Effectiveness of the Teach-Back Method for Improving Caregivers' Confidence in Caring for Hospice Patients and Decreasing Hospitalizations

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Health care professionals use teach-back to foster adherence to treatment recommendations and to improve safety and quality of care. This improvement project, conducted in one division of a home care agency, used a pretest-posttest design with an interprofessional group of hospice home care clinicians to incorporate teach-back into home visits to evaluate if the use of teach-back enhanced caregiver and patient-provider communication, improved caregivers' confidence in caring for hospice home care patients, and decreased hospitalizations. After the intervention, the teach-back group had zero hospitalizations compared with 2 for the non–teach-back group (0% and 1.97%, respectively), and patient-caregiver ''confidence'' increased from 58% to 81%, pre to post intervention. In conclusion, teach-back is a cost-effective teaching methodology that can be implemented by any discipline to improve patient-provider communication and patient outcomes.

KEY WORDS

evidence-based practice, hospice care, hospitalizations, palliative care, patient satisfaction, teach-back

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An increasing number of adult patients are electing to receive hospice services at the end of life. In 2014, more than 1.6 million patients received hospice services, of those nearly 60% received care in their own residence. Considering the number of patients requesting hospice care, it is critical for providers to help them meet their goals—that is, to die with dignity at home.[1] Thus, there is a pressing need to implement evidence-based strategies, on a wider scale, aimed at increasing patient and caregiver confidence in providing necessary support to patients and thus helping the patient to remain at home at end of life.

The Agency for Healthcare Research and Quality (AHRQ) suggests that providers' communication with patients directly impacts health outcomes (positively or negatively).[2] Effective communication decreases patients' confusion about their self-care, particularly when the information relates to new medication regimens or instructions for follow-up care. Reports indicate that patients instantly forget 40% to 80% of health care information presented to them, and approximately 50% of the information remembered is inaccurate.[2,3] Therefore, enhancing communication between frontline providers and patients and their caregivers is essential to improve the latter's recall and understanding of health information, increasing their confidence in providing care at home.

One way to improve patient-provider communication is by using the teach-back method. Teach-back entails providers asking patients and caregivers to repeat back (in their own words) what they have learned, and comprehension is validated when the patient or caregiver can correctly explain the key points back to the provider.[3,4] Instead of a health care provider asking, "Do you understand?" the provider might ask the patient and/or caregiver to explain or demonstrate how he/she will carry out a recommended treatment. If the patient or caregiver cannot correctly explain or demonstrate, the information is retaught until the patient or caregiver achieves mastery. This is called closing the loop or teaching to goal[3] (see Example, Appendix). This is a research-based, patient-centered, health literacy strategy and open communication intervention that improves patient-provider communication, enhances care management, fosters adherence to treatment plans by increasing one's confidence

in carrying out that plan, and improves health outcomes.[4,5] This method has been identified as a top patient safety practice by the AHRQ.[2] Therefore, the purpose of this article is to describe an evidence-based practice improvement project aimed at fostering confidence in carrying out the plan of care and decreasing hospitalizations through the use of the teach-back method by frontline providers with home-based hospice patients and their caregivers.

SETTING AND LOCAL PROBLEM

The performance improvement (PI) project was carried out with an interprofessional hospice team within the Hospice and Palliative Care (HPC) Program at a home care agency (HCA) in a large northeastern city. This agency is one of the largest and oldest not-for-profit HCAs in the United States[6] and provides hands-on care and support services to patients of all ages, from birth to end of life. The HPC Program provides compassionate and specialized health care delivered to individuals who are facing a life-limiting illness. Services include, but are not limited to, pain management, comfort measures, and spiritual and emotional support.[6] At the time the project was initiated (August 2014), the HCA's administration identified 2 overarching organizational goals for improvement in all programs, divisions, and departments: decreasing hospitalizations and improving the "customer experience" (patient-caregiver satisfaction).

