

# Assessing the effects of an educational intervention for chronic disease management in rural China

<b>Submission date</b> 22/03/2017	<b>Recruitment status</b> No longer recruiting	<input type="checkbox"/> Prospectively registered <input checked="" type="checkbox"/> Protocol
<b>Registration date</b> 04/04/2017	<b>Overall study status</b> Completed	<input type="checkbox"/> Statistical analysis plan <input checked="" type="checkbox"/> Results
<b>Last Edited</b> 03/07/2025	<b>Condition category</b> Nutritional, Metabolic, Endocrine	<input type="checkbox"/> Individual participant data

## Plain English summary of protocol

### Background and study aims

China is facing a serious situation with the increasing prevalence of chronic (long-term) diseases. According to the report published by National Health and Family Planning Commission in 2015, 19% of the population in China suffers from different kinds of chronic diseases. Moreover, the country's previous strategy for chronic disease management has focused on the much more costly hospital care, instead of primary care and self-management in rural areas. High health expenses still prevail, which may also increase the economic burden on patients and influence health care seeking behavior. Hence, new strategies are needed to improve treatment of chronic diseases in rural areas. Currently, different outcomes have been used to test the effects of chronic disease management strategies. Despite an increasing number of studies focusing on type 2 diabetes (T2DM) and high blood pressure (hypertension) management in China, most have been performed in urban areas. Moreover, most researchers test physical outcomes, but other important outcomes such as the patient's perspective, health care seeking behaviour, and the knowledge of healthcare professionals are ignored. The aim of this study is to improve the care of patients with T2DM and hypertension in rural areas through an educational intervention directed at healthcare professionals, to shift the care of patients with T2DM and hypertension from hospital to primary care services.

### Who can participate?

Patients aged 35-75 with T2DM or primary hypertension and health care professionals from the participating counties, townships and village clinics

### What does the study involve?

The participating areas are divided into different groups according to economic status and health development, and then two areas are randomly selected from each group: one to the intervention group and one to the control group. Patients in the intervention areas receive services including lectures about self-management strategies, follow-up interviews, physical examination, and special medical services (such as medical treatment, transfer treatment, return visits, and clinical care). The healthcare professionals in the intervention groups are provided with professional development including training lessons, regular meetings, team

communications, technical checks, and new performance appraisal. For patients and healthcare professionals in the control areas, current routine health services continue as usual. The patients' blood glucose, blood pressure, health status, satisfaction with health services, health insurance, understanding of diabetes, health seeking behaviour, and out-of-pocket costs of care are assessed before and after the intervention. The health care professionals' knowledge about chronic disease management and their general perceptions about the intervention are assessed before and after the intervention.

What are the possible benefits and risks of participating?

Patients in the intervention areas benefit from receiving information and guidance in issues related to chronic diseases and self-management. Health care professionals who are participating in the intervention may benefit from the possibility of being offered a promotion. Moreover, the intervention contains a performance appraisal, including a bonus and professional development for healthcare professionals. A potential risk for the patients is the leak of information as some sensitive data is collected. In order to reduce the risk of a leak, all members of the research team are asked to sign a confidentiality agreement. There are no risks for healthcare professionals participating in the study.

Where is the study run from?

The study is conducted in three counties in Jiangsu province (Gaochun, Jingjiang, Huaiyin) together with the township health centers and villages clinics in those townships. In total, 22 township health centers are involved in the study. The whole process is led by the research team and coordinated by the local health bureau.

When is the study starting and how long is it expected to run for?

January 2015 to December 2018

Who is funding the study?

The National Natural Science Fund of China

Who is the main contact?

Prof. Dongfu Qian  
dqian@njmu.edu.cn

## Contact information

**Type(s)**

Scientific

**Contact name**

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**Contact details**

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211166

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## **Additional identifiers**

EudraCT/CTIS number

IRAS number

ClinicalTrials.gov number

Secondary identifying numbers

No. 71473130

## **Study information**

### **Scientific Title**

Vertical integrated service model: an educational intervention for chronic disease for patients and healthcare professionals in rural China

### **Study objectives**

1. The education-based intervention will have a positive effect on the patients' physical health and their understanding of their chronic disease.
2. The educational intervention will improve the professionalism and understanding of chronic disease management for local healthcare professionals.

### **Ethics approval required**

Old ethics approval format

### **Ethics approval(s)**

Nanjing Medical University Ethics Committee, 02/08/2015, ref: 300

### **Study design**

Cluster randomised controlled trial

### **Primary study design**

Interventional

### **Secondary study design**

Cluster randomised trial

### **Study setting(s)**

Community

### **Study type(s)**

Other

### **Participant information sheet**

Not available in English, please use the contact details to request a patient information sheet

## **Health condition(s) or problem(s) studied**

Optimising care for adult patients with type 2 diabetes or primary hypertension

## **Interventions**

The project is an interventional study conducted in three counties in Jiangsu Province, China. The selection of intervention and control groups is done by the local (township level) health bureaus. They will firstly divide the townships into different groups according to economic status and health development, and then randomly select two townships (one as intervention, one as control) from each group.

The educational intervention will be conducted by a service team which has been assembled by the local health bureau in each county.

Patients in the intervention group will receive the following services:

1. Lectures mainly focusing on prevention and self-management strategies for chronic disease, nutrition and physical activity, proper health behaviours, and psychological counselling
2. Periodical follow-up interviews along with an annual physical examination
3. Special medical service, including helping patients with medical treatment, transfer treatment, return visit, and clinical care, etc

Healthcare professionals in the intervention group will receive the following services:

1. Training lessons for the village GPs.
2. Regular meetings to discuss their work progress
3. Team communications about analysing patients' conditions or formulating personalized therapeutic regimens
4. Technical checks to inspect the patients' disease monitoring schemes, prevention and treatment plans
5. New performance appraisal for doctors and nurses containing two parts:
  - 5.1. Bonus for those who do well in the project
  - 5.2. Opportunities for professional development for outstanding doctors or nurses

For patients and healthcare professionals in the control areas, current routine health services will continue as usual and there will be no service team.

