2023

Teach-Back as an Evidence-Based Tool in Patient Education

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Walden University
2023

Abstract

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Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Discharge instructions are a valuable component of patient education as they can influence outcomes post-discharge, leading to positive social change through improved morbidity and mortality. The use of teach-back education by registered nurses is a best practice that assures understanding of discharge instructions. However, consistent use of this method relies on the staff's conviction and confidence in this manner of education. The purpose of this project was to develop, deliver, and evaluate a program to educate staff on the best practice of teach-back to effectively deliver patient education. The logic model helped guide and develop the stages of the project while Dorothea Orem's self-care theory served as the theoretical framework. Sources of evidence included scholarly written articles, and information from the Institute for Healthcare Improvement (IHI), and the Agency for Healthcare Research and Quality (AHRQ). A total of 32 registered nurses and respiratory therapists participated in the education and completed pre/post-education evaluation using the IHI Conviction and confidence Scale (CCS) and a knowledge evaluation survey. The pre/posttest mean scores from the CCS 4 item Likert-type scale were compared using descriptive statistics. Correct answer frequency from the 10 multiple choice items of the knowledge evaluation were compared pre and post education. Analysis showed an improvement in all areas evaluated in regard to conviction, confidence and knowledge of teach back. Discussion of findings with site leaders led to recommendation to provide the education to all new nursing and respiratory therapy employees and repeat annually thereafter.

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Dedication

I dedicate this project to my husband who has stood by me, weathered many storms, supported me, and encouraged me to keep going even when times were tough. You believed in me when I wanted to give up, and you have always been my source of strength and faith. To my daughter who inspires me to be the best person I can be and helps me see the world through different eyes, I love both of you more than words can say.

Acknowledgments

I want to thank Dr. Taylor who from the beginning was the calm voice of reason, who always encouraged me to keep writing and called me when she needed to give me that extra boost. I appreciated every piece of advice you gave me. Also, to Dr. Burton who made excellent recommendations for improvements in my writing and supported my project, thank you for your knowledge and your willingness to share it.

I also appreciate the team at my project site. You were open and transparent with your thoughts and recommendations. It was your willingness and want to improve the care at your facility that drove this project forward.

Table of Contents

List of Tables

Section 1: Nature of the Project

Introduction

Patients are discharged from the hospital with a myriad of information such as medication management, dietary restrictions, follow-up appointments, and signs and symptoms to look for that indicate a worsening of their condition. After discharge, patients must contend with a complex posthospital environment which, if they do not grasp a solid understanding of the expectations outlined in the discharge instructions, may lead to an adverse event (Maclean et al., 2018). Healthcare professionals are tasked with the responsibility of educating their patients which includes an assessment of the patient's ability to comprehend what they have learned (Agency for Healthcare Research and Quality [AHRQ], 2017). The teach-back method of delivering education is an evidence-based practice (EBP) that allows staff to evaluate the patient's ability to recall instructions and therefore, leads to improved care of self once back in the community (Thi, T. et al., 2016).

For this project I developed, delivered, and evaluated an evidence-based staff education project on appropriate teach-back methods. A staff education project on the teach-back method and the evaluation of the staff's ability to utilize teach-back consistently and appropriately improved their teaching skills.

Problem Statement

The selected site for the project was a community-based, 45-bed, not-for-profit hospital located in the southern portion of the United States. The staff selected to participate in the education was comprised of respiratory therapists (RT) and registered

nurses (RN). In this small community hospital, nurses from the progressive care unit (PCU) float between the different areas of the hospital, therefore, the chief nursing officer (CNO) selected this team as they have a wide range of scope to educate patients. RTs were selected as they share the responsibility of discharge education for respiratory medications, oxygen use, and posthospital pulmonary rehabilitation.

The use of an EBP model to assure patients understand and can retain the discharge information should be a standardized part of their practice (Yen & Leasure, 2019), however, nursing leadership had determined this model was not in place. A gap analysis obtained through observations and discussions with staff during and after delivery of discharge education determined the teach-back method was not utilized consistently, and of those nurses that attempted to perform teach-back, they did not utilize the method appropriately.

The IHI and AHRQ recommend teach-back as a method to improve the health literacy of patients at discharge. Most patients not only do not understand their instructions but fail to recognize their lack of comprehension (Miller et al., 2021). Approximately 35% of Americans have a lower than intermediate level of health literacy, leading to increased use of health system resources and poor outcomes. Health information that is focused on the patient's needs has been shown to increase their self-management skills and promote health outcomes (Yen & Leasure, 2019).

Purpose Statement

The leadership team has identified a gap in EBP in delivering discharge instructions. The teach-back method is a best practice shown to help staff gain confidence

in evaluating the patient's understanding of their education. Effective interpersonal communication between patients and staff is fundamental to the patient's understanding of education. This can be fostered through staff education on clear communication techniques which begin at the point of first contact and lasts throughout the entire therapeutic relationship (Green et al., 2014).

The teach-back method results in improvements in the quality of care delivered by the staff and in quality post-discharge outcomes including disease-specific knowledge, retention of discharge instructions, adherence to treatment, patient satisfaction, self-efficacy, and self-care (Miller et al., 2021). The teach-back method utilizes plain language, avoids the use of medical terminology, and recommends speaking slowly while making eye contact, asking open-ended questions, and asking the patients to demonstrate what they learned. Orem's self-care theory is an appropriate framework as it focuses on motivation, experience, and skill to perform behaviors to maintain and improve their health, through the use of self-care (Khademian et al., 2020).

Orem's theory is based on patients' ability to perform self-care activities that help maintain, restore, or improve their health. Nurses consider patients as active participants in their healthcare and see them as capable, decision-making members of the healthcare team, who can take care of their health needs. The patient's self-efficacy is important as nurses gain confidence and perform teach-back as a method of assuring patients understand discharge instructions. The project-focused question for this doctoral project was: In selected staff, both RNs and RTs, at a small rural hospital in the southern United States, how does an evidence-based staff education project regarding teach-back as a

method of delivering patient education improve the knowledge, conviction, and confidence of the staff measured through a pre-posttest design?

The identified gap is the staff's inconsistent, inappropriate use of teach-back as a method of delivering patient education. The staff education project focused on developing and delivering staff education and evaluating their knowledge, confidence, and conviction in using this methodology as a best practice in patient education. A long-term goal of this project is to prepare the staff with the tools to be successful in using teach-back methodology as a best practice in delivering patient education. Furthermore, the purpose of this project was to develop, deliver, and evaluate an education program regarding teach-back methodology as a best practice for staff delivery of discharge instructions.

Nature of the Doctoral Project

Communication between patients and healthcare providers is essential for healthcare to be effective; however, there is often a problem with patients' understanding of what they have heard and what the healthcare provider thinks they have taught the patient. This project addressed this issue through a program to educate staff about the process of teach-back as best practice. The logic model served as an established framework in the development of the timeline of events, inputs, activities, outputs, and short- and long-term goals (Kettner et al., 2017). The logic model assists the program planner in conceptualizing the outcomes of a program through visualization of the activities needed to meet the outcomes measured. To ensure the success of the program, I worked in conjunction with the local team of experts and owned the responsibility to

assure relationships between the theoretical foundations, the program goals, and objectives were in alignment (Hodges & Videto, 2010).

The plan was to develop an educational program based on the Institute for Healthcare Improvement (IHI) Always Use Teach Back! Toolkit (2018) and other relevant sources from the literature, including from the ARHQ. I also involved key local expert participants including the CNO, the PCU Manager, the RT manager, the education manager, and the shared governance council. This group of project participants provided feedback on the developed education plan. This feedback was incorporated into the education plan to meet the needs of the staff receiving the teach-back education. This team was responsible for helping to guide the development of the course content, based on the IHI Always Use Teach Back! Toolkit (2018). The PCU manager assisted in aligning the hospital values and goals with that of the project. The site's expert team secured resources and took responsibility for pretest and posttest data collection, aggregation, and reporting of de-identified results.