Scores from 3 of the questions contained in the 2014 Family Evaluation of Hospice Care (FEHC) survey, which measure caregivers' assessment of the hospice care experience, were reviewed. Scores from 2 of the questions indicated that the interprofessional hospice teams in the 5 divisions of the HPC at this agency consistently provided families with enough instructions about patient care and exceeded the agency's benchmark of 80%, and most caregivers rated the hospice care experience as excellent. The scores from a third question reviewed, however, indicated that caregivers were not confident in the knowledge needed to provide adequate care to their loved ones. This metric continually fell below the benchmark of 80%. After presenting these data to the HPC division managers and hospice team 2 at the agency, an interdisciplinary team of registered nurses, social workers, and a chaplain volunteered to participate in this PI project. The project leaders were 2 nurse practitioner doctor of nursing practice students, and the project team included a faculty mentor, a clinical mentor who was the director of quality improvement, and the clinician participants.

In addition to reaching agency goals in achieving benchmark levels, an important goal for hospice patients is symptom management and to die comfortably at home. Therefore, it is essential that providers empower families to be confident in carrying out the plan of care, or quality of life is compromised, resulting in unnecessary hospitalizations. In 2014, approximately 40% of hospice patients were not at their residence at the time of death, but rather at a hospice inpatient facility (31.8%) or an acute care hospital (9.3%).[1]

Review of Evidence

Published literature linking the use of teach-back to improvement goals is limited and included a total of 5 research studies and 4 PI reports from hospitals at the time this project was undertaken.[7-15] There were 3 main outcomes of interest, which related to this PI project. Five articles (1 systematic review, 3 randomized controlled trials, and 1 prospective cohort study) studied the effect of teach-back on self-management, self-care, and knowledge of disease.[7-11] Five articles (1 prospective cohort study and 4 PI evaluations) sought to determine the impact of teach-back on hospital readmissions,[11-15] and 1 study explored nurses' knowledge about the use of, and perceived value of, teach-back as an educational strategy.[8] Knowledge of self-care and/or self-management of disease were addressed in 4 studies.[7,9-11] In each of these studies, as a result of using teach-back, researchers reported a statistically significant increase in patients' ability to recall medical information, such as proper inhaler technique, discharge instructions, and medication adherence.[7,9-11] While the evidence supports the teach-back method as an effective educational strategy to enhance patient self-care and self-management, there are noted limitations in each of the studies: small sample size, short-term follow-up, lack of a control group, and failure in some studies to report reliability and validity of tools used to assess outcomes. In addition, the samples may not be representative of the general population; therefore, generalizing the results is limited. Moreover, because of the short-term follow-up in these studies, long-term outcomes are not known. Finally, several articles reviewed were quality improvement reports that need to be replicated in other agencies and settings in order to determine the long-term effectiveness and sustainability of the intervention.[12-15]

While the reviewed studies show the promise of the teach-back method in acute care and clinic settings, there is a lack of evidence on the potential benefit of teach-back on patient care outcomes in a hospice setting whether in an institution or at home. For example, it is not known if incorporating teach-back into hospice home care PI programs (such as those previously mentioned) will produce similar results. Yet, the evidence thus far indicates that the teach-back strategy can be effective in achieving improved patient and caregiver knowledge about and management of self-care.

The impact of teach-back on hospital readmissions was assessed in 4 case reports and 1 prospective cohort study.[11-15] In the prospective cohort study conducted by White et al,[11] implementation of teach-back during hospitalization and 1 week after discharge did not significantly reduce

hospitalizations for heart failure (HF) patients, although the authors noted a trend toward significance. Despite the fact that readmissions were not significantly reduced in this study, the authors deemed the teach-back method a promising strategy that has the potential to reduce readmissions. Also, hospitals have reported the impact of teach-back on rehospitalizations in their facilities, and although results may not be statistically significant, the outcomes are clinically important.[12-15]

Several studies also addressed the ease of incorporating teach-back into practice.[8,9,11] Results from these studies suggest that teach-back improves patients' ability to manage their health, but researchers often fail to incorporate health outcomes such as hospital readmission and patient satisfaction into their study design; specifically, none of the studies addressed patient or caregiver confidence in carrying out a plan of care. Moreover, the PI reports[12-15] indicated the success of the teach-back method for reducing 30-day readmissions for HF patients; however, more PI programs are needed to determine if this teaching strategy has similar success among other patient populations in different settings, such as patients receiving home hospice care.

