EQIC
EASTERN US QUALITY
IMPROVEMENT COLLABORATIVE

Care Partner Program
Implementation Guide

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EQIC is an initiative of the Healthcare Association of New York State in partnership with:

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FOUNDATION FOR HEALTHY COMMUNITIES/NEW HAMPSHIRE HOSPITAL ASSOCIATION

NORTH CAROLINA HEALTHCARE FOUNDATION

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Introduction

The Eastern US Quality Improvement Collaborative was established in 2020 to deliver services for the Centers for Medicare and Medicaid Services' Hospital Quality Improvement Contract to further advance the quality and safety of healthcare provided in hospitals across the region. EQIC is working to achieve the CMS HQIC goal of reducing readmissions and avoidable hospital-acquired conditions using a care partner approach.

Engaging the patient and the care partner during treatment has been shown to help enhance patient care, reduce HACs, improve equity in healthcare delivery and increase patient satisfaction.[1,2,3] A care partner is a family member, friend or caregiver selected by the patient to be a member of the care team. This term can be used interchangeably with "caregiver" as defined by the Caregiver Advise, Record and Enable (CARE) Act.[4] Becoming a care partner hospital will assist the organization in addressing health equity and improve delivery of care across diverse patient populations. Per the Patient and Family Engaged Care: An Essential Element of Health Equity,[3] published by the National Academy of Medicine:

> The time for changing organizations from the inside moving forward with patients and their caregivers as full partners, for creating the inclusive environments that break down the usual siloed and biased care, and for driving a shift toward health equity that lifts health for all is now.

In recognition of the positive impact care partners have on healthcare quality, readmission reduction, resource utilization, patient satisfaction and health equity, EQIC developed this guide to support hospitals in implementing or enhancing a care partner program. The following section describes EQIC's four-step framework and strategies for establishing a care partner program.

The *EQIC Care Partner Program Implementation Guide* supports your hospital's care partner champions, who are leading initiatives to start or enhance a care partner program, and is designed to help hospitals develop and tailor a hospital-specific strategy for a care partner program that will assist in reducing readmissions.

Each chapter contains strategies corresponding to the EQIC Care Partner Framework that hospitals can adapt and use to reduce variation in processes; establish a method for obtaining feedback on care transitions; apply quality improvement principles to identified trends; and gather feedback from patients, families and care partners when a readmission occurs.

Hospital teams can use all the tools and resources within this guide in sequence or as needed. Additionally, teams can modify specific tools that meet the team's quality improvement needs.

For example, teams may choose to review this entire guide of strategies or select tools for use or modification based on specific goals — and then complete EQIC's *Care Partner Program Implementation Checklist* to identify opportunities for improvement.

Care Partner Framework

STEP 1: Commit

- Dedicate a program leader
- Establish a care partner program
- Broadly promote the care partner role
- Continuously evaluate and improve the program

STEP 2: Identify

- Support patient to designate a care partner
- Introduce care partner to the medical team
- Identify a proxy care partner in special circumstances
- Display name and contact information of care partner in highly visible areas
- Provide a visual identifier for care partner to wear in the hospital

STEP 3: Include

- Orient the care partner to the unit environment and routine
- Invite care partner to daily patient rounds and bedside huddles
- Involve care partner in discussions about the patient's care plan
- Empower care partner to perform simple patient care activities

STEP 4: Prepare

- Assess care partner's education needs
- Educate care partner on essential care activities at home
- Allow care partner to demonstrate understanding using teach-back
- Integrate care partner into discharge planning
- Discuss and plan for post-discharge medical care with care partner

Chapter 1

Step 1: Commit

Become a care partner hospital

Processes within this step include:

1.1 Dedicate a program leader

1.2 Establish a care partner program

1.3 Broadly promote the care partner role

1.4 Continuously evaluate and improve the program

Making a commitment to a care partner program is helped by establishing a formalized process that facilitates patient, family and care partner engagement and creates a standard practice for how care is delivered in your organization. Support from hospital leadership, including the chief executive officer, chief operating officer, chief nursing officer and chief medical officer is also beneficial to implementing and enhancing a care partner program.

