

SCREENING PRACTICES TO IMPROVE PATIENT AND FAMILY ENGAGEMENT:

5 WAYS HOSPITALS PRIORITIZE FAMILY CAREGIVERS WHO NEED EXTRA SUPPORT

ABOUT THE SERIES

Supporting Family Caregivers Providing Complex Care

The Caregiver Advise, Record, Enable (CARE) Act is now law in more than 40 states and territories. Policy makers recognize that family caregivers need support to perform the medical/nursing tasks they face at home after a family member or friend is discharged from the hospital.

The landmark 2012 AARP and United Hospital Fund report *Home Alone: Family Caregivers Providing Complex Chronic Care*, funded by The John A. Hartford Foundation, drove rapid adoption of the CARE Act. The report also inspired the creation of the Home Alone AllianceSM, a partnership of public, private, and nonprofit US organizations coming together to change the way health care organizations and professionals interact with family caregivers.

Home Alone Alliance members are conducting a national CARE Act implementation scan to identify promising practices in hospitals and ways to overcome barriers. Some practices involve applying proven strategies to empower a new audience—family caregivers. Ten major themes emerged and provide a glimpse into the value and complexity of CARE Act implementation.

The Supporting Family Caregivers Providing Complex Care series includes 10 papers that highlight these themes. The series also features Promising Practice papers that provide specifics on a single practice in one health care system and Spotlight papers that describe innovative state efforts to promote change or a health care system that is implementing multiple practices simultaneously. See www.aarp.org/nolongeralone.

These early snapshots from the field share insights about how hospitals are supporting family caregivers and open a dialogue among leaders involved in enhancing health care delivery. These early observations ultimately could inform practice recommendations.

Overview

Some family caregivers require considerably more support than others to provide safe, effective care at home after a friend or family member's discharge. Identifying these family caregivers in the hospital is an important element of care planning.

The family caregivers who need deeper guidance and support include people caring for a patient at high risk for postdischarge complications and those struggling with literacy; meeting basic needs; or managing their own physical, mental, or behavioral health issues.

To identify and prioritize family caregivers who need extra help, hospitals implement strategic screening practices, such as the following:

- **Using patient risk stratification tools to help predict the likelihood of adverse events, emergency department visits, and readmissions after discharge**
- **Conducting assessments for conditions family caregivers are especially unprepared to handle, like frailty, dementia, deconditioning, and other physical, psychological, and emotional factors**
- **Involving pharmacists when family caregivers will be managing complex medication regimens**
- **Creating new standards, such as assigning a case manager or nurse to each patient and having nurses continuously assess for safety and home conditions**
- **Establishing defined triggers for involving social work and engaging community-based organizations for ongoing postdischarge family caregiver empowerment, education, and support**

Some supports were in place before the CARE Act and changes simply facilitate consistency across an organization. Some supports are new. Innovations are small and large. In one geographic area, multiple separate health care systems partner to share and scale successful practices that help coordinate care among area hospitals, home health agencies, skilled nursing facilities, and home.

Emerging Themes of the *Supporting Family Caregivers Providing Complex Care* Publication Series

➔ Screening practices

- Learning resources for family caregivers
- Staff training
- Communication practices
- EHR supports to identify and include family caregivers
- Transition in care programs and postdischarge support
- Approaches to making practice and system changes
- Pharmacy innovations
- Addressing needs of specific populations
- Benefits of the CARE Act

Identifying Themes from Hospital Visits

To learn how hospitals are supporting family caregivers after CARE Act implementation, we assembled a research team of Home Alone Alliance and AARP Public Policy Institute leaders, nurse researchers, and policy experts to design and conduct site visits to hospitals across the country. This work was funded in part by The John A. Hartford Foundation, the Ralph C. Wilson, Jr. Foundation, and AARP.

The research team has visited dozens of health systems and hospitals in Arkansas, California, Colorado, Illinois, Michigan, Nebraska, Nevada, New Jersey, New York, Virginia, and West Virginia. We typically meet with leaders and staff from at least two health systems per state and two to three hospitals per system. The team visits a variety of types of hospitals: nonprofit, for-profit, and government hospitals; academic health centers; midsize suburban systems; critical access hospitals in rural communities; and level I through V trauma centers.