Overall, the evidence suggests the potential of the teach-back method to improve knowledge of self-care and self-management in COPD and asthma patients using respiratory inhalers, to recall discharge instructions for HF patients, and to reduce readmissions in HF patients.[7,9-11] In addition, 2 small studies reported the incorporation of teach-back into practice as a valuable approach to consistently and effectively educate all patients regardless of race, age, gender, and ethnicity.[8,11]

In summary, after carefully weighing the strengths, limitations, and quality of the evidence, the project team leaders concluded that although more evidence is needed to demonstrate the effectiveness of teach-back in a hospice setting, current evidence supports teach-back as a promising educational strategy to improve patient health care knowledge and self-care management. Given the low cost, no risk, and ease of implementation of the teach-back strategy, the project team deemed this a viable practice innovation, especially for hospice patients for whom the goal of treatment is to remain comfortable in their home at end of life.

INTENDED IMPROVEMENT

The intended improvement therefore was for clinician participants to implement a new teaching strategy with their patients and caregivers to improve understanding and confidence in care management. Hospice patients, through their caregivers, were provided with the knowledge and skills they needed in order to have increased confidence in providing and managing end-of-life care at home, thus avoiding unnecessary hospitalizations. The innovation implemented by participants was the "teach-back" method, an evidence-based teaching strategy successfully adopted by many hospitals and primary care providers to foster adherence to treatment recommendations and to improve safety and quality of care.

METHODS

Planning the Intervention

Conceptual/Operational Framework

The Evidence-Based Practice Improvement (EBPI) Model[16] was used as the conceptual framework for this project. The EBPI Model is a systematic approach to improving clinical practice that merges the best of the evidence-based practice paradigm with an implementation strategy, which comes from practice/quality improvement models (Figure 1). The process begins with describing the practice problem. This includes an assessment of internal (local) organizational quantitative metrics and qualitative data to support the need for improvement as well as background external evidence to support the significance of the problem in a wider societal context. Collecting and evaluating internal and external evidence leads to the development of a focused clinical question, which in turn guides the search for evidence on how to solve the problem. Once the evidence is accumulated, critically appraised, and synthesized, recommendations for improvement (creating aim statements) may be made. The Plan, Do, Study, Act (PDSA) cycles then guide project implementation and evaluation. Important to note is that these cycles are actually small tests of change with relatively few clinicians and patients. This is important in order to perfect the implementation process prior to a full-scale decision to change practice. The final component of the EBPI Model is dissemination, which includes internal organizational reporting, as well as local, national, and potentially international presentations and publications.

Protocol for the Evidence-Based Practice Change

This project was exempt from review by the university institutional review board and was submitted and given exempt status by the HCA's institutional review board.

Prior to the intervention, the project team leaders took part in an online teach-back train-the-trainer program. This training involved completing the Interactive Teach-back Learning Module, a part of the Always Use Teach-back! Toolkit, and reviewing the materials provided by the teach-back program established by the Minnesota Health Literacy Partnership.[5,17] Then, the intended improvement was presented to an interprofessional hospice team of 16 clinicians, 8 of whom volunteered to participate in this PI project (6 coordinators of care [registered nurses]), social worker, and 1 chaplain). Using the training materials from

