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Teach-Back Process as a Best Practice 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
2019

Abstract

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MSN, Walden University, 2012

BA, University of South Dakota, 1995

Project Study Submitted in Partial Fulfillment

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Abstract

Limited health literacy is a national problem. Nurses are in a position to address patients' limited health literacy skills using a universal precautions approach through the teach-back process. The purpose of this project was to plan a program to educate nurses on best practices in patient education. The theoretical framework informing this work was Bandura's social cognitive theory, which asserts that increases in knowledge and self-efficacy are precursors to affecting behavior change. The logic model was used to guide the project planning processes. Evidentiary sources included literature obtained online and through database searches, input from a team of experts and institutional stakeholders, and surveys from project participants. Ongoing evaluation analyses of team members' feedback allowed for real-time changes to program content and meeting logistics. Team members' agreement about the meaningfulness of the project's goal, activities, and leader effectiveness revealed a mean score of 4.64 out of 5. Team members indicated that teach-back could improve patients' self-management ability and understanding of disease processes. The project outcome was a nurse education toolkit containing easy access to comprehensive learning resources tailored for use at a critical-access hospital. Nurses can positively impact social change by honing skills in the teach-back process as a way to evaluate patients' understanding of self-management and understanding of disease processes. The patients' understanding of educational materials pertinent to their disease process, self-care, and discharge is vital to their well-being and safety in the post hospital environment.

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Dedication

I want to dedicate this project to my amazing and loving husband. You supported me throughout this journey, and without you, I could not have come this far. You believed in me even when I did not. You were my legs to stand on, my shoulder to cry on, and my beacon of hope. I love you more than words can express.

Acknowledgments

I want to thank my family for supporting me through this life-changing journey. A special thank you to my mom, who was here with me in spirit with every step. Thank you, Dad, for inspiring me each day to be the strongest person I can be. My entire family has made sacrifices on my behalf, and I will be forever grateful to you.

I would also like to extend my appreciation to the nursing staff, providers, and administrative leaders at my project site. You allowed me into your space, revealed your weaknesses, and demonstrated your strengths. You all do amazing work, and your patients are fortunate to have you in their lives.

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Section 1: Nature of the Project

Introduction

Results from the 2003 National Assessment of Adult Literacy indicated that only 12% of adults in the United States have proficient health literacy skills (Kutner, Greenberg, Jin, & Paulsen, 2006). The U.S. Department of Health and Human Services (2010) defined health literacy as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (p. 1). Regardless of the patient's health literacy level, healthcare professionals must work to assure the patient's understanding of their health, self-care management, and discharge instructions (Agency for Healthcare Research & Quality [AHRQ], 2017). The teach-back methodology, whereby patients are asked to repeat back in their own words what is being taught, is a universal precautions approach to address low health literacy and is endorsed by the AHRQ as a best practice.

In this doctoral project, I developed a staff education project addressing health literacy by equipping nurses with skills to effectively use teach-back as a method to evaluate patient understanding. Nurses can positively impact social change through use of teach-back to evaluate patients' understanding. The patients' understanding of educational materials pertinent to their disease process, self-care, and discharge is vital to their wellbeing and safety in their post-hospital environment.

Problem Statement

I selected a critical-access hospital (CAH) in the midwestern United States as the site for this doctoral project. The target audience for the project comprised nurses

working in the medical-surgical unit at this hospital. Nurses working in this unit are often required to work in other areas including obstetrics, the emergency department, and outpatient infusion throughout a shift. Because of their work in multiple areas, these nurses are uniquely positioned to educate patients on many different topics. In observations of and discussions with the nursing staff on this unit, I learned that many were not familiar with the teach-back method and were not using it. Those nurses who stated that they were familiar with the technique, also admitted they lacked confidence in using it. When asked about evidence-based practice (EBP) in nursing, the nurses could not express how EBP is formally incorporated into their routine practices. Moreover, nurses lacked competency in EBP and the use of teach-back as a best practice in patient education.

In 2004, the Institute of Medicine published a ground-breaking document purporting that health systems are placing increased demands on consumers, requiring more individual responsibility for self-management of disease and navigation of the complicated available sources of health information, rights and responsibilities, and resources for making health decisions (as cited by Nielsen-Bohlman, Panzer, & Kindig, 2004). The U.S. Department of Health and Human Services' Healthy People 2020 (2018) identified increasing patient health literacy skills as a necessary strategy to improve health care quality and population health outcomes. With the most recent statistics showing that only 12% of U.S. adults have adequate health literacy skills and that U.S. adults aged 65 years and older have lower health literacy levels than younger adults (Kutner et al., 2006), nurses' evaluation of what patients understand from patient

education encounters is even more important now as the increasing complexities of the healthcare environment continue to rise. These points are especially pertinent, given that this hospital inpatient setting served a large population of elderly patients in 2017 and 2018.

Patient teaching is a fundamental skill for all nurses in all patient care settings. As patient educators, nurses play a crucial role in assisting patients with self-management techniques and disease-specific information. Patient understanding is a critical element of the teaching process. A staff education project addressing best practices in patient education techniques and teach-back methodology as a best practice to evaluate understanding will aid the nurses in honing their patient teaching skills.

Purpose

The identified gap in nursing practice in this setting was that nurses lack knowledge of EBPs in patient education. Use of a methodology such as teach-back is a best practice that helps nurses evaluate patient understanding and can universally address patients with low health literacy. McCormack, Thomas, Lewis, and Rudd (2017) developed a social-ecological model that moves the onus of health literacy from the patient to that of the health delivery system. In the social-ecological model, the delivery approach, communication skills of healthcare professionals, teaching tools and materials, and attributes of the health system all work to create an environment more suitable for the public to access and understand health information (McCormack et al., 2017).

Researchers have shown that use of teach-back as a method to address limited health literacy has resulted in improvement in patient outcomes such as self-management

(Griffey et al., 2015; Ha Dinh, Bonner, Clark, Ramsbotham, & Hines, 2016), discharge instructions including medication management (Griffey et al., 2015; Ha Dinh et al., 2016), rehospitalizations, disease-specific knowledge (Ha Dinh et al., 2016; Peter et al., 2015), and self-efficacy (Ha Dinh et al., 2016). Although the social-ecological approach shifts the responsibility of these patient outcomes to the health delivery system, for purposes of this doctoral project, the nursing staff will bear ultimate responsibility. For this reason, I used Bandura's social cognitive theory as the guiding theoretical framework for this project.

Bandura (1997) asserted that people with high self-efficacy are more likely to overcome difficult challenges, anticipate likely outcomes, and persevere by focusing on achievement rather than obstacles. The nurse must believe in the importance of teach-back as a patient education skill and have confidence in their ability to use teach-back to assure a patient's understanding despite that patient's health literacy level. The project-focused question for this doctoral project was as follows: In nursing staff within a CAH in the Midwestern United States, how does education of best practices in patient education and the teach-back process impact the nurse's confidence and conviction in using the teach-back method as measured from responses using a pre-post survey design?

This doctoral staff education project addresses the gap in nursing practice in various ways. It increases the nurse's knowledge about best practices in patient education, specifically the teach-back methodology, to reinforce the patient's understanding of teaching materials despite the patient's health literacy level. It also

equips the nursing staff with skills to increase their confidence in using the teach-back method and their conviction as to the importance of this best practice.

Nature of the Doctoral Project

The purpose of this project was to plan a program to educate nurses about the teach-back process as a best practice for patient education. The logic model provided a framework by which the relationships among project objectives, activities, resources, and outcomes were easily visualized (Stinson & Wilkinson, 2004). Successful project development includes the planning of all aspects of the program upfront, including objectives, activities, expected outcomes, a timeline, and evaluation methods (Hodges & Videto, 2011). Stakeholder participation in program development was essential. Inclusion of members of the target population, the nurse senators in this case, made the program content more meaningful and impactful (Woodford & Preston, 2011). A team of content experts from this institution's health system also provided input on the curriculum content of patient education best practices.

At the onset of this project, stakeholders met to discuss my objectives in planning a project to teach the nursing staff about the teach-back methodology. The majority of the activities throughout this project involved stakeholders' input into the curriculum content and appropriate delivery modalities. The expected outcome was that the team would assist me in developing an evidence-based education program on teach-back tailored to meet the unique needs of this CAH. Nurse senators, who I included in the planning process as representatives of the frontline nursing staff, were helpful in uncovering potential reasons that nurses lack knowledge of EBPs in patient education. I incorporated

their ideas into the education program. A timeline was shared for the planning stages of this project, and timeline changes took place based on stakeholder availability. A survey to assess the effectiveness of the planning processes and my leadership skills was the method of evaluation for this project.