Significance

Patients, who are key stakeholders in the project, come from different backgrounds, including socially, economically, and culturally: therefore, they differ in their ability to retain and understand education. Teach-back education is designed to simplify the education process through the use of open-ended questions which allow the staff to evaluate the patient's understanding, thereby increasing their ability to promote their health. Staff can positively influence a patient's ability to retain their education once they leave the facility, which has been shown to improve the outcomes for those patients

(Liu et al, 2017). This improvement in quality of life impacts social change in this small rural community and allows the site to build partnerships with the community through expertise in research and delivery of EBP, which aligns with Walden University's Mission (2017).

The significance of the staff's improved use of the EBP of teach-back education is to improve the patient's understanding of their discharge instructions. Reduction of hospital 30-day readmissions for chronic diseases is another long-term goal for the facility. Teach-back education performed at discharge assures patients understand their home care instructions and how symptoms of exacerbations should lead them to seek additional care. After project completion, once the staff consistently incorporate the use of teach-back as an EBP, the leadership team at the site will determine additional costs to cover education hours. However, the expected long-term goal of decreasing readmissions through the staff's consistent use of teach-back could offset those education costs.

Summary

The staff holds the responsibility of delivering patient education and the ability to evaluate the effectiveness of that learning on their patients. The gap in delivering consistent, appropriate discharge education existed at this small rural community hospital in the southern United States and is based on the staff's lack of knowledge, conviction, and confidence about teach-back as a best practice. The purpose of this project was to develop an educational program on teach-back education, deliver the education, and evaluate the selected staff's knowledge, conviction, and confidence in this method of education. The education was be delivered in person with a pre-posttest evaluation. The

next section explores the background and context of the project on teach-back education as an evidence-based process and its application to the chosen project site. Furthermore, I review my role as a DNP student who served as the project lead and the roles and responsibilities of the site's project team members.

Section 2: Background and Context

Introduction

The purpose of this project was to develop, deliver, and evaluate a program to increase the staff's knowledge, conviction, and confidence regarding the best practice of teach-back methodology for delivering patient education. The gap in delivering evidence-based education at this small rural hospital was defined as the inconsistent use of teach-back due to the staff's verbalized and witnessed lack of knowledge, conviction, and confidence. The project goal was to increase the staff's knowledge, confidence, and therefore their conviction in using the teach-back method. The practice-focused question was: In selected staff, both RNs, and RTs, how does an evidence-based staff education project regarding teach-back as a method of delivering patient education improve the confidence of the staff measured through a pre-posttest design?

In this section, I review the background for the project, based on Orem's theory of self-care deficit and the relevance of teach-back to improve methods of delivering education and improving nursing practice. Lastly, my role as a DNP student and my integration into the project lead role will be reviewed.

Concepts, Models, and Theories

Dorothea Orem's self-care deficit nursing theory provided a framework as a strong theory that supports patient education. According to Orem, patients possess abilities such as writing, reading, verbal skills, and reasoning which form the basis of their ability to perform self-care. The patient's ability to read, comprehend, and

communicate information regarding their health status is linked to their ability to perform self-care and achieve improved outcomes (Khademian et al., 2020).

Orem's theory described limitations placed on patients as they experience health-related setbacks, leaving them incapable of providing self-care. The framework describes the following propositions:

> Self-Care is the responsibility of the individual. People who participate in their self-care already possess relevant knowledge and skill, rooted in science and/or culture, but they often need health professionals to supplement their healthcare abilities. Deficits in self-care result from the lack of knowledge about the situation and/or the available options for self-care agency. Self-care behaviors that meet the individual's self-care requisites lead to outcomes of an improved life, health, and well-being. (Wilson et al., 2008, p.9)

Orem's theory, in conjunction with the use of the logic model framework for developing the project, addressed the gap in the staff's lack of knowledge, conviction, and confidence regarding the consistent use of EBP in patient discharge education.

The logic model utilizes a visual representation of the relationship between the project's inputs, outputs, and outcomes. During the planning and evaluation process, the logic model guided the team members in visualizing their roles in the project. Additionally, the logic model presented the team with a framework to keep the project moving in a timely, effective manner, and in line to utilize teach back as an effective EBP for educating patients (Frye et al., 2018). The staff improved their conviction and confidence in the use of teach-back as an educational method, allowing them to better

assess their patients understanding of their education, thereby improving the patient's health care abilities. The site does not currently have a formal, consistent process for delivering education. Therefore, this project served as an EBP for improving the delivery of patient discharge instructions. The education project involved both RNs and RTs, therefore I use the term *staff* to refer to those participants receiving the teach-back education.

Relevance to Nursing Practice

Communication between healthcare providers and patients is an important tool in providing effective patient education. Miller et al. (2021), stated that there is often a discrepancy between what the provider communicates and what the patient hears or understands. Additionally, Miller et al. found that many patients retain less than half of the details regarding their medical visits and typically refrained from admitting that they had this knowledge gap. Miller et al. described teach-back as an evidence-based approach that is patient-centered and allows the patient to repeat back, using their own words, what was presented to them. The American Academy of Family Physicians endorses this method, as do the AHRQ and the IHI, due to the positive impacts on disease-specific knowledge, patient outcomes, retention of discharge instructions, and treatment adherence.

Despite this endorsement of teach-back as an EBP in delivering patient education, healthcare professionals lack conviction and confidence in using this method. Connell et al. (2022), argued that healthcare professionals should receive educational competencies for health literacy comprehension. They contended that healthcare providers bridge the

gap patients experience post-interaction by determining the level of comprehension at which their patients function, and that the facility uses health literacy strategies to assess whether the end user understands the information. Teach-back as a methodology for delivering education allows for the staff to meet this competency through the project.

The Always Use Teach-Back! program is evidence-based and designed to be tailored to fit the needs of adult learners. Its purpose is to improve the knowledge, conviction, and confidence of the staff's use of teach-back as a form of patient education, thereby increasing patients' knowledge and understanding of what is expected post-discharge. The use of teach-back allows patients to speak, in their own words, what they understand about the education, thereby allowing the staff to evaluate the level of understanding and, based on that evaluation, perform additional education or clarify points that are not clearly understood (Green et al., 2014).

The Joint Commission (TJC) requires effective discharge teaching that takes into consideration patient understanding, utilizes appropriate materials that meet their learning needs, and evaluation of feedback from patients. However, there is no standard tool for teaching or evaluating patient understanding. Even though clinicians are advised to explicitly assess their patient's understanding, clinicians seldom evaluate how well their patients comprehend health information. Alberti et al. (2013) performed a literature review regarding the lack of patients' comprehension of discharge instructions. The use of an educational program to increase the conviction and confidence of the staff's use of teach-back addresses the gap in consistent use of EBP, leading to standardized education

and materials. The patient's perspective of what they are hearing, and comprehending is vital to and drives posthospital outcomes.

Local Background and Context

The project was set at a rural 45-bed acute care not-for-profit hospital in the southern portion of the United States. The U.S. Census Bureau estimates the county population of 35,000 as of 2019, and the population of the city where this hospital resides is estimated at 7,700. The population by race is as follows: white 39.9%, Black 26.6%, Hispanic 33.5%, and by age: under 18 years 25.3%, 19-64 years old 41%, 65 years and older 32.9%. The largest industry for employment is agriculture (farming, fishing, and forestry) and the median poverty rate is more than twice the national average at 26.8%. Additionally, 19% of community members do not have any health care coverage, which is higher than the 12% national statistic, lastly, the literacy level is 30%, lacking behind the Florida average of 56% (DataUSA, n.d.).

The chief financial officer (CFO) supplied the following data as it relates to the hospital admissions: the average age of an admitted patient in 2021 was 77 years old and for the year to date 2022, the average age is 79 years old. Additionally, the hospital sees a higher overall percentage of unfunded patients at 20.9%, higher than the national average of 12% (DataUSA, n.d). The gap analysis and conversation with the staff determined a lack of standardization for delivering discharge instructions. The education was performed at different times during the patient stay, with some staff focusing on admission education and others waiting until the day of discharge to begin delivering a vast amount of education, including medication administration, follow-up with specialists

and primary care providers, and signs and symptoms of disease exacerbations. Based on the data provided regarding the patient's age and literacy level, nurses verbalize the need for a standardized process for delivering education.