Evidence Based Practice Improvement (EBPI) Model

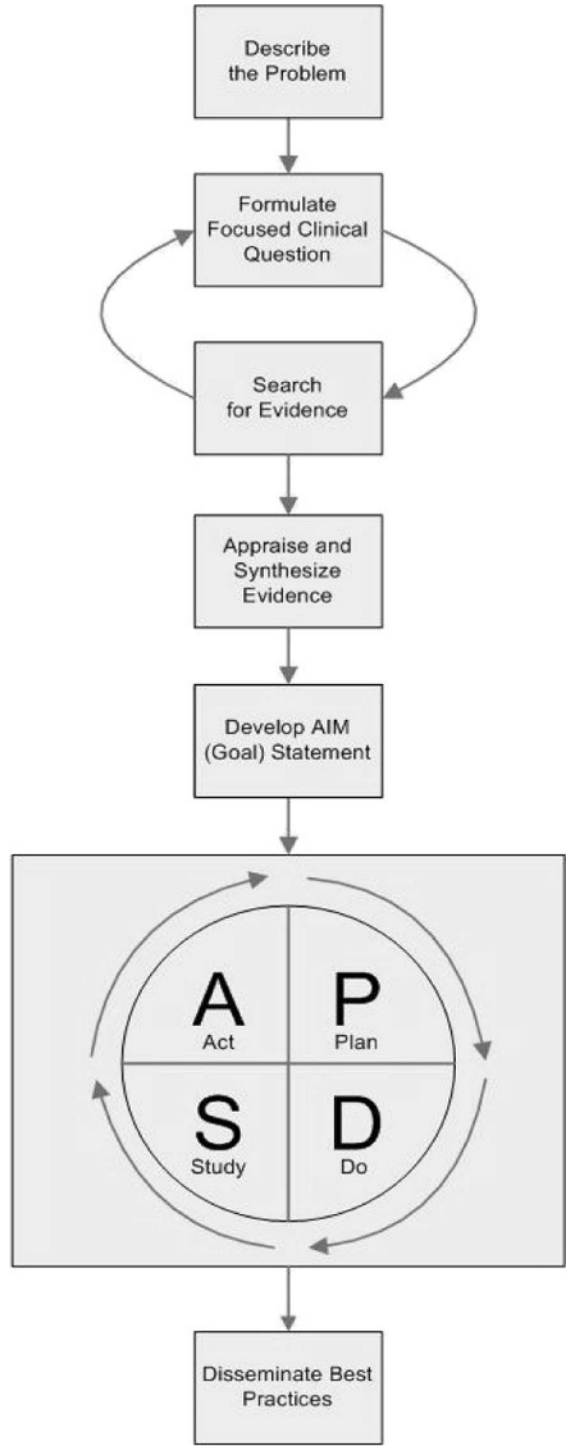

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FIGURE. Evidence-based practice improvement model depicting a problem-solving approach to the delivery of health care integrating the best evidence from research studies, conducting a small test of change, and disseminating best practices.

the programs listed above, the clinician participants were instructed (via a 1-hour training session that included a PowerPoint presentation, teach-back videos, and role playing) to use the teach-back method as a means to confirm that the patient and caregiver understood and recalled what was taught. The 8 participants were taught that teach-back is referred to as "closing the loop" or "show me" and is intended to foster communication and enhance patients and caregivers' knowledge of how to confidently manage care with the goal of improving care and avoiding hospitalizations. Although the content of teaching may differ by role, the concept of teach-back is the same for all disciplines, and the participants were instructed to use teach-back for the 1 or 2 main points they wanted the patient-caregiver to learn and understand between visits. They were instructed to ask patients and caregivers to repeat back (in their own words) what they have learned, and dialogue continued until the patient or caregiver could correctly explain the key points back to the clinician, validating comprehension.[3-5] After a patient visit, the clinician participants were to document, on a teach-back log, patients who received teach-back, information that was taught (eg, medication management), and whether the patient or caregiver was able to correctly teach-back.[2] To facilitate fidelity of process, each team member was given a handout from the Always Use Teach-back Toolkit: 10 Elements of Competence for Using Teach-back Effectively.[5] The team was informed of the weekly schedule for team meetings and advised to send tracking tools weekly to the project team leaders. The project team leaders used the Coaching Tips as a tool throughout the process to encourage clinician participation.[5]