Significance

One group of key participants for this project was the team of experts at the health system's enterprise office. The expert team consisted of the director of learning and development for the patient and community education department, the senior director of learning strategies, and a clinical educator. These individuals provided access to available institutional resources and guidance on possible modalities for the delivery of curriculum content; their assistance was helpful in tailoring the education project to meet this institution's needs. Nurse leaders in the organization were internal stakeholders. The chief nursing officer (CNO) and medical-surgical nurse manager are responsible for empowering the nurses toward professional learning and growth. These stakeholders are also responsible for the patients' satisfaction and health outcomes as a result of the care provided in this setting. This project contributed additional resources to both reinforce and expand the teaching skills of the nurses for whom the CNO and nurse manager are responsible. Two nurse senators were also internal stakeholders for this project. This institution has a nursing senate whereby nurses are elected as senators to represent the interests of the frontline staff. The insight from the nurse senators was invaluable to the design of this project. The chief executive officer (CEO) and finance director were additional stakeholders who were impacted by this project. A staff education project such

as this requires an investment of resources such as non-productive work hours and training materials. Once the program is deployed and as nursing staff transition to use of teach-back, this may negatively impact nurse productivity and potentially add to the initial cost of patient care as reflected in an increase in worked hours per patient day. However, the expected outcomes of increased knowledge of patient education best practices, and nurses' confidence and conviction in using teach-back could have positive long-term financial implications for the organization. All of the identified stakeholders served as evaluators of my leadership throughout the planning process.

Brooks, Spillane, Dick, and Stuart-Shor (2014) asserted that although much evidence exists supporting the effectiveness of evidence-based nursing interventions, there continues to be a gap in what is known and what is practiced. This project helped frontline nurses realize what EBP is and how it is translated into real-world practice. Some nurses in this setting have minimal exposure to EBP and a limited understanding of how it impacts nursing practice. This project helped bridge that knowledge gap.

Nurses who work within the medical-surgical unit at this CAH also work in other patient care areas. Skills and knowledge gained from this project apply to patient teaching in all patient care areas. The teach-back methodology is a means to evaluate the patients' understanding of information that is vital to their wellbeing and safety in their post-hospital environments. Teach-back is also an evidence-based method to address health literacy with a universal precautions approach (AHRQ, 2017). The universal precautions approach holds that because the actual health literacy level is unknown in most patients, the nurse uses patient education techniques with all patients with all health literacy levels.

Health literacy universal precautions are aimed at creating an environment where all patients have equal opportunity to learn, and all patients can thrive in a complicated healthcare environment (AHRQ, 2017). One of Walden University's goals for social change is to leverage research and resources to impact the lives of those living in various communities throughout the United States. (Walden University, 2017). Very few nurses practicing in this rural community are educated beyond a Bachelor of Science in Nursing. As a Walden University Doctor of Nursing Practice (DNP) student, I conducted a scholarly project that will help enable nurses in the rural Midwest to glean the best evidence and incorporate a change that could have a profound impact on the quality of life of the patients served. Additionally, the implementation of this doctoral project reinforced the translation of evidence to knowledge through EBP, which is an essential nursing competency missing in this setting.

Summary

Limited health literacy is a concern nationwide. The responsibility of patient learning, comprehension, and outcomes has shifted to healthcare providers. I identified a gap in nursing practice in a CAH in the midwestern United States involving nurses' lack of knowledge about best practices in patient education. The purpose of this doctoral staff education project was to plan an educational program through use of a team of stakeholders. The program was designed to teach nurses about the use of the teach-back process as a best practice in patient education. In the next section, I further explore the background and context of the staff education project and its applicability to the local setting. Additionally, I further detail both my role and those of project team members.

Section 2: Background and Context

Introduction

The purpose of this project was to plan a program to educate nurses about the teach-back process as a best practice for patient education. The practice problem I noted in this CAH was that nurses lack knowledge of EBPs in patient education. My desire was to increase nurses' knowledge so that they will routinely use teach-back as a best practice to evaluate patient understanding. The practice-focused question was as follows: In nursing staff within a CAH in the midwestern United States, how does education of best practices in patient education and the teach-back process impact the nurse's confidence and conviction in using the teach-back method as measured from responses using a pre-post survey design?

In this section, I discuss the background of this project, Bandura's social cognitive theory that informed this doctoral project and is described in more detail, and the relevance of health literacy and teach-back to nursing practice and the institution. I conclude the section by exploring my role as DNP student and the role of the project team.

Concepts, Models, and Theories

Albert Bandura's (2004) social cognitive theory "specifies a core set of determinants, the mechanisms through which they work, and the optimal ways of translating this knowledge into effective practices" (p. 144). The core determinants include knowledge, perceived self-efficacy, outcome expectations, goals, perceived facilitators, and impediments (Bandura, 2004). These concepts framed this doctoral

project. Increasing nurses' knowledge of the teach-back methodology as a best practice in patient education was my goal in this project. However, nurses must be confident in their ability to use the teach-back technique to be most impactful. When developing this project, it was necessary that I considered the barriers and facilitators of teach-back in order for the new knowledge gained through this project to be translated into everyday practice.

According to Bandura (2004), knowledge is the precondition for change. However, additional self-influence and a belief that one is capable of overcoming impediments to change are necessary to assure motivation and action (Bandura, 2004). Behavior is also affected by the outcomes people expect their actions to produce (Bandura, 2004). As nurses gain knowledge, confidence, and conviction in the use of teach-back, they will increasingly use it when conducting patient education activities.

In this CAH setting, nurses conduct much of the patient education. Thus, I have referred to them as *educators* throughout the project. Health literacy refers to basic literacy skills, which is the ability to read, write, speak, compute, and solve problems (U.S. Department of Health & Human Services, 2010). Health literacy also refers to numeracy (U.S. Department of Health & Human Services, 2010), which includes understanding the meaning of numbers and the ability to decipher medication dosages, labels, and dollar values. Because there is not a standardized method of screening patients for health literacy levels at this institution, I used a universal approach in this project. The universal approach assumes that all patients have limited health literacy. The term *patients* refer to people occupying a bed within the medical-surgical unit of the CAH.

The term *project* refers to my planning and implementation process as I developed the educational content and deployment strategies. The term *program* applies to the final product, which is the educational content that will be disseminated to the institutional leaders.

Relevance to Nursing Practice

Limited health literacy is a problem in the United States. Lower health literacy has been associated with higher mortality rates among older patients, patients' poorer abilities to take medications correctly and to interpret labels and health messages, and their poorer overall health status (Berkman et al., 2011). The AHRQ (2017) has adopted the teach-back method to address health literacy universally among all patients. Healthy People 2020 developed a national action plan to improve health literacy (U.S. Department of Health & Human Services, 2010). Despite poor patient outcomes and national efforts to draw attention to the urgency of this topic, healthcare professionals often lack adequate knowledge about health literacy and the patient teaching skills needed to address patients with limited health literacy (Coleman, Hudson, & Maine, 2013). Nurses play a pivotal role as healthcare educators and are in a position to impact the outcomes of all patients. Coleman et al. (2013) argued that standardized competencies on health literacy would help increase overall knowledge among healthcare professionals.

Nurses must learn to recognize health illiteracy (Nierengarten, 2018). Statistics have indicated that approximately 90% of U.S. adults are not health literate (Kutner, 2006). Health illiteracy reaches persons in all socioeconomic classes and educational levels (Nierengarten, 2018). If health literacy screening is not available, nurses can

incorporate recognition of health illiteracy warning signs into their daily practice. Some indicators of health illiteracy are patients' (a) frequently missed appointments, (b) incomplete medical or registration forms, (c) inability to state medication names and purposes, (d) inability to identify medications by looking at them, (e) infrequency of asking questions, and (f) not following through on tests or follow-up care (Nierengarten, 2018).

In the past, healthcare providers have used screening tools to address health literacy. In early research, many of the screening tools measured literacy and were adapted to apply to healthcare (Berkman, 2011). Newer instruments used to measure health literacy skills have focused on the patient's ability to read and, to some extent, use numbers (Berkman, 2011). Currently, no instrument is widely available to measure oral health literacy (Berkman, 2011). Several different screening tools exist, and each measures health literacy in different ways. However, no gold-standard tool is available to assess all aspects of health literacy including the interactions of reading ability, numeracy, and oral literacy (Berkman, 2011).

Healthcare providers have worked to adopt best practices in provider-patient communication to address health literacy. Clear health communication techniques include speaking in plain, non-medical language (Green et al., 2014; Nierengarten, 2018); confirming understanding using the teach-back method (Green et al., 2014) or the Ask Me-3 technique whereby patients state three things they will tell a loved one about their appointment; use of analogies or images to explain complex topics (Nierengarten, 2018); and inviting conversation through use of open-ended questions (Green et al., 2014;

Nierengarten, 2018). Healthcare leaders have used educational programs designed to instruct nurses on the teach-back method as a strategy to address health literacy. Reinforcing teach-back skills through simulation-based learning and interviewing patients following patient teaching by nursing staff to ascertain the patient's perspective on learning have been effective components to educational programs (Mahranus et al., 2012; Miller, Lattanzio, & Cohen, 2016). Systematic reviews of literature have shown that use of the teach-back technique is a best practice in health education programs and results in statistically significant improvements in patients' ability to self-manage chronic diseases (Dantic, 2014; Ha Dinh et al., 2016), and adherence to treatment regiments (Ha Dinh et al., 2016). A randomized control trial showed significant improvements in post-discharge medication management, understanding of discharge instructions, and self-care strategies of patients cared for by nurses using teach-back as a best practice (Griffey et al., 2015).