Implementing a care partner program is a process of building a strong foundation and infrastructure that hardwires an effective delivery model to support a culture of patient and family engagement.

EQIC supports the care partner model because it:

- enhances patient care;
- assists with improving scores in the Hospital Consumer Assessment of Healthcare Providers and System categories for communication, satisfaction and understanding medication;
- improves hospital readmission rates; and
- aligns with your facility's efforts to provide inclusive care and achieve health equity.

1.1 Dedicate a program leader

Leaders make a commitment to patients and care partners by supporting the implementation of a hospital-wide care partner program. Identify an executive sponsor and select a staff person in a senior leadership role to support the project goals and promote and communicate the value of a hospital-wide care partner program. Possible personnel for this role may include:

- chief medical officer;
- chief nursing officer;
- chief operating officer;
- chief quality officer;
- vice president or director of case management; or
- chief patient experience or engagement officer.

If the executive sponsor cannot be the team leader, choose a well-respected leader for this role. Hospitals may want to consider someone from quality improvement as a facilitator in the selection process for a program leader.

The hospital-wide leader should engage collaborators, promote the vision and communicate the value of the care partner program throughout the organization. The leader should continually raise awareness of the opportunity for staff to engage patients and care partners and for members of the community to participate as a care partner.

Helpful tools

Use the following tools for more information on how to select a hospital leader for your project:

- *Care Partner Program Implementation Checklist*
- *Guide to Patient and Family Engagement in Hospital Quality and Safety*
- *Patient-Preferred Practice Primer: Care Partners*

1.2 Establish a care partner program

Convene a multidisciplinary team of key staff and leaders to develop the hospital's care partner program. The multidisciplinary team helps to build the foundation and infrastructure of the care partner program by supporting a culture of patient and family engagement and reducing readmissions.

Creating the care partner team

- Identify unit-level physician and nursing champions.
- Create a multidisciplinary task force, including direct care clinical staff, to promote the program on the units. Include the following personnel:
  - frontline nursing staff;
  - medical staff/hospitalist;
  - case management;
  - patient family advisory council representative;
  - dietician;
  - admission department representative;
  - information technology; and
  - patient or family representative/patient and family advisory council member.

The team members must establish how they will obtain staff input to implement or enhance a care partner program to more effectively engage patients and care partners. Immerse the staff, including physicians, in information about the value of the care partner model. To foster staff engagement:

- consider starting with one or more pilot sites, then spreading these actions:
  - use a multidisciplinary task force with identified unit-level physician, nursing champion, unit clerk and direct care clinical staff to promote the program on the units;
  - schedule routine team meetings;
  - identify roles and responsibilities; and
  - 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. Additionally, define your quality improvement strategy by using:

- Plan-Do-Study-Act;
- Lean-A3; and
- Institute for Healthcare Improvement's Model for Improvement.

Gathering staff input

- Elicit clinical staff and physician input using:
  - focus groups;
  - questionnaires;
  - staff interviews; and/or
  - involvement in the care partner team.
- Work with admitting, ED and nursing on the best process for the unique needs of the hospital.
- Gather feedback and contributions from the PFAC using some of the above methods. Additionally, ensure that the PFAC's role in developing care partner materials and implementation strategy is clearly defined.
  - Review EQIC care partner program details and options.
  - Define the hospital's care partner program; i.e., what do we want the care partner to do? Consider:
    - participating in huddles or rounding;
    - performing simple medical treatment tasks; 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.
- Patients and care partner representatives should also contribute to the development of policies and procedures to help identify and address barriers to engagement.

Setting up the program

- Create a project plan with clear goals, objectives and a defined team.
- Document your project plan and create an action plan.