The PCU unit selected for the project has an average daily census of 20 patients for the current year to date 2022. The unit is staffed with RNs, patient care technicians (PCT), and a monitor tech. The RTs float throughout the hospital and there are two on duty at all times. The nurse-to-patient ratio is 4:1, however, will flex up to 5:1 when staffing is short or when other areas of the hospital require additional help. The average length of stay is 4.2 days and patients are directly discharged from this unit as there is no step-down area. The current method for educating patients about discharge occurs when a physician enters a discharge order in the electronic health record (EHR). The staff then print out disease-specific and medication-specific discharge instructions, highlighting areas they deem important. This information is then taken to the bedside and reviewed as the patient is preparing to leave, often getting dressed and packing their room during this education process. The discharge process ends when the staff asks if the patients have any questions about what was discussed. The EHR only has a free text box for the delivery of patient education, however, no area exists for assessing or documenting patient understanding. The education material is then combined with a post-acute care summary that is printed from the EHR that contains copies of lab work, test results, and physician notes, which, depending on the length of stay (LOS) can be as many as 50 total pages, leading to further confusion once the patient arrives home.

The need for a standardized process for educating and evaluating patient understanding is based on the information gathered at the site. Patient age, literacy level, staff workload demand, staff observations, and lack of confidence in using teach-back as an evidence-based methodology provided the basis for the need for this project at this site.

The facility is a standalone, not-for-profit acute care hospital with an active Board of Trustees who have the ultimate oversight in the approval of care delivery at the facility. Changes to policies and procedures begin at the hospital level as the appropriate senior executive team member presents the requested changes. Once approved, those changes flow to the quality committee, department of medicine, medical executive team, then to the board for final approval. This is the same process for the review of all quality metrics including 30-day readmission data. The site has set benchmark quality metrics for readmissions below the national average of 24%, the current facility data shows a rolling 12-month average of 42% of readmission within 30 days of the original discharge date. The administrators at this site are concerned about this readmission rate and the effects of continued hospitalization on this patient population. They are incurring penalties under the Hospital Readmissions Reduction Program (HRRP), which reduces payments to facilities deemed to have poor outcomes due to their readmission rates (Wei-Kong & Wilkinson, 2020). The current PI goals are outlined in an annual report to the Board that includes performance improvement initiatives surrounding the 30-day readmissions rate. The project for teach-back education ties directly into the improvement

of this goal through a betterment in staff conviction and confidence in the use of this EBP.

Role of the DNP Student

Currently, I am the CNO of a small rural acute care facility that is part of a large nationally known hospital corporation. My current responsibilities include delivering quality, evidence-based nursing care that is fiscally accountable to the community members that utilize both inpatient and outpatient areas of our facility. I hold responsibility for the nursing inpatient areas, emergency department, perioperative services, pharmacy, therapy services, mental health services, outpatient wound care, and care management teams. I have witnessed firsthand in my facility the difficulty of delivering education to patients that they understand and can retain. This is the driving force behind my project, as I witness the difference this type of program can make in the lives of the patients. The site selected for my project is not one within my current health system and one for which I am not employed.

The site was chosen for its involvement in the community, the need for and request by the CNO for developing and delivering EBP at her facility, and the enthusiasm shown by the team during previous clinical practicum rotations. I have collaborated with this CNO in previous clinical rotations and am impressed by her transformational leadership style and her ability to make and sustain change leading to improved outcomes. My role was to develop, deliver and evaluate an EBP by utilizing teach-back as a methodology to improve the delivery of discharge instructions, through collaboration with a local team of experts.

Throughout my career, as both a bedside nurse in the emergency department (ED) and as a leader in both small and large healthcare facilities, I have seen a need for consistent delivery of education to patients. My own family has seen a wide variety of education processes during their discharge and the difference in whether they understand the post-acute care expectations. My father had a chronic illness and although was a very educated man, struggled with the vast number of changes to medications and therapy services once he left the facility. There was, on more than one occasion, a misunderstanding that led him to have to return to the ED due to medication administration errors. My father was not an illiterate man, but with the chronic disease and the medications he was placed on, his ability to recall certain details was greatly diminished. Teach-back was never used in all the times he was admitted and discharged from the facility.

The project site had previously attempted to establish teach-back as a best practice, however, according to the expert team on-site, it was not supported at an executive level as the cost of education at the time was not budgeted. This left a disjointed program where nurses would, if they felt compelled by time constraints, dismiss using teach-back and deliver the education in a manner that did not allow for the assessment of patients' understanding. This project is now fully vested by the executive team at the project site, including budgetary dollars for education, and overtime during the implementation phase.

Role of the Project Team

The project team consists of facility-level experts who assisted with guiding the curriculum development concerning the needs of the staff and managing de-identified data collection. The CNO, the PCU director, the RT Director, shared governance council members, and the education manager were core team members with the CEO, CFO, and quality director as ad hoc members.

The CFO approved budgeted finances for the cost of the education both initially, and as it is incorporated into the new hire orientation process. The decision was made not to add hours to the productivity bucket, but to code, those extra hours as nonproductive education time that will not effectively worked hours per patient day (HPPD). Additional needs were brought to his attention for guidance as the project moved forward.

Meetings regarding the project were held both in-person and through internet calls. Information regarding the relevance of the teach-back method through a discussion of the EBP and its ties to improved quality for patients was completed. The local expert team shared thoughts regarding past practices and reasons for post-implementation failure to sustain the project. This information drove the project and validated the use of the conviction and confidence scale as an indicator for sustaining the practice of teach-back.

Through meetings with the team of experts, the project was developed and sent to the team for review, at which time their recommendations were discussed, and the project was tailored to meet the needs of the adult learner participants. The PowerPoint presentation was also edited to reinforce critical ideas on best practices and to pair the presentation down to 1 hour, also leaving room for a question-and-answer session at the

end. This was critical to the success of the education as it was noted by the educator that 1 hour had shown to be the most effective timeframe to complete education and still maintain their attention.

Summary

Orem's self-care deficit nursing theory laid the groundwork for this education project on the teach-back methodology. The staff at the project site have been introduced to this model previously, however, without the support of leadership, the staff did not consistently use teach-back and therefore, lost confidence in their ability to educate patients in this manner. Teach-back is an evidence-based method that applies to the gap in nursing practice identified by leadership and is appropriate for the patient population they serve. Working in partnership with a team of local experts, I developed, delivered, and evaluated a staff education project on the use of the teach-back methodology for delivering patient discharge instructions.

The next section provides additional details regarding the identified gap and the identified practice focus question. Additionally, a review of the primary sources of evidence used to support the project in conjunction with the selected model of project evaluation is presented. The team and learner participant roles are clearly defined, and the steps of the project are outlined. Finally, the data analysis and synthesis are described.

Section 3: Collection and Analysis of Evidence

Introduction

The staff holds the duty to assure patients understand the education provided to them at discharge. This education includes medication administration, follow-up appointments, and signs and symptoms of worsening health conditions. Patients require education on all aspects of their healthcare and this education forms the foundation of the staff's duty to care for patients. The purpose of this project was to develop, deliver and evaluate a program to educate staff on the best practice of teach-back in delivering patient education. The logic model served as the framework for developing the project timeline and content.

The following sections identify how the practice-focused question aligned with the project and filled a practice gap that was identified by hospital leadership regarding inconsistent use of the teach-back method as an EBP. The sources of evidence connect the practice focus question and data collection and analysis.

Practice-Focused Question

The identified gap in the selected project site is the lack of knowledge, conviction, and confidence in the use of teach-back as a method to educate patients during the delivery of discharge instructions. The staff at this site educate patients on medication administration, follow-up appointments, and signs and symptoms of disease exacerbations; however, they did not have a formal process to deliver this education in an evidenced-based manner that also assisted the staff in evaluating whether the patients understood the information given to them. The project-focused question for this doctoral

project was: In selected staff, both RNs and RTs, at a small rural hospital in the southern United States, how does an evidence-based staff education project regarding teach-back as a method of delivering patient education improve the conviction and confidence of the staff measured through a pre-posttest design?