Nurses' assessment of health literacy is problematic, and there are no standardized tools available to screen patients in all aspects of health literacy (Berkman, 2011). Teach-back is a universal precautions approach to addressing limited health literacy and is a best practice recommended by quality, safety, and professional healthcare organizations nationwide (AHRQ, 2017; Institute for Healthcare Improvement, 2018). Teach-back is a best practice widely supported in literature as well (Dantic, 2014; Griffey et al., 2015; & Ha Dinh et al., 2016). This doctoral staff education project plan included teach-back as a method to address nurses' lack of knowledge about best practices in patient education.

Local Background and Context

The project site is a CAH located in the rural Midwest. According to the U.S. Census Bureau, as of 2010, this CAH serves a community of approximately 4,600 people and a greater county area of 161,000 people (DataUSA, n.d.). The mean age is 40 years (DataUSA, n.d.); however, according to the hospital's financial analyst, the mean age of patients admitted to the medical-surgical unit at this CAH in 2017 was 85 years, and in 2018 was 79 years. My observations of the nurses in the medical-surgical unit revealed that methods of patient teaching were not standardized. Many nurses chose to do all patient education at the time of discharge. Nurses did not use a method to evaluate the patient's understanding of educational materials. When asked about knowledge of the teach-back methodology, most nurses stated they were only vaguely familiar with the concept. Of those nurses who were familiar with the teach-back methodology, many admitted they lacked confidence in using it and stated that it was time-consuming. Nurses also expressed concern that due to the advanced age of many of their patients, methodologies such as teach-back would not be effective.

The mean patient census on this medical-surgical for the calendar year (CY) 2017 was 5.5 patients per day; this figure did not account for multiple daily discharges and admissions. The unit was staffed with a nurse to patient ratio 1:3-4; however, nurses on this unit were often asked to assist in other areas such as emergency department, obstetrics, or outpatient infusion throughout their shift. In CY 2017, the average length of stay (LOS) per acute patient was 3.11 days. The nurse could document the patient's preferred learning method in the electronic medical record (EMR) used at this facility.

However, the EMR functionality did not allow the nurse to assess a patient's health literacy level. The nurses on this unit stated that one of the most significant challenges to patient education occurs at the time of discharge. The nurses felt that when patients know they are being discharged, it is often difficult for the patient to concentrate on the content of discharge instructions. The nurses had access to printed patient education materials through the EMR. The EMR also provided an after-visit summary that includes all discharge instructions, including return appointments, a reconciled medication list, and specific instructions based on the patient's diagnosis. The short patient LOS, advanced patient age, demands of the nursing staff, limited educational resources, and lack of EMR functionality to assess health literacy contributed to nurses not conducting patient education at times and at a level conducive to patient learning. These factors, along with evidence based on observation of nurses and nurses' statements, highlighted the need for improved knowledge of best practices in patient education. The nurses' inability to screen for health literacy strengthened my decision to use a universal precautions approach to addressing patients with limited health literacy through the use of teach-back.

This institution is governed systematically by a board from the larger health system, and is governed locally by an advisory board. Administrative leaders report patient quality outcomes, such as readmission data, patient experience scores, and budget data comparing costs versus revenue to both governing bodies. Quality goals are outlined yearly in a performance improvement (PI) plan; progress toward goal achievement is shared regularly with all staff. The central themes of the PI goals are to reduce costs, which includes reducing patient readmissions within 30 days, improve patient

satisfaction, and improve the quality of care. Leaders of this health system believe that by addressing health literacy through best practices such as the use of plain language and teach-back methodology, the PI goals can be accomplished.

In this paper, the term *board* refers to a group of key stakeholders, including executives, nursing officers, financial officers, physicians, and community members, that convenes to discuss the institution's operations. This institution is one hospital and clinic amongst hundreds of others within the same health system. The term *enterprise* is used to indicate the entirety of all hospitals and clinics within the health system across four states in the Midwest. A CAH must meet critical access criteria defined by the Centers for Medicare and Medicaid Services (CMS, 2017).

The project site hospital is in Minnesota and is a member of the Minnesota Hospital Association (MHA); the CEO is as a board member for the quality and patient safety division of this organization. One initiative that the MHA sponsors and this institution participates in involves the use of roadmaps for various patient quality and safety programs. The goals for the use of the roadmaps are to help hospital staff formulate improvement plans based on gap analyses (MHA, n.d.). Many of the fundamental elements in these quality and safety initiatives involve patient and family education. Use of best practices in patient education is a mitigating factor in improving patient safety and quality outcomes.

Role of the DNP Student

Professionally, I work for a national performance improvement company as a programmatic advisor on a CMS-funded grant program to improve the quality outcomes

and lower the cost of care for ambulatory care settings nationwide. In this professional space, I advise ambulatory leaders, providers, and nurses on patient and family engagement and health literacy. I have experienced first-hand that health literacy is unknown to many nurses and physicians across large and small health systems nationwide. By implementing a staff education project that addresses patients' health literacy through the use of best practice approaches to patient education, I am aligning academic and professional ambitions with national, state, and institutional priorities.

The site chosen for this project is part of the same health system in which I was employed for over 10 years. In my former role as nurse director, I collaborated with the CNO of this CAH on several projects. The leadership staff at this facility are open-minded and remain patient-centered in all aspects of healthcare delivery. I am also a patient at this facility and use the primary care clinic that is housed in the same building as the hospital.

I have several motivating factors driving the decision to focus on health literacy. I am the primary caregiver for my elderly father, who meets the previously described criteria of being health illiterate. I realize that the use of plain language, clear communication strategies, and teach-back are essential to help him understand his health and how to navigate the health system. Throughout my professional career, I have observed many nurse-patient encounters where clear communication techniques and methods to reinforce learning were not utilized. I witnessed nurses labeling patients as *noncompliant* or *difficult* when patients did not follow through with the suggested follow-up care, rather than considering that the patient may be health illiterate.

This health system has a health literacy department that has worked on the development of patient education materials for many years. I worked in this same health system previously and know that historically, resource availability has not been communicated effectively to all institutions, enterprise wide. The CEO and CNO at this project site did not realize that the health literacy department existed. There have not been deliberate efforts made to deploy hands-on learning of teach-back at this site. These experiences may have contributed to personal bias. I mitigated these biases by involving members from the health literacy department on my team. Their skillset as content experts provided a unique perspective from the enterprise level. I worked together with this team to provide an assessment of nurses' needs institutionally, and together we tailored the educational content accordingly. This relationship helped strengthen this institution's ability to adapt other best practices in patient education by utilizing similar planning processes as the teach-back project.

Role of the Project Team

A team of internal stakeholders consisting of the CNO, medical-surgical manager, nurse senators, CEO, and experts from the enterprise's education and health literacy departments, participated in the planning of this doctoral project. The finance director was an ad-hoc member of the team; as financial implications of this project arose, we sought her assistance. I held an in-person meeting, with a virtual option for attendance, to give background information and supporting evidence, and to show the local relevance of teach-back.

Meetings and email provided opportunities for team members to share insights into past patient education practices, previously used education strategies, and important local context. The research evidence outlined in Section 3 that validated the teach-back methodology as a best practice and demonstrated effective hands-on strategies of the teach-back technique was included in meetings. All stakeholders were invited to a final report-out in which I presented the complete staff education program package.

At the first stakeholder meeting, I asked members to serve as evaluators of my leadership and execution throughout the planning process of this project. Evaluators were emailed a link to an online survey after each meeting to be completed within 1 week. The online survey platform was very user-friendly and protected the anonymity of the evaluators.

Summary

Bandura's social cognitive theory informed the work for this DNP project. Health literacy is a topic unfamiliar to many nurses, including those at this institution. Taking into consideration the demographics of the patient population, the nursing staff structure, the noted gap in nursing practice, and organizational goals of this CAH, this staff education was both relevant and impactful. With the assistance of a team of key stakeholders, I planned a staff education program to address best practices in patient education tailored for use at this project site.

The next section expands on the practice-focused question and provides more details on the sources of evidence used to support this work. I describe the evidence

generated for the DNP project, including specific data collection steps. Finally, I share the plan for data analysis and synthesis.

Section 3: Collection and Analysis of Evidence

Introduction

Limited health literacy is a concern nationwide. Despite the unknown health literacy level of patients, the responsibility of patient learning and comprehension has shifted to healthcare providers. Patient teaching is a fundamental skill for all nurses in all patient care settings. Patient understanding is a critical element of the teaching process. The purpose of this project was to plan a program to educate nurses about the teach-back process as a best practice for patient education. The logic model was the framework by which the project planning elements were organized and evaluated.

In the following subsections, I offer a more expansive look at the purpose of the project and its alignment with the practice-focused question. I then discuss the sources of the evidence that informed the practice-focused question and collection methods. Section 3 concludes with a discussion on the evidence generated for this doctoral project, including a plan for data analysis and synthesis.