The process of using PDSA cycles to implement and refine the evidence-based intervention was discussed. Project implementation and data collection took place over 7 weeks beginning August 2014. It is recommended to implement use of teach-back slowly, often 1 patient a day, because providers are often uncomfortable with the technique initially, and this enables participants to build confidence in the use of the skill.[2,4] Therefore, we urged participants to plan their approach and think about what information was most important for the patient/family caregiver to know.[2,4] Participants did convey feelings of uneasiness at first because they were concerned patients may feel they are being tested; as a result, participants were instructed to implement teach-back with each new admission and/or the first patient of the day until a caseload of 8 patients was reached. The participants then continued to use teach-back with these same patients throughout the intervention period. Subsequently, the project team met weekly, either in person or via phone conference, to discuss successes and challenges in each week. Based on the feedback, the project team decided to make changes or continue the process as initially proposed. During weekly meetings, documentation was reviewed, and participants presented examples of how teach-back was incorporated into patient visits and discussed scenarios where teach-back was most effective, such as with medication management and how to follow through with care if patient's symptoms worsened.

Methods of Evaluation

The following outcomes, clinician participants' knowledge of and confidence in use of teach-back, caregiver confidence in carrying out plan of care, hospitalizations, and process outcomes, were evaluated as part of this improvement project.

Conviction and Confidence Scale

The first 2 of the 4 questions of the Always Use Teach-back! Conviction and Confidence Scale survey were used to assess how convinced and confident clinician participants were that teach-back was a successful strategy to use in practice.[5]

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 in their own words)?"
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)? "

Responses were monitored before and after intervention, thus allowing the project team to receive clinician participants' feedback on the teach-back educational strategy. A score of 1 indicated "not at all important," and a score of 10 indicated "very important." Although specific validity and reliability of this tool are not reported, the Institute for Healthcare Improvement (IHI) supports its use, recommending it to be an Always Event in every institution and in every encounter between providers and patients.[18]

Caregiver Confidence

Caregiver confidence in carrying out a plan of care for the patient was measured by collecting data from 1 of the 3 questions of the FEHC survey.[19] At the end of the implementation period, the project team leaders and director of quality improvement reviewed the teach-back and non–teach-back groups' scores to assess the impact of the teach-back method for following 3 questions from the FEHC survey:

1. "Did you receive enough information to do what was needed?" (Yes or no)
2. "How confident did you feel about doing what you needed to do in taking care of the patient?" (Responses: very confident, fairly confident, or not confident).
3. "Overall, how would you rate the care the patient received while under the care of hospice?" (Responses: excellent, very good, good, or fair).

The National Hospice and Palliative Care Organization reported the full FEHC survey was tested and validated for consistency and accuracy in assessing quality of hospice care from the perspective of the bereaved family.[20] Although

before implementation caregiver scores were determined by the FEHC survey, after implementation data were not available because this survey is sent to families 6 weeks after a patient has died. Therefore, caregiver confidence after implementation was measured by adding the 3 questions to a telephone survey conducted by agency volunteers while patients were still under hospice care. All caregivers of patients who received teach-back were contacted.

Hospitalizations

Before and after implementation, the project team leaders and the director for quality improvement utilized the agency's validated Hospice Hospitalization Audit Tool to evaluate deidentified patient records to determine clinicians' documentation of teach-back and possible causes leading up to hospitalizations. The records were reviewed separately and then together by 3 auditors. Results from each audit were compared, and any differences were discussed until all auditors came to a mutual agreement. Hospitalization rates were calculated by dividing the total number of hospice patients admitted to a hospital by the average daily census (ADC) of hospice patients in the HCA during a specific time period and then multiplying by 100.