The alignment of the practice-focused question and the developed education project is expressed through the use of an evidence-based teach-back program to deliver patient education that meets the identified gap in the consistent use of this method. The local site team of experts provided feedback regarding the development of the program. I delivered the education in a face-to-face format at the selected site, and the staff evaluated their confidence and conviction in the use of the method. The teach-back education had been attempted previously at the site, however, due to a lack of key stakeholder support, the initiative was not sustained. The local site expert team is also involved in the project planning to give insight as to how to tailor the education to the needs of the staff.

The planning process was targeted to the EBP of teach-back education and utilized key stakeholders from the site to give input on the development of the education. The planning process included a timeline, project objectives, inputs, outcomes, and the evaluation method. The program content focused on improving the staff's knowledge, conviction, and confidence in teach-back education and increasing their certainty of this method as a manner of improving discharge education delivery.

Sources of Evidence

Primary sources of evidence for this project were derived from literature, using the search terms *teach-back, logic model, plain language,* and *nurse education*. The search databases included MEDLINE, CINAHL, and national databases such as AHRQ, Centers for Disease Control, IHI, and Centers for Medicare and Medicaid Services The search was limited to articles published between 2008-2022. The project focus was on teaching the staff regarding the EBP of teach-back as a methodology for delivering patient education; therefore, the focus of the literature utilized supported this project and was based on the use of the logic model. The practice focus question aimed to determine if an education project increased the knowledge, confidence, and conviction of the staff's use of the teach-back method. The literature selected supported teach-back as a best practice, delineated clear communication methods between providers and patients, and supported the use of self-care as a foundation for the project.

Teach-back education research is published on the Always Use Teach Back! website and includes the AHRQ Health Literacy Universal Precautions Toolkit (2017). The toolkit includes the conviction and confidence scale which were used as a well-resourced, evidence-based tool to determine if there was an increase in the staff's use of the teach-back technique. Additionally, aspects of the toolkit, such as the observation tool and the coaching tool were utilized by the site after project implementation for assessing the ongoing confidence and conviction of the team. Last, the Google Scholar search engine was utilized to secure additional resources on patient education and adult learning practices.

The project site participated through a team of local experts who gave input regarding the project; this input was utilized to tailor the education to meet the needs of the adult learners included in the education. Teach-back had been previously rolled out at this facility and failed due to a lack of formalized education programs and local leadership support. The expert team provided feedback regarding the curriculum as it relates to the techniques used in teach-back. Additionally, they supported their teams through the use of the Always Use Teach-Back! coaching tips for building motivation, understanding barriers, promoting skill development, building reliability, and managing relapses (AHRQ, 2017).

The logic model was used during the team's evaluation of the project. The logic model utilizes the team's analysis of the program's inputs, outputs, and measurable outcomes (Frye et al., 2018), and is an effective tool for the structure and evaluation of the education program. The advantages of the logic model used in the evaluation of the program include the use of a stepwise process through identifying inputs through outcomes and clear identification of points of uncertainty. As the team proceeded with an evaluation of the planning process and project implementation, the logic model helped keep the project on time, and in line with goals and determined objectives.

Evidence Generated for the Doctoral Project

Team Participants

The manager of education, who is currently responsible for developing and disseminating EBP to the staff, disease-specific community education, and reviewing patient education for content was selected as a key team member due to her expertise in

adult learning development and understanding of health literacy for the community. She carries knowledge regarding available resources for the staff regarding teach-back education and has valuable insight into teaching strategies for the front-line staff selected to receive the project education. The PCU nursing manager and the respiratory manager, who understand the culture of the facility and have been exposed to project implementations before this teach-back project, are team participants. Their awareness of both successful and failed attempts at delivering education was valuable as they evaluated the teach-back program and my implementation of the project. They are highly motivated, engaged in the premise of the project, and hold high standards for their teams and themselves. They have established themselves as transformational leaders, which adds reliability to their ability and willingness to be team members in the project.

Learner Participants

Registered nurses and respiratory therapists volunteered to attend the face-to-face classes on teach-back as a method to deliver patient education. In addition, these learners provided feedback on their conviction and confidence in using teach-back as an education method for delivering patient education, both before and immediately after receiving the education. This feedback was elicited from their completion of the Always Use Teach-Back Conviction and Confidence scale.

Procedures

The local expert team served to provide feedback on the education developed regarding teach-back. The feedback was elicited through a summative approach as a means of project evaluation, through a 5-question Likert scale questionnaire, where 1 =

strongly disagree and 5 = *strongly agree* (see Appendix A). This feedback was then incorporated into the education to meet any identified gaps. The Logic Model was utilized to give a visual representation to the team members regarding their role in this feedback loop.

The Always Use Teach Back! Conviction and Confidence Scale, (CCS) is a well-resourced, evidence-based collection tool. Post-education, this tool served as the evaluation of the staff's conviction and confidence in the use of the teach-back method (see Appendix B). This tool has not established validity and reliability, however, is recognized by AHRQ as an evidence-based tool for staff to assess their confidence in performing teach-back education. The CCS is made up of 4 items related to conviction and confidence in the use of teach-back, the tool was utilized just before and immediately after the staff received the education. Conviction measures the staff's perception of the importance of teach back as a patient education method and is reported through the use of a Likert Scale where 1 is *not at all important* and 10 *is very important*. Confidence measures the staff's ability to use the tool consistently, again using a 10-point Likert Scale with 1 *being not at all confident* and 10 *being very confident*. Additionally, a multiple-choice question is used to assess the frequency with which the staff currently uses teach back with answers that range from, never and do not plan to, not now but plan to in the next 2-6 months, not now but plan to in the next month, I have been doing this for < 6 months, or I have been doing this for 6 months or more. Finally, the participants select which elements of teach-back they have used more than half the time in the past work week. These answers include using a caring voice and attitude, displaying

comfortable body language, use of plain language, asking the patient to use their own words to explain what they were told, use of open-ended questions, avoidance of yes/no questions, taking responsibility for clear communication, explaining and rechecking of the patients is unable to verbalize teach back, use of reader-friendly materials, documenting use and patients response to teach back, and inclusion of family members if present. At the end of the questionnaire, there is a space for the staff to free-text any notes they would like to include for the reviewer.

Additionally, a knowledge evaluation of using teach-back effectively multiple-choice questionnaire was developed by me as a means to evaluate the staff's perceived improvements in knowledge of the teach-back method. Although this tool is not sourced, it was created using the teach-back education information presented in the Always Use Teach Back Toolkit (2018).

Protections

The Doctoral Project held ethics approval through Walden University's Institutional Review Board (IRB) in conjunction with the site's policies and procedures for ethics and compliance. The project utilized the Preapproved Site Agreement and the Consent Form for Anonymous Questionnaires as the project falls into those predefined categories (Walden University, 2017). The consent form details the questionnaire procedure including stakeholders' autonomy and privacy, the voluntary nature of the project, the risks, and benefits of being involved in the project, the privacy of their identity, and a contact number for questions and concerns. The project used the following site data once approved by the IRB: deidentified records on previous staff training

opportunities, training materials, and protocols. All data obtained will be retained according to the Walden University DNP Program policy.

Analysis

The data collected from both the pre and post-CCS questionnaires on conviction and confidence and the Knowledge Evaluation for using Teach-Back Effectively were analyzed for improvements between pre and post-test scores. The multiple-choice questions were analyzed through frequencies of each answer on both pre and post-test, this occurred on the Knowledge Evaluation tool and the behavioral question, and the elements of the CCS teach-back use questions. The questionnaires were collected and aggregated by the facility team education manager. All information was presented to me as deidentified, with an expected outcome to increase the staff's conviction and confidence in the use of teach-back as a method to deliver patient education.

Summary

The education project sought to close a gap in the knowledge, conviction, and confidence of the staff in the consistent use of teach-back education as an evidence-based practice for delivering patient education. Sources of evidence from the literature, feedback from the facility expert team members, and nationally recognized organizations such as AHRQ and IHI. The logic model provided the framework for the team to provide feedback regarding the planning and allowed for the evaluation of the teaching method. The Always Use Teach Back Toolkit! provided an evidence-based questionnaire to collect data regarding the staff's conviction and confidence of teach back.