Helpful tools

These resources provide general information on developing a care partner program:

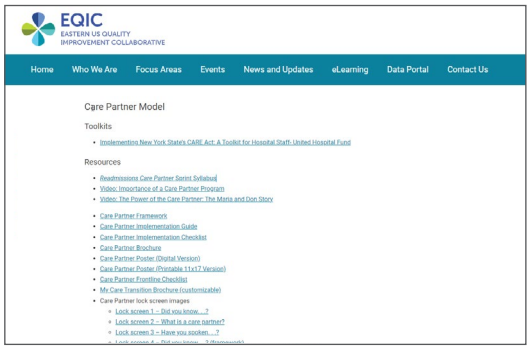
- EQIC Care Partner Tools and Resources
- Institute for Patient- and Family-Centered Care
- *Implementing New York State's CARE Act: a Toolkit for Hospital Staff*
- Connecticut CARE Act
- New Hampshire CARE Act
- West Virginia CARE Act

Sample materials that can be used in development of a care partner program:

- EQIC Care Partner Tools and Resources
- Institute for Patient- and Family-Centered Care Strategies for educating staff

Sample materials to help plan the initiative and create a project plan:

- Idealized Care Partner Engagement Process Map (see below)
- LEAN - A3 Template
- Plan-Do-Study-Act Worksheet



1.3 Broadly promote the care partner role

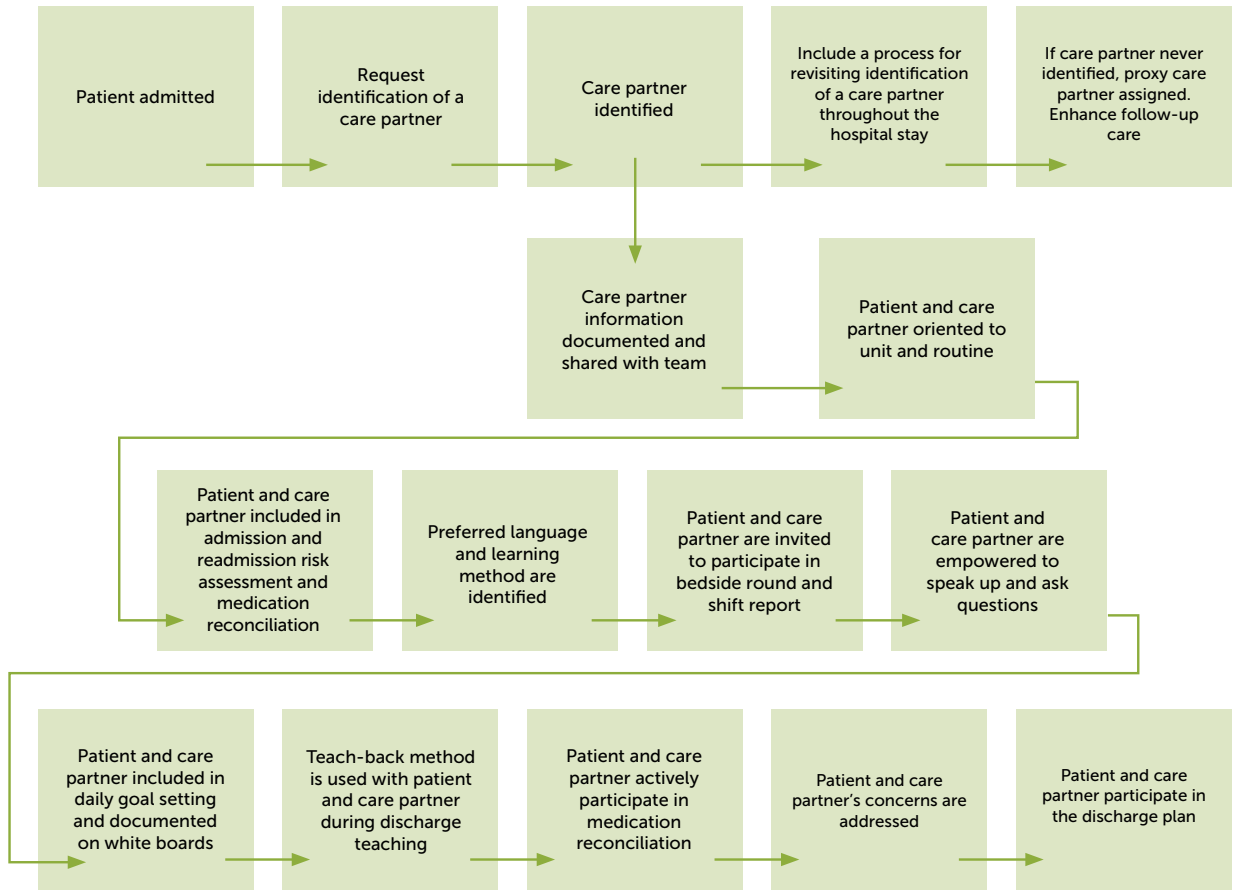
The hospital care partner program team should develop or identify materials that can be used to promote the program and the role of the care partner to staff and patients.

