Care Partner Program

Implementation Checklist

EQIC
EASTERN US QUALITY IMPROVEMENT COLLABORATIVE

What is this tool?

A checklist with strategies that can be implemented to optimize care partner engagement in patient care.

Who should use this tool?

The care partner program implementation team at your hospital.

How to use the tool:

1. Use the checklist with the EQIC *Care Partner Program Implementation Guide* to identify and select which strategies to implement to optimize processes at your hospital and enhance care partner engagement in patient care.
2. Refer to the *Guide* for tools and strategies for implementation. Each section of the checklist corresponds to and expands upon a step in the Care Partner Framework (see diagram).

HQIC | Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP

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STEP 1: COMMIT
Become a Care Partner Hospital

Process steps	Options/ideas	In place Yes	In place No
Identity an executive sponsor	Select a staff person in a senior leadership role to support, promote and communicate the project goals and the value of a hospital-wide care partner program. Possible personnel for this role may include: • chief medical officer; • chief nursing officer or director; • chief operating officer; • chief quality officer; • vice president or director of case management; or • chief patient experience or engagement officer or director.	○	○
Dedicate a program lead	If the executive sponsor cannot be the team leader, choose a well-respected leader for this role. Consider someone from quality improvement as a facilitator.	○	○
Determine and identify the care partner team	Create a multidisciplinary team to help build the foundation and infrastructure of the care partner program by supporting a culture of patient and family engagement and reducing readmissions. Include the following personnel: • nursing, including frontline nursing staff (consider key unit-based nurse champions); • medical staff/hospitalist; • case management; • patient engagement department staff and potentially patient and family advisory council representative; • admissions department representative; • unit clerk (if you anticipate a role for them); and • information technology.	○	○
Establish a care partner program	Identify how the team will obtain staff input to implement or enhance a care partner program to more effectively engage patients and care partners by using the strategies listed below:	○	○
Team	Immerse the staff (including physicians) in information about the value of the care partner model: • consider starting with one or more pilot sites then spreading: use multidisciplinary task force with identified unit-level physician, nursing champions, unit clerk and direct care clinical staff to promote the program on the units;	○	○
	• schedule routine team meetings;	○	○
	• identify roles and responsibilities;	○	○

	• determine baseline data, for example:
	  • percent of patients who identified a care partner on admission;
	  • review patient satisfactions scores/HCAHPS; or
	  • review readmission rates.
		○	○

	• Create a project plan with clearly defined goals.	○	○

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Process steps	Options/ideas	In place Yes | No
Gathering Input	Elicit input/suggestions for additional care partner roles and materials: • Conduct patient and care partner focus groups to identify opportunities and barriers to care partner engagement.	○ ○

	• Solicit clinical staff and physician input on how to effectively engage care partners by using:
	  • focus groups;
	  • questionnaires;
	  • staff interviews;
	  • involvement in care partner team;
	  • work with admitting, ED and nursing on the best process for the unique needs of the hospital.
		○ ○

Patient and Family Advisory Council	Define the role of the hospital's patient and family advisory council and the patient and family in the care partner implementation strategy. • Clearly define the request of the PFAC.	○ ○
	• Review EQIC Program details and options	○ ○
	• Define the hospital's care partner program	○ ○

	• What do we want the care partner to do? Consider:
	  • participating in huddles or rounding; and
	  • providing access to comfort items such as linens or nutritional items.
		○ ○

	• Document the necessary routine medical information exchanges with the care partner, such as: "patient and/or care partner present for teaching" in patient record.	○ ○
Tools and Materials	Modify or create Care Partner materials • EQIC Care Partner Tools and Resources	○ ○