In the next sections, I will discuss the project findings and implications of the project on closing the gap in the project-focused question. Recommendations were made by this writer to the facility project and senior leadership team based on the data from the project and included all applicable tools and educational materials. Additionally, the strengths and limitations of the project will be reviewed and self-analysis regarding my role as project manager and its applications to my professional goals.

Section 4: Findings and Recommendations

Introduction

Health literacy or the absence of health literacy is shown to affect patients in a negative manner including increasing their risk for hospitalization and mortality through a lower understanding of their health-related knowledge (Connell et al., 2022). Additionally, the risk increases exponentially based on lower socioeconomic status, lower completion of educational requirements, and age. The average age of the admitted patient at the small rural community hospital at the time or study was 79 years old. RNs and RRTs carry the responsibility for educating their patients in a manner that is effective both while in their care and as they prepare to depart the hospital back into the community. However, when the study began, staff lacked the required evidence-based knowledge in effective patient education methodologies such as teach-back. The practice-focused question was: In selected staff, both RNs and RTs, at a small rural hospital in the southern United States, how does an evidence-based staff education project regarding teach-back as a method of delivering patient education improve the knowledge, conviction, and confidence of the staff measured through a pre-posttest design? The purpose of this doctoral project was to develop, implement, and evaluate an evidence-based, best-practice, education program on the teach-back process.

Sources of Evidence

Sources of evidence include scholarly written journal articles, academic database searches including CINAHL, and MEDLINE, and information from the IHI and the AHRQ. Articles were chosen based on the highest level of evidenced based practice to

demonstrate the teach-back method as a best practice in delivering patient education. The use of the teach-back method as a technique to improve a patient's understanding of their education and improve outcomes post-discharge were also included.

There were 2 separate tools utilized for the evaluation of the education program. The CCS tool (Always Use Teach-Back, 2018), used both pre- and post-education, assessed the staff's conviction and confidence in using teach-back, the importance and frequency of using this method, and the frequency of use for the best practices in sustaining teach-back. The responses were recorded based on a Likert scale and the mean value of all responses is the statistical analysis for change evaluation. The second evaluation tool, also used in both the pre- and post-education process, involved the staff's responses based on their knowledge of the elements of teach-back. The responses were measured through the percentage of correct answers on a multiple-choice questionnaire.

Team meetings with the local site experts provided to be valuable sources of evidence due to their knowledge of patient education and previous practices that led to failed initiatives. The current state of education practices for the staff was revealed by this team, including possible barriers to teach-back implementation. The local site expert team provided information on the lack of standardized practices and evidence-based initiatives specifically surrounding the use of teach-back as a methodology. Additionally, they assisted in the structure of the education program to meet the needs of their staff members and verified the value of this program to address the identified nursing practice gap in delivering education. The final sources of evidence came from the local expert site team completion of a team member project evaluation (Appendix A), which provided

their feedback on my planning and implementation of the project. Additionally, the learner participants completed the pre/post-CCS Scale (Appendix B), and the pre/post knowledge evaluation for using teach-back effectively (Appendix D) as a manner to evaluate their knowledge, confidence, and conviction of teach-back. The data from the local expert site team members' surveys assisted with adjustments to the program's curriculum. The pre/post education CCS scales determined the effectiveness of the staff's conviction and confidence in the use of teach-back. Furthermore, the pre/post knowledge evaluation assisted in evaluating the learner participants' knowledge of the steps utilized in the teach-back method.

The project planning goal was to develop a teach-back education program tailored to the needs of the adult learners in this small community hospital. The IHI Always Use Teach Back! Toolkit served as the basis for the face-to-face education project. The toolkit contains an implementation guide, learning objectives, learning resources, tools for nurse leaders to assist with change and sustainment, an evaluation plan, and references. The toolkit provided an online self-directed tutorial for the learners to watch; however, the project team felt that face-to-face education in place of the staff watching a video would derive better outcomes. These tools, along with the training program, allowed me to create a program that would close the gap in nursing practice identified by the nursing leadership team.

The education was delivered by me in four separate face-to-face education sessions lasting 1 hour each. The participant-learners received a handout of the PowerPoint presentation with room for them to write notes, clarifying points, and

questions. The program objectives assisted the learner in understanding the premise of the project. Although not a part of this education project, the toolkit does contain a nurse leader portion to assist them with coaching through the change and how to best support their staff during the implementation phase, these tools are listed as the teach-back observation tool (Always Use Teach-Back n.d.) and the coaching tool (Always use Teach-Back n.d.), and can be found in Appendix C.

The education program was developed and delivered using a PowerPoint presentation that was both utilized as a visual teaching tool and distributed as a handout for participant learners to take notes. Appendix E contains the slides used in the face-to-face classroom presentation. The material was tailored to the local needs and included previous barriers to success which were identified by the local site in the planning phase. The learning methodologies used during the project included lectures, open interactive conversations, role-playing for practice, and group discussions.

The education program occurred in four separate face-to-face sessions lasting 1 hour each. After introductions were made, the participant learners were asked to complete the two evaluation tools: The CCS (Always Use Teach-Back, 2018), and the knowledge evaluation for using teach-back effectively. The education lecture consisted of dissemination of the EB practice of teach-back, allowing for open discussion on teach-back based on the PowerPoint slides, time for a question-and-answer session, review of case-based scenarios, and a role-playing opportunity, and ended with the learners completing the same evaluation tools for comparison.

Findings and Implications

Findings

The program was evaluated by the local expert team using a summative evaluation (see Appendix A), responding to questions, and providing recommendations for changes regarding the practice problem, the presentation of evidence-based literature, the project goal, the project objective, and their ability to give input into the project. The respondents were clear in their understanding of the project goals, the project objectives, felt they were able to give input, and, that their input was valued and incorporated into the program. There was a trended concern regarding the practice problem as some respondents did not feel that teach-back was a valuable tool as they had tried this method previously without success. To mitigate this concern, the evidence-based literature was reviewed a second time, with a focus on teach-back as a best practice in patient education. Additionally, the literature (Wei-Kong et al., 2020) showed a decrease in 30-day readmissions when this method of teaching was used, and this project team was very committed to this patient safety indicator. A total of seven surveys were collected for data review which represented 70% of the team. Responses to the survey are reflected in Table 1 and are based on a 5-point Likert scale ranging from 1 = *strongly disagree* to 5 = *strongly agree*.

Table 1

Team Member Project Evaluation

Questions	Mean value
I understood the practice problem	4.0
Evidence-based literature was presented, analyzed, and synthesized	4.8
The project goal was appropriate	4.8
The project objective was met	4.8
I was able to give input into the project	4.8

The results in Table 1 reflect the project team members' understanding and support of the project, where the only question scoring lower than the others was regarding their understanding of the practice problem. This was an interesting finding as this team had attempted to roll out teach-back as a method for patient education; however, lack of resources and support for the project meant they were unable to sustain the practice and soon went back to their previous manner of educating patients, which lacked structure and the ability to assess a patient's understanding of the education.

Additionally, the volunteer participants who received the education completed a 10-question pre- and post-education knowledge evaluation (See Appendix D) for using teach-back effectively. The answers were analyzed through an evaluation of the frequency of correct answers. The questions were created based on the content of the educational materials presented to the learners during the 1-hour face-to-face education classes presented by this writer. A total of 32 pre- and post-education knowledge tests were administered, reflecting 100% of participants completing the test.

Table 2

Knowledge Evaluation for Using Teach-Back Effectively

Question	Pre Ed.	Post Ed.
Use of a caring tone and attitude	78	81
Understanding body language	63	75
Use of plain language	97	100
Use of open-ended questions	100	100
Use of yes/no questions as ineffective	100	100
Method of assessing patients' understanding	81	100
Understanding who is responsible for effective teaching	91	91
Understanding the next steps if the patient does not understand	50	70
Understanding the use of print materials	97	100
Understanding documentation of teach-back	75	81

Table 2 reflects the breakdown, by the question, of the pre- and post-education teach-back knowledge test administered to the learner participants. The two lowest post-education scores, related to the use of body language, and what to do if the patient is unable to repeat back what they learned, were discussed for opportunities. Regarding the use of body language, the learners voiced they did not see the importance of a relaxed posture and felt it lacks professionalism. We discussed how a relaxed posture brings a sense of confidence to the learners and aids the patient in an environment conducive to learning, Additionally, they verbalized an uncertainty about how to proceed if, on the first try, the patient is not able to teach-back. We discussed how to re-phrase the teaching in a manner that would allow the patient to understand the education. Both areas are important to the overall process of teach-back and the learners were open to this feedback.

