TMF Health Quality Institute

QI Snapshot

Brief #01

Applying Teach-back Methods in a Puerto Rico Hospital

According to the Agency for Healthcare Research and Quality (AHRQ), the teach-back method is means of confirming that patients understand what has been explained to them in a health care facility, typically at bedside in a hospital. More importantly, this method helps to ensure the patient understands the information and medical instructions given in the transition of care process. This method can be performed by any health professional and consists of asking the patient to repeat, in their own words, the instructions given by the health professional. This method is not measuring a patient's education, but ensuring the patient understands what's next in their transition of care and treatment plan. This evidence-based method was chosen by a hospital in Southeast Puerto Rico with the goal of reducing hospital readmissions by improving transition of care and poor health literacy among their Medicare population. This TMF project aimed to reduce readmission rates among the Medicare FFS population by 1) identifying the population with health literacy risks, 2) implementing the teach-back method in an acute care hospital and 3) ensuring patient empowerment during the transition of care.

Project Overview

Intervention

Based on Project BOOST methodology, a teach-back flow chart and reference guide was developed to familiarize the hospital team with the intervention (to learn more about Project BOOST, please visit the organization's site at hospitalmedicine.org/BOOST). The steps for identifying a patient at risk of readmission and the subsequent implementation of the teach-back method were as follows:

1. The patient is admitted to the hospital.
2. The admission department identifies Medicare FFS patients.
3. Upon admission, nurses perform a risk assessment using Better Outcomes by Optimizing Safe Transitions, which evaluates eight risks for readmissions.
4. The discharge planner proceeds to perform an initial discharge plan evaluation 24 – 48 hours after admission. BOOST specifies various risk-specific interventions that should be done with patient. When poor health literacy is identified as a risk, the teach-back method is specified as an intervention.
5. In the 24 – 48 hours prior to discharge, the discharge planner re-evaluates the patient. The teach-back method is then used to confirm that the patient understands the discharge process and follow-up treatment.

Teach-back Methods

1. Using simple/lay language, explain the concept or demonstrate the process to the patient/caregiver.
2. Ask the patient/caregiver to repeat, in his or her own words, how he or she understands the concept as it was explained. If a process was demonstrated to the patient, ask the patient/caregiver to demonstrate it, independent of assistance, for the clinician.
3. Identify and correct misunderstandings of or incorrect procedures by the patient/caregiver.
4. Ask the patient/caregiver to demonstrate his or her understanding or procedural ability again, to ensure the above-noted misunderstandings are now corrected.
5. Repeat Steps 3 and 4 until the clinician is convinced that the patient/caregiver understands the concept and can perform the procedure accurately and safely.
6. The patients must be capable of understanding teach-back. If a patient cannot understand teach-back, then teach-back is provided to the patient's caregiver.
7. The patient/family member/caregiver signs a document acknowledging that instructions were discussed using the teach-back method.

The TMF team developed a collection tool based on risk-specific interventions specified by BOOST. This tool gathered patient record numbers, admission dates, discharge dates, confirmations of Medicare FFS patient, whether a committed caregiver was identified and noted when the teach-back method was carried out with patient and caregiver. The hospital assembled a care transition team to oversee all necessary interventions. Information was collected by the hospital by performing a retrospective records review for Medicare FFS patients admitted and identified as at-risk the previous month. The gathered data was submitted to TMF every month.

Assessment

To assess hospital performance and improvements based on the intervention, the following ratio was tracked monthly:

$$\frac{\text{Number of Medicare FFS beneficiaries at-risk of readmission receiving education using the teach-back method}}{\text{Number of Medicare FFS beneficiaries at-risk discharged}}$$

To assess completeness and accuracy of data, the hospital staff created a checklist of interventions, including teach-back and the needs of admitted patients; the record was verified every morning. If anything was missing, a flag was placed on the patient record with the checklist specifying what needed to be completed.