Education for patients

Consider the following strategies to raise awareness of care partner programs in the hospital and community:

- Display posters and pamphlets in the ED, admitting, hallways and hospital units promoting the care partner role.
- Advertise using various media to communicate the hospital's commitment to engaging care partners.
- Host community education programs.
- Add programming to patient television channels on how to select a care partner and how a care partner can participate in patient care.

Idealized care partner engagement process map



- Long term, introduce the program to continuum of care partners. Share stories and positive results from engaging care partners in patient care in newsletters and other hospital updates. Use EQIC, Institute for Patient- and Family-Centered Care and Agency for Healthcare Research and Quality care partner tools to promote the care partner role.

Helpful tools

- EQIC *What is a Care Partner?* brochure
- EQIC Care Partner poster
- EQIC Importance of a Care Partner video
- EQIC *My Care Transition* brochure
- EQIC Care Partner lock screen images:
  - Lock screen 1 – Did you know. . .?
  - Lock screen 2 – What is a care partner?
  - Lock screen 3 – Have you spoken. . .?
  - Lock screen 4 – Did you know. . .? (framework
- CMS Partnership for Patients Community-based Care Transitions Program

Education for staff

Continue the immersion process and begin formal education of all staff on the roles and responsibilities of a care partner and how to engage and work with patients and their care partners. Consider the following strategies:

- Use EQIC tools to develop an education program, plan for training and provide talking points/scripts for staff.
- Include an introduction to the care partner program in your orientation for new staff.
- Ensure there is ongoing education and training opportunities (i.e., by including in annual core competencies) for key staff (nursing, physicians, unit staff, admitting, clinical and ancillary staff). Training should review key techniques to engage patients and care partners, such as:
  - care partner interaction and management;
  - teach-back;
  - bedside rounds;
  - bedside shift reporting;
  - whiteboard use; and
  - active inquiry.
- Utilize unit champions as staff mentors who are a go-to resource on the topic or institute a formal mentoring program.
- Continue to ensure awareness of the program using:
  - communication boards;
  - newsletters; and
  - lock screen images and media tools.

Education should be developed and provided to all staff — including physicians — on the roles and responsibilities of a care partner and how to engage with patients and care partners.

1.4 Continuously evaluate and improve the program

Conduct ongoing PDSA cycles to hardwire the program integrity and reliability. Ensure that the success of the program can be evaluated by identifying and selecting measures that align with team goals and hospital priorities. Sample measures that can be used include:

- percent of patients with a care partner clearly identified in medical record (target of at least 90%);
- readmission rates;
- HCAHPS Measures 20, 21 and 22;[5]
  - *During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my healthcare needs would be when I left;*
  - *When I left the hospital, I had a good understanding of the things I was responsible for in managing my health;*
  - *When I left the hospital, I clearly understood the purpose for taking each of my medications; or*
- custom process measure(s) based on hospital-specific targets:
  - percent of patients with evidence of teach-backs (based on sampling or 100%);
  - percent of patients with evidence of the care partner's participation in discharge planning and instructions (sampling or 100%);
  - percent of patients with evidence of the care partner's participation with any identified disciplines (therapy, nutrition, diabetes education, etc.) (sampling or 100%); or
  - percent of patients and care partners who report satisfaction with the care partner role on the follow-up phone calls.