Practice-Focused Question

Nurses in this CAH are required to educate patients on many different topics. The nurses do not have a method to assess a patient's health literacy level, and many nurses state they are unfamiliar with methodologies to assure patient understanding, such as teach-back. The identified gap in nursing practice in this setting was that nurses lack knowledge of EBPs in patient education. The project-focused question for this doctoral project was as follows: In nursing staff within a CAH in the midwestern United States, how does education on best practices in patient education and the teach-back process

impact the nurse's confidence and conviction in using the teach-back method as measured from responses using a pre-post survey design?

The alignment between the education project and the practice-focused question was demonstrated in several ways. Experts on health literacy and patient education best practices contributed to the program's curriculum content and delivery modalities. The institution's nurse leaders spoke about any training on best practices that nurses had received in the past and the delivery methods that were successful and unsuccessful. Nurse senators assisted in recognizing barriers and facilitators to use of teach-back so that mitigation strategies could be incorporated into the education program. It was through this planning process and use of key stakeholders that the educational content was tailored enough to ultimately improve the nurse's confidence in the use of the teach-back and belief in the importance of its use.

One key operational definition that may require further clarification is that of *planning*. The planning process consisted of a series of meetings with me, the experts, and the internal stakeholders. The agenda for each meeting targeted teach-back and related patient education best practices, and meaningful modalities for delivery of the educational content to the nursing staff. The planning also included a timeline, objectives, activities, expected outcomes, and an evaluation strategy.

Sources of Evidence

Relationship and Appropriateness of the Evidence

I drew primary sources of evidence for this doctoral project from the literature. I searched CINAHL, MEDLINE, Cochrane, and Joanna-Briggs databases using keywords

such as *teach-back, teach back, health literacy, logic model,* and *plain language*. The search was limited to articles with publication dates ranging from 2004 to 2018. With the practice-focused question, I sought to determine if educating nurses in the use of teach-back methodology as a best practice in patient education can increase the nurse's confidence and conviction in using the teach-back technique. Moreover, articles supporting teach-back as a best practice, techniques in patient education, and the theoretical underpinnings of self-efficacy were chosen to inform this doctoral project. Online resources obtained using the Google and Google Scholar search engines on topics of health literacy and resources employed by several nationally recognized healthcare organizations served as additional sources of evidence to lend credibility to this doctoral project. I also used video clips found in the public domain in the education program to reinforce concepts of patient education best practices and teach-back. The purpose of the project was to plan staff education; therefore, I chose sources about best practices of program planning and evaluation based on the logic model.

A team of experts provided additional evidence for this project. The experts consisted of a director of learning and development for patient and community education, a senior director of learning strategies, and a clinical educator. The experts contributed insight on best practices to address adult learners. The teach-back method requires patient teaching techniques such as the use of plain language and explanation of concepts in short phrases. The nurse must rephrase if the patient is not able to repeat back the concept accurately. These experts provided curricular ideas and advice on how best to teach these strategies to nurses with all levels of experience. The experts added awareness of the

availability of education delivery modalities within the health system. They also aided in the creation of new resources that blended the concepts of health literacy and self-efficacy. Other stakeholders at the project site who contributed evidence to this project were the CEO, CNO, nurse manager, and nurse senators.

The final source of evidence was the team's evaluation of the planning process and my leadership of the project. The logic model was the framework I used to evaluate the effectiveness of the program (see Frye, Poe, Wilson, & Milligan, 2018). The logic model helped the participants visualize the project inputs, outputs, and outcomes (Frye et al., 2018). I used the logic model to provide a project framework from which the team members worked to incorporate formative evaluations of the planning process. This model also helped assure all activities were effective, timely, and remained in-line with the project objectives and goals. I asked all team members involved with this project to provide a summative evaluation of the planning process and team leadership.

Evidence Generated for the Doctoral Project

Participants. The director of learning and development for patient and community education was chosen because of his expertise in health literacy and adult learning principles. He worked at the health system's enterprise level in developing a standardized model for patient education and had in-depth knowledge of available resources to aid in teaching the elements of the teach-back technique. The senior director of learning strategies was a DNP prepared nurse with vast amounts of experience in patient education and leadership of the complex elements of project implementation. She was an expert on the creation of patient education resources that blended health literacy,

self-efficacy, and motivational interviewing techniques. The clinical educator brought a fresh perspective on methods of teaching to frontline nurses of all skill levels. She was an expert on health literacy and teaching these concepts to nurse residents and providers at the enterprise level. All of these experts verbally agreed to participate in this doctoral project. Each had knowledge about available resources and authority to share them. These experts provided a foundational gateway for local leaders at the project site to leverage enterprise-level resources to impact future EBP changes. Finally, these experts were instrumental to the dissemination of the findings from this doctoral project.

I chose the internal stakeholders to contribute local context and background to the project. These stakeholders had a deep understanding of the nursing culture and historical context of attempts at instituting best practices that the staff has undergone. I worked with these stakeholders on previous projects where they demonstrated characteristics of being change agents, were highly engaged, and had established credibility within the organization.

Procedures. I collected evidence from the sources above via meetings with team members. Since the purpose of this doctoral project was planning of the educational program, it was imperative that the structure of each meeting be action-oriented. The logic model, as shown in Figure 1, was used to illustrate to each team member their role in contributing to the planning and evaluation process.

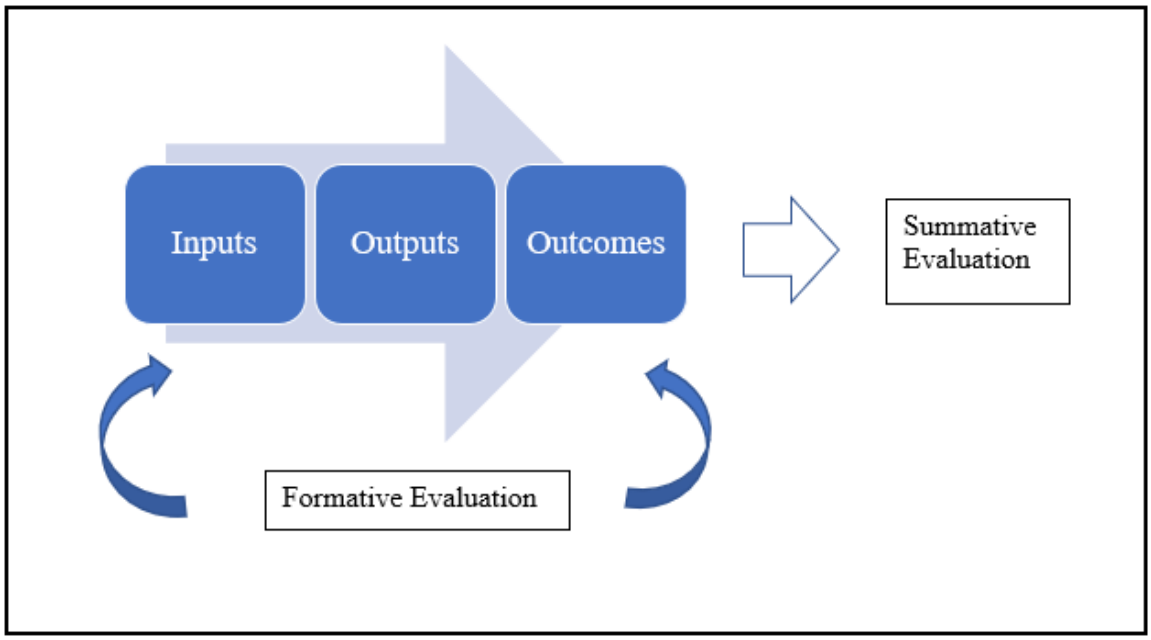

Figure 1. Logic model for planning and evaluation of teach-back education. Adapted from "Basic Logic Model Template," by U.S. Department of Health and Human Services, n.d., retrieved from https://www.hhs.gov/ash/oah/sites/default/files/logic-model-template-worksheet3_0.pdf

The project inputs included meetings that involved sharing of the project background, analysis and synthesis of the evidence-based literature, and discussion of my goals and objectives for the project. An assessment of the current state of patient education tactics along with historical context were also inputs into this body of evidence. The outputs included the activities necessary to design the educational content and delivery modalities of the teach-back technique. Comparisons of available resources about teach-back and patient education techniques against sources on best practices in the literature were among the activities. The outputs section also included each participant's role and responsibility as it related to the activities. A Gannt chart showed the project timeline for each of the events. The outcome was an education program to teach nurses

on use of the teach-back technique, equipped with all relevant content to deploy to nursing staff.

The team members conducted the formative evaluations of the project planning throughout all stages of the logic model. These evaluations assured that the most effective communication techniques, agenda structures, activities, and member participation were taking place to produce the desired outcome. For purposes of the summative evaluation, I used a survey form with questions designed to evaluate the effectiveness of the meetings, meeting contents, meeting logistics, and my leadership as the project leader. The final evaluation involved a 10-question Likert scale with agreement options ranging from 1 = strongly disagree to 5 = strongly agree, and two additional questions to obtain qualitative data.