The intervention will last for one year in two counties and for two years in the third county. During this period, the county level and township level health bureaus will be responsible for administrating the whole process. The research team will conduct periodical quality controls.

## **Intervention Type**

Behavioural

## **Primary outcome measure**

For patients:

1. Physiological measures (blood glucose/glycosylated haemoglobin (HbA1C)/blood pressure), collected during the medical examination
  2. Health status, measured using the generic health-related quality of life instrument EQ-5D
  3. Satisfaction with health services, health insurance, understanding of diabetes, health seeking behaviour and patients' out-of-pocket costs of care, assessed using a questionnaire
- Measured at baseline and follow-up (12 months after start of intervention)

## **Secondary outcome measures**

For healthcare professionals:

1. Knowledge about the current epidemiological situation of chronic disease in their own village, assessed through a knowledge test
  2. The general procedure of diagnosing and registering chronic disease, assessed through in-depth interviews
  3. The chronic disease management situation before and after intervention, assessed through in-depth interviews
  4. Their general perceptions about the intervention, assessed through in-depth interviews
- Measured at baseline and follow-up (12 months after start of intervention)

**Overall study start date**

01/01/2015

**Completion date**

30/12/2018

## **Eligibility**

**Key inclusion criteria**

1. Diagnosed with type 2 diabetes (FBG  $\geq 7.0$  mmol/l, and/or 2hPBG  $\geq 11.1$  mmol/l) or primary hypertension (SBP  $\geq 140$  mmHg, and/or DBP  $\geq 90$  mmHg) and has been on medications for more than one month
2. Aged 35-75
3. Lived in the intervention/control areas for more than two years (no records of moving within the last year)
4. Has no plan of moving from the intervention/control areas or no long-term travelling plans (more than one year)
5. Has his/her records on the chronic disease management information system of township health center or village clinic, and has accepted the chronic disease service provided by township health center or village clinic
6. Willing to participate in this project and has a preferable compliance, cognition and receptivity

**Participant type(s)**

Patient

**Age group**

Mixed

**Sex**

Both

**Target number of participants**

1,980

**Key exclusion criteria**

1. Has serious complications of diabetes or hypertension (for example, diabetic foot III/IV, diabetic retinopathy IV or higher, diabetic nephropathy IV/V, hypertension III)
2. Has been diagnosed with secondary hypertension

3. Has been diagnosed with any other serious disease, such as terminal stages of cancer, AIDS, etc

4. Pregnant women or patients with psychiatric problems

**Date of first enrolment**

01/01/2015

**Date of final enrolment**

01/02/2015

## **Locations**

**Countries of recruitment**

China

**Study participating centre**

**Nanchengji Health Center**

China

223341

**Study participating centre**

**Yangzhuang Health Center**

China

223305

**Study participating centre**

**Xindu Health Center**

China

223302

**Study participating centre**

**Lingqiao Health Center**

China

223306

**Study participating centre**

**Zhaoji Health Center**

China

223343

**Study participating centre**  
**Yuanji Health Center**  
China  
223303

**Study participating centre**  
**Wangxing Health Center**  
China  
223307

**Study participating centre**  
**Sanshu Health Center**  
China  
223333

**Study participating centre**  
**Qiqiao Health Center**  
China  
211302

**Study participating centre**  
**Zhuanqiang Health Center**  
China  
211305

**Study participating centre**  
**Yangjiang Health Center**  
China  
211313

**Study participating centre**  
**Dongba Health Center**  
China  
211301

**Study participating centre**

**Chunxi Health Center**  
China  
211399

**Study participating centre**  
**Gubai Health Center**  
China  
211316

**Study participating centre**  
**Gucheng Health Center**  
China  
211304

**Study participating centre**  
**Yaxi Health Center**  
China  
211303

**Study participating centre**  
**Dongxing Health Center**  
China  
214533

**Study participating centre**  
**Xieqiao Health Center**  
China  
214513

**Study participating centre**  
**Houhe Health Center**  
China  
214525

**Study participating centre**

**Chengnan Health Center**

China  
214599

**Study participating centre****Huifeng Health Center**

China  
214532

**Study participating centre****Gushan Health Center**

China  
214522

## **Sponsor information**

**Organisation**

Nanjing Medical University

**Sponsor details**

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**Sponsor type**

University/education

**Website**

<http://english.njmu.edu.cn/>

**ROR**

<https://ror.org/059gcgy73>

## **Funder(s)**

**Funder type**

Government

**Funder Name**

# Results and Publications

## Publication and dissemination plan

Planned publications in high-impact peer reviewed journals as well as Chinese core journals (in total 6-10 papers). Moreover, 4-8 policy advisory reports to different Chinese governmental departments as well as 4 research reports will be provided.

## Intention to publish date

30/12/2019

## Individual participant data (IPD) sharing plan

The datasets generated during and/or analysed during the current study are/will be available upon request from Prof. Dongfu Qian (dqian@njmu.edu.cn)

## IPD sharing plan summary

Available on request

## Study outputs

Output type	Details	Date created	Date added	Peer reviewed?	Patient-facing?
<a href="#">Protocol article</a>	protocol	20/07/2018		Yes	No
<a href="#">Results article</a>	results	26/07/2019	31/07/2019	Yes	No
<a href="#">Results article</a>		20/03/2020	06/06/2023	Yes	No
<a href="#">Results article</a>		02/07/2025	03/07/2025	Yes	No