The team should ensure that performance on the measures is shared with staff, physicians and, if appropriate, patients and care partners. 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

If there are trends or recurrent issues, ensure that you can identify them by:

- tracking and addressing issues with discharge preparation identified by the patient and/or care partner on follow-up calls; and
- conducting readmission interviews with the patient and care partner.

Helpful tool

Sample care partner policy

- Valley Hospital Partners in Care Welcome Policy

Chapter 2

Step 2: Identify

Patients choose their care partner

Processes within this step include:

2.1 Support patient to designate a care partner

2.2 Introduce care partner to the medical team

2.3 Identify a proxy care partner in special circumstances

2.4 Display name and contact information of care partner in highly visible areas

2.5 Provide a visual identifier for care partner to wear in the hospital

2.1 Support patient to designate a care partner

Identifying a care partner requires a thoughtful conversation with the patient and should not be an activity completed just to comply with the CARE Act. Care partners can be family members, friends, neighbors or paid assistants. The care partner should be available to support the patient both during and after the hospital stay.

Choosing a care partner can be a challenge for some patients, so it is critical to build redundancy into this process. A sudden change of environment, the patient's medical condition or hospital activity can become a barrier to making this choice. If a care partner is not identified the first time a patient is asked, the patient should be asked again at different times throughout the hospitalization until a care partner is identified.

Develop a workflow that supports the patient's identification and designation of a care partner as early in the care as possible. Consider implementing one of the following processes to facilitate identification of a care partner:

- Designate a specific staff member (or members) to ask the patient to identify a care partner on admission to hospital (i.e., admissions, emergency department, unit clerk, champion nurse per shift, primary nurse, etc.).
- Designate select hospital staff to receive training on how to obtain care partner information from the patient, understanding that an explanation of what a care partner is and might do during and after the hospital stay may help patients think through the options of people in their life who may fit the role.
- Build in redundancy in identifying the care partner; if a care partner has not been identified by the first designated staff member to ask, determine who will ask the patient next.
- Identify a proxy care partner under special conditions; consider working out relationships 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 education materials including:
  - care partner definition; and
  - care partner roles and responsibilities.
- Develop a script for staff for obtaining care partner identification from patient (see sample script).
- Ensure written materials and media describing what it means to be a care partner are available to the designated staff to provide to patients. Such materials might include those listed on page 5 of this guide.

Sample script for staff to help patient identify a care partner

- *"We have learned that patients do better if they have someone participating in their care in the hospital and helping after you go home. Do you have someone who can help you?"*
- *"Is there someone who helps you at home? Someone who you would like to learn about your situation and can help you while you are here and when you leave the hospital?"*
- *"Is there someone you can identify as a care partner while you are in the hospital and when you go home? This is the person who we will update about your care while you are in the hospital and teach along with you to understand your condition and help get you ready to go home and after you leave the hospital."*

Educate staff on how to support the patient in identifying a care partner

Consider implementing the following processes to support staff assisting the patient in identifying a care partner:

- Ensure written material and media describing how to select a care partner are available for staff to provide to patients.
- Identify unit-based and hospital champions to support staff.
- Designate a place in the electronic medical record for documenting who the identified care partner is and ensure that all staff are aware of where to find that information (see *Chapter 3: Include* for more information).
- 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?"
- Provide staff training on the care partner program and why it is so important for the patient's well-being. Additionally, it can be helpful to note that identification of a care partner is important for compliance with the CARE Act.
- Ensure that once a care partner is identified, there is a standard workflow to provide information to the care partner as well as visual identifiers (see the following sections).

