

Trial of the CarePartner Program for Improving the Quality of Transition Support

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Summary: Patients hospitalized with complex chronic conditions frequently experience preventable short-term readmissions due to a lack of coordinated care and inadequate support when they transition from the hospital to the home setting. Proactive, post-discharge followup by continual patient monitoring and ensuring that patients have caregiver support to assist with managing their health and illness can reduce patients' re-hospitalization risk and improve the quality of care when transitioning from the hospital to home.

This study will evaluate the CarePartner (CP) intervention intended to improve the effectiveness of support for transitions from hospital to home for patients with common chronic conditions. The CP intervention uses low-cost health information technology (IT) and coordinated communication among patients' informal caregivers or CPs and their clinical teams to address their needs and manage their health. Patients in the CP intervention will receive comprehensive discharge planning for managing their chronic condition and coordinating their care across transitions. They will also receive direct, tailored monitoring and communication on self-care education via regular automated telephone calls post-discharge.

A randomized controlled trial of 380 patients will compare those with common chronic conditions receiving usual discharge planning and post-discharge support to outcomes among patients receiving the CP intervention. Patients will be recruited from the University of Michigan Health Center General Medicine Inpatient Service and will be asked to identify up to three CPs. CP intervention patients will receive automated assessment and behavior change calls, and their CPs will receive structured feedback and advice following each assessment. Patients' clinical teams will have access to patients' assessment results via the Web, will receive automated reports about urgent health problems, and will be able to communicate with patients and CPs using a secure Web page and a specially-designed voicemail service. Patients will complete surveys at baseline, 30-days, and 90-days post-discharge to assess measures such as health service use, health-related quality of life, self-care behaviors, and understanding of the transition process. CPs will complete surveys at baseline and 90-days post-discharge to evaluate factors such as CP burden and satisfaction with the intervention. Data on inpatient and outpatient clinic visits will be abstracted from patient medical records to assess utilization, readmission, and mortality outcomes. The primary outcome of the trial will be 30-day readmission rates. Secondary outcomes include functional status, self-care, and mortality risk.

The CP intervention targets multiple stakeholders and implements innovative IT approaches to promote

successful care transitions by improving the effectiveness of patients' caregiving network, clinician followup, and patients' self-management of their health. This coordinated approach has strong potential to improve the quality of care and success of care transitions among patients with common chronic conditions.

Specific Aims:

- Determine whether the CP model for supporting effective transitions from hospital to home improves outcomes of care, including lower readmission rates, emergency department visits, and improved patient functional status. **(Upcoming)**
- Evaluate the impact of the intervention on process measures of transition quality and patients' medication-related self-management. **(Upcoming)**
- Determine whether the intervention increases the quality of life and quantity of support for patients' self-care using a mixed-methods approach to identify whether service reduces caregivers' stress and increases their disease-specific communication with the patient. **(Upcoming)**

2011 Activities: The project is in the development phase. Activities thus far have involved hiring essential staff for project startup, receiving institutional review board approval, developing the interactive voice response (IVR) system for the CP intervention, and training project staff to use the IVR system.

As last self-reported in the AHRQ Research Reporting System, project progress and activities are completely on track and the project budget funds are somewhat underspent because not all project staff has been hired.

Preliminary Impact and Findings: This project has no findings to date.

Target Population: Chronic Care*

Strategic Goal: Develop and disseminate health IT evidence and evidence-based tools to support patient-centered care, the coordination of care across transitions in care settings, and the use of electronic exchange of health information to improve quality of care.

Business Goal: Implementation and Use

** This target population is one of AHRQ's priority populations.*