Protections. Working at this project site through practicum experiences in Walden University's DNP program afforded me the ability to establish relationships with the team of experts and internal stakeholders. Each participant received a preapproved consent form. This document provided an explanation of the questionnaire procedure, information on the voluntary nature of the project, risks and benefits of project involvement, a privacy notice, and information on who to contact if there were questions (Walden University, 2017). Through this project, I have referred to team members by his or her title only. The hospital and healthcare system were identified by general location rather than by name. All project participants were offered the opportunity to provide feedback in an anonymous online platform. All data collected will be retained according to the Walden DNP program policy. Walden University's institutional review board

(IRB) assigned approval number 11-14-18-0178333 to this project before any activities specific to the doctoral project began. All data sources I used for this project were in agreement with the IRB clearance, which included publicly available data, video clips located in the public domain, literature, and anonymous questionnaires.

Analysis and Synthesis

A repository of evidence from literary sources and the team members was collected and organized in an Excel workbook. As the team members presented curriculum concepts and content, these were compared to best practices found in the literature. The team used a Gannt chart to track the planning activities in comparison to the expected timeline. The workbook also contained the meeting agendas, meeting minutes, and other materials pertinent to the planning process.

The opportunity for team members to provide feedback throughout the planning process was offered through the use of an online platform called SurveyMonkey. I sent an email that included meeting minutes and a link to a SurveyMonkey survey that prompted the participant to provide anonymous feedback in a qualitative format.

I analyzed the qualitative data received throughout the formative evaluation process for common themes. I incorporated any common themes regarding necessary changes to program content into future meeting agendas. Common themes about programmatic changes, meeting structures, or leadership style concerns were reflected upon and changes were made accordingly. The summative evaluation form was based on a Likert scale. I converted the results from the online platform to a .csv file and exported them to an Excel spreadsheet. Due to the small number of survey responses, mean values

were the statistical test for each question. The mean value was an appropriate test for ordinal level data such as the scores from a Likert scale (Grove, Burns, & Gray, 2013). In this context, lower numbers represented less of the construct, and higher numbers represented more of the construct (Grove et al., 2013). The last two questions on the summative evaluation were reviewed for emerging themes.

Summary

Literature reviews, input from the enterprise's team of experts and internal stakeholders, and evaluations were the sources of evidence I used for this doctoral project. The logic model was the framework that aided in the visualization of the planning and evaluation processes. I used Excel and SurveyMonkey to collect, organize, and analyze the contributions from the evidentiary sources and related materials throughout the project planning process.

In Sections 4 and 5, I expand on the project findings, implications, and dissemination plan. In Section 4, I present the project results, recommendations to address the practice gap, and applicable tools and resources developed as a result of this project. Section 4 concludes with discussion of the contributions from the project team, and project strengths and limitations. Section 5 includes more details on the dissemination plan for the project findings and a self-analysis.

Section 4: Findings and Recommendations

Introduction

It is estimated that 78% of U.S. adults 65 years and older have low health literacy skills (Kutner et al., 2006). The mean age of patients in the medical-surgical unit at this CAH in 2017 and 2018 was 85 and 79 years respectively. Nurses in this setting are in a position to conduct patient education routinely due to limited available resources. The onus of assuring patient understanding is on the nurse rather than the patient, yet nurses in this hospital lack knowledge of EBPs in patient education and teach-back process. The practice-focused question was: In nursing staff within a CAH in the midwestern United States, how does education on best practices in patient education and the teach-back process impact the nurse's confidence and conviction in using the teach-back method as measured from responses using a pre-post survey design? The purpose of this doctoral project was to plan a program to educate nurses about the teach-back process as a best practice for patient education.

Sources of Evidence

As discussed in Section 3, scholarly journal articles and information from reputable websites were the primary sources of evidence. I searched academic databases including CINAHL, Medline, Joanna-Briggs, and Cochrane for recent and relevant articles. Of these articles, those with the highest level of available evidence were chosen to demonstrate teach-back methodology as a best practice in patient education, as well as the use of the teach-back technique to improve patient outcomes.

Team meetings with internal stakeholders and a team of experts in patient education served as valuable sources of evidence. The internal stakeholders gave insightful information about the current state of patient education practices among nursing staff, perceived barriers to the use of teach-back, and previous education they received about best practices in patient education. The internal stakeholders confirmed that education on patient education best practices, and specifically teach-back, was lacking. None could recall recent education opportunities on these topics. The experts gave guidance on how to best structure the program to meet adult learners' needs. The experts offered advice on building self-efficacy in the use of patient education best practices among nursing staff. The team reinforced that a comprehensive, tailored, and accessible education program such as this would prove valuable to address the gap in nursing practice.

The final source of evidence came from anonymous surveys that members of the team completed throughout the program planning process. Following each team meeting, members received a link to an online survey whereby he or she shared qualitative feedback. I analyzed the data to capture any themes regarding program content, meeting structure and logistics, and leadership characteristics, and made adjustments accordingly. Following the final meeting in which the final project report-out occurred, team members completed an online survey using both a Likert scale and a free text option for final comments. The results of this survey were exported to Excel, where I performed statistical analysis and qualitative data review.

Findings and Implications

Findings

Formative evaluations were one strategy I used in this project. Team members provided responses to questions asking about recommendations for changes to the program curriculum, the meeting format, content, logistics, and my leadership skills. Several themes emerged that are worth noting. Respondents expressed frustration about the virtual platform used to allow meeting access for remote team members, stating that it was difficult to hear and see each other. Some respondents suggested that I pause more often to allow adequate time for commentary or feedback. Concerns arose about the proposed length of the classroom lecture and the overall program. Finally, many expressed their satisfaction with my willingness to listen to feedback and for repeating key discussion points. These qualitative data prompted several changes as the project progressed. A different delivery format of the online platform was used that allowed participants to hear and see each other; however, due to technological limitations, participants in the virtual setting had to open documents on their computers for viewing. I made adjustments by referencing the materials being viewed and built in more pauses for reflection. I held two ad-hoc meetings in smaller groups to discuss the delivery format and program length.

Summative evaluations were used as an additional approach to project evaluation. Team members responded to 10 questions related to the project's content and conduction, as well my leadership throughout project planning and implementation (see Appendix A).

A total of five surveys were collected, which represented a 63% response rate. Answers were recorded on a Likert scale.

Table 1

Summative Evaluation Results

Questions	Mean value
The problem made clear at the beginning.	4.8
DNP student analyzed and synthesized evidence-based literature.	4.8
Meeting agendas sent out in a timely manner.	4.8
Meeting minutes submitted in a timely manner.	4.8
Feel that you had input into the process.	4.8
Stated program goal appropriate.	4.6
DNP student's leadership throughout the process.	4.6
Meetings held to the allotted time frame.	4.6
Consider the meetings productive.	4.4
Stated project objective met.	4.2

Note. Responses measured on a Likert scale from 1 = strongly disagree to 5 = strongly agree.

As noted in Table 1, the majority of participants felt that the project goal was clearly defined and the meeting agendas and minutes were communicated in a timely manner. Most team members felt that I effectively communicated the supportive evidence from the literature. Although participants thought that they had input into the planning process, there were mixed feelings about the productivity of each meeting. The respondents also seemed unclear if the project objectives were met.

The summative evaluation contained two additional questions regarding opinions of my strengths and areas in need of improvement and the potential impact of teach-back in the local community (Appendix A). These qualitative data revealed that team members felt that I listened to them. This was evident by statements such as "receptive to

feedback" and "responded to feedback, especially about adjusting the time frame for program participation to support frontline staff being able to attend." Participants also found that the project will have the potential to be impactful to community members. One team member wrote, "It will improve the patient's understanding of all education…and hopefully [patients will] have a better understanding of their diagnosis." Another member responded similarly, stating that regarding the patient, teach-back "will result in greater understanding of how to care for themselves and better understanding of their medications and diagnosis."

Technology issues were an unanticipated limitation encountered during the planning process. Use of a virtual platform enabled the team of experts to participate remotely; however, interacting with team members while viewing documents was not possible. The formative evaluations reflected this frustration, and the team attempted mitigation strategies with limited success. These limitations may contribute to the team's reluctance to participate in future evidence-based practice projects requiring the assistance of others from remote locations.

An additional unexpected limitation of this project was the expert team's desire for enterprise standardization of patient education materials. Rigorous standardization without regard to local barriers and context has so far resulted in a lack of resources and engagement by nursing staff regarding patient education at this project site. Due to standardization, program materials consisting of computer-based learning modules have been the primary source of nurse education. Local leadership receives no outcomes data

or other insight pointing to the effectiveness of this type of learning modality as a method to increase nurse's knowledge or affect behavior change.

Implications

Each nurse senator played a vital role in this project; their assessments of the current state of nursing practice regarding patient education largely contributed to the final program content. Each participant could realize first-hand the impact that formative evaluations can have in driving change throughout project planning. This project was insightful to the institution's leadership team as well. Although not new to the institution, both the CNO and nurse manager were newly appointed to their positions at the onset of this project. Participation in this project helped to enhance these nurse leaders' capabilities in leadership and knowledge translation of EBP. Equally as important as building skills, members of this institution learned about system-level experts that can aid in future EBP patient education projects. Institutional leaders were unaware of the health literacy experts previous to this project.