Process Outcomes

A PDSA tracking log, developed by the agency, was used to document and monitor the small tests of change throughout the implementation process and was used as a guide to perfect the process of using teach-back. The clinician participants used the teach-back tracking log to document and evaluate each teach-back encounter (included what was taught, what the patient or caregiver taught back, what was retaught or clarified, and the main education points taught back).[2] Discussions of teach-back encounters were presented during weekly meetings, and this feedback was used to monitor and refine the implementation protocol/process.

Analysis

Data for the demographic characteristics of clinician participants, "Conviction and Confidence" scales, patient satisfaction, and hospitalizations were entered into Microsoft Excel, and outcome measures were analyzed using descriptive statistics. Inferential statistics were not appropriate because of the small sample size and the inability to meet criteria for use. Process outcome data were analyzed throughout the implementation phase using PDSA cycles and small tests of change to perfect providers' use and documentation of teach-back.

RESULTS

Use of Teach-Back

Data for only the first 2 questions of the Always Use Teach-back! Conviction and Confidence Scale were analyzed: "How convinced are you that it is important to use teach-back?" and "How confident are you in your ability to use teach-back?" were measured on a 10-point Likert scale (1 = not important and 10 = very important).[5] Results from clinician participants indicated that preintervention and postintervention results were similar; most participants were convinced teach-back was very important (preintervention and postintervention mode = 10 and mean = 8), and most were very confident in its use (preintervention and postintervention mode = 9 and mean = 8 and 7, respectively).

Caregivers' Confidence

There were 38 patients who received teach-back by the clinician participants. After intervention, 21 of the 38 patients' caregivers (55%) in the teach-back group responded to the telephone survey. Of these, 95% reported they had received enough instructions to do what was needed (95% preimplementation from FEHC survey); 81% stated they were "very confident" in doing what they needed to do in taking care of the patient (58% preimplementation from FEHC survey), and 76% indicated that overall the care received by the patient was "excellent" (74% preimplementation from FEHC survey) (Table).

Hospitalizations

Hospitalization rates were calculated using the formula as follows: number of home care hospice patients admitted to a hospital divided by ADC of home care hospice patients during a specific time period, and then multiplied by 100. The average hospitalization rate for the entire hospice team 3 months prior to implementation was 5.4% (7 admissions and ADC of 130 per month). Four weeks after implementation of the teach-back intervention, the hospitalization rate for the non–teach-back group was 7.5% (8 admissions, ADC 107.3) compared with 5.7% for the teach-back group (1 admission, ADC 17.5). After implementation, the hospitalization rate for the non–teach-back group was 1.97% (2 admissions, ADC 104.6) compared with 0% for those patients in the teach-back group (0 admissions, ADC 14.6).

Process Outcomes

Each week the project team leaders reviewed the teach-back logs and then discussed findings with the clinician participants. The logs included documentation of what was taught and if the patient's caregiver was able to teach-back what was taught to ensure the loop was closed. Successes and challenges using teach-back were discussed in order to refine the process. Concerns emerged after the first 2 weeks: (*a*) clarification was needed about the number of patients with whom to initiate teach-back and what to do if a patient died or was discharged; and (*b*) clinicians indicated that documenting on the teach-back logs was too time consuming. To address the first concern, project team

TABLE Caregivers' Evaluation of Hospice Care Before and After Intervention

Metric: Evaluation of Hospice Care	Preintervention Q1 and Q2 2014 Hospice Team 2[a]	Agency Benchmarks	Postintervention Teach-Back Group[b]
Family had enough instructions on patient care (% yes, no. of caregivers who responded yes)	95% (39/41)	80%	95% (20/21)
Confidence in doing what was needed to care for the patient (% very confident, no. of caregivers very confident)	58% (15/26)	80%	81% (17/21)
Overall care patient received while under care of hospice (% excellent, no. of caregivers who reported care was excellent)	74% (34/46)	75%	76% (16/21)

