National Caregiver Support Collaborative
Building our capacity to support family, kinship, and tribal caregivers

Key Takeaways: Integrating Caregivers as Care Team Partners

August 6, 2025, 2:00-3:00 PM ET

The Administration for Community Living (ACL) National Caregiver Support Collaborative (NCSC) hosted a webinar for aging, tribal, and kinship caregiver networks on August 6, 2025. This document summarizes key content presented during the event. Additional information on this webinar and the NCSC can be found on the NCSC website.

Overview from ACL on the Integration of Health Care and Social Services

***Kristie Kulinski**, Director, Office of Network Advancement, ACL*

- Partnerships between national networks and healthcare organizations have developed over the last two decades. Partnerships have served as a foundation for improving health outcomes for care recipients and caregivers by scaling evidence-based programs, value-based care, and roles for community-based organizations.
  Recent ACL efforts prioritize contracting through centralized networks called community care hubs (CCHs), which manage community-based organizations' (CBOs) administrative functions, enabling them to focus on delivering services.

Introduction to Panelists and Resources

- UCSF's Caregivers as Partners in Care Teams (CAP-CT) is a national training program that provides healthcare teams with the skills and confidence to include family caregivers in a care recipient's care journey. As part of a grant funded by ACL, CAP-CT is developing training and resources to support partnerships between family caregivers and healthcare teams across clinical settings. Such resources, including a Caregiver Identification Tool and Billing Guides for Healthcare Providers are available on the NCSC website.
- The University of New Hampshire's Center on Aging and Community Living leads several caregiver support initiatives, including the New Hampshire Alliance for Healthy Aging, a statewide coalition that supports older adults and family caregivers.

Panel: Strategies for Integrating Caregivers as Care Team Partners

***Anna Chodos**, Division of Geriatrics, The Regents of the University of California, San Francisco (UCSF)*
***Jennifer Rabalais,** Center on Aging and Community Living, University of New Hampshire*

Effective Strategies in Caregiver Integration

- Promoting caregiver self-identification is a key strategy for integrating caregivers into care teams. The New Hampshire Alliance for Healthy Aging's "Do You Care?" materials help individuals recognize caregiving responsibilities, helping caregivers self-identify and obtain resources early.
- Routine use of structured tools, such as caregiver assessments and the electronic health record (EHR), supports caregiver integration. Care delivery models such as the Guiding an Improved Dementia Experience (GUIDE) Model require providers to identify and document caregivers in the care recipient's

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record and assess caregiver strain with a validated instrument (e.g., Zarit Burden Interview). These steps make caregiver engagement routine rather than ad-hoc.

- Acknowledging both the caregiver and care recipient's needs and concerns is critical, especially when they conflict. Early intervention, routine support, and flexible resources such as respite care help prevent burnout and sustain healthy caregiving relationships.

Skill Building

- Using relationship-based strategies to engage healthcare teams is critical, including leveraging regular staff meetings, trainings, and internal champions. Integrating caregiver referrals and documentation into EHRs, with attention to privacy policies, is also key.
- Person-centered and disease-specific trainings in New Hampshire empower and educate caregivers, while building their confidence as active health care team members.

Indicators of Success

- Success in caregiver integration should be measured by caregiver inclusion, improved quality of life, and better health outcomes for both caregivers and care recipients. Early identification and ongoing engagement are key indicators.
- A New Hampshire care transition pilot that successfully integrated caregivers into discharge planning through partnerships between hospitals and aging and disability resource center showed reduced hospital readmissions, improved care recipient satisfaction, and decreased caregiver stress.

Recommendations for the Aging Network

- Aging network organizations should help providers in making caregiver engagement a standard, EHR-driven workflow: identify and document caregivers, use tools to assess caregiver strain (e.g., Zarit Burden Interview), include caregivers in after-visit/discharge summaries, and set up a simple e-referral pathway to the Aging and Disability Resource Center/Area Agency on Aging (ADRC/AAA). Consider pairing this with on-site CAP-CT training for providers, partnering on privacy reviews so teams feel comfortable documenting caregiver information, and supplying plug-and-play templates and tailored resource lists, enabling teams to start early and avoid ad hoc, crisis-only support.
- Aging, kinship, and tribal organizations should build relationships with local healthcare providers, establish formal partnerships, understand Caregiver Advise, Record, Enable (CARE) Act legislation, and align with hospitals' community health assessments.