Lastly, the learner participants completed a pre/post education CCS scale to compare conviction of the importance of the use of teach-back and how confident they were in their ability to use the teach-back methodology. Table 3 compares the mean score

of the answers of the pre-education CCS to the post-education CCS scale. There was a total of 32 scales completed representing 100% of the participants, and the results are based on a 10-point Likert scale with 1 = *not at all important* to 10 = *very important*.

Table 3

Conviction and Confidence Scale

Questions	Mean value
How convinced are you on the importance to use teach-back (pre-test)	6.0
How convinced are you on the importance to use teach-back (posttest)	8.0
How confident are you in your ability to use teach-back (pre-test)	4.0
How confident are you in your ability to use teach-back (post-test)	8.0

Table 3 depicts the participant learner's improvement post-education delivery in both conviction and confidence of using the teach-back method. An analysis of the CCS scale showed no scores lower than a 7 for either the conviction or the confidence post-education scales, with 50% of the scales scoring a 10 in both categories.

A limitation of this project includes the fact that this type of project had been attempted previously. The learners' participants had voiced this before the start of the project and expressed frustration that it was being attempted a second time. Local leadership and the CNO who stated they support the project and have added resources for the implementation will be responsible for sustaining the initiative to ensure ongoing success.

Implications

Evidence-based practices such as teach-back are instrumental in improving patient outcomes post-discharge. For the staff and leadership at this small community hospital, the ability to implement and sustain practices had been difficult. Their

participation in this project helped them increase their knowledge of how this best practice can lead to improvement in the lives of their patients and therefore the overall health of the community. Additionally, they can share this practice at a systems level with their partners in the community including physicians' offices, therapy services, and the local health department.

The staff at this facility have the potential to impact social change through the implementation and sustainment of this evidence-based best practice method of delivering discharge instructions. The community will benefit as a whole when they improve their health literacy surrounding follow-up instructions, medication administration and adherence, and improved recognition of chronic disease symptoms and exacerbations. This project gave the staff the education and understanding they needed to move forward in accepting the responsibility of properly educating their patients at a level they can understand.

Recommendations

The education project emphasized the need for a consistent method for the staff to utilize when delivering patient education. The teach-back method provides the needed tools for staff to become proficient in this method and allows for a consistent method in which patients can better understand their education. The recommendation for the project site is to continue the use of the teach-back education program, including the use of the materials found in the appendix of this paper, as an educational offering to all new nursing and respiratory therapy employees and annually as a refresher to the same set of employees.

The project will be extended beyond the DNP doctoral project timeline as the CNO is supportive of this as a best practice. Therefore, the nursing and respiratory leaders will access the toolkit and carry the responsibility of continued evaluations of teach-back as a method to deliver patient education. Additionally, the CNO has reviewed with the education director how to best implement this program by adding the education to their annual competency fair and new hire orientation.

The project site has a 30-day readmission rate that is almost twice the national average of 42% of all Medicare patients. Their long-term goal is to decrease the 30-day readmission rate for the same/similar diagnosis below their current rate as a means to reach their benchmark of 24%. Teach-back is shown to have a positive effect on a patient's ability to retain discharge education, therefore, a decrease in the 30-day readmission rate, year over year post implementation of the teach-back project can serve as an ongoing evaluation of this program.

Contribution of the Doctoral Project Team

The local site team of experts provided valuable information regarding the defined practice problem, and the nature of the project to address the identified gap in knowledge, goals, objectives, and timelines related to the development and project implementation. In addition, I presented the final education project to them as though they were a part of the learner participants. I performed an oral presentation of the project, and project materials, allowed for question-and-answer sessions, and completed a case-based role-playing scenario. The project team then submitted their evaluations, as presented in Table 1.

The CNO plans to extend teach-back education as a method to deliver patient education beyond this DNP project. For this reason, the nursing and respiratory leaders also reviewed the coaching and observation tools, which allowed for questions and feedback as to how to use the tools for ongoing evaluations of their teams. Also, I met with the director of education to review the information on the PowerPoint slides as her ongoing responsibility includes using this presentation for new hire orientation and annually at their competency fair.

The feedback from the local site experts supports the education project and my recommendation is to continue the process of utilizing teach-back as a formal process of delivering patient education. The use of teach-back consistently may increase the confidence of use and allow them to use this method in every patient education opportunity. The project site could evaluate the impact of the use of teach-back on their 30-day readmission scores as part of an ongoing performance improvement project.

Strengths and Limitations of the Project

The input from the local site team led to strengthening this project as they had attempted this type of rollout previously without success. Their transparency as to the reasons for the unsuccessful attempt was integrated into this project with support from the CNO. Another strength of this project was the learner participants, who showed great engagement and support for the project through their interest in education and their follow-up questions.

One limitation included scheduling of classes to meet all shift availability as this facility has many non-standard shifts. For example, they have the standard day and night

12-hour shifts that run seven AM to seven PM or seven PM to seven AM, however, they also have eight-hour shifts that do not match up to any of the times offered. There was an attempt to do a class at the off time, however, when no volunteers signed up, that class was shifted to another time to accommodate more learners. Another limitation was the education presented to a total of 32 participants, which is limited and may not represent all staff members' opinions.

Section 5: Dissemination Plan

The entire program for teach-back education was presented to the CNO in form of internet links, paper form, and a flash drive of copied information. The CNO will work with her leadership team to continue to validate the project through the use of the teach-back toolkit and as part of their annual skills lab program and new hire orientation. The results of the project, showing the noted improvement in conviction, confidence, and knowledge of this evidence-based method, will be presented to their Medical Staff and Board of Governors as part of the performance improvement program.

The project site is a stand-alone facility; however, they partner with community resources such as the health department, free clinic, and physicians' offices. Each of these entities has a requirement to educate their patients regarding their health and currently none have a standardized practice to deliver education or to evaluate if their patients understand the information presented to them. Based on this evaluation, the CNO will present the findings to the next quarterly community partnership meeting and based on their interest, assist with a community-wide roll out of teach-back education.

Analysis of Self

This project was valuable in broadening my scope of understanding of healthcare delivery in a small rural facility with limited resources. The challenges faced by the frontline staff in assuring their patients understand their education in a post-COVID world, where resources are scarce and staffing is limited, makes bedside care even more challenging. The staff at the project site serve in many capacities, floating throughout the different departments, requiring them to have a broad knowledge base for patient care.

This is unlike many facilities that have set units and set staff for each type of patient. I have gained valuable perspectives on how to address a problem with limited resources; however, the robust attitude of the team allowed for a project that unfolded and was tailored to meet their needs while maintaining the integrity of the evidenced-based research.

Leading this project with the local experts added to my management skills by helping to understand out-of-the-box thinking to solve a problem. Incorporating EBP, especially in light of a previously failed attempt, meant we had to understand the reasons behind the previous process breakdowns and implement plans to solidify this practice into the staff's everyday life. This is important to the leader or project manager as any project can fail due to a myriad number of reasons; planning for potential failure was integral in assuring we addressed this issue. The frontline staff was the key stakeholders in determining how best to spearhead this issue as they are ultimately the ones responsible for continuing the process.

The final report out of the data showing the improvement in conviction and confidence, and the high scores in the post-education knowledge evaluation for using teach-back effectively allowed me to reinforce to the leadership team the staff did have the tools they needed to be successful and that they understood the value added by this project for their patients.