[a]*Source: Results of 3 questions taken from the Home Care Agency's Family Evaluation of Hospice Care Survey.*
[b]*Source: Results obtained via a telephone survey.*

leaders clarified that teach-back should be used on the same 8 patients throughout the process but to initiate teach-back with the next new admission if a patient died or was discharged. Next, because only 2 participants submitted logs in the first few weeks, it was important to refine the process of documentation. To facilitate use of the logs and to reduce time to complete them, participants were encouraged to copy and paste their documentation from the electronic health record into the log. (c) Documentation had to include the patients' response to teach-back, not only a notation that the "patient verbalized understanding." During weekly meetings, providers shared their experiences using teach-back. A common theme reported by clinician participants was that they used teach-back most often for issues related to medications and how to manage symptom exacerbation. One provider indicated a patient felt "empowered," and some providers conveyed they initially felt uncomfortable using this approach, but in the end found it a "valuable" strategy to assess understanding of information conveyed to patients and caregivers and were inclined to use again.

DISCUSSION

Most clinician participants reported they were confident in using teach-back and were convinced its use was important; this may have positively influenced patients' and caregivers' confidence in carrying out the plan of care. Similar to preimplementation, respondents in the teach-back group also reported having enough instructions to do what was needed for the patient, and most rated the care as "excellent." However, after implementation, most of the patients/caregivers surveyed indicated they were "very confident" in doing what was needed to care for the patient. There was a 23% increase from preintervention, and scores exceeded the agency's benchmark of 80%.

As a result of this EBPI project, data revealed a decrease in hospice hospitalization rates after the implementation period among the patients in the teach-back group. Although these results are clinically significant, they should be interpreted with caution. It is important to note that the sample size was small, and this project should be replicated with other hospice teams in the same agency, as well as in other hospice settings, over a longer period, to determine if results are similar. Results of this project are not generalizable to other areas and apply only to this setting. It is recommended that future PI projects build on the findings from this project and should use teach-back resources available in order to train staff and to develop protocols for PI initiatives.

The average caregiver score for "confidence in doing what is needed" increased by 23% at the end of the 7-week teach-back intervention period. These results have important implications for HCAs and hospice divisions of hospitals as well. Lack of confidence in doing what is needed to manage expected symptoms could result in unnecessary hospitalizations. If results seen in this project are sustainable on a wider scale and over the long term, HCAs and hospitals should consider policy changes, following the recommendation made by the IHI: making teach-back an Always Event.[18]

Sustainability of Practice Change

A key factor in achieving quality patient outcomes is the ability of health care providers and their organizations to rapidly spread best practices and innovative new ideas. Through regulatory standards, hospice is a process-driven care delivery system for critically ill patients who want to remain in their homes or at an inpatient hospice facility. The success of the patient remaining at home depends on the caregiver's ability and confidence to care for the patient. Patient-caregiver education and patient-caregiver engagement to participate meaningfully in patient care

are foundational skills for hospice providers, and these skills have been enhanced by using teach-back as a method of educating and engaging patients and their caregivers. The demonstrated value of teach-back as an evidence-based intervention showing improved caregiver confidence and decreased hospitalization rates was acknowledged across the HCA's HPC Program by senior leadership to clinicians alike. The hospice team manager communicated the ongoing learning and successes of the teach-back team at the regulatory required Quality Assurance Performance Improvement meeting, and managers voted for the teach-back method initiative as a top priority for team improvement for the upcoming year.