Through working in this project, it became evident that there is a significant lack of technological solutions to patient education at a system level. The CNO expressed concerns that many of the patient education materials were only available in a computer-based platform. This institution did not have access to tablets or other devices that enabled the patient to see and hear the educational materials effectively. After further investigation of other regional CAHs, system leaders realized that this problem existed elsewhere and was due in part to budgetary constraints. Shortly after the CNO raised this concern, the CEO received an enterprise-generated survey asking about the facility's

availability of tablets or other similar devices for patient education purposes. The team was hopeful that work with this project was the impetus for the inquiry, and that this technology barrier will be mitigated.

The desire is that there will be downstream effects on community members as a result of this project. This project has enhanced a local awareness of health literacy, patient education best practices, and teach-back methodology. This project site is in a rural location where many of the patients are also community members. Community members will ultimately benefit from the change in nursing practice, as nurses are persuaded of the importance of teach-back and feel more confident in their patient teaching abilities. As nurses assume accountability for patient education regardless of the patient's health literacy level, he or she can profoundly impact the health outcomes of patients in their communities. Through this project, the internal stakeholders and staff nurses are more equipped to accept this responsibility.

Recommendations

The project planning culminated with the design of a patient education toolkit. The toolkit is intended to be a document with comprehensive content sufficient to conduct patient education to a target audience of medical-surgical nurses at this CAH. As shown in Appendix B, the toolkit contains sections titled Implementation Guide, Objectives, Learning Resources, Tools for Nurse Leaders, Evaluation Plan, and References. The implementation plan provides a background on health literacy and teach-back methodology as a best practice in patient education. The local context and gap in nursing practice are identified in this section, which helps the learner realize the

program's importance and relevance. The implementation plan also includes a step-by-step guide to maximize the use of the toolkit. This guide supports the nurse educators in better understanding of how to deploy each of the learning resources, address the logistical aspects of the course, and prepare any class materials in advance.

The education program will likely be deployed by a formal nurse leader (or leaders) within this institution; there is not a formal nurse educator at this facility. The objectives articulate the program's intentions and set expectations for the educator and learners. The Learning Resources section contains links to the materials necessary to deploy the program curriculum. Several of the learning resources are described in more detail in the following paragraphs. The toolkit's Tools for Nurse Leaders segment has links to resources that will enable both informal and formal leaders to coach and mentor the nurses as they begin using the best practices in patient education and teach-back. In the Evaluation Plan section, there is a link to an Excel workbook where the results of the Conviction and Confidence Scale (Always Use Teach-Back, 2018) can be recorded. References make up the final piece of the toolkit.

Secondary Products

One of the primary learning resources for this education program is a PowerPoint presentation designed to be administered as a lecture in a classroom setting. Appendix C contains a sample of this presentation. I have changed the design and some content of the PowerPoint slides in Appendix B from the original format to maintain the confidentiality of the project site. The PowerPoint has 30 total slides, including the title and references. The lecture is estimated to take approximately 1 hour to complete. The content for the

lecture is from several evidence-based sources that are referenced at the end of the slide deck. The selected material provides a brief background on the topic of health literacy, gives local context and current state, teaches about the patient education process, and further develops the concepts of the patient education process through different learning methodologies. The content also addresses the local needs and barriers that the internal stakeholders identified at the initial team meeting, including perceptions of not enough time to use teach-back and waiting until discharge to conduct the majority of patient teaching. The presentation's learning methodologies include lecture, interactive dialogue, watching videos, practice exercises, and group activities. The content's delivery modalities vary throughout the lecture to appeal to adult learners with various learning styles. Each of the slides has speaker notes that assist the educator in teaching the content and reinforcing the corresponding key points.

The tools for nurse leaders are essential components of the toolkit. Appendices D and E show examples of a handout with coaching tips (Always Use Teach-Back, n.d.) and an observation tool (Always Use Teach-Back, n.d.) respectively. In the toolkit's Tools for Nurse Leaders section, there are links to several video clips to aid in coaching and mentoring the nursing staff. All of the elements in the nurse leader section are relevant for both formal and informal nurse leaders. Appendix F includes a copy of the Conviction and Confidence Scale (Always Use Teach-Back, 2018) that will be used as the evaluation strategy for this program. In Appendix G there are sample graphs from the Excel workbook designed to visualize the data and monitor the progression of the nurses'

responses to the Conviction and Confidence Scale (Always Use Teach-Back, 2018) throughout program deployment.

Implementation and Evaluation

Program implementation begins by asking nurses to complete the Conviction and Confidence Scale (Always Use Teach-Back, 2018). Nurse leaders must decide on what portions of the toolkit make sense to deploy to staff in advance of the classroom lecture, if desired. The toolkit's Learning Resources area contains links to two options that would be advantageous for the nurse to complete in advance. One is a handout describing teach-back competencies, and the other is an online interactive module. The classroom lecture reinforces the competencies from these two resources. The classroom lecture using the PowerPoint, followed by a second completion of the Conviction and Confidence Scale (Always Use Teach-Back, 2018), are the final implementation elements. The lecture includes a discussion with the frontline nurses about accountability, and prompts the educator to demonstrate the observation tool (Always Use Teach-Back, n.d.). Based on these discussions, nursing leaders will decide on a suitable format for holding frontline nurses responsible for teach-back and the patient education best practices learned in the program.

The evaluation strategy for this program involves use of the Conviction and Confidence Scale (Always Use Teach-Back, 2018), which is a tool used to assess the nurse's confidence in using the teach-back technique, sense of importance and frequency of use of teach-back, and frequency of use of several best practices related to teach-back methodology. The responses to the conviction, confidence, and frequency in use of teach-

back are recorded on a Likert scale. The nurse also chooses from a list of best practices in teach-back methodology that he or she used more than half the time in the past week. Nurses will record responses to the survey during the periods of pre-program implementation, immediately post-program implementation, and again at 1- and 3-month intervals following the program's conclusion. The mean value of all responses is the statistical analysis used to measure change.

Contribution of the Doctoral Project Team

Team members attended the introductory meeting in which I described the synthesis of literature, project vision, goals, objectives, timeline, and each team member's responsibility. Each member received the preapproved consent form and agreed to participate. The internal stakeholders gave perspectives on the current state of frontline nurses' patient education assessments and on several different barriers that nurses encounter with patient teaching and teach-back. The team of experts listened to the internal stakeholders and confirmed that many similar barriers exist in other like-sized hospitals across this health system. The expert team also suggested I use learning methodologies that apply to adult learners. Following the introductory meeting, I developed the first draft of the program and emailed it to the team of experts for review.

In an ad-hoc meeting with the expert team, each member recommended program adjustments that ultimately led to a conceptual change from the original idea of a competency to a toolkit. The expert team also gave suggestions on changes to the classroom lecture PowerPoint that helped reinforce critical messages. At the second all-member team meeting, we examined the toolkit and the PowerPoint lecture. This meeting

concluded with a collective agreement that the projected program length of 2.5 hours was too long. As a result, the internal team met in an ad-hoc meeting where we dissected the toolkit to assure that the instructions and contents within each section of the toolkit were easy to follow, value-added, and accessible. This process included scrutinizing every slide within the lecture PowerPoint and also the Excel workbook. The internal stakeholders offered ideas to shorten the program, including reducing the number of lecture slides, and determining which of the toolkit's program elements could be deployed and completed ahead of the classroom lecture. Presently, there are no plans to extend the project beyond the DNP doctoral project timeframe. However, the internal stakeholders plan to utilize the toolkit and launch the program in an upcoming skills lab.

Project Strengths and Limitations

The use of nurse senators to help identify barriers to using teach-back and offer insight into actual nursing practice was a strength of this project. The input from a diverse team of experts who specialize in both patient and nurse education was an additional strength. The application of various learning methodologies for adult learners improved the education program and helps assure successful implementation.

The team's conflicting schedules made it impossible for all members to be present at all the meetings. Competing priorities caused some team members not to have opportunities to review meeting materials ahead of time. The technology was not available that allowed all participants to hear and see each other, while simultaneously viewing the documents. These limitations collectively resulted in participants' inability to listen to all perspectives and required rework of several program items. Time constraints

limited the ability for frontline nursing staff to review and provide commentary on the program. A final limitation was that the survey data included a limited number of responses and may not be representative of all staff members' opinions.

Before commencing a future nurse education project, I suggest securing any available template(s) the health system uses for competencies or toolkits. Exploring alternative venues to sharing materials other than email and Skype, such as a shared computer drive on the organization's intranet, is strongly recommended for future projects. Additionally, more frequent team meetings with a narrower scope of material to review should be considered.

Section 5: Dissemination Plan

I provided all of the program materials to the institution's executive director in a paper form and on a flash drive. The CNO and nurse manager have made plans to implement the program as part of the nurses' skills lab requirement. The results from the implementation of this program will be featured in poster format in this health system's upcoming performance improvement (PI) symposium.

