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Evaluation of the impact of a discharge coordinator on continuity of care from hospital to home

Submission date 01/09/2005	**Recruitment status** No longer recruiting	[_] Prospectively registered [_] Protocol [_] Statistical analysis plan [_] Results [_] Individual participant data [_] Record updated in last year
Registration date 01/03/2006	**Overall study status** Completed	
Last Edited 14/08/2008	**Condition category** Other	

Plain English summary of protocol
Not provided at time of registration

Contact information

Type(s)
Scientific

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Additional identifiers

EudraCT/CTIS number

IRAS number

ClinicalTrials.gov number

Secondary identifying numbers
138311

Study information

Scientific Title

Study objectives
This project proposes to develop, implement and evaluate the model of using a discharge planner to facilitate the transition between hospital and home on a general medical in-patient unit at a university-affiliated hospital. Development of the intervention will require exploration of what behavioural and organisational factors facilitate implementation of the intervention. Evaluation will include assessment of the impact of this intervention on the quality of care including adherence to discharge plans (attendance at follow-up appointments, completion of follow-up tests), readmission, adverse events, length of stay, patient satisfaction, and mortality. While a composite endpoint reflecting quality of care will be used, the relationship between the intervention and each component outcome will be explored to assist in determining appropriate outcome(s) for further evaluation of this intervention.

Ethics approval required
Old ethics approval format

Ethics approval(s)
Not provided at time of registration

Study design
Randomised controlled trial

Primary study design
Interventional

Secondary study design
Randomised controlled trial

Study setting(s)
Hospital

Study type(s)
Other

Participant information sheet

Health condition(s) or problem(s) studied
Continuity of care from hospital to home

Interventions
Only patients who have been admitted as an in-patient with a diagnosis of acute coronary syndrome, congestive heart failure, pneumonia, exacerbation of chronic obstructive airways disease, falls, or confusion will be approached to participate.

During the intervention phase, patients admitted to a general medical in-patient unit at the Toronto Western Hospital with one of the six common medical diagnoses noted above will be randomly allocated either to receive care from a discharge coordinator or to usual care.

Computer generated randomisation will be used in blocks of six and randomisation will be stratified by living arrangements (e.g. from long-term care facility or independent living accommodation) and by ability to speak English. Randomisation is being used because one discharge coordinator would not be able to provide care for all eligible patients and it is unclear from the literature how this intervention should be targeted. Allocation will be concealed.

All four Clinical Teaching Units (CTUs) at this hospital will participate in this study. Letters inviting participation in this study will be sent from the General Internal Medicine Program Director to all medicine residents assigned to the CTUs during the study period. Letters of invitation will also be sent from the General Internal Medicine Division Director to all staff physicians who will be attending on the medicine CTUs during the study period. Notification of the study will be provided to all members of the health care teams on the medical wards.

The research assistant will continue to attend bullet rounds each morning to identify eligible patients. The discharge coordinator will only be present from 9 am to 5 pm on Monday to Friday. Once eligible patients are identified, a research assistant will approach them for consent to participate as outlined above. If patients agree to participate, baseline demographics will be obtained. We will also attempt to collect baseline information from patients who decline the invitation to participate in the trial and determine why they are not interested in participating in the study. Once the consent has been obtained, the patient will be randomised and the discharge coordinator will be notified by the research assistant if the patient has been allocated to that intervention.

Discharge planning should include assessment, planning, implementation and monitoring phases. Those patients assigned to the discharge coordinator will receive an assessment of their supports, financial situation, living situation, medical and functional status. Data collection forms that will be used were developed in consultation with a former case manager on a neurosurgical unit and members of the allied health care team. Functional status will be assessed using the Barthel Index. Elicitation of this information will be done in collaboration with the patient; their caregivers, physicians, social workers, physiotherapists, occupational therapists, pharmacists, nurses and home care coordinators.

The discharge coordinator will work with the patient and health care team (including the home care coordinator) to identify a discharge date, and to coordinate supports, medications, follow-up tests and appointments upon discharge. Information about the diagnosis and ongoing management of the patients will be shared with the patient and their caregivers and with their family physician who will provide ongoing care.

Colleagues with expertise in human factors engineering and the development of consumer educational materials will assist in the preparation of the patient-centred materials. Patient materials will also be translated into Cantonese and Portuguese, reflecting the multicultural mix of patients admitted to the Toronto Western Hospital. This will be done to ensure that both written and verbal information is provided to patients.

The discharge coordinator will prepare the discharge summary with the physician responsible for caring for the patient focusing on the list of medications, and a description of the management plan in hospital and after discharge. The discharge coordinator will also coordinate arrangements for homecare and will disseminate relevant information about the discharge plan

to the patient, caregiver, attending physician, medical house-staff and family physician. They will also provide a follow-up telephone call to the patient 48 hours and two weeks after discharge to determine if any medical issues have arisen that need attention or if any problems with follow-up have occurred. Additional referrals to appropriate services (including home care) will be made at that time as necessary. Patients will be followed up at 4, 8 and 12 weeks by the research assistant who will contact them to assess their satisfaction and quality of life.

Patients allocated to the usual care group will receive care from the health care team without the addition of the discharge coordinator. They will be followed-up at 4, 8 and 12 weeks by the research assistant and information will be obtained on the selected outcomes.

Intervention Type
Other

Phase
Not Specified

Primary outcome measure
In this study, the primary outcome will be a composite endpoint to assess the level of discontinuity of care and will include:
1. The number of patients admitted with the target conditions who do not complete at least one recommended follow-up test
2. The number of patients admitted with the target conditions who do not attend at least one recommended follow-up appointment
3. The number of patients admitted with the target conditions who do not fill at least one medication prescribed at discharge

Secondary outcome measures
Secondary outcomes include mortality and the proportion of patients readmitted to hospital (including admissions to the Emergency Department). Reasons for readmission will be assessed to determine if a medical error had an impact on readmission. Quality of life will be assessed using the 12-item Short Form health survey (SF-12) and patient satisfaction will be assessed using the Patient Satisfaction Questionnaire which includes items on convenience of care, access to care, continuity of care, competence, explanations of care, degree of consideration shown and overall satisfaction. Outcomes will be assessed at 4, 8, and 12 weeks after the intervention has been implemented.

Overall study start date
20/06/2005

Completion date
20/06/2006

Eligibility

Key inclusion criteria
Participants will be patients who:
1. Will be in hospital for more than 48 hours
2. Who are greater than 65 years of age
3. Who have a diagnosis of acute coronary syndrome, congestive heart failure, pneumonia, exacerbation of chronic obstructive airways disease, falls, or confusion

Participants will also undergo a Short Portable Mental Status Questionnaire and must score above 5 out of 10 questions.

Participant type(s)
Patient

Age group
Senior

Sex
Both

Target number of participants
160

Key exclusion criteria
Patients will be excluded if they score less than 5 on the Short Portable Mental Status Questionnaire, or if they are transferred to another in-patient service at an acute care hospital

Date of first enrolment
20/06/2005

Date of final enrolment
20/06/2006

Locations

Countries of recruitment
Canada

Study participating centre
Toronto Western Hospital
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Sponsor information

Organisation
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Sponsor type
Government

Funder(s)

Funder type
Government

Funder Name
Premier's Research Excellence Awards (Canada)

Results and Publications

Publication and dissemination plan
Not provided at time of registration

Intention to publish date

Individual participant data (IPD) sharing plan

IPD sharing plan summary
Not provided at time of registration