Helpful tools

- *EQIC Care Partner Program Checklist for Frontline Staff*
- *Implementing New York' State's CARE Act: A Toolkit for Hospital Staff*

2.2 Introduce care partner to the medical team

Processes to consider for implementation include:

- Once the patient identifies a care partner, ensure the care partner's information is documented in a designated place within the EMR.
- Introduce the care partner to the medical team at huddles or rounds and to other interdisciplinary team members.
- Ensure the care partner is aware of rounding times and other opportunities to engage with the medical team.

2.3 Identify a proxy care partner in special circumstances

If it becomes clear the patient truly does not have someone to fill this role, they should be considered at high risk for readmission. A patient who does not have a care partner should trigger an automatic referral to discharge planning/case management to identify a proxy care partner in the community. Navigators, home care agencies, health homes, primary care and community support networks are examples of where to locate a care partner if the patient does not have friends or family nearby who can fulfill this role.

2.4 Display name and contact information of care partner in highly visible areas

Clearly display the care partner's name and contact information in highly visible areas such as:

- whiteboards;
- within EMR on highly visible screens; or
- huddle boards or documents.

2.5 Provide a visual identifier for care partner to wear in the hospital

Consider a care partner identifier such as:

- wrist band;
- unique care partner name badge; or
- electronic access ID.

Chapter 3

Step 3: Include

Care partner is a member of the healthcare team

Processes within this step include:

- 3.1 Orient the care partner to the unit environment and routine
- 3.2 Invite care partner to daily patient rounds and bedside huddles
- 3.3 Involve care partner in discussions about the patient's care plan
- 3.4 Empower care partner to perform simple patient care activities

An active care partner is a member of the healthcare team. Communication about and collaboration on the patient's care should be tailored to the patient's health literacy level and cultural considerations.

Preparation for a successful discharge should begin at admission. Educating the patient and care partner on the care they may be expected to continue at home starts on admission and continues throughout the hospital stay. Ensuring the patient and care partner are included in discussions about the patient's goals and care plan and that the care partner helps the medical team to get to know the patient as a person enables the team to provide care that best suits the patient's needs.

Helpful tool

- Successful Discharge Planning Starts at Admission

3.1 Orient the care partner to the unit environment and routine

Care partners should be encouraged to share their preferred language and form of communication (e.g., written, verbal, email or text) with the healthcare team. The care partner should be oriented to the unit environment and routine, which may include:

Medical orientation

- Review care partner role with the patient and care partner; use educational materials such as hand-outs and promotional items (i.e. *What is a Care Partner?* brochure); document that education was provided.
- Ensure exchange of contact information between the team and care partner and that it is readily available.
- Share how to participate in the care of the patient.
- Allow access to a general unit schedule, including when the patient will attend therapy, meals, etc.
- Provide a list of safety tips for the patient (e.g., hand washing, fall precautions);
- Explain how to use the whiteboard or other communication tools for sharing information such as:
  - care team members;
  - milestones;
  - daily goals;
  - appointments; and
  - questions and concerns.
- Introduce and identify team members caring for the patient:
  - Designate who on the team is responsible for care partner communication.
  - Establish expectations on the frequency of formal 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.
- Explain how to communicate concerns or ask questions about the patient's care; consider *My Care Transition* brochure or designated area of the whiteboard.
- Explain how to participate in rounds and bedside shift reports.

Environment orientation

- Review unit-specific routines and schedules with patient and care partner, including:
  - when meals are delivered;
  - when daily rounds, huddles and bedside shift reports occur and where to be to participate in these activities with the medical team; and
  - where and when therapies and/or consultations occur.
- Provide a tour of the unit to include:
  - family lounge or resting room;
  - ice and water on the unit;
  - location of linens and comfort items; and
  - location of nutritional items.
- Consider care partner access to these areas.