STEP 1: COMMIT
Become a Care Partner Hospital

Process steps	Options/ideas	In place Yes | No
Physician and staff education	Continue immersion process and begin formal education of all staff on the roles/ responsibilities of a care partner and how to engage and work with patients and their care partners by:	
	• implementing an orientation program for key staff (nursing, physicians, unit staff, admitting, ED, clinical ancillary areas and all other necessary medical staff);	○ ○
	• using EQIC or hospital-specific tools and resources to develop an educational plan and talking points for staff;	○ ○
	• including information on the care partner program in hospital newsletters;	○ ○
	• communicating program goals through lock screen images and other media tools;	○ ○
	• providing ongoing educational updates;	○ ○
	• mentoring staff or instituting a formal mentoring program (may be a spread strategy);	○ ○
	• integrating care partner program promotion with that of other relationship development or patient-centric programs; and	○ ○
	• once fully established, conduct annual education to develop competencies on the following key elements:	○ ○
	◦ care partner interactions and management;	○ ○
	◦ teach-back method;	○ ○
	◦ bedside rounds;	○ ○
	◦ bedside shift report; and	○ ○
	◦ active inquiry.	○ ○
Broadly promote the care partner role (ongoing immersion)	• Display posters and pamphlets in the emergency department, admitting, hallways and hospital units promoting the care partner role. In addition to any materials developed by the hospital, other materials that can be used include the following EQIC tools and resources:	○ ○
	◦ What is a Care Partner? brochure	○ ○
	◦ Care Partner poster	○ ○
	◦ Video: Importance of a Care Partner Program	○ ○
	• Advertise using various media to the public highlighting the hospital's commitment to engaging care partners.	○ ○
	• Host community education programs.	○ ○
	• Add care partner programming to patient television channel.	○ ○
	• Long term, introduce the program to continuum of care partners.	○ ○

STEP 1: COMMIT
Become a Care Partner Hospital

Process steps	Options/ideas	In place Yes | No
Continuously evaluate and improve the care partner program	• Continue to conduct ongoing PDSA cycles to hard-wire the program integrity and reliability.	○ ○
	• Identify interim and ongoing measures to monitor and evaluate success of the program. See the *EQIC Care Partner Program Implementation Guide* for sample measures.	○ ○
	• Regularly share results with frontline unit staff and physicians.	○ ○
	• Maintain an active care partner hospital team to monitor selected measures and ensure sustainability. Celebrate target improvement in HCAHPS scores and readmission rates.	○ ○
	• Once sustained, consider the adoption of a care partner program as a marketing tool for your hospital.	○ ○

STEP 2: IDENTIFY:
Patients choose their care partner

Process steps	Options/ideas	In place Yes | No
Support the patient to designate a qualified care partner	Develop a workflow and processes that support the patient's identification and designation of a care partner as early in the care as possible by doing the following:	
	• Designate specific staff to ask the patient to identify a care partner on admission to hospital (i.e., admissions, ED, unit clerk, champion nurse per shift, primary nurse, etc.).	○ ○
	• Build in redundancy in identifying the care partner; if not obtained by first designated staff, determine who will ask the patient next.	○ ○
	• Identify proxy care partner under special conditions (consider working out relationship with home care, county adult services, primary care office, etc.)	○ ○
	• Educate staff on how to obtain care partner information. Identify and provide a location on the unit to access material that includes:	○ ○
	◦ care partner definition; and	○ ○
	◦ care partner roles and responsibilities.	○ ○
	• Develop a script for staff for obtaining care partner identification from patient.	○ ○
	• Ensure written materials and media describing what it means to be a care partner are available to the above designated staff to provide to patients. Such materials might include:	○ ○
	◦ EQIC What is a Care Partner? Brochure	○ ○
	◦ My Care Transition Plan Brochure	○ ○
	◦ information on patient television channel.	○ ○
	◦ Care Partner Poster	○ ○
	• Ensure the medical team is aware of the patient's designated care partner, especially if they are not present. Ask during rounds, "Who is the patient's care partner? Is the care partner aware of the treatment plan?"	○ ○
	• Use unit-based and hospital champions for ongoing support. (Can begin now if not previously established).	○ ○

STEP 2: IDENTIFY:
Patients choose their care partner

Process steps	Options/ideas	In place Yes	No
Introduce the care partner to the medical team	• Once the patient identifies a care partner, ensure the care partner's information is documented in a designated place within the electronic medical record.	○	○
	• Clearly display care partner's name and contact information in highly visible areas:	○	○
	• utilize whiteboards, medical team rounding forms or boards; and	○	○
	• introduce the care partner to the medical team at huddles or rounds to interdisciplinary team members (therapist, nutritionist/dietician, wound care/ certified diabetic educator/specialty nurses, discharge planner, etc.).	○	○
Provide a visual identifier for care partner to wear in the hospital	• Consider care partner identifier such as: • wrist band	○	○
	• badge; or		
	• ID.		

