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Euro Diabetes 2016: Hypertension management for community dwelling older people with diabetes in Nanchang, China: Study protocol for a cluster randomized controlled trial -QiangTu - Flinders University

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Abstract:

Background: It is estimated that one third of adults with type 2 diabetes round the world sleep in China. The continual growth of the older population will inevitably increase the incidence of hypertension and diabetes during this population group, leading to an increased burden on the healthcare system. Hypertension frequently coexists with diabetes. It's reported that 50–80% of patients with diabetes are suffering from concurrent hypertension. People with comorbidity of diabetes and hypertension are related to twice higher risk of developing disorder and 7.2 times higher death rate compared to those that have diabetes only. Even though China geographies a sizable amount of older people living with diabetes and hypertension, the first care system is infantile then supervision of those conditions in communal care settings is suboptimal. Studies have revealed that the concerted care model across care settings that address both nonpharmacology and pharmacology involvements are able to do hypertension control for elder people with diabetes. Barriers to implementing and evaluating this model of care are widely known in low and middle-income countries including China. This study as a result test the hypothesis that a hypertension supervision program built on teamwork between community health service centers and hospitals in China can progress vigorous sign control in people aged 60 years and of age with diabetes as associated to usual care.

Methods: A group randomized measured trial will casually allocate 10 wards from four hospitals in Nanchang to either an involvement group (N=5) or a normal care group (N=5). A minimum of 27 participants are going to be recruited from each ward and therefore the estimated sample size are going to be 135 patients in each group. The intervention includes individualized self-care education before discharge and 6-month follow-up in community health service centers. Health specialists from both community health service centers and hospitals are going to be resourced to work together on the application of the post-discharge interferences that strengthen self-care. The first outcome is systolic vital sign at 6-month follow-up adjusted for baseline value. Secondary consequences are quality of life, HbA1c and lipid levels, self-care facts, treatment adherence, and the incidence of contrary events and so the incidence of unexpected hospital readmission at six months continuation used to for baseline value. A multilevel mixed-effect rectilinear regression model is going to be wont to compare the changes in health outcomes between the intervention and usual care groups.

Discussion: The transition between hospitalization and community care may be a critical period within the care of elderly patients with diabetes and hypertension who often have complex medical problems. The incidence rate of adverse events after discharge and therefore the readmission rate are high thanks to the inappropriate self-care behaviors of patients and lack of timely monitoring of patients' conditions by health professionals. It is been reported that within every week after hospital discharge, primary health care is required by 80% of patients.

Continuity of care through follow-up in medical care because the first contact for patients after discharge can bring positive outcomes for older patients. The transition from passive care to proactive and preventive care is often achieved through establishing a care continuum within the current health systems in China and other low and middle-income countries. At present, most patients in China only call doctors when the indications of sicknesses appear. Many complications don't show symptoms within the early stages once they are easier to treat then the simplest treatment period could also be delayed or missed. By establishing continuous care after discharge, disease-related complications are often prevented or detected earlier then promptly treated within the medical care system. As recommended by the planet Health Organization, patients with chronic conditions require long-term, comprehensive and coordinated care after discharge that's easy to access and provided by the first health system. A well-developed medical care system contributes to alleviating disparities in healthcare utilization. In 2015, the Chinese government issued an "Outline for the design of the National Medical and Health Service System (2015-2020);" which emphasizes collaboration between hospitals and community health service centers. The aim is to enhance prevention and management of chronic disease in medical care settings, reduce hospitalization burden and lower national medical costs. This study will define whether cooperative care among health professionals between hospitals and community health service centers will progress hypertension management for elder people with diabetes contained the study sites. The program, if effective, will have an instantaneous application to hypertension management within the healthcare system in China.

Keywords: Hypertension, Diabetes, Cluster randomized controlled trial, China, Collaborative care, Primary health.

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