This health system has over 20 CAHs in the Midwest, many with comparable patient demographics. Because nurses in these hospitals all use the same EMR system, barriers to health literacy assessment likely exist across the health system. It is probable that nurse leaders working in these CAHs face the similar challenges of lack of resources and restrictions of time to educate nurses about best practices in patient education. Nurse leaders would welcome the toolkit because it provides convenient access to evidence-based methods for patient education. This health system has several venues by which to disseminate the toolkit and results from program implementation, including regional PI symposiums, CNO retreats, and CEO meetings. This project site is also intimately involved with the MHA's patient safety and quality division, whose members represent rural CAHs across the state. Dissemination of the toolkit to this broader audience would enhance the patient education skills of nursing professionals across the state.

Analysis of Self

This project experience gave me valuable insight into the strengths and challenges facing bedside nurses and nurse leaders in rural CAHs. Although my experience as a practicing bedside nurse was in a rural hospital, I have not experienced the complexity

and fluidity that nursing practice in a critical access setting requires. Nurses in the CAH environment must be generalist practitioners. These nurses may experience patient encounters in obstetrics, emergency department, and medical-surgical areas over the course of a single shift. Gaining perspective from nurses in this setting and having them as members of my team proved invaluable as the project unfolded.

My experiences as a nurse director and quality improvement advisor fueled my desire to produce a useful resource to aid nurse leaders in teaching nurses about best practices in patient education. Locally, there is a major lack of resources of both time and materials for nurse leaders to educate frontline practitioners about the importance of and potential impact that patient education best practices can have on patient outcomes. The awareness of health literacy and usefulness of teach-back is even more scarce. My experience working with healthcare organizations across the country has indicated that these trends exist nationally as well, and are notable in hospitals large, small, urban, and rural.

Leading this project with an interdisciplinary team of professionals honed my skills as a nurse leader. Harnessing my passions for patient and family engagement and fostering the development of frontline nurses and nurse leaders while producing practical resources to improve patients' lives proved an even more invaluable experience. Professionally, I work with healthcare teams across the United States. My long-term professional goals include helping emerging leaders across the country incorporate EBP into their health systems to improve the lives of patients in their respective communities. I also want to serve as a subject matter expert on EBP translation.

This project culminated with a final report-out and presentation of the teach-back education toolkit. At the last meeting I was able to reinforce several key points that made this project successful, such as including nurse senators as participants, incorporating feedback throughout the planning process, and maintaining momentum. The quantitative data from the summative evaluations indicated that not all participants felt the meetings were productive, and there was uncertainty whether the project objectives were met. In future projects I will incorporate the project objectives into each meeting agenda. The team may have found more value in each meeting knowing that the activities were customized to meet the objectives and goal.

Summary

Health literacy is a problem in the United States. Even though formal health literacy assessments are not performed, the patient demographic at the project site CAH suggests that limited health literacy exists. Regardless of a patient's health literacy level, it is the nurse's professional obligation to teach the patient using methods grounded in EBP. The gap in nursing practice I identified early in this project was that nurses at this CAH lacked knowledge of best practices in patient education and were not using a method to evaluate the effectiveness of the teaching process. As such, a team of internal stakeholders and experts in patient education helped in planning a program to address teach-back methodology as a best practice in patient education. Ongoing feedback throughout the planning process contributed to changes in program content, length, and delivery modalities, as well as meeting structure. Summative evaluations showed strong agreement that the problem of health literacy, supporting literature, and project goals

were clearly articulated. Most strongly agreed that the goal of designing an education program about teach-back was appropriate, and members felt they had adequate input into the planning process. Several team members commented that the use of teach-back will be effective in improving patient's self-management and understanding of their diagnosis.

This project brought attention to the idea that health literacy can be addressed universally through the use of teach-back. Nurses at this CAH can impact positive social change by improving patient outcomes through the adoption of EBP to improve patient education. Nurse senators' participation in the planning process as members of the target population assured that the frontline nurses' voices and perspectives were woven into the education program. Nurse leaders now have access to a practical and user-friendly toolkit in which to conduct nurse education. This project showed that incorporating EBP into routine nursing practice is achievable and something all frontline nurses have the power to influence.

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Appendix A: Project Summative Evaluation

Stakeholder/Team member Evaluation of DNP Project

Problem:

Purpose:

Goal:

Objective:

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

	1=SD	2=D	3=UC	4=A	SA=5
Q1 Was the problem made clear to you in the beginning?	___	___	___	___	___
Q2 Did the DNP student analyze and synthesize the evidence-based literature for the team?	___	___	___	___	___
Q3 Was the stated program goal appropriate?	___	___	___	___	___
Q4 Was the stated project objective met?	___	___	___	___	___
Q5 How would you rate the DNP student's leadership throughout the process?	___	___	___	___	___
Q6 Were meeting agendas sent out in a timely manner?	___	___	___	___	___
Q7 Were meeting minutes submitted in a timely manner?	___	___	___	___	___
Q8 Were meetings held to the allotted time frame?	___	___	___	___	___
Q9 Would you consider the meetings productive?	___	___	___	___	___
Q10 Do you feel that you had input into the process?	___	___	___	___	___

Q11 Please comment on areas where you feel the DNP student excelled or might learn from your advice/suggestions:

Q12 How do you feel the patient education/teach-back skills gained from this program will be most impactful to the patients served in this hospital or in the surrounding communities?

Appendix B: Patient Education Toolkit

BEST PRACTICES IN PATIENT EDUCATION TEACH-BACK

ABC Hospital – 2019
Estimated Completion Time = 1.5 Hours

TOOLKIT

1. Implementation Guide

Background and Local Context

Only 12% of U.S. adults ≥ 65 years have proficient health literacy skills (Kutner, Greenberg, Jin, & Paulsen, 2006).

Healthcare professionals have an obligation to assure patient's understanding (AHRQ, 2017).

Teach-back methodology is a universal precautions approach to address health literacy (AHRQ, 2017) & has demonstrated improvement in patient outcomes (Griffey et al., 2015; Ha Dinh et al., 2016; Peter et al., 2015).

Local context:

- Mean patient age = 85 years in 2017 and 79 years in 2018 for medical-surgical unit
- Observations reveal methods of patient education not standardized; many nurses choose majority of patient education at time of discharge. Assessments specific to what patient already knows about the topic; health literacy level; motivation or capacity to learn; and barriers to learning are not routinely conducted by nursing staff.
- Informal interviews and observations reveal many nurses not using teach-back, are not knowledgeable about teach-back, and those who are state they lack confidence in using it

The desire is that by increasing the nurse's knowledge of evidence-based practices in patient education and the teach-back methodology, the confidence and conviction in use of the teach-back technique will increase. With improved skills and knowledge, these evidence-based practices will translate into behavior change among the nursing staff.

How to Use the Toolkit

Intended audience: Registered Nurses at ABC Hospital (Applicable for ancillary staff such as RT, PT, OT, Pharmacists, etc. if desired)

Educational resources: The toolkit is designed with resources that appeal to adult learners. The learning methodologies consist of classroom lecture with group participation and practice sessions, a classroom style or self-paced online learning module, and self-assessments.

Suggested steps for delivery of educational resources:

1. Review all items in the toolkit, print applicable materials, and schedule enough classroom sessions to accommodate nurses from the desired nursing unit(s).
2. Determine roles and responsibilities of leaders (formal and/or informal). The Tools for Leaders section has resources to assist with implementation, coaching, and accountability of patient education best-practices and use of Teach-Back. See also the Evaluation Plan for recording and analysis of survey results. This step can be implemented after the conclusion of the classroom lecture, if desired.
3. Reserve classroom with overhead projection capability to display lecture materials.

4. Have all participants complete the Conviction and Confidence Scale (Always Use Teach-back!, 2018) survey. This survey could be handed out in a unit meeting or other venue prior to conducting the classroom lecture and deploying any pre-lecture work.
5. Have nurses complete the interactive online learning module as a self-paced exercise ahead of the classroom lecture. Send the link to the module via email after they complete the conviction and confidence scale.
6. Utilize PowerPoint slides for lecture, group participation, and practice sessions (est. completion time = 1 hr.).
7. Have all participants complete the Conviction and Confidence Scale (Always Use Teach-back, 2018) survey after completion of the learning resources. Suggested to have participants complete the survey again at 1- and 3-months post-learning.
8. Record survey results in the Excel workbook located in Evaluation Plan section.
9. Discuss survey results, observation tool results, and qualitative feedback obtained from nursing staff among nurse leader group to determine any necessary mitigation or follow-up.

2. Objectives

1. Assess nurse confidence and conviction in use of the teach-back technique (pre- and post-completion of learning activities).
2. Analyze patient education concepts of assessment, planning, teaching, and evaluation.
3. Evaluate strategies to overcome perceived barriers to patient education and teach-back.
4. Apply concepts of patient education fundamentals: focusing on 2-3 main topics, slowing down, using plain language, chunking and checking, and evaluation through teach-back technique.
5. Evaluate results of the nurses' confidence and conviction to determine areas of learning to reemphasize or review.
6. Apply concepts of leader coaching, mentoring, and accountability to reinforce learning, and help guide the desired behavior change.

