Connecting primary care, sport and physical activity. Evaluation of the role of Care Sport Connectors in connecting primary care, sport, and physical activity and residents* participation.

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Ethical review	Approved WMO
Status	Recruiting
Health condition type	Other condition
Study type	Observational invasive

Summary

ID

NL-OMON40628

Source
ToetsingOnline

Brief title
Connecting primary care, sport and physical activity

Condition

- Other condition

Synonym
chronic diseases, diabetes, Non communicable diseases

Health condition

mensen met risicofactoren (overgewicht, hoge bloeddruk, hoge suikerwaarde, hoog cholesterol) voor welvaartsziekten en mensen met een welvaartsziekte zoals diabetes type II,

hart en vaatziekten.

Research involving
Human

Sponsors and support

Primary sponsor: Universitair Medisch Centrum Sint Radboud
Source(s) of monetary or material Support: ZonMw

Intervention

Keyword: Broker role, Care Sport Connector, Physical activity, Primary care

Outcome measures

Primary outcome

The primary outcome measure is maintained physical activity after the

completion of the exercise program or combined lifestyle intervention or not.

Secondary outcome

The secondary outcome measures are physical fitness - measured with the

physical fitness scan-, perceived health, motivation, illness and care,

self-efficacy, perceived importance, behavioral, social support,

self-monitoring and exercise goals.

Study description

Background summary

In 2012, the Dutch Ministry of Health, Welfare, and Sport introduced Care Sport Connectors (CSCs), to whom the broker role has been ascribed. These CSCs are 40% funded by the state; the remaining 60% is funded by the municipality or other local organisations. The defined outcome of CSCs is an increased number of residents participating in local sports facilities and being physically active in their own neighbourhood. Therefore, CSCs are employed to connect primary care, sport, and physical activity and to guide primary care patients on lifestyle programmes towards local physical activity facilities. The CSC

function is new. In 2013, 90% of Dutch municipalities had appointed CSCs. However, neither the CSCs* job description and competencies, nor how they can be embedded in their context, are yet clear. It is accepted that CSCs will operate differently because of their different backgrounds and contexts.

The reason for this is that in the Netherlands, 25% of the total population is diagnosed with a chronic disease. The expectation is that this number will increase in the next 20 years. The increase in chronic diseases is alarming considering that chronic diseases are highly preventable. Chronic disease risk factors relate to individual behaviour and lifestyle, the social and physical environment in which people live, and the healthcare system. There is an increased need to join forces both within the healthcare sector and between the health and other societal sectors, because no organisation has the resources, access, and trust relationship to address the wide range of community determinants of public health problems alone. Working in alliances between health and other societal sectors is challenging, because it means working in a new area or setting, with new people, with different backgrounds, interests, and perspectives. For example, a study on alliances in the Dutch BeweegKuur showed that it was difficult to create the connection between care and sport because of the different culture and target groups of the care and sport sectors. A health broker role seems to offer the promise of improving intersectoral collaboration.

Study objective

Adequate scientific research is needed to assess CSCs impact in: 1) connecting primary care, sport en physical activity and 2) promoting the health of primary care patients. Therefore, the research project consists of two studies.

Study I focuses on the intermediary target groups; CSCs and professionals in primary care, sport and physical activity who implement lifestyle programs. CSCs are expected to form alliances for health by connecting professionals from different sectors, to achieve and sustain collaboration in these alliances. Consequently the following research questions will be examined:
a. What are the processes that contribute to the connection between primary care, sport and physical activity?
b. What are the conditions at national and local level that facilitate or hinder CSCs in connecting primary care, sport and physical activity?
c. Which impacts are mediated by CSCs and what are the perceived societal benefits for the municipality, neighborhood and local residents?

Study II concentrates on health and physical activity behavior changes of primary care patients who participate in lifestyle programs. Center of attention is the target group, adults from the neighborhood who participate in lifestyle programs organized by professionals from the alliances of study I. Following research questions will be addressed:
a. Which lifestyle programs are implemented and which target groups are reached?

b. What are effective principles to enlarge participation, self management and hand over primary care patients and which preconditions are essential to accomplish this?
c. What is the effect in terms of physical activity behavior and maintenance, their self- reliance, quality of life, experienced health and health gains? For this part of the review of the METC is required.

Study design

Only traject 2c is described because this is the part which is relevant for the review of the METC .

The physical fitness scan is used three times to measure of physical actvities or a combined lifestyle interventions contributes to health benefits . Participants who enroll, on referral from a health care professional, in an exercise program or combined lifestyle intervention are measured at the moment of entry, after six months and one year.
Elements of the test are:
- Blood Pressure
- Resting Heart Rate
- Height
- Weight
- Waist circumference
- Body fat percentage
- Cholesterol
- Blood glucose
- Arm curl
- 30 second chair stand
- Grip strength
- 3 meter up and go
- Straight leg raise
- Modified Schober test
- Back Scratch
- Astrand endurance test

In addition, after the physical fitness scan the participants fill in a questionnaire about the topics : physical activity, perceived health, motivation, illness and care, self-efficacy, perceived importance, behaviour change, social support, self- monitoring and exercise goals .

Study burden and risks

The risks for participation in the study are minimal. There are no reserved operations included.The subtests of the fittest are performed regularly in practice and unproblematic.

It's fair to carry out this research because the load is not too high (3x 1.5 hours), and the risk is minimal. In addition, most exercise programs or combined lifestyle interventions already contain a physical fitness scan. Many people also find it helpful to have insight in their physical health. Through this study, the effects of the combined lifestyle intervention or physical activity can be demonstrated. In this way it can be shown whether policy pretensions around the Care Sport Connector are realized. RCT studies showed that physical activity is helpful, but it is relevant to show whether this intended effect is also achieved in practice through community based interventions, which involves many more factors than just physical activity .

Contacts

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Trial sites

Listed location countries

Netherlands

Eligibility criteria

Age
Adults (18-64 years)
Elderly (65 years and older)

Inclusion criteria

Adults who are referred by primary care to a combined lifestyle intervention or physical activity in which the Care Sports Connector is involved.

Exclusion criteria

Insufficient understanding of the Dutch language.
A negative advice from the Par-Q

Study design

Design

Study type: Observational invasive

Masking:	Open (masking not used)
Control:	Uncontrolled
Primary purpose:	Prevention

Recruitment

NL

Recruitment status:	Recruiting
Start date (anticipated):	12-09-2014
Enrollment:	640
Type:	Actual

Ethics review

Approved WMO Date:	11-09-2014
Application type:	First submission
Review commission:	CMO regio Arnhem-Nijmegen (Nijmegen)
Approved WMO Date:	01-10-2014
Application type:	Amendment

Review commission:	CMO regio Arnhem-Nijmegen (Nijmegen)
Approved WMO Date:	03-06-2015
Application type:	Amendment
Review commission:	CMO regio Arnhem-Nijmegen (Nijmegen)
Approved WMO Date:	22-09-2015
Application type:	Amendment
Review commission:	CMO regio Arnhem-Nijmegen (Nijmegen)
Approved WMO Date:	07-01-2016
Application type:	Amendment
Review commission:	CMO regio Arnhem-Nijmegen (Nijmegen)

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
CCMO	NL49642.091.14