CarePartner Model for Disease Management Support

John D. Piette, PhD[1,2], Nicolle Marinec, MPH[1], Jenny Chen, MPH[1], Sarah Yon, MPH[1], Kathy Swalwell, BSW[1]
Sheila Krishnan, MPH[1], Dana Striplin, MHSA[2], Steven Bernstein, MD[1,2]

[1] Program on Quality Improvement for Complex Chronic Conditions, University of Michigan, [2] Ann Arbor VA Center for Clinical Management Research, Center of Excellence

For more information, contact: jpiette@umich.edu

BACKGROUND

Why go beyond traditional care management for chronic illness care?

- While care management improves outcomes, care managers are not available in most community practices
- Formal care management programs are often ineffective for socioeconomically vulnerable patients with limited treatment access
- Many patients need more frequent help than community providers can realistically deliver given resource constraints
- Many patients have social network members (e.g., adult children) who are an untapped resource for supporting their self-management
- Unfortunately, informal caregivers often lack the tools they need to be successful

Why focus on solutions for informal caregivers living outside of the patient's household?

- 7 million adults are long-distance caregivers (living an average of 450 miles away)
- Patients increasingly live alone as younger generations leave communities in search of employment opportunities
- 80% of long-distance caregivers work full or part time and have limited ability to provide support

What are the barriers to self-management support by informal caregivers?

- Caregivers may be too busy to be in frequent, systematic contact
- When caregivers communicate with patients, they often don't know how to monitor key health indicators
- Even if they ask the right questions, informal caregivers often have no idea how they should respond to patients' needs

OBJECTIVES

- To determine the proportion of patients with heart failure who can identify an eligible informal caregiver willing to use an automated telephone service as a tool to improve the frequency and quality of their support for chronic illness self-care
- To evaluate patients' and caregivers' success in using the system and satisfaction with this resource for supporting self-care
- To evaluate the service's impact on health and self-care outcomes and extend the model to support patients with other chronic illnesses

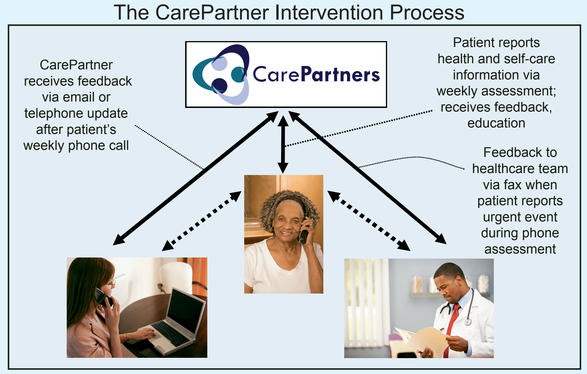
CarePartner Materials

Patient Materials

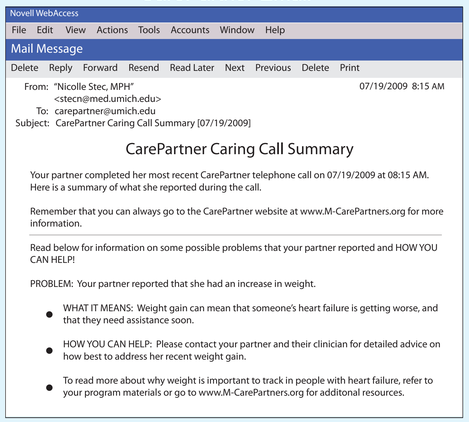
METHODS

- 52 pairs of patients with New York Heart Association Class II-IV heart failure and their informal caregivers were identified by electronic records and telephone screening
- Patients received weekly automated health assessment and behavior change support calls. Calls provided tailored feedback and education based on the patient's needs.
- CarePartners had access to the internet and received structured email updates, based on the patient's automated assessment
- Care Managers received fax reports when a patient reported an urgent health issue, such as frequent shortness of breath or significant weight gain
- Quantitative surveys were conducted with both patients and CarePartners at baseline and 6 weeks; Qualitative surveys were done with both parties at 12 weeks
- Additional analyses used data from the automated assessment system

The CarePartner Intervention Process



CarePartner Email


Novell WebAccess

File Edit View Actions Tools Accounts Window Help

Mail Message

Delete Reply Forward Resend Read Later Next Previous Delete Print

From: "Nicolle Stec, MPH" <stecn@med.umich.edu>
To: carepartner@umich.edu
Subject: CarePartner Caring Call Summary [07/19/2009]
07/19/2009 8:15 AM

CarePartner Caring Call Summary

Your partner completed her most recent CarePartner telephone call on 07/19/2009 at 08:15 AM. Here is a summary of what she reported during the call.

