New York State Partnership for Patients

Engaging and Optimizing Care Partners
Implementation Checklist

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WHAT IS THIS TOOL?

A checklist of 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 NYSPFP *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).

CARE PARTNER PROGRAM FRAMEWORK

STEP 1: **COMMIT**

STEP 2: **IDENTIFY**

STEP 3: **INCLUDE**

STEP 4: **PREPARE**

STEP 1: COMMIT

Become a care partner hospital

Process Steps	Options/Ideas	In Place? (Y/N)
Dedicate a program leader	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 • director of patient engagement • director of case management • chief patient experience or engagement officer	
Establish a care partner program	Establish how the team will obtain input to implement or enhance a care partner program to more effectively engage patients and care partners by using the following strategies • Create a multidisciplinary taskforce with identified unit-level physician and nursing champions and direct care clinical staff to promote the program on the units • Define the role of the hospital's patient and family advisory council in the care partner implementation strategy • Conduct patient and care partner focus groups to identify opportunities and barriers to care partner engagement • Solicit staff and physician input on how to effectively engage care partners	
	Educate 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, clinical ancillary areas, and all other necessary medical staff) • Using NYSPFP tools to develop an educational plan and talking points for staff • Including information on the care partner program in hospital newsletters • Communicating program goals through screen savers and other media tools • Providing ongoing educational updates • Mentoring staff or instituting a formal mentoring program • Integrating care partner program promotion with that of other relationship development or patient-centric programs at the hospital	

Process Steps	Options/Ideas	In Place? (Y/N)

Establish a care partner program (continued)	• Conducting annual education to develop competencies on the following key elements:
	  ◦ teach-back method
	  ◦ bedside rounds
	  ◦ bedside shift report
	  ◦ active inquiry	

Broadly promote the care partner role	• Display posters and pamphlets in the emergency department (ED), admitting, hallways, and hospital units promoting the care partner role. Other materials—in addition to any materials developed by the hospital—that can be used include:
	  ◦ NYSPFP *What is a Care Partner?* brochure (https://www.nyspfp.org/Materials/NYSPFP_CarePartner_Brochure.pdf)
	  ◦ NYSPFP Care Partner poster (https://www.nyspfp.org/Materials/NYSPFP_CarePartner_Poster.pdf)
	  ◦ NYSPFP Care Partner Video (https://www.youtube.com/watch?v=I0FJxumvTdg)
	  ◦ NYSPFP Importance of a Care Partner video (https://youtu.be/Poji5nU12oE)
	• Advertise using various media to communicate the hospital's commitment to engaging care partners
	• Host community education programs
	• Add care partner programming to patient television channel
	• Share stories and positive results from engaging care partners in patient care in newsletters and other hospital updates
	• Utilize NYSPFP, Institute for Patient- and Family-Centered Care and Agency for Healthcare Research and Quality care partner tools to promote the care partner role	

Continuously evaluate and improve the care partner program	• Identify measures to monitor and evaluate the success of the program. See the NYSPFP *Care Partners 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	

STEP 2: IDENTIFY

Patients choose their care partner

Process Steps	Options/Ideas	In Place? (Y/N)

Support the patient to designate a qualified care partner	Develop a workflow and processes that support the patient's identification and designation of a qualified care partner 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, admitting nurse per shift, etc.)
	• Build in redundancy in identifying the care partner; if not obtained by first designated staff, determine who will ask the patient next
	• 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:
	  ◦ NYSPFP *What is a Care Partner?* brochure
	  ◦ information on patient television channel
	• Ensure the medical team is aware of the patient's designated care partner, especially if they are not present. During rounds ask, "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	

Introduce the care partner to the medical team
Display name and contact information in highly visible areas
Provide a visual identifier for the care partner to wear in the hospital
	• Once the patient identifies a care partner, ensure the care partner's information is documented in a designated place within the electronic medical record (EMR)
	• Clearly display care partner's name and contact information in highly visible areas:
	  ◦ utilize whiteboards
	  ◦ create name badges to provide a visual identifier for the care partner
	• Introduce the care partner to the medical team at huddles or rounds and to interdisciplinary team members (therapist, nutritionist/dietician, wound care/certified diabetic educator/specialty nurses, discharge planner, etc.)	

STEP 3: INCLUDE

Care partner is a member of the healthcare team

Process Steps	Options/Ideas	In Place? (Y/N)

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. (NYSPFP *What is a Care Partner?* brochure)
	• Ensure exchange of contact information between the team and care partner
	• Establish expectations on frequency of communication from the medical team to the patient and care partner on:
	  ◦ key staff contact person
	  ◦ daily condition update(s)
	  ◦ test results and/or changes in plan
	• Educate the patient and care partner on how to use the whiteboard as a communication tool for sharing information such as:
	  ◦ care team members
	  ◦ milestones
	  ◦ daily goals
	  ◦ appointments
	  ◦ questions and concerns
	• Review unit-specific routines and schedules with patient and care partner, including:
	  ◦ meals
	  ◦ rounding, huddles, and shift-change reports
	  ◦ therapies and/or consultations
	• Provide a tour of the unit to include:
	  ◦ family lounge or resting room
	  ◦ access to linens
	  ◦ location of nutritional items	

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 and education on patient care (inpatient and in preparation for discharge)
	  ◦ participate in readmission risk assessment discussion or interview on admission, etc.	

Process Steps	Options/Ideas	In Place? (Y/N)
Empower care partner to perform simple patient care activities (continued)	• NYSPFP Mitigating Risk Factors for Readmission tool (https://nyspfp.org/Materials/Readmissions_Tracking_tool.pdf) ◦ 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 NYSPFP *My Care Transition Plan* (https://www.nyspfp.org/Materials/Readm_NYSPFPBrochure_8_22_17.pdf) 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 ◦ skin care ◦ preventing harms, (i.e., infection, falls, and pressure injury prevention) • 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	
Invite the care partner to daily patient rounds and bedside huddles Involve the care partner in discussions about the patient's care plan	• 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 • 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" ◦ include EMR documentation of care partner participation in and understanding of daily goals in 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 e-mail, text, and phone to communicate changes in care plan etc., with the care partner, depending on his or her preference	

STEP 4: PREPARE

Care partner is prepared for the next transition step

Process Steps	Options/Ideas	In Place? (Y/N)

Assess the care partner's education needs	• Use the NYSPFP Mitigating Risk Factors for Readmission tool or another tool to identify whether the care partner has any:
	  ◦ language barriers
	  ◦ cultural considerations that may impact care
	  ◦ social determinants
	  ◦ mental health issues
	  ◦ comorbidities
	  ◦ 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	

Educate the care partner on essential care activities at home
 	
Allow the care partner to demonstrate understanding using teach-back
	• 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
	  ◦ 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
	  ◦ how to arrange for additional support services post-discharge, if needed
	• 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	

Process Steps	Options/Ideas	In Place? (Y/N)

Integrate the patient and care partner into discharge planning	• Address the care partner's concerns (for example, by using the NYSPFP *My Care Transition Plan* brochure)
	• Gather feedback from the patient and care partner on the patient's readiness for discharge and document to ensure that the healthcare team knows about any identified issues and will address them
	• 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:
	  ▪ care partner call-in program versus hospital-driven follow-up call
	  ▪ 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
	  ▪ 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
	  ▪ 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:
	  ◦ verbal hand-off
	  ◦ sending electronic notification and/or EMR connectivity with primary care physician office	

For detailed recommendations and links to helpful resources, please refer to NYSPFP's companion document, *Care Partner Program Implementation Guide,* available at www.nyspfp.org.