STEP 3: INCLUDE
Care partner is a member of the healthcare team

Process steps	Options/ideas	In place Yes	No
Orient the care partner to the unit environment and routine	• Identify and document the care partner's preferred communication methods (e.g., written, verbal, text, preferred language).	○	○
	• Review the care partner role with the patient and care partner:	○	○
	• Use educational materials such as handouts, promotional items, etc.		
	• EQIC What is a Care Partner? brochure		
	• Document that education was provided.		
	• Ensure exchange of contact information between the team and care partner; ensure it is readily available.	○	○
	• Educate care partner on importance of sharing questions or concerns. Consider *EQIC's My Care Transition Plan* brochure or designated area of white board.	○	○
	• Designate who on the team is responsible for care partner communications.	○	○
	• Establish expectations on the formal frequency of communication from the medical team to the patient and care partner on:	○	○
	• key staff contact person;	○	○
	• daily condition update(s); and	○	○
	• test results and/or changes in plan.	○	○
	• Educate the patient and care partner on how to use the whiteboard or other method as a communication tool for sharing information such as:	○	○
	• care team members;		
	• milestones;		
	• daily goals;		
	• appointments; and		
	• questions and concerns.		
	• Review unit-specific routines and schedules with patient and care partner, including:	○	○
	• meals;	○	○
	• rounding, huddles and shift change reports; and	○	○
	• therapies and or consultations.	○	○
	• Provide a tour of the unit to include and consider care partner access to:	○	○
	• family lounge or resting room;		
	• access to linens; and		
	• location of nutritional items.		

STEP 3: INCLUDE

Care partner is a member of the healthcare team

Process steps	Options/ideas	In place Yes	In place No
Optimize care partner participation	• Issue an invitation for the care partner to participate in rounds and huddles.	○	○
	• Invite the patient and care partner to share questions or concerns during rounds and huddles to ensure both are active participants in care.	○	○
	• Make sure care partners are aware of how to contact the medical team and the patient during the day.	○	○
Invite the care partner to daily patient rounds and bedside huddles	• Include the care partner in discussions about the patient's goals and care plan as part of standard daily workflow:	○	○
	• empower the patient and care partner to share "what matters to them;" and	○	○
	• include EMR documentation of care partner participation in and understanding of daily goals in patient's care plan.	○	○
Involve the care partner in discussions about the patient's care plan	• Establish a schedule for daily care partner updates.	○	○
	• Create a contingency plan if care partner is unable to participate in the daily patient rounds or bedside huddle.	○	○
	• For example: Include the care partner in rounds by phone, or use email, text and phone; consider setting a designated time to communicate changes in care plan etc., with the care partner, depending on their preference (hint: think NICU or pediatrics that have call-in times or a support person designated line).		

STEP 3: INCLUDE
Care partner is a member of the healthcare team

Process steps	Options/ideas	In place Yes	In place No
Empower care partner to perform simple patient care activities	To empower the care partner to assist in patient care, the hospital's healthcare team should:		
	• Educate patients and care partners on the care partner's role to:	○	○
	• assist staff with getting to know the patient as a person;	○	○
	• provide information about home medications and medical history upon admission;	○	○
	• participate in rounds, therapies and education on patient care (inpatient and in preparation for discharge);	○	○
	• participate in readmission risk assessment discussion or interview on admission, etc.;	○	○
	• EQIC Mitigating Risk Factors for Readmission Tool		
	• assist with ensuring the patient can attend follow-up appointments. During the discharge planning process, elicit patient and care partner availability prior to scheduling these appointments;	○	○
	• Consider the *My Care Transition Plan brochure* or similar feedback document from patient and care partner.		
	• Assess, educate and re-assess the care partner's readiness and ability to participate in and perform daily care activities utilizing the teach-back methodology for:	○	○
	• meals;	○	○
	• toileting;	○	○
	• ambulation; and	○	○
	• skin care.	○	○
	• Teach the patient and care partner any advanced treatments or tasks early in the admission to allow for practice time (e.g., teaching on proper technique) if needed for:	○	○
	• medication administration and injections;	○	○
	• wound care;	○	○
	• use of equipment; and	○	○
	• preventing harms, (i.e., infection, falls and pressure injury prevention).	○	○