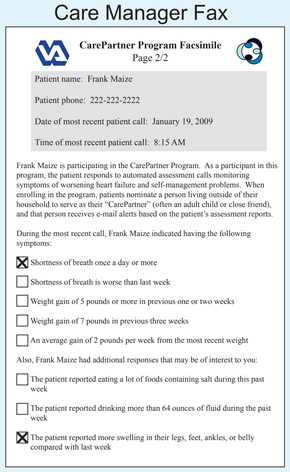
Remember that you can always go to the CarePartner website at www.M-CarePartners.org for more information.

Read below for information on some possible problems that your partner reported and HOW YOU CAN HELP!

PROBLEM: Your partner reported that she had an increase in weight.

- WHAT IT MEANS: Weight gain can mean that someone's heart failure is getting worse, and that they need assistance soon.
- HOW YOU CAN HELP: Please contact your partner and their clinician for detailed advice on how best to address her recent weight gain.
- To read more about why weight is important to track in people with heart failure, refer to your program materials or go to www.M-CarePartners.org for additonal resources.

Care Manager Fax


CarePartner Program Facsimile
Page 2/2

Patient name: Frank Maize

Patient phone: 222-222-2222

Date of most recent patient call: January 19, 2009

Time of most recent patient call: 8:15 AM

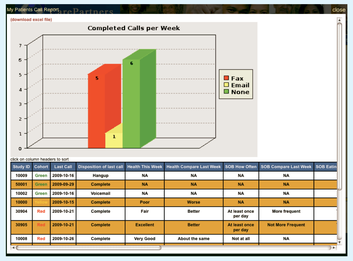
Frank Maize is participating in the CarePartner Program. As a participant in this program, the patient responds to automated assessment calls monitoring symptoms of worsening heart failure and self-management problems. When enrolling in the program, patients nominate a person living outside of their household to serve as their "CarePartner" (often an adult child or close friend), and that person receives e-mail alerts based on the patient's assessment reports.

During the most recent call, Frank Maize indicated having the following symptoms:

- [x] Shortness of breath once a day or more
- [ ] Shortness of breath is worse than last week
- [ ] Weight gain of 5 pounds or more in previous one or two weeks
- [ ] Weight gain of 7 pounds in previous three weeks
- [ ] An average gain of 2 pounds per week from the most recent weight

Also, Frank Maize had additional responses that may be of interest to you:

- [ ] The patient reported eating a lot of foods containing salt during this past week
- [ ] The patient reported drinking more than 64 ounces of fluid during the past week
- [x] The patient reported more swelling in their legs, feet, ankles, or belly compared with last week



RESULTS OF THE PILOT STUDY

- 75% of CarePartners were adult children, 40% daughters, 58% women
- 77% of patients said it was important to talk with their CarePartner about their illness
- 78% of patients felt their CarePartner helped them do things they needed to do to stay healthy
- 75% of patients made changes in their self-care as a result of the intervention
- 586 completed assessments yielded a 92% successful assessment completion rate
- 92% of CarePartners reported rarely or never feeling stressed by participating in this program in addition to their other family responsibilities
- 50% of patients reported worse shortness of breath compared with the previous week
- 35% of patients had less than a 2 week supply of medication
- 40 urgent reports were generated to clinicians for 30 patients
- 1 urgent report led to a change in the patient's treatment regimen
- 92% of patients agreed that they would be more satisfied with their health care if this service were available
- 92% of CarePartners reported that it was important to talk to the patient about their illness and that they rarely or never had difficulty doing so
- Over 80% of CarePartners reported greater knowledge of their loved one

EXPANDING THE PROGRAM TO INCLUDE OTHER DISEASES AND NON-ENGLISH SPEAKERS

- A randomized trial among VA patients with heart failure is underway. More than 50 out of an eventual 300 patients have been enrolled and are successfully using the service.
- Community-based demonstration of CarePartners for depression management in primary care practices is underway with support from Blue Cross Blue Shield
- VA is disseminating CarePartners for patients with heart failure, depression, and/or diabetes treated in rural practices around the midwest
- Development of a version of CarePartners for Spanish-speaking diabetes patients has been funded by the Center for Health Research and Transformation
- Trials of CarePartners for patients undergoing cancer chemotherapy and patients with chronic pain are also underway
- QUICCC is collaborating with ministries of health and university investigators in Mexico, Chile, and Honduras to develop strategies for using CarePartners in other countries

CONCLUSIONS

- CarePartners represents a potential source of support for community-dwelling patients with chronic disease and can help fill the gaps in traditional models of chronic illness care
- By structuring relationships with caregivers outside of the patient's home, CarePartners will increase patients' access to self-management support without increasing demands on stressed primary care practices or requiring unsupportable increases in healthcare expenditures
- CarePartners provides the tools adult children and other social network members need to be effective in supporting disease self-management at a distance
- This service can improve access for the growing population of non-English-speaking patients, including patients served in developing countries and those served in safety-net systems of care