Participant informants include chief nursing officers, chief technology officers, service and unit managers, patient experience leaders, quality champions, administrators, educators, front-line nurses, physicians, electronic health record (EHR) leaders, and staff from areas such as clinical and social services, accountable care organizations, pharmacy, registration, and admissions. We consult individuals from family advisory councils, community-based

organizations, AARP state offices, consumer advocacy organizations, professional groups, and state hospital associations. We conduct focus groups with family caregivers who have had a recent experience with a particular hospital or system. Interviews are recorded and then analyzed, identifying common themes and novel approaches.

The intention of the [*Supporting Family Caregivers Providing Complex Care*](#) series is to describe the experiences of those making changes that align with the CARE Act. These early snapshots from the field describe the highlights of supports in place for family caregivers who provide complex care at home to a family member or friend after discharge from the hospital. The series opens a dialogue among health care leaders with a wide variety of perspectives. The papers share insights and could form the basis for future recommendations about supporting family caregivers.

The Need

Many Family Caregivers Need Extra Guidance and Ongoing Support

To provide safe care at home, family caregivers must understand how to implement the discharge care plan. More than half do not receive instruction about the care they are expected to manage at home; more and/or better instruction is the most common response from family caregivers when asked what would make it easier for them to manage care.¹

Hospital staff must provide the guidance family caregivers need to ensure optimal outcomes. The depth of that guidance and instruction must align with the severity and number of comorbidities of the care recipient as well as the family caregiver's situation, willingness, availability, knowledge, and confidence. Providing the level of guidance family caregivers need and delivering it in ways that work for them can make all the difference to the care recipient's recovery.

Patient and family caregiver risk factors that drive the need for an especially deep level of family caregiver support include, but are not limited to, those listed below. For many family caregivers, all of these factors apply. Screening for these risk factors is the first step to addressing them.

Patient and Family Caregiver Risk Factors

- **Severity and number of conditions**—The more acute and complex the overall condition of the care recipient,

the more knowledge, skill, and confidence the family caregiver needs. For example, someone who is caring for an older adult with heart disease, diabetes, neuropathy, and a long recovery period from a major surgery needs substantial guidance and instruction in the hospital and support for an extended time after discharge.

- **Frailty**—Family caregivers who care for frail older adults require additional awareness about fall prevention, medication toxicity, and a host of other facets of aging.
- **Practical and safety considerations**—Many families struggle to meet basic needs like food, housing, and child care. Adding family caregiving responsibilities creates further turmoil, which undermines preparations for caregiving. Unemployment, low wages, and long work hours create barriers to obtaining medications, durable medical equipment, and disposable medical supplies—items that are necessary for safe care. Many family caregivers even struggle to arrange safe transportation for the care recipient to get home from the hospital. In some rural areas, public transportation and internet service are not available at all.
- **Cultural and language differences**—When family caregivers receive instruction that is not in their primary language, their understanding is reduced, even with an interpreter. Instruction that clashes with their cultural norms slows understanding while they process how or whether the information can fit with their culture and values. Social isolation compounds these issues. Multicultural family caregivers have fewer social connections compared with White caregivers; Black/African American caregivers are most at risk of being socially isolated and less satisfied with the quality of their social relationships.²
- **Level of education**—Family caregivers who cannot read or have had less practice or success in learning new information will experience difficulty learning the large amounts of complex information family caregivers become responsible for knowing. Language barriers intensify such issues.
- **Level of health literacy**—Health literacy is the ability to obtain, read, understand, and use health care information to make appropriate health decisions and follow instructions for treatment. Family caregivers who do not have experience managing health issues and interacting with the health care system face barriers to learning and need appropriate pacing to build basic caregiving skills and confidence without being overwhelmed.