3. Learning Resources

Conviction and Confidence Scale (Always Use Teach-Back, 2018) assessment (Complete before starting any other activities. Complete again after finishing all learning activities. Suggested to repeat survey at 1 and 3 months.) (Est. time: 5 minutes)

Classroom lecture PowerPoint – built-in group participation and practice sessions (Est. time: 1.5 hours)

Lecture Patient Education Best Prac

Handout 10 Elements of Competency for Using Teach-Back Effectively (Always Use Teach-Back, 2003) (Est. time: 10 minutes)

Classroom or Self-Paced Interactive Teach-Back Learning Module (Always Use Teach-Back, 2019) (Est. time: 45 minutes)

4. Tools for Nurse Leaders

Coaching Tips (Always Use Teach-Back, n.d.)

Coaching Overview Video (Always Use Teach-Back, 2012)

Coaching Keys Video (Always Use Teach-Back,2012)

Coaching Overcoming Obstacles Video (Always Use Teach-Back, 2012)

Teach-back Observation Tool (Always Use Teach-Back, n.d.)

Success within any organization is because of its culture (White, Dudley-Brown, & Terhaar, 2016). Building the knowledge and skills of formal and informal leaders and providing access to tools and resources are key elements to overcome challenges to translating evidence into practice (White et al., 2016). Leadership support, role modeling, and accountability are essential for knowledge transfer to occur (White et al., 2016). As such, the resources in this section are to assist leaders (formal or informal) in the coaching, mentoring, and accountability pieces necessary for knowledge transfer and culture change.

5. Evaluation Plan

The Excel™ workbook can be utilized to record results of the Conviction and Confidence Survey (Always Use Teach-Back, 2018)

Conviction and Confidence Scale Re

The average score from each of the sections 1-4 from the survey will be calculated and displayed on the bar graphs. Leaders can view trends and compare scores from pre-program, immediate post-program, 1-month post-program, and 3-months post-program survey results.

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Peter, D., Robinson, P., Jordan, M., Lawrence, S., Casey, K., & Salas-Lopez, D. (2015). Reducing readmissions using teach-back. *Journal of Nursing Administration, 45*(1), 35-42. doi:10.1097/NNA.0000000000000155

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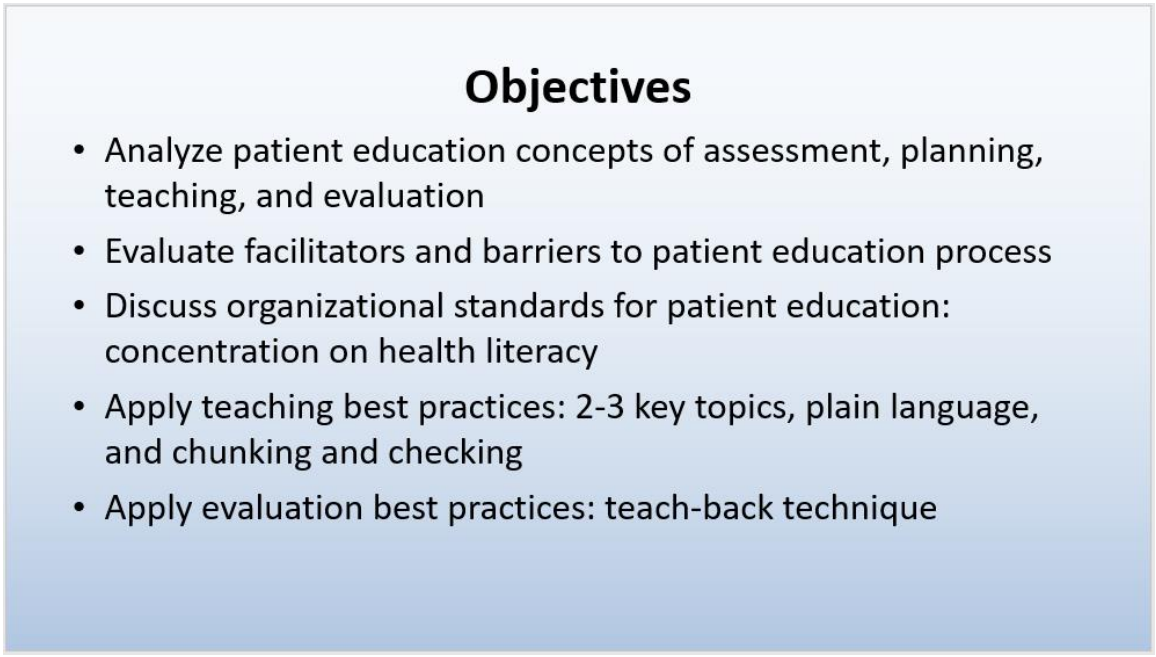
Appendix C: Classroom Lecture PowerPoint

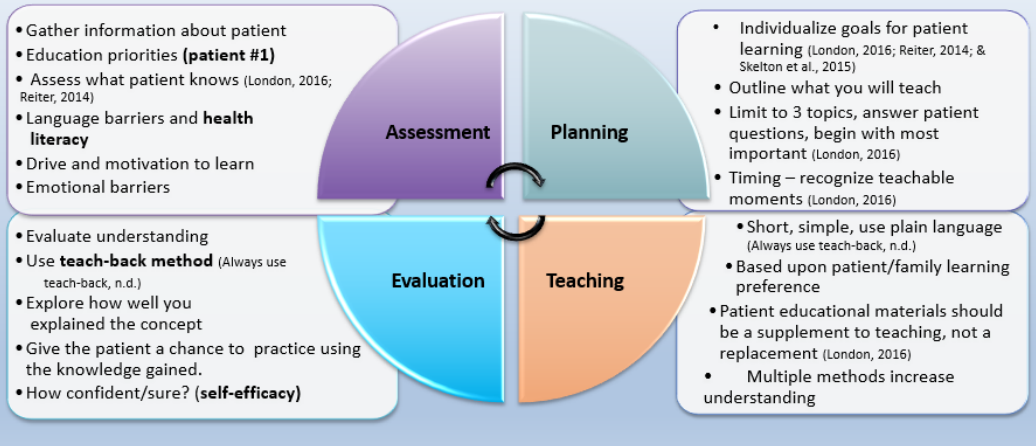
The following are samples of slides from in the lecture PowerPoint. The slides were changed from their original format to protect the identity of the health system and project site. The final PowerPoint was provided to the institution on a flash drive and also as a link within the toolkit.



Background

- Only 12% of U.S. adults ≥ 65 years have proficient health literacy (HL) skills (Kutner, Greenberg, Jin, & Paulsen, 2006).
- HL = basic reading, basic math, knowledge nutrition, & knowledge of understanding risks (Centers for Disease Control & Prevention, n.d.)
- Healthcare professionals have obligation to assure patient's understanding (AHRQ, 2017).
- Teach-back methodology is a universal precautions approach to address HL (AHRQ, 2017) & has demonstrated improvement in patient outcomes (Griffey et al., 2015; Ha Dinh et al., 2016; Peter et al., 2015).

Patient Education Science: The Process



(Hedman & Preussler, n.d.)

Time to Teach

- Assessment, Teach-Back, and Listening!!!!! (5:38-7:21) (Patient Educators Update, 2014)
- Teachable Moments (Patient Educators Update, 2012)
- Time to teach outside of discharge
  - Teachable moments – listen, probe and investigate if needed & don't let it go
  - Tips to saving time – assess first, tailor material, verify with teach-back
  - Address to family/caregiver is patient not capable
  - Use written materials or videos to fill time until you can come back to go over it
  - Create a teachable moment

Evaluation of Learning: Teach-Back

- Teach back is an evaluation of how well you explained the information.
- It is not a test for the patient.
- Ask the patient to teach back the information, using their own words
- If they do not understand, rephrase and try again.

(Hedman & Preussler, n.d.)

Why Do Teach-Back?

Reported by a ABC Hospital Nurse

"I asked my dad about his recent doctor's appointment. He told me his blood pressure was a little high, so the doctor doubled his medication dose."

"I asked to see the medication bottle – noticing the dose was doubled. Instead of 10 mg it was now 20 mg."

"It was just by chance that my dad said, 'I'll have to remember to take 2 pills tomorrow.' I realized that my dad thought that doubling the dose meant he would need to take 2 pills. Teach-back would have prevented a potentially grave misunderstanding."

(Hedman & Preussler, n.d.)

How to Use Teach-Back?

- "We covered a lot of material, please tell me in your own words what you heard me say, so I can be sure I taught you correctly."
- "When you get home, I know your daughter is going to want to know what you talked about today. What are you going to tell her?"
- "So I know that I taught you correctly, please demonstrate to me how you're going to use your inhaler when you get home."

(Hedman & Preussler, n.d.)

Let's Practice

- Read the Krames education material provided
- After assessing your patient and using the Krames material, select the 3 most important topics to teach
- Using plain language and "chunk and check", teach your patient
- Use the teach-back method – remember "I" statements

Appendix D: Coaching Tips Handout

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!

Appendix E: Teach-Back Observation Tool

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 F: 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 G: Excel Display of Conviction and Confidence Scale Results

The data shown in both graphs are fictitious. The graphs are samples of what would be displayed when the nurse leader(s) records the nurses' responses to the survey. The top graph demonstrates responses from the teach-back conviction, confidence, and frequency of use sections of the survey. The bottom graph shows responses from the patient education best-practices segment.