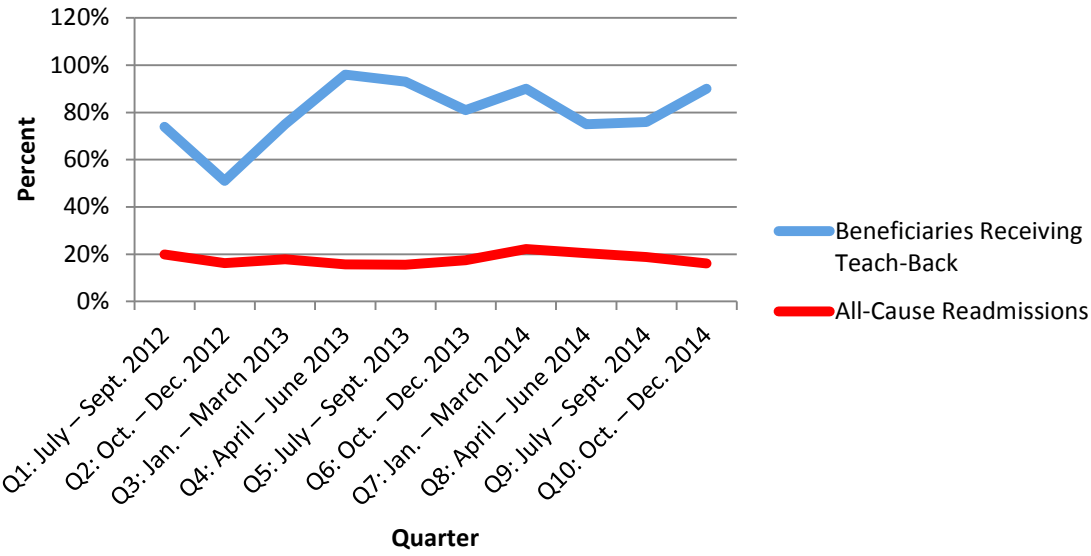
During this phase, the TMF team visited the hospital monthly to evaluate patients' records, any data that was data collected, the staff's teach-back technique and to correct any issues. Thereafter, data

validation consisted of the TMF team calling the hospital monthly—after data had been submitted—and evaluating reasons why a patient or caregiver had not received education using teach-back. The TMF team provided technical assistance in-person and through telephone calls. Also, the team visited the hospital every quarter to validate data that was previously submitted.

Outcomes

The implementation of the teach-back intervention had mixed effects over time. Overall, hospital readmissions fluctuated as high as 22.19 percent to as low as 16.14 percent over the course of two years (July 2012 – December 2014) (see Figure 1). During this time, the percent of patients receiving teach-back fluctuated from quarter to quarter, resulting in an inconsistent decrease of readmissions, even when the teach-back percent was at its highest. Reasons for the mixed effects were identified as challenges in leadership, teamwork and communication. Resistance to new and additional workload for under-staffed, overworked hospital personnel was evident. As discovered during root cause analysis prior to implementation, there was a lack of interdepartmental communication, which could affect the overall fluidity and efficiency of the intervention.

Figure 1: Comparison of Teach-back Received to All-cause Readmissions



Lessons Learned

The root cause analysis performed for the hospital revealed areas of opportunity in the process of care transitions for the FFS population, specifically in the delivery of medical information to patients and others who are involved in the transition of care. Since the common limitation discovered in this analysis was lack of knowledge, the teach-back method was employed.

However, in addition to a lack of knowledge among patients, it was inferred that other issues may have impacted the teach-back intervention with the patient population, such as patients who choose not to follow correct treatment and who prefer going into an emergency room to a primary care

physician for basic care. According to the data provided, the association between the teach-back method and the reduction in the readmission rate is possible. Nevertheless, the fact that patients are readmitted for other causes cannot be ignored, and previous education through the teach-back method may not be a factor in the new admission and, consequently, the readmission rate.

Recommendations

Implications for practice in this field are to gather specific data about populations that are at-risk of readmission—due to poor health literacy—and analyze data about patients receiving the teach-back method and the readmission rates of these patients. Although a direct correlation between teach-back education and readmission rates was not observed, factoring in other variables such as a history of medication non-compliance, use of urgent care instead of primary care and low health literacy may explain fluctuations in readmissions.

Note: Content of this QI Snapshot was taken from the SQUIRE Report: *Evaluating Teach-Back Method Effectiveness as an Intervention of Care Transition to Medicare Fee-for-Service Beneficiaries in an Acute-Care Hospital in Southeast Puerto Rico; Priscilla Pacheco Lausell, MPH and Kristy Z. Vélez De Jesús, MPH*