STEP 4: PREPARE
Care partner is prepared for the next transition

Process steps	Options/ideas	In place Yes	In place No

Assess the care partner's education needs	• Use the Mitigating Risk Factors for Readmission Tool or another tool to identify whether the care partner has any health equity issues, including:
	  • language barriers;
	  • cultural considerations that may impact care;
	  • social determinants;
	  • mental health issues;
	  • comorbidities; or
	  • financial barriers.
		○	○

	• Ensure all education and information provided to the patient or care partner addresses the above identified factors at the level of health literacy the care partner is most comfortable with.	○	○
	• Make necessary internal consults and post-hospital referrals to address issues.	○	○
	• Plan and discuss discharge date with physician staff upon admission. Notify the patient and care partner of planned discharge date 24 to 48 hours in advance.	○	○
Educate the care partner on essential care activities at home	• Through use of teach-back, ensure patient and care partner understand the following in preparation for care transition:	○	○
	• disease and appropriate management;	○	○
	• proper medication administration and storage;	○	○
	• food intake/nutrition and impact on disease;	○	○
	• signs and symptoms of worsening disease and what to do:	○	○
	• how to assist patient in self-management;	○	○
	• who to call;	○	○
	• where to go in case of emergency;	○	○
	• preventing patient harms such as falls, pressure injury or device-related injury;	○	○
	• what equipment, supplies or home care support services are needed;	○	○
	• how to receive and properly utilize equipment, supplies and home care support services required on discharge; and	○	○
	• how to arrange for additional support services post-discharge, if needed.	○	○
Allow the care partner to demonstrate understanding using teach-back	• Ensure post-hospital discharge instructions are provided to the patient and care partner in writing and in language/terminology that can be understood by the patient and care partner and assess understanding of instructions using teach-back.	○	○

STEP 4: PREPARE
Care partner is prepared for the next transition

Process steps	Options/ideas	In place Yes	No
Integrate the patient and care partner into discharge planning	• Address the care partner's concerns (for example, by using the *My Care Transition Plan brochure*).	○	○
	• Gather feedback from the patient and care partner on the patient's readiness for discharge. Document any identified concerns and ensure all issues are addressed by the healthcare team.	○	○
	• Include the patient and care partner in developing and writing discharge instructions.	○	○
Discuss and plan for post-discharge medical care with care partner	• Establish a process for preparing the patient and care partner for the post-discharge follow-up call:	○	○
	• Identify barriers to the follow-up call and implement an alternative plan if needed, such as:	○	○
	• encourage care partner to make appointments themselves prior to discharge, or the hospital sets up follow-up appointments;	○	○
	• set up follow-up hospital call; and	○	○
	• consider calls to both patient and care partner separately.	○	○
	• Conduct the medication reconciliation with the patient and care partner to ensure:	○	○
	• understanding and adherence with medication(s);	○	○
	• ability to obtain medications;	○	○
	• knowledge of medication side-effects; and	○	○
	• questions from patient and care partner are addressed.	○	○
	• Coach the patient and care partner to share information on the follow-up call, including:	○	○
	• unanticipated changes in health status;	○	○
	• questions or issues with medical equipment or supplies (e.g., questions about how to use, or frequency of usage, etc.);	○	○
	• homecare or support services; and	○	○
	• issues or concerns about follow-up appointments.	○	○
	• Ensure processes are in place to address any issues identified during the post-discharge follow-up call.	○	○
	• Provide the discharge summary to primary care or other transitional care provider:	○	○
	• including sending electronic notification and/or EMR connectivity with primary care physician office.	○	○
	• Be sure to share with any necessary transitional care providers such as treating specialty provider, skilled nursing facility, palliative care, hospice and home healthcare.	○	○

Continue care partner implementation process quality improvement until spread (scaled across hospital/system) and sustainability are reasonably achieved.

For detailed recommendations and links to helpful resources, please refer to EQIC's companion document: *Care Partner Program Implementation Guide* available at:
qualityimprovementcollaborative.org/focus_areas/readmissions