3.2 Invite care partner to daily patient rounds and bedside huddles

Optimize care partner participation and ensure they are empowered to engage in and actively contribute to patient rounds and bedside huddles by:

- educating the care partner on the importance of sharing questions or concerns;
- inviting the care partner to participate in rounds and huddles and provide information and tips on how to effectively advocate for the patient;
- encouraging the patient and care partner to share questions or concerns during rounds and huddles; and
- making care partners aware of how to contact the medical team and patient at appropriate times during the day.

If the care partner is unable to make it to rounds, there should be a process in place to share information about the patient's care or decisions made during the rounds with the care partner. Consider use of technology options when the care partner cannot be physically present.

3.3 Involve care partner in discussions about the patient's care plan

Communication is at the center of patient and care partner engagement. Successful communication can only be accomplished through effective listening and information sharing among staff, patients and care partners. Listening to the patient's story, unique preferences and individual needs is vital for promoting continuity across the plan of care.

Ways to ensure that the patient and care partner are involved in discussions about the care plan:

- Include the care partner in discussions about the patient's goals and care plan as part of the standard daily workflow by:
  - providing staff with a script to elicit the patient and care partner's concerns on daily rounds;
  - empowering the patient and care partner to share "what matters" to them; and
  - documenting in the EMR the care partner's participation in and understanding of the daily goals in the patient's care plan.
- Establish a schedule for daily care partner updates.
- Create a contingency plan if the care partner is unable to participate in daily patient rounds or bedside huddles.
  - Include the care partner in rounds by using technology platforms or phone; consider a designated time to communicate changes in care plan, etc., with the care partner, depending on their preferred method of communication. An example is how neonatal ICU or pediatric departments have call-in times or a designated line for support personnel.

Helpful tool

For more ideas on how to effectively engage the patient:

- *Partnering with Patients and Families to Design a Patient- and Family-Centered Health Care System: A Roadmap for the Future: A Work in Progress*

3.4 Empower care partner to perform simple patient care activities

Provide education for the patient and care partner

The hospital's healthcare team can empower the care partner to assist with patient care by educating patients and care partners on their 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 patient care activities such as rounds, therapies and other educational opportunities to learn more about the patient's care needs (inpatient and in preparation for discharge), including:
  - therapies;
  - nutrition;
  - diabetes education;
  - medications; and
  - treatments.

Care partners can assist the patient in remembering medications/treatments or issues the patient may have been having at home that led to hospitalization. It is beneficial that the patient and care partner be included in ensuring the accuracy of information gathered on admission, including:

- medical history;
- medication reconciliation; and
- readmission risk assessment.

Care partners should be encouraged to participate in the readmission risk-assessment discussion or interview on admission, which can be done using the EQIC Mitigating Risk Factors for Readmission Tool. Care partners also can assist with ensuring that the patient is able to attend follow-up appointments and voice when they are available for appointments with the patient if needed, so their availability is accounted for during the discharge planning process. Consider using the *My Care Transition* brochure or a similar feedback document for the patient and care partner to assess and document any issues.

Assess, educate and re-assess the care partner's readiness and ability to participate in care

Ensure the care partner is ready and able to perform daily care activities utilizing the teach-back methodology for:

- meals;
- toileting;
- ambulation;
- skin care; and
- medications and treatments.

Helpful tools

For comprehensive resources on medication reconciliation:

- Agency for Healthcare Research and Quality: Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation
- Making the Transition to Nursing Bedside Shift Reports

Teach the patient and care partner any advanced treatments or tasks early in the admission

Providing education throughout the hospital stay for tasks that may need to be performed upon discharge ensures that there is an opportunity for the patient or care partner to ask questions and practice the technique. Skills or tasks that may need to be taught include:

- how to safely administer medications and give an injection;
- wound care;
- use of equipment and mobility aids; and
- preventing harm (i.e., infection, falls and pressure injury).

Include signs and symptoms to watch for and when to alert the medical team in the education.

Ensure that written materials are provided to the patient and the care partner in addition to verbal instructions and in-person demonstrations during the hospital stay. These materials can be a helpful memory aid for the patient and care partner when they are at home.

