Central Utrecht Elderly Care Project 'Om U': “Somebody who knows what’s going on and can see things from my side.”

No registrations found.

Ethical review	Positive opinion
Status	Recruitment stopped
Health condition type	-
Study type	Interventional

Summary

ID

NL-OMON26480

Source
Nationaal Trial Register

Brief title
Om U (Ouderenzorgproject Midden Utrecht)

Health condition

frailty, multimorbidity, complex care needs, daily functioning, quality of life.

kwetsbaarheid, multimorbiditeit, complexe zorgbehoefte, dagelijks functioneren, kwaliteit van leven.

Sponsors and support

Primary sponsor: University Medical Center Utrecht
P.O. box 85500
3508 GA Utrecht
088 75 555 55

Source(s) of monetary or material Support: The Central Utrecht Elderly Care Project received a grant of the National Programme of Elderly Care (ZonMw)

Intervention

Outcome measures

Primary outcome

The primary outcome parameter is change in daily functioning. General functioning (ADL and IADL) is measured with the Katz 15 questionnaire, which is included in the minimal data set (MDS), the questionnaire used in this project.

Secondary outcome

1. Quality of life, as registered with the RAND-36, partially included in the MDS;

2. Health care consumption, as expressed in:

A. Number of ‘elective’ admissions to hospitals, nursing homes and elderly homes;

B. Number of emergency department visits and ‘emergency’ admissions to hospitals, nursing homes and elderly homes;

C. Number of contacts with the GP’s surgeries, outside the regular hours;

D. Number of contacts with the healthcare assistant, the GP, the general practice assistant and the GNPC;

E. Medication use, dysfunctional and functional polypharmacy;

F. Consultation with other primary carers (General Social Work, elderly care, physical therapy, homecare).

3. Mortality, as registered in the EMR of the GP, and confirmed by dead certificates of the municipal administration (gemeentelijke basisadministratie);

4. Cost-effectiveness analysis (CEA). For the CEA, the ratio of differences in the main outcome measure - (I)ADL - between the three groups and differences in costs will be analyzed;

5. Patient satisfaction with -changes in- primary health care. Patient satisfaction will be measured in the MDS;

6. Comparison of frailty index courses between groups, and particular attention to the proportion of patients with polypharmacy, multimorbidity and a care gap of > 3 years, and the correlation between the frailty index score and daily functioning and quality of life;

7. Time spent on informal caring and burden of care for informal carer; health status and

quality of life of informal carer.

Study description

Background summary

In the Central Utrecht Elderly Care Project, the transition will be made from reactive towards proactive care for potentially frail older people in general practices. The hypothesis is that more proactive care leads to greater self-sufficiency, higher retention of functions and thus improved quality of life, less use of care facilities and a lower burden of care for older people and their informal carers.

Study objective

In general practices, proactive care for potentially frail older people with the use of Utrecht Periodic Risk Identification and Monitoring (UPRIM) and the use of a Geriatric Nurse Primary Care (GNPC) will result in better daily functioning in comparison to potentially frail older people who receive care as usual.

Study design

Both primary and secondary parameters are recorded in all three groups (groups A, B and C) on three different measurement moments:

1. After randomization at baseline (TO);

2. After six months (T1);

3. After 12 months (T2).

For the primary and secondary outcome measures, MDS data as well as UPRIM data will be used.

The MDS is obligatory used nationwide in all projects which are part of the National Program of Elderly Care. It includes questions about general well-being, psychological and social functioning, cognitive functioning, multi-morbidity and ADL functioning, as well as questions pertaining to demographic information.

Intervention

1. Group A: Utrecht Periodic Risc Identification and Monitoring (UPRIM).

UPRIM is a method adapted for elderly care also known in the literature as panel management. It entails preventive identification of potentially frail older people on the basis of automatic quarterly screening for relevant risk factors in the Electronic Medical Records of the GP. Using ICPC / ATC codes, UPRIM will screen for three core components: multimorbidity, polyfarmacy and care gap, scored positive as defined in the inclusion criteria section.

The result is a UPRIM report for each general practice of older people who can be classified as ‘potentially frail’. With this report, the GP has the possibility to carry out (preventive) interventions and coordination of care. the interventions required in follow-up of the UPRIM report are not described in a protocol, but are left up to the GP, who follows the usual protocols, standards and guidelines for best practices in primary care.

