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Conference Abstract

Community integrated care for chronically ill patients in rural china: a clustered randomized controlled trial in Chongqing

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Abstract

Introduction: Chronic disease is a major cause of death in China. One of the primary aims of Chinese Health System Reform was to reducing fragmentation in the health delivery systems. Researches have showed that integrated care seems to have positive effects on improving continuity, coordination of care and quality of life for chronically ill people. We designed a package of interventions of community integrated care for patients in rural Chongqing, implemented by barefoot and county doctors based in township hospitals. Our research aims at improving the utilization and effectiveness for chronically ill people.

Description of practice/policy: A package of interventions of community integrated care includes:

a) A multidisciplinary patient care team (barefoot doctor with the responsibility to follow up the patients, clinical doctors to treat patients and pharmacist to support for drug compliance);

b) Structured and personalized clinical follow-up and case management project (patients divided into three levels based on the health condition and needs for health care);

c) Healthy lifestyle counseling (smoking cessation, and salt, oil, and alcohol reduction, exercise, psychological counseling) for patients;

d) Education for professionals (to improve the ability of professionals);

e) A positive leadership and management attributes (quality and outcomes measurement and incentives for professionals) organized both under the local bureau of health and our research team.

Targeted population: people with chronic diseases (i.e. hypertension, diabetes)

Theory:

a) The most influential framework was Chronic Care Model (CCM) develop by Edward Wagner and colleagues. The CCM comprises four interacting system components including: self-management support, delivery system design, decision support and clinical information systems.

b) Researches showed that one of the most common components of integrated care for community chronically ill people were self-management support and patient education combined with structured clinical follow-up and case management; a multidisciplinary patient care team and education for professionals.

Methods: A clustered randomized controlled trial (RCT) was initiated for patients with hypertension and/or diabetes from July 2012 to July 2013 in Chinese western rural areas, Chongqing City. The RCT included strict inclusion and exclusion criteria for participants. Baseline and twelve months data were measured by the teams in the term of several process and outcome indicators including incidence of PPCs and QOL of patients.

Highlights: Our Community integrated care combined the CCM with the primary care and as we know, we are the first to implement community integrated care for chronically ill people in rural china. After the preliminary analysis, we found that it seems to have positive trends on the indicators including: the incidence of PPCs, QOL, hospitalization, functional status and patient satisfaction. However, the cost-effectiveness and disease burden remained a further investigation. Our project was supported by China Medical Board.

Comments on transferability: Our framework of community integrated care could be easily replicated locally even though there is no universally accepted definition of integrated care. The key elements were described above.

Keywords

integrated care, case management, multidisciplinary teamwork, chronic care model, chronic diseases, primary care

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PowerPoint presentation:

http://www.integratedcarefoundation.org/content/integrated-care-practice-0
