Feedback has been positive.

5 NEXT STEPS

Communities for Healthy Hearts is currently upgrading the eHTN.Tracker to include more comprehensive hypertension management data, including information about modifiable risk factors and make it completely embedded and intraoperabe with the MOH data systems for NCD.

The Vietnam Ministry of Health has requested that Communities for Healthy Hearts continue testing the eHTN.Tracker in HCMC, and use this experience to support in the development of the new Noncommunicable Disease Data Management System, eventually making digital data and case management for hypertension available nationwide.

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