In addition to leadership acknowledgement and proven team success, the key characteristics of interventions that predict the likelihood of adoption include relative advantage, simplicity, and compatibility.[21] Teach-back as a skill-based intervention, and not a system change, requires only clinician education and limited electronic health record enhancements to implement. It is not complex or resource intensive, and is seen as feasible by clinicians, thus having a high likelihood of being adopted. Teach-back, once learned, is an enhancement to an already foundational skill that adds value, with no additional time, and is easily integrated into practice. Thus, the HCA's HPC made a decision to incorporate teach-back into the entire program and spread the innovation to all hospice program divisions. The dissemination plan is based on the IHI's initiative of Protecting 5 Million Lives From Harm.[22] A successful spread plan includes establishing specific aims and identifying target population, developing a communication plan, using organizational structures such as information systems and educational initiatives, and building monitoring and feedback systems.[21]

The primary factors that not only determine an organization's readiness to spread an idea, but also contribute to its ability to sustain change, are the characteristics of the culture and infrastructure of the organization that support change, including the willingness or ability of the adopters to try new ideas. Quality results-driven cultures require that the involved providers improve performance through organized system-wide processes for PI, including the capacity to measure, report on, and analyze quality and patient experience metrics against benchmarks.

Limitations

Results should be interpreted noting the following limitations. Initially, there were 8 clinician participants, but only 5 fully contributed throughout the implementation process. The lack of follow-through on the part of some participants decreased the potential number of patients who could have received teach-back. During weekly conferences and the final focus group, some participants reported a lack of sufficient time, because of their perceived workload, to provide teach-back. In addition, for the 3 questions reviewed from the FEHC survey, preintervention and postintervention measures were not assessed in the same manner, and results could have been skewed because paper-and-pencil responses are different than interview responses. Because the hospice care experience is typically measured after a patient is deceased, it was not possible to measure because patients either were still living or had recently passed away at the time of the phone survey. Therefore, patients and caregivers were called and asked the same 3 questions from the hospice care survey over the phone. The findings from this PI project are promising, but it is necessary to monitor data over a longer period to determine if outcomes continue to meet or exceed benchmarks.

Conclusion

Teach-back is an effective teaching/learning methodology that can be implemented by any discipline to improve caregiver/patient-provider communication. When providers are able to confirm patients' knowledge of what was taught via a return demonstration or verbalization of the instructions, then they have successfully "closed the loop" on patient understanding and comprehension.[3] Patient education is fundamental to nursing practice; therefore, validating the benefits of teach-back as a viable methodology has far-reaching implications for PI, reducing the costs associated with unnecessary hospitalizations and increasing quality and patient satisfaction. Context factors that helped determine the intervention's effectiveness included engaging stakeholders in the planning of the project, use of PDSA cycles iteratively to support a more timely response to clinician participants' concerns, and alignment of the intervention to the organization's strategic goals.

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APPENDIX

Example of Teach Back

Juanita returned from the hospital yesterday with a diagnosis of Type I Diabetes Mellitus. She is a 14 year-old female whose native language is Spanish; she has been in the U.S. for 5 years and attends the local high school. The Home Care Nurse is visiting with Juanita in her home for follow-up teaching and medication management. Juanita's mother is also present. This is an excerpt of that interaction where the nurse is using the teach-back method:

Nurse: "Standard insulin contains 100 units of the medication in one milliliter of liquid. This is also called U-100 insulin. Most insulin syringes are marked for giving you U-100 insulin. Every notch on a standard insulin syringe is equal to one unit of insulin. Now, can you tell me in your own words what the standard dose of insulin is?"

Juanita: "Ah, *cien* milliliters."

Nurse: "Can you tell me what *cien* means in English?"

Juanita: "Si, one hundred."

Nurse: "I see. Let me repeat what I said in a different way then. Standard insulin contains *cien* units of insulin in *un* (one) milliliter. This is very important because if you give yourself more than you need per dose, you could have a very bad reaction. Can you tell me now what the standard dose of insulin is?"

Juanita: "Ah, yo entiendo ahora! I mean, yes, I think I understand. There are *cien* units in *un* milliliter."

Nurse: "Perfecto!" Now let's continue.