Summary

Health literacy affects the ability of patients to understand the education presented to them at discharge. This lack of understanding can lead to poor outcomes as patients

navigate their post-acute care encounters. The staff at this project site have a responsibility to their patients that includes an assurance they understand the education provided to them. Utilizing an EBP method such as teach-back for delivering education helps the staff to meet this requirement. The gap in nursing practice identified before the start of this project was that staff lacked the knowledge of EBP in delivering patient education and did not have a formal standardized process by which to determine the level of comprehension their patients experienced. To close this gap, I worked with the local site expert team, a group of internal stakeholders, and the CNO as the senior leadership representative to plan, deliver and evaluate an EBP education program on teach-back methodology. Summative evaluations served as feedback both during the development phase and as a tool for the learner participants to give their feedback regarding any improvement made to conviction, confidence, and knowledge of teach-back methodology. There is a strong agreement, based on the analysis of the summative evaluations, that the education program on feedback did increase those indicators.

The staff at this facility will impact social change in their small community by utilizing an EBP program to increase the understanding their patient has regarding their post-discharge phase of health care. Understanding medication administration, when to make a follow-up appointment and who to make it with and knowing the signs and symptoms of exacerbations can help improve the outcomes for patients. Additionally, the staff has a deeper understanding of the value this EBP brings to their delivery of healthcare, and ultimately the improvement of the small community in which they practice.

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Appendix A: Summative Evaluation

Team Member Project Evaluation

Scale: SD=Strongly Disagree D=Disagree U=Uncertain A=Agree SA=Strongly Agree

	1=SD	2=D	3=U	4=A	5=SA
1. I understood the practice problem.	____	____	____	____	____
2. Evidence based literature was presented, analyzed and synthesized.	____	____	____	____	____
3. The project goal was appropriate.	____	____	____	____	____
4. The project objective was met.	____	____	____	____	____
5. I was able to give input into the project.	____	____	____	____	____

Appendix B: Conviction and Confidence Scale

Always Use Teach-back!

Conviction and Confidence Scale

Fill this out before you start using teach-back, and 1 and 3 months later.

Name: _____

Check one: ◯ Before - Date: _____
◯ 1 month - Date: _____
◯ 3 months - Date: _____

1. On a scale from 1 to 10, how **convinced** are you that it is important to use teach-back (ask patients to explain key information back in their own words)?

Not at all important — Very Important

1 2 3 4 5 6 7 8 9 10

2. On a scale from 1 to 10, how **confident** are you in your ability to use teach-back (ask patients to explain key information back in their own words)?

Not at all confident — Very Confident

1 2 3 4 5 6 7 8 9 10

3. How often do you ask patients to explain back, in their own words, what they need to know or do to take care of themselves?

◯ I have been doing this for 6 months or more.
◯ I have been doing this for less than 6 months.
◯ I do not do it now, but plan to do this in the next month.
◯ I do not do it now, but plan to do this in the next 2 to 6 months.
◯ I do not do it now and do not plan to do this.

Conviction and Confidence Scale continued

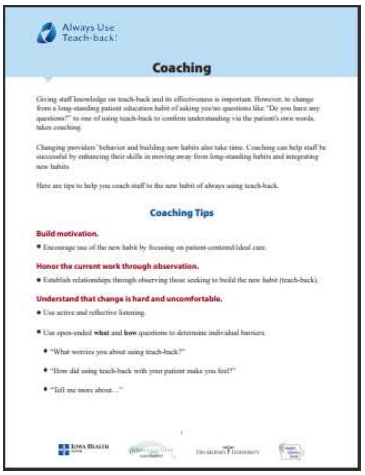
4. Check all the elements of effective teach-back you have used **more than half the time in the past work week.**

◯ Use a caring tone of voice and attitude.
◯ Display comfortable body language, make eye contact, and sit down.
◯ Use plain language.
◯ Ask the patient to explain, in their own words, what they were told.
◯ Use non-shaming, open-ended questions.
◯ Avoid asking questions that can be answered with a yes or no.
◯ Take responsibility for making sure you were clear.
◯ Explain and check again if the patient is unable to teach back.
◯ Use reader-friendly print materials to support learning.
◯ Document use of and patient's response to teach-back.
◯ Include family members/caregivers if they were present.

Notes: _____

Appendix C: Coaching Tool

Observation Tool



Always Use Teach-back!

Coaching

Giving staff knowledge on teach-back and its effectiveness is important. However, to change from a long-standing patient education habit of asking yes/no questions like "Do you have any questions?" to one of using teach-back to confirm understanding via the patient's own words, takes coaching.

Changing providers' behavior and building new habits also take time. Coaching can help staff be successful by enhancing their skills in moving away from long-standing habits and integrating new habits.

Here are tips to help you coach staff to the new habit of always using teach-back.

Coaching Tips

Build motivation.

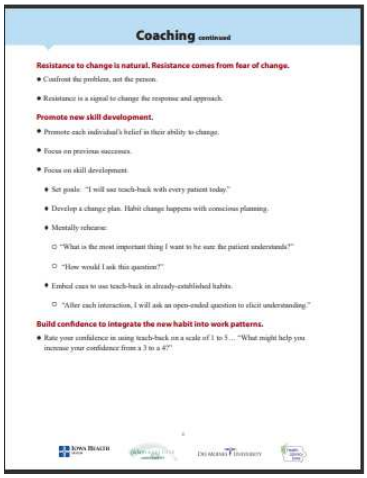
- Encourage use of the new habit by focusing on patient-centered/ideal care.

Honor the current work through observation.

- Establish relationships through observing those seeking to build the new habit (teach-back).

Understand that change is hard and uncomfortable.

- Use active and reflective listening.
- Use open-ended **what** and **how** questions to determine individual barriers.
  - "What worries you about using teach-back?"
  - "How did using teach-back with your patient make you feel?"
  - "Tell me more about…"



Coaching continued

Resistance to change is natural. Resistance comes from fear of change.

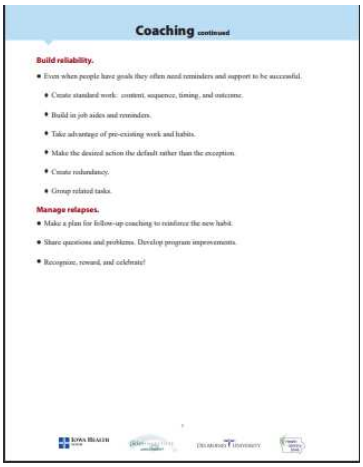
- Confront the problem, not the person.
- Resistance is a signal to change the response and approach.

Promote new skill development.

- Promote each individual's belief in their ability to change.
- Focus on previous successes.
- Focus on skill development.
  - Set goals: "I will use teach-back with every patient today."
  - Develop a change plan. Habit change happens with conscious planning.
  - Mentally rehearse.
    - "What is the most important thing I want to be sure the patient understands?"
    - "How would I ask this question?"
  - Embed cues to use teach-back in already-established habits.
    - "After each interaction, I will ask an open-ended question to elicit understanding."

Build confidence to integrate the new habit into work patterns.

- Rate your confidence in using teach-back on a scale of 1 to 5… "What might help you increase your confidence from a 3 to a 4?"



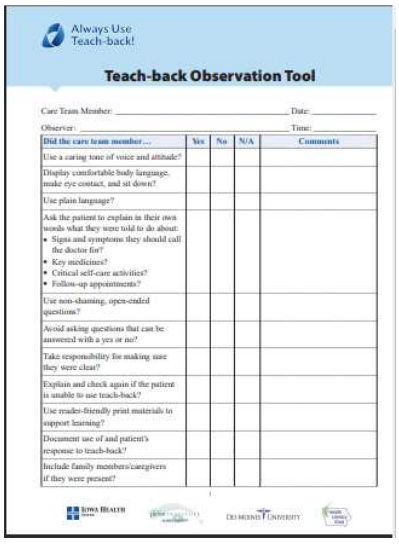
Coaching continued

Build reliability.

- Even when people have goals they often need reminders and support to be successful.
  - Create standard work: content, sequence, timing, and outcome.
  - Build in job aides and reminders.
  - Take advantage of pre-existing work and habits.
  - Make the desired action the default rather than the exception.
  - Create redundancy.
  - Group related tasks.

Manage relapses.

- Make a plan for follow-up coaching to reinforce the new habit.
- Share questions and problems. Develop program improvements.
- Recognize, reward, and celebrate!



Always Use Teach-back!

