The effects of a new care model for people aged 75 years and older.

No registrations found.

Ethical review	Positive opinion
Status	Pending
Health condition type	-
Study type	Interventional

Summary

ID

NL-OMON22872

Source
NTR

Brief title
Integrated Elderly Care Program (IECP)

Health condition

English:
Care model
Integrated care
Elderly (people)

Dutch:
Zorgmodel
Samenhangende zorg
Ouderen

Sponsors and support

Primary sponsor: University Medical Center Groningen
Source(s) of monetary or material Support: Dutch Organization for Health Research and Development (ZonMW) and Dutch Healthcare Authority (Nederlandse Zorg Autoriteit (NZA))

Intervention

Outcome measures

Primary outcome

Elderly:

Complexity of care needs (INTERMED), 12 months.

Caregivers:

Caregiver burden (Caregiver Strain Index (CSI)), 12 months.

Quality of care:

Complexity of care needs (INTERMED), 12 months.

Health care use and costs:

Health care plans, Quality Adjusted Life Year (QALY), 12 months.

Secondary outcome

Elderly:

1. Frailty (Groninger Frailty Indicator (GFI)), 12 months;

2. Wellbeing (Welbevindenlijst, RAND 36-item Health Survey (RAND-36) in the Minimal Data Set (MDS)), 12 months;

3. Self management ability (Self-Management Ability Scale (SMAS-30)), 12 months;

4. Self management knowledge (Partners In Health Scale (PIH scale)), 12 months;

5. Quality of life (EQ-5D in the Minimal Data Set (MDS)), 12 months.

Caregiver:

1. Caregiver burden (Self-rated Burden Visual Analogue Scale (Self-rated Burden VAS) and

the Carer Quality of Life (Carer QOL)), 12 months;

2. Experienced health (RAND-36 in MDS), 12 months;

3. Experienced quality of life (RAND-36 and Cantrill’s Ladder in MDS), 12 months.

Quality of care:

1. Goal attainment, 12 months;

2. Patient experiences and satisfaction (Patient Assessment of Chronic Illness Care (PACIC)), 12 months.

Study description

Background summary

Background:

The current Dutch care system was designed to solve acute and short-term problems in an effective and efficient way. However, this model has considerable shortcomings concerning the provision of appropriate and coherent care for elderly. In particular the care for elderly with increasing numbers of long-term health problems and problems with (social) functioning is inadequate. Redesigning the care model is therefore essential and a new care program was developed, the Integrated Elderly Care Program (IECP). This program is based on the four basic elements of the Chronic Care Model in combination with the Kaiser Permanente Triangle.

Methods/design:

The IECP is an intervention program in which patients aged 75 years and older registered with general practitioners will receive care and counseling by an Elderly Care Team. This team, under supervision of a general practitioner, consists of a specialist elderly care, a casemanager (district nurse or nurse practitioner) and a social worker. The intensity and duration of the counseling of the patients, estimated with a triage instrument, depends on the complexity of the care needs and their frailty.

Elderly with complex care needs will receive intensive care and counseling by a casemanager. Elderly without complex care needs will be offered self management support by a social worker. In this group, people with increased frailty will receive individual support.

Elderly with complex care needs and elderly with increased frailty will be subjected to an anamnesis, with the focus on living, well-being and health care. An individual health care plan will be formulated by the elderly and the Elderly Care Team. This health care plan will be realized in cooperation with an extensive network of health care workers, social workers, caregivers, volunteers, municipalities and other relevant parties concerned.

Effects on complexity of care needs (INTERMED), frailty (GFI), well-being (well-being questionnaire) and self-management ability (General Self-efficacy Scale and PIH scale) of elderly, caregiver burden (Caregiver Strain Index), quality of care (ACIC and PACIC), service use and (healthcare) costs will be studied in a randomized controlled trial.

Study objective

We expect that, compared to the usual care, the complexity of care needs and the level of frailty of the elderly will diminish, wellbeing will increase, overall health care costs will decrease or at least remain equal and that quality of care will increase.

Study design

0-12 months.

Intervention

The Integrated Elderly Care Program is an intervention program in which patients aged 75 years and older who are registered with a general practitioner, and who are assigned to the intervention group, will receive care and counseling by an Elderly Care Team. This team, under supervision of a general practitioner, further consists of a specialist elderly care, a casemanager (district nurse or nurse practitioner) and a social worker. The intensity and duration of the counseling of the patient depends on the annually estimated complexity of the care needs and frailty.
Elderly with complex care needs will receive intensive care and counseling by a casemanager. Elderly without complex care needs will be offered self management support performed by a social worker. In this latter group, people with increased frailty will receive individual support. The remaining elderly, i.e. elderly without complex care needs and without increased frailty, will be offered group support.

Elderly with complex care needs and elderly with increased frailty will be subjected to an anamnesis, with the focus on living, well-being and health care. Next, an individual health care plan will be formulated by the elderly and the Elderly Care Team. This health care plan will be realized in cooperation with an extensive network of health care workers, social workers, caregivers, volunteers, municipalities and other relevant parties concerned. If an informal caregiver is present, he or she will be invited to participate in the study as well. Support will be given to the caregiver in order to diminish the caregiver burden.

The control group will receive care as usual, offered by their general practitioner, medical specialist(s), home care services, etc. involved.

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Eligibility criteria

Inclusion criteria

1. People aged 75 years and older;

2. Living at home or in a retirement home;

3. Registered with one of the 15 participating general practitioners.

Exclusion criteria

1. Long term stay in a home for the elderly, in a nursing home or in another long-term care facility;

2. Receiving other types of integrated care;

3. Participating in another study.

Study design

Design

Study type:	Interventional
Intervention model:	Parallel
Allocation:	Randomized controlled trial
Masking:	Open (masking not used)
Control:	Active

Recruitment

NL

Recruitment status:	Pending
Start date (anticipated):	01-01-2012
Enrollment:	2400
Type:	Anticipated

Ethics review

Positive opinion

Date:	24-08-2011
Application type:	First submission

Study registrations

Followed up by the following (possibly more current) registration

No registrations found.

Other (possibly less up-to-date) registrations in this register

No registrations found.

In other registers

Register	ID
NTR-new	NL2893
NTR-old	NTR3039
Other	ZonMw : 60-61900-98-382
ISRCTN	ISRCTN wordt niet meer aangevraagd.

Study results

Summary results
N/A