- **Mental preparation for caregiving**—Those who have not anticipated becoming a family caregiver must cope with the shock and worry of a medical crisis as well as the enormous lifestyle change that intense family caregiving entails. Emotional turmoil makes it very difficult to learn and retain the myriad practical and financial aspects of handling new medical/nursing tasks.
- **Deep-seated anxiety about providing hands-on care**—Performing medical/nursing tasks for a family member or friend makes many family caregivers feel extremely uncomfortable and overwhelmed. These individuals need help getting accustomed to the idea of handling complex care activities like changing urinary catheters and wound bandages, administering tube feedings, and injecting medications.
- **Fear of making a mistake**—Family caregivers, especially those not mentally prepared for the role, justifiably worry about making a mistake that will harm the care recipient or even lead to death. Multicultural family caregivers are more likely to experience strain and worry about making a mistake, regardless of income.³

For more information on the importance of identifying family caregivers, see [*Communication Practices to Improve Patient and Family Engagement: 10 Ways to Identify and Engage Family Caregivers*](#) in this publication series.

COVID-19 Complicates the Need

With the many unknowns about COVID-19 (severe acute respiratory syndrome coronavirus 2), it is especially important for family caregivers who are caring for someone who has COVID-19 to understand their role. They must recognize the importance of isolating the person from the rest of the household for the recommended quarantine or isolation period. They also need information about recognizing potential warning signals about side effects and complications of the virus, including worsening symptoms and when to call for help, medication issues, and other conditions during and after a hospitalization for COVID-19.

Family caregivers should be aware of over-the-counter medications to take and avoid and how to differentiate symptoms and warning signs that may be related to COVID-19 from those related to other conditions and medications.

This level of responsibility, and therefore the need for support, increases significantly for family caregivers who are caring for older adults; people with physical, cognitive,

and behavioral health issues; or other individuals at high risk for serious complications from and long-term effects of COVID-19. The need for guidance also increases when family caregivers themselves are struggling with any of those risk factors.

Interventions Must Reflect Family Caregiver Diversity

Family caregivers are diverse and multigenerational. Family caregiving is an issue for men and women in all racial and ethnic groups and across the lifespan. Different

age cohorts face distinct challenges for their life stage. One in four US family caregivers handling medical/nursing tasks at home is a millennial—the most diverse caregiving generation.⁴ Interventions to meet the varied needs for support and guidance must be diverse and flexible.⁵ Assessing all family caregivers helps reduce social disparities by tailoring family caregiver preparation and structuring interventions to fit each family's needs.

An opportunity exists to develop a comprehensive multidimensional measure that captures the complexity of care and where caregivers are in the caregiving journey.⁶

Interrelated Barriers: A Vignette

The following example illustrates some of the issues facing family caregivers who need an especially deep level of guidance and support to help a family member or friend after discharge from the hospital. The promising practices shared in this paper can help address those issues.



Example: Naomi is hospitalized after having a stroke and wounding her head in a related fall. She and her husband, Marcos, do not have a car, so a friend drives Marcos to the hospital at discharge to bring Naomi home. Marcos receives a packet of information in English, but even in his native language his literacy level is very low. He listens carefully to the instructions from Naomi's nurse, but he has a hard time understanding them. He does not wait for an interpreter or clarification because the friend who drove him is waiting impatiently in the car and they live 30 minutes away.

The discharge instructions recommend a rehabilitation facility for Naomi, but she does not qualify for Medicare or Medicaid and cannot afford to pay out of pocket. They cannot even afford the medications listed in the discharge instructions. Because Marcos has never interacted with the health care system in a hospital setting, he does not know that resources and less expensive medications may be available and that he could ask for help.

Marcos is overwhelmed because Naomi needs around-the-clock care, he will not get paid if he does not work,

and he is not even capable of providing the care Naomi needs. But he does not want to be seen as vulnerable, so he tells a nurse they are all set to leave the hospital.



Repercussions: Naomi was readmitted to the hospital days later after another fall. Missing medications and lack of basic care contributed to Naomi's fall during a bathroom transfer, which was especially difficult because Marcos and Naomi are overweight and not physically strong.