2. Group B: UPRIM & Geriatric Nurse Primary Care (GNPC).

In the second intervention group, following UPRIM, a specially trained GNPC will provided a structured care program for each of the domains of frailty . The GNPC will send 3 questionnaires: the Groningen Frailty Index (GFI), the Intermed Self Assessment and the Groningen Wellbeing Questionnaire. Patients will return the questionnaires to the General Practice. The GNPC will discuss the outcome with the GP and makes an appointment with the patient to visit the patient at home. During this home visit the GNPC takes some geriatric assessments and will develop an tailor made care plan. Assessments are bases on ten common health problems; functional decline, falling, mood and loneliness, urinary incontinence, malnutrition, visual impairment & hearing loss, cognition, polypharmacy, caregiver burden, and wellbeing. The GNPC will discuss this first drafts with the GP. The GNPC will monitor ands register progress and type of interventions after each visit.

3. Group C: Control group.

Patients in this group will receive care as usual.

Contacts

Public
Postbus 8605
C.I.M. Heijst, van
Utrecht 3503 RP
The Netherlands
+31 (0)30 2953622
Scientific
Postbus 8605

C.I.M. Heijst, van
Utrecht 3503 RP
The Netherlands
+31 (0)30 2953622

Eligibility criteria

Inclusion criteria

The target group of this project is made up of potentially frail older people in general practice setting, who are defined as persons of 60 years and older with:

1. Multimorbidity (defined as a moderate-to-high frailty index score, which is a reflection of the proportion of health deficits present.), AND / OR;

2. Polypharmacy (defined as the actual chronic use of 4 or more different medications), AND / OR;

3. A care gap in primary care of > 3 years, except for the yearly influenza vaccination.

Exclusion criteria

1. Terminally ill patients;

2. Patients living in or on a waiting list for an elderly home or nursing home.

Study design

Design

Study type:	Interventional
Intervention model:	Parallel
Allocation:	Randomized controlled trial
Masking:	Single blinded (masking used)
Control:	Active

Recruitment

NL

Recruitment status:	Recruitment stopped
Start date (anticipated):	01-10-2010
Enrollment:	3092
Type:	Actual

IPD sharing statement

Plan to share IPD: Undecided

Ethics review

Positive opinion

Date:	14-04-2010
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	NL2164
NTR-old	NTR2288
Other	ZonMW / CCMO : 60-61900-98-128 / ABR 30071 ;
ISRCTN	ISRCTN wordt niet meer aangevraagd.

Study results

Summary results

1. Development of a Proactive Care Program (U-CARE) to Preserve Physical Functioning of Frail Older People in Primary Care.
Bleijenberg N, Ten Dam VH, Drubbel I, Numans ME, de Wit NJ, Schuurmans MJ.
J Nurs Scholarsh. 2013 Mar 26. doi: 10.1111/jnu.12023. [Epub ahead of print]
PMID: 23530956 [PubMed - as supplied by publisher]

2. [Proactive and structured care for the elderly in primary care].
Ten Dam VH, Bleijenberg N, Numans ME, Drubbel I, Schuurmans MJ, de Wit NJ.
Tijdschr Gerontol Geriatr. 2013 Apr;44(2):81-9. doi: 10.1007/s12439-013-0013-9. Dutch.
PMID: 23494688 [PubMed - in process]

3. Exploring the expectations, needs and experiences of general practitioners and nurses towards a proactive and structured care programme for frail older patients: a mixed-methods study.
Bleijenberg N, Ten Dam VH, Steunenberg B, Drubbel I, Numans ME, De Wit NJ, Schuurmans MJ.
J Adv Nurs. 2013 Mar 5. doi: 10.1111/jan.12110. [Epub ahead of print]
PMID: 23461433 [PubMed - as supplied by publisher]

4. Prediction of adverse health outcomes in older people using a frailty index based on routine primary care data.
Drubbel I, de Wit NJ, Bleijenberg N, Eijkemans RJ, Schuurmans MJ, Numans ME.
J Gerontol A Biol Sci Med Sci. 2013 Mar;68(3):301-8. doi: 10.1093/gerona/gls161. Epub 2012 Jul 25.
PMID: 22843671 [PubMed - indexed for MEDLINE]

5. Proactive and integrated primary care for frail older people: design and methodological challenges of the Utrecht primary care PROactive frailty intervention trial (U-PROFIT).
Bleijenberg N, Drubbel I, Ten Dam VH, Numans ME, Schuurmans MJ, de Wit NJ.
BMC Geriatr. 2012 Apr 25;12:16. doi: 10.1186/1471-2318-12-16.
PMID: 22533710 [PubMed - indexed for MEDLINE] Free PMC Article