Chapter 4

Step 4: Prepare

Care partner is prepared for the next transition

Processes within this step include:

- 4.1 Assess care partner's education needs
- 4.2 Educate care partner on essential care activities at home
- 4.3 Allow care partner to demonstrate understanding using teach-back
- 4.4 Integrate care partner into discharge planning
- 4.5 Discuss and plan for post-discharge medical care with care partner

Planning and preparing the patient and care partner for discharge should begin at admission, with patients, families and care partners participating in initial assessments as well as discharge planning. This level of involvement helps to ensure the patient's preferences are incorporated into the discharge plan and facilitates a smooth transition home or to a skilled nursing facility.[1]

Helpful tools

Additional resources to assist in open communication with the patient and care partner:

- *My Care Transition* brochure
- *Your Discharge Planning Checklist: For patients and their caregivers preparing to leave a hospital, nursing home, or other care setting*
- IDEAL discharge planning overview, process and checklist

4.1 Assess care partner's education needs

Ensure that any information given to the patient and care partner is tailored to their ability to understand and use the information. You can use the EQIC Mitigating Risk Factors for Readmission Tool or another readmission risk 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 at which they are most comfortable. Make necessary internal consults and post-hospital referrals or appointments to address any issues. Plan and discuss an anticipated discharge date with physician staff upon admission and notify the patient and care partner of the planned discharge date 24 to 48 hours in advance.

4.2 Educate care partner on essential care activities at home

Through use of teach-back, ensure the 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 the patient in self-management;
  - who to call; and
  - where to go in case of emergency;
- preventing patient harm such as falls, pressure injury or device-related injury;
- what equipment, supplies or home care support services are needed;
- how to receive and properly use equipment, supplies and home care support services required on discharge; and
- how to arrange for additional support services post-discharge if needed.

4.3 Allow care partner to demonstrate understanding using teach-back

Ensure the care partner understands their role after the patient leaves the hospital. The post-hospital discharge instructions should be provided to the patient and care partner in writing and in language/terminology that can be understood by them. Before discharge, assess the care partner's understanding of the instructions using teach-back.

4.4 Integrate care partner into discharge planning

As previously noted, the patient and care partner should be part of the discharge planning process from admission; this can be accomplished using the following approaches:

- Address the care partner's concerns; for example, by using the *My Care Transition* 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 writing discharge instructions.
- 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 have the hospital set up follow-up appointments; or
    - set up follow-up post-hospital phone calls to both the patient and care partner separately prior to discharge;
  - conduct the medication reconciliation with patient and care partner to ensure:
    - understanding and adherence withmedications;
    - ability to obtain medications;
    - knowledge of medication side-effects; and
    - questions from the 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; and
  - ensure processes are in place to address any issues identified during the post-discharge follow-up call.

If the care partner is unwilling to participate and help the patient with the medical tasks and support desired, an alternative care partner, proxy or formal hired support will be needed.

4.5 Discuss and plan for post-discharge medical care with care partner

Discussions aimed at preparing for discharge and transitioning from hospital to home or the next care provider can more effectively prepare the patient and care partner for what to expect post-discharge. The patient and care partner will need to know and understand what they need to do to help the patient after they leave the hospital. This information should be communicated to the patient and care partner in both verbal and written instructions and should include how to:

- make follow-up appointments with primary and specialty care providers;
- get diagnostic testing;
- receive pending results from in-hospital tests, i.e., patient portal, phone call from hospital team or primary care or specialty provider; and
- determine who specifically will provide treatments, medications, supplies or support, i.e., homecare agency or durable medical equipment/infusion provider.

Additionally, encourage the patient and care partner to make follow-up appointments or have the hospital make follow-up appointments prior to discharge. Provide the discharge summary to primary care or other transitional care provider, including treating specialty provider, skilled nursing facility, palliative care, hospice or home healthcare. Send electronic notification and/or via EMR connectivity with the primary care physician office.

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

Footnotes and references

Footnotes

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