Opportunity: The hospital could screen for family caregiver readiness at admission. Staff could arrange transportation for Marcos to visit throughout the hospital stay for guidance and instruction. At each visit, nurses could use the teach-back instructional method, with an interpreter if needed, to ensure understanding of how to perform medical/nursing tasks. A case manager or social worker could explore how care would be managed at home, identify potential resources, and assist Marcos in considering his options.

Marcos would feel prepared to manage the situation, know how to arrange help for when he is at work, and perform transfers safely. He would get the medications Naomi needs and know the warning signs of complications. Marcos would feel empowered to take action and respond appropriately before Naomi develops a problem that results in readmission. Marcos and Naomi would have a better experience and less disruption of their lives.

5 Highlighted Practices

Ways Hospitals Identify and Prioritize Family Caregivers Who Need Deeper Levels of Support

Health care systems use a variety of screening practices to identify and prioritize family caregivers who need an especially deep level of support. Highlighted practices from our ongoing national CARE Act implementation scan include the activities listed below. Hospital leaders use one or a combination of these practices.

1 Using EHR-based stratification tools

Health care systems use patient risk stratification tools to help predict the likelihood of adverse events, emergency department visits, and readmissions after discharge, and then use the results to identify and prioritize additional support for family caregivers of individuals with high-risk conditions.

One hospital discharges high-risk patients through a dedicated discharge suite. The staff identify and provide extra support for the family caregivers who will manage medications and provide care at home for those individuals. For additional details about supporting family caregivers during care transitions, see [*Transitions in Care and Hospital Discharge Practices to Improve Patient and Family Engagement: 16 Ways to Prepare Family Caregivers*](#) in this publication series.

2 Conducting assessments

Hospitals assess patients to detect conditions that can be difficult to identify, like frailty, dementia, deconditioning, and those related to mental and behavioral health. Family caregivers are often especially unprepared to handle these conditions, so hospital staff focus additional attention on those caring for individuals with these conditions.

One health care system uses a frailty tool designed specifically for use in the emergency department. A nurse manager then performs rounds on patients identified as needing additional attention and talks with family caregivers to assess their readiness.

At another hospital, case managers assess every patient automatically as part of the standard care process to determine and provide the appropriate level of family caregiver support. For example, they can identify, prioritize, and address situations such as unreliable electricity at home, which causes a safety issue related to medications that require refrigeration.

Another example is intervening when family dynamics that include abuse or neglect prevent safe care delivery at home. Some families need support when making decisions for a care recipient who is nearing the end of life.

3 Involving pharmacists

Many hospitals arrange for staff pharmacists to meet with family caregivers who will be managing certain medications. Some health care systems employ pharmacists specifically for this purpose. They also often advise family caregivers about issues relevant to older adults. These concerns include medications older adults should potentially avoid because they can increase the risk of falls and create medication toxicity by being metabolized differently in older adults. Pharmacists also conduct medication reconciliations to eliminate medication duplications and gaps as well as avert and address adverse side effects.

For additional details about equipping family caregivers to manage medications, see [*Pharmacy Innovations to Improve Patient and Family Engagement: 10 Ways Hospitals Help Family Caregivers Prepare to Manage Medications*](#) in this publication series.

4 Enhancing care coordination and continuity of care

Hospitals create new standards to enhance continuity of care, which allows staff members to get to know family caregivers and assess their readiness. Nurses can then prioritize family caregivers who need the most guidance and support and bring in a social worker or case manager as needed.

One health care system assigns a specific nurse to care for and follow a patient over the course of the hospital stay. The nurses continuously assess for safety and home conditions and contact the social

work department as appropriate for additional or postdischarge support.

Another hospital automatically assigns a specific case manager to each floor for continuity throughout the hospital experience and even after discharge. This means clinicians do not need to write an order to obtain case management support, which saves time for all involved and streamlines the overall workflow of case management involvement.

A care transitions program at one health care system includes postdischarge home visits by a nurse practitioner.

5 Establishing triggers to involve a social worker

Some health care systems establish specific points in the workflow when nurses can signal the need for social work involvement. Social workers can then assess family caregiver readiness and engage community-based organizations for ongoing postdischarge family caregiver empowerment, education, and support.