Teach-back Observation Tool

Care Team Member: _____ Date: _____

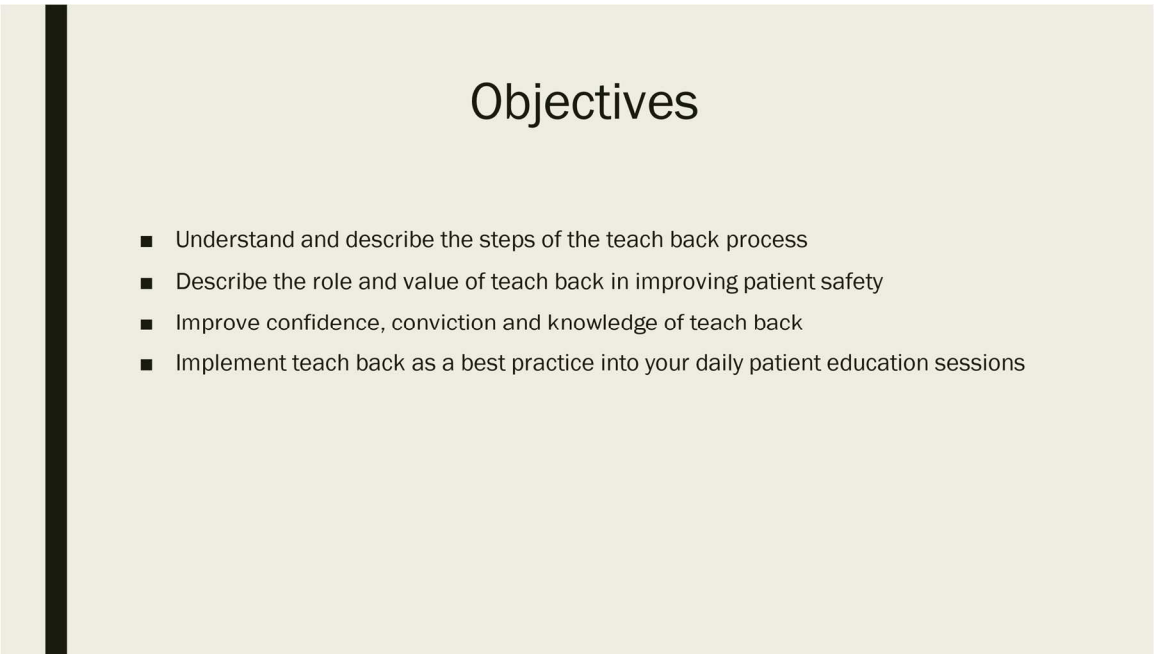
Observer: _____ Time: _____

Did the care team member…	Yes	No	N/A	Comments
Use a caring tone of voice and attitude?				
Display comfortable body language, make eye contact, and sit down?				
Use plain language?				
Ask the patient to explain in their own words what they were told to do about: • Signs and symptoms they should call the doctor for? • Key medicines? • Critical self-care activities? • Follow-up appointments?				
Use non-shaming, open-ended questions?				
Avoid asking questions that can be answered with a yes or no?				
Take responsibility for making sure they were clear?				
Explain and check again if the patient is unable to use teach-back?				
Use reader-friendly print materials to support learning?				
Document use of and patient's response to teach-back?				
Include family members/caregivers if they were present?				

Appendix D: Knowledge Evaluation for Using Teach-Back Effectively

1. When speaking to a patient during teach-back you should:
    a. Use a caring tone of voice and attitude
    b. Use a loud, harsh tone of voice
    c. Use a whisper quiet tone of voice
    d. None of the above
2. During teach back you should:
    a. Stand rigidly at the foot of the bed
    b. Sit slumped in a chair
    c. Display comfortable body language
    d. Be sure not to make eye contact
3. What type of language should you use during teach back:
    a. One they cannot understand
    b. Plain language
    c. Spanish only
    d. None of the above
4. At the end of the teach back process you should:
    a. Act surprised if they did not understand
    b. Roll your eyes at their questions
    c. Use open ended questions to assess understanding
    d. Shame them for not understanding
5. Using simple yes or no questions at the end of the teach back sessions:
    a. Is the correct manner to assess their understanding of the teaching
    b. Is not the correct manner to assess their understanding of the teaching
    c. Neither of the above
    d. Both of the above
6. What method should you use to assess the patients understanding of the education presented to them?
    a. Ask the patient to explain back, using their own words
    b. Tell the patient exactly what they should have understood
    c. Tell the patient to read the papers given to them
    d. It is not required to assess the patients understanding of their education
7. The responsibility of delivering clear education falls on:
    a. The patient
    b. The family
    c. The person delivering the education
    d. The patient in the bed next door
8. If the patient is not able to teach back correctly, you should:
    a. Become frustrated
    b. Explain again and re-check their understanding
    c. Get someone else to talk to them
    d. None of the above
9. Print materials for use in teach back should be:
    a. Cartoons only
    b. Reader friendly
    c. Pictures only
    d. No printed materials should be used
10. Once the teach back process is completed you should:
    a. Document the patient's response
    b. Do nothing
    c. Yell because it was difficult
    d. None of the above

Appendix E: Classroom Lecture PowerPoint



Health Literacy

- Health Literacy
  - *The capacity to:*
    - Obtain, process, understand heath information
    - Make appropriate health care decisions
    - Access/navigate the health care system
- Health Literacy Universal Precautions approach
  - *Structure the delivery of care as if everyone haslimitd health literacy*
    - You cannot tell by looking
    - Higher literacy skills does not equal understanding
    - Anxiety reduces ability to manage health
    - Everyone benefits from clearcomunication

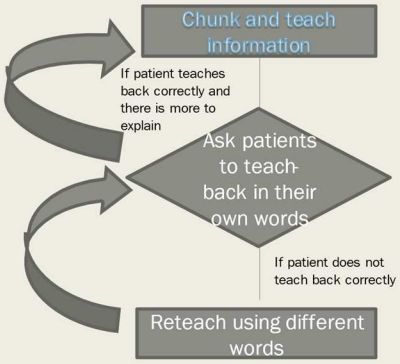
Strategies to improve patient understanding

- Use teach-back method
  - *Ensures agreement and understanding of materials presented*
  - *Improves outcomes*
- Use clearly written education materials
  - *A combination of clear verbal and written communication assures success*
- Focus on most important message
  - *Brings attention to what needs to be done to take care of their health*
- Case Example: A78-year old woman is discharged from the hospital with heart failure, a stress fracture, and hypertension. Which message from this list is the most important to convey about the first 24 hours after discharge to ensure a successful transition home?
- Low-salt, high-calcium diet
- Physical therapy for stress fracture
- Reasons to call the doctor
- Flu shot information

What is teach back

- Method of delivering patient education
  - *Ensures patient understands their education*
  - *Patients use their own words to explain what they learned*
  - *Allows staff to assess/reassess and redeliver the message as needed*

The teach back method



How is teach back different

- Patients frequently will not ask questions even if they have them
  - *Embarrassment*
  - *Intimidation*
  - *They think they understand*
- The only way to know if they understand is to hear it back from them in their own words

Why teach back is a best practice

- Clinicians underestimate patients need for information
- Clinicians overestimate their ability to convey information effectively
- Up to 80% of medical information patients are told is forgotten
- Up to 50 % of the information retained in not correct
- Low health literacy effects patient adherence to treatment
- Effective communication drives outcomes

How to be successful

- Use this method on all patients
- Be approachable
- Emphasize how teach back is important to patient safety
- Take time and speak clearly
- Position yourself atpatients eye level
- Use plain language

Plain language

INSTEAD OF	TRY SAYING
Hypertension	High Blood Pressure
Modify	Change
Fracture	Broken bone
Oral	By mouth
Ambulate	Walk
Optimal	Best way
Negative	"Good" or "Bad" result
Diet	What you eat

Special consideration

- Older adults
  - *Consider use of lower voice pitch for hearing impaired*
  - *Speak naturally and distinctly*
  - *Minimize background noise*
  - *Limit information delivered at one sitting*
  - *Speak slowly*
- Non-English speaking
  - *Use medical translation devices*
  - *Use verbal and non verbal cues*
  - *Use visual aids*

Examples

- Can you tell me….
- Can you explain to me….
- Can you show me…..
- What else can you do….

Practice