One trigger is an EHR-based health literacy screening tool nurses can use to alert the social work department that a patient or family caregiver needs nonclinical support or might face challenges in the family caregiver role.

One accountable care organization gives family caregivers a phone number at discharge to reach a social worker from home.

Quantifying the Benefits

Benefits of Identifying and Including Family Caregivers

For Organizations and Staff

- **Preventing discharge delays**—Instructing family caregivers helps hospital staff avoid discharge delays. Staff can provide and reinforce information gradually throughout the hospital stay rather than deliver large quantities of information to distracted family caregivers during the flurry of discharge activity. Staff can also better coordinate discharge scheduling when family

caregivers understand the process and are prepared to arrive at the hospital at the time of discharge.

- **Streamlining staff communication with family members**—Family caregivers can relay information to other family members and friends, saving hospital staff the time and energy spent repeating the same information to multiple individuals. When families are uncertain about who is the most suitable person to serve as the primary family caregiver, offering time for families to come to consensus is helpful. Allowing extra time also helps when large families want to divide caregiving tasks among multiple individuals.
- **Improving quality by taking advantage of the knowledge family caregivers have about the person receiving care**—During live learning opportunities, family caregivers can share relevant details about the hospitalized person's goals, values, fears, preferences, and responses to treatment. That information helps inform care plans and improve the quality and safety of care. Family caregivers can also bring to the staff's attention subtle changes in the patient that signal a need for intervention and provide additional context that can affect decisions about care. Having information about unique circumstances such as social determinants of health, known medication side effects, delirium, dementia, and substance use can be vital in developing a successful care plan.
- **Instructing the right person in postdischarge care**—By correctly identifying the person or people who will be helping at home, hospital staff can focus their efforts appropriately. It is vital to ask who will serve as the primary family caregiver because staff may not ever encounter that individual in the hospital room. It is also important to let families know they should inform the hospital staff if someone else becomes the primary family caregiver.

For Families

- **Detecting complications early to prevent problems that can lead to readmissions**—Qualitative data indicate that discharged patients may be less likely to have a complication at home that interferes with their recovery or requires an emergency department visit or hospital readmission when staff across roles and shifts

assess family caregivers and fully prepare them for the care they will be providing. When family caregivers understand how to identify a potential complication early, they can seek help before the problem requires treatment in the hospital setting.

- **Decreasing family caregiver emotional, practical, and financial strain**—Family caregivers who are adequately prepared to provide care at home can experience reduced strain and disruption of daily life during and after a family member's hospital stay. They are better equipped to manage complex medical/nursing tasks and pain, which is a major issue that carries an emotional as well as practical and sometimes financial strain.⁷

When family caregivers understand what to do and expect and how to look for potential complications, they have increased confidence and attentiveness. Good preparation allows them to focus at home on providing emotional support to the care recipient and to address the impact of caregiving on their own health and well-being. Good preparation also gives care recipients confidence in the family caregivers.

- **Facilitating continuity of care**—A designated primary family caregiver with a good understanding of the care he or she will be providing at home can serve as the main point of contact to ensure continuity of care before, during, and after a hospital stay. The hospitalized individual may move to a skilled nursing or assisted-living facility or—more commonly—back home or to a family member's home. Continuity of care during all transitions within and outside the hospital helps ensure medication reconciliation and accurate and complete communication of patient-specific details, including values and preferences, and prevents care and communication gaps, errors, and omissions.
- **Arranging appropriate support at home to foster a successful recovery**—By having early and ongoing conversations about care for the patient after discharge, staff and family caregivers can collaborate to determine what will be needed and arrange for adequate instructions, supplies, and equipment necessary to manage medical/nursing tasks at home and any further help that may be required. Staff can provide referrals

to community resources that support the plan for postdischarge care.

- **Supporting independent living**—Because a person's ability to continue living independently can depend on the care he or she receives following hospital discharge, it is particularly important for staff to collaborate with family caregivers who will help people with special needs or older adults at home. It is also helpful for hospital staff to know if the person receiving care will have a temporary stay at another facility, such as a rehabilitation center, so they can provide information that will facilitate transitions to and from that setting.

What Does Success Look Like?

During site visits with health care organizations that are implementing changes to include family caregivers in the care process, we examined the impact of the enhancements. Although hospitals use scorecards and track many metrics, there wasn't universal identification of the direct link of family caregiver engagement with improvements in complication rates, emergency department visits, readmissions, follow-up inbound and outbound phone calls, and patient satisfaction.

An opportunity exists to set up a scorecard that monitors key metrics over time with a special emphasis on linking family caregiver interventions to specific outcomes. Health systems can consider tracking and trending data by unit and department to measure the impact of including family caregivers throughout the hospital stay.

Ultimately, the best measure of success is the experience of the family caregiver and whether they feel included, heard, confident, and prepared to go home for the next phase of care.

Overcoming Perceived Barriers

Resolving Challenges to Identifying and Prioritizing the Screening of Family Caregivers

Some approaches to screening family caregivers will work for some hospitals but not others, for various reasons. Leaders work with their organizational structure and culture to discover which approaches may be the most effective for their teams.

Initial reactions to the provisions of the CARE Act by hospital leaders and staff during site interviews generally include concerns that ultimately diminish.



Challenge: Lack of necessity—“We already do what the CARE Act requires.”



Resolution: Attention to the requirements of the CARE Act helps hospitals recognize the need to standardize their identification and support of family caregivers. Initial concerns diminish when clinicians hear poignant personal stories about the existing gap between the information family caregivers facing extra challenges receive at hospital discharge and the care they need to provide at home. Listening to patient stories during patient and family advisory council meetings or in focus groups of community members reinforces the need for staff to consistently identify and provide detailed information to family caregivers. Content from the AARP *Home Alone* report creates additional awareness of process gaps.⁸



Challenge: There are not enough resources to provide the ideal level of support to every family caregiver.



Resolution: Hospitals increasingly innovate to provide instruction to support family caregivers and prevent complications that result in the readmission of those receiving care. Some develop close working relationships or partnerships with community-based organizations to put supports in place during the hospital stay and afterward.



Challenge: Family caregivers often cannot process information well enough in the hospital setting for myriad reasons.



Resolution: Physicians can prescribe home health support so patients and family caregivers get skilled nursing instruction at home shortly after discharge. This path is particularly helpful for patients with Medicare and/or Medicaid, who may receive the skilled nursing support at home at no charge.



Challenge: Some patients simply do not have an individual who can fill the role of family caregiver or are unable to name a family caregiver because they have dementia or are unconscious.



Resolution: At many hospitals, a nurse can select an EHR option such as “Patient declined” or “Unable to respond” on a documentation screen. The case management or social work department automatically receives a request for a consult.

Additional Information

Implications of COVID-19

The COVID-19 pandemic has intensified the importance of identifying and engaging family caregivers. Strict visitor policies have hampered the ability of family caregivers to be part of the hospital experience and be available to support their family member and participate in care. Limited face-to-face interaction between hospital staff and family caregivers hinders communication about contextual

details and decision support—creating challenges for staff members to maintain care quality and for family caregivers to obtain guidance and instruction on postdischarge care.

Innovations are emerging to foster communication and support caregivers in new ways through technology. The timely launch of the [Supporting Family Caregivers Providing Complex Care](#) publication series highlights a wide variety of promising practices in family caregiver support just when they are most urgently needed.

Helpful Resources

The CARE Act

The name of the law and its specific provisions vary by state, but CARE Act legislation generally requires that hospitals do the following to support family caregivers:

- Advise individuals in the hospital of their opportunity to identify a family caregiver.
- Record the caregiver's name and contact information in the health record (with the patient's permission).
- Enable family caregivers by providing as much notice as possible about discharge timing, consulting with them about the discharge plan, discussing their role in carrying out that plan, and instructing them on the medical/nursing tasks they will handle at home.

See the [CARE Act map](#), which shows more than 40 states that have passed the legislation.

Researcher Contact Information for Health System Leaders

The Home Alone Alliance and AARP Public Policy Institute leaders, nurse researchers, and policy experts continue to conduct the national scan of hospitals that have implemented the CARE Act and will share further results of that work. We welcome the opportunity to discuss findings with health system leaders to facilitate the culture change involved in fundamentally integrating family caregivers into existing hospital practices. To contact us, please email homealonealliance@aarp.org.

Free Video Demonstrations of Medical/Nursing Tasks for Family Caregivers

How-to videos and printable resource guides created specifically for family caregivers show how to manage specific tasks related to wound care, mobility, managing medications, preparing special diets, and handling incontinence. These resources, many of which are available in both English and Spanish, are free of charge to all. Visit aarp.org/nolongeralone.

Related Publications for Professionals, Clinicians, and Policy Makers

To see details and data about the 20 million family caregivers in the United States who perform medical/nursing tasks and

worry about making a mistake, see [Home Alone Revisited: Family Caregivers Providing Complex Care](#), a 2019 special research report by the founding partners of the [Home Alone Alliance](#)SM, a collaborative of AARP, and funded by The John A. Hartford Foundation.⁹

The [Supporting Family Caregivers Providing Complex Care](#) series of publications is based in part on insights in *Home Alone Revisited* and [The Care Act Implementation: Progress and Promise](#), a 2019 AARP Public Policy Institute Spotlight report.^{10,11}

The [American Journal of Nursing](#) (AJN) publishes award-winning evidence-based, peer-reviewed articles and videos that teach clinicians how to best support family caregivers. AJN also disseminates the work of the Home Alone Alliance to nurses through editorials, podcasts, and social media content. Home Alone Alliance articles approved for continuing education credit are funded by AARP, The John A. Hartford Foundation, the Retirement Research Foundation on Aging, and the Ralph C. Wilson, Jr. Foundation.

The [National League for Nursing](#) (NLN) offers simulation modules nurse educators can use at no cost to teach students about the individualized needs of family caregivers. The Advancing Care Excellence for Caregivers (ACE.C) program was developed with generous funding from The John A. Hartford Foundation and the AARP Foundation.

Additional Theme Papers in This Series

- [Learning Resources and Practices to Improve Patient and Family Engagement: 12 Ways to Facilitate Family Caregiver Education in Hospitals](#) (PDF)
- [Staff Training Practices to Improve Patient and Family Engagement: 16 Ways to Include Family Caregivers and Prevent Discharge Delays](#) (PDF)
- [Electronic Health Record \(EHR\) Practices to Improve Patient and Family Engagement: 9 Ways to Help Staff Access Data on Family Caregiver Discharge Preparation](#) (PDF)

Publications in the *Supporting Family Caregivers Providing Complex Care* series are available at www.aarp.org/nolongeralone. For more information about the CARE Act, visit the AARP Public Policy Institute website or <https://states.aarp.org/tag/the-care-act>. To learn more about the Home Alone Alliance, visit www.aarp.org/nolongeralone.

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¹⁻³ Susan C. Reinhard et al., *Home Alone Revisited: Family Caregivers Providing Complex Care* (Washington, DC: Home Alone Alliance, 2019), <https://www.aarp.org/ppi/info-2018/home-alone-family-caregivers-providing-complex-chronic-care.html>.

⁴ AARP and National Alliance for Caregiving, *Caregiving in the United States 2020* (Washington, DC: AARP, 2020), <https://www.aarp.org/ppi/info-2020/caregiving-in-the-united-states.html>.

⁵⁻⁷ Reinhard et al., *Home Alone Revisited*.

⁸ Susan C. Reinhard et al., *Home Alone: Family Caregivers Providing Complex Care* (Washington, DC: AARP Public Policy Institute, 2012), aarp.org/home-family/caregiving/info-10-2012/home-alone-family-caregivers-providing-complex-chronic-care.html.

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¹¹ Susan C. Reinhard et al., *The CARE Act Implementation: Progress and Promise* (Washington, DC: AARP Public Policy Institute, 2019), aarp.org/ppi/info-2017/from-home-alone-to-the-care-act.html.

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