Influencing Change in Healthcare Providers: Communication Strategies for a New Era in Healthcare

Ceonne Raasikh
USF, craasikh@usfca.edu

Follow this and additional works at: https://repository.usfca.edu/dnp

Part of the Nursing Administration Commons

Recommended Citation
https://repository.usfca.edu/dnp/17
Influencing Change in Healthcare Providers:
Communication Strategies for a New Era in Healthcare

Ceonne Raasikh
University of San Francisco

October 15, 2013
# Table of Contents

Abstract…………………………………………………………………………………………………4

Introduction……………………………………………………………………………………………5
  Background Knowledge……………………………………………………………………………5
  Local Problem………………………………………………………………………………………8
  Purpose of Change…………………………………………………………………………………12
  Review of Evidence………………………………………………………………………………12
  Conceptual/Theoretical Framework……………………………………………………………16

Methods……………………………………………………………………………………………18
  Ethical Issues……………………………………………………………………………………18
  Setting……………………………………………………………………………………………19
  Planning the Intervention………………………………………………………………………19
  Implementation…………………………………………………………………………………21
  Planning the Study of the Intervention………………………………………………………22
  Methods of Evaluation………………………………………………………………………..24
  Analysis…………………………………………………………………………………………27

Results……………………………………………………………………………………………30
  Program Evaluation/Outcomes…………………………………………………………………30

Discussion…………………………………………………………………………………………33
  Summary…………………………………………………………………………………………33
  Relation to Other Evidence……………………………………………………………………34
  Barriers To Implementation/Limitations………………………………………………………35
  Interpretation……………………………………………………………………………………36
Effective provider communication is the key to patient engagement. However, many providers are not able to effectively communicate with patients, in part due to low health literacy. Evidence in the literature supports the use of specific strategies aimed at improving communication with patients. The purpose of this quality initiative was to influence providers to adopt new communication strategies with their patients. Pharmacists, nurses and physicians were invited to participate in a free, full-day, educational event. During the event providers were alerted to the issue of health literacy and provided communication strategies to improve patient comprehension and engagement. Following the presentation, providers were surveyed and asked if they intended to change the way they communicated with patients. Six weeks after the event, providers were administered a follow-up survey to determine if they had in fact changed their practice as originally intended. This author presents the results of these surveys to understand which areas providers committed to changing in comparison to those actually changed. Results showed most providers who committed to change in the areas of communicating with patients, using teach back and implementing patient follow-up phone calls, subsequently reported they had in fact changed their practice. Whereas many providers intended to utilize communication tools with patients, fewer reported actually incorporating this change into their practice. Future opportunities lie in integrating observations to assess knowledge, along with ongoing management to sustain change and removing barriers for adopting communication tools.
Introduction

Background Knowledge

At the time of this writing, our nation’s healthcare delivery system is embarking upon phenomenal changes. This time will undoubtedly be marked in history as the largest transformation in healthcare. In a single legislation, known as the Affordable Care Act, the healthcare industry, its leaders and practitioners, have scrambled to establish rapid changes to comply with the numerous, and often complex, mandates. One mandate is to reduce hospital readmissions, or face lower reimbursements (Centers for Medicare and Medicaid Services, 2013). Recent data revealed 18.4% of all Medicare patients in 2012 were readmitted to hospitals within 30 days (Gerhardt et al., 2013). Although this is a decrease from prior years, it still represents billions of dollars in unnecessary costs for the Medicare program (Gerhardt et al., 2013). The readmissions reduction initiative is designed to shift some of these costs back to hospitals whose patients are discharged and subsequently readmitted. Components of the program include reducing 30-day hospital readmissions for patients with heart failure, pneumonia, and myocardial infarction. In 2014 this will expand to include chronic obstructive pulmonary disease, along with knee and hip arthroplasty (Centers for Medicare and Medicaid Services, 2013). It is widely suspected more diagnoses will be added and other payers will begin to emulate similar reimbursement penalties. In order to be successful with improving the overall quality of care, patients must partner with healthcare institutions and become engaged in their own health care (Snowden, 2013).

What is patient engagement and how does one become engaged? Patient engagement, accountability or compliance, have been matters, which historically have intrigued health care
providers. In a 1975 published study, titled “Good Patients and Problem Patients: Conformity and Deviance In a General Hospital”, Judith Lorber discusses the idea of patient compliance and the perceptions of nurses and physicians. The study showed that physicians expected patients to be passive and submissive, obeying orders without question. Lorber also found the sickest patients were most compliant and submissive, as they were totally dependent on clinicians for their health. The educated patients were least “compliant”, as demonstrated by their intense questioning and interruptions in an established routine. Lorber concluded, as the population gets better educated on health, “it is likely that patients will probably be asking more questions, demanding more explicit information about their cases, and insisting on more personalized attention” (1975). This study serves as an example of how the concept of patient compliance has transformed over the years, from patients being expected to comply without questioning to one where patients are encouraged to actively participate in their care, be informed and question providers anytime information is unclear.

Other authors have attempted to define patient accountability or engagement. In 2004, Hibbard, Stockard, Mahoney and Tusler conceptualized what they termed patient activation, and identified four domains critical to its existence: (a) self-management, (b) collaboration with provider, (c) maintain function/prevent declines, and (d) access to appropriate and high-quality care. Kemper (2013) described health care’s greatest unrealized resource as the patient, and asserts patient accountability is the mechanism for patients to maximize their potential. Patient accountability depends on the patient (a) knowing what is reasonably expected, (b) having the information, skills and tools to do what is reasonably expected, and (c) economically and socially accountable to do what is expected (Kemper, 2013). The Center for Advancing Health (2013) defines patient engagement as “the actions we take to benefit from the health care available to
us". The organization lists 43 engagement behaviors for consumers, which are separated into ten categories, one category being communication with providers. Patient engagement has also been defined as a process, in which patients grow towards becoming invested in their own care. It is a natural progression that occurs with regular, focused communication between a patient and provider (Patient Engagement Systems, 2013).

Throughout the years, a number of expressions have been used to define and explain patients who choose to adhere to prescribed medical regimens. There is minimal distinction in the definitions of engagement, compliance and accountability. However, the concepts are all the same, and each identifies some form of communication and knowledge as being necessary precursors for patients to become invested, participants in their own health care. For the purposes of this writing, this behavior will be referred to as patient engagement.

As described earlier, effective communication is essential to building bridges towards patient engagement. When provider-patient communication is done correctly, it builds trust with patients, which in turn establishes an environment conducive to building agreements regarding medical treatments and goals (Wood, 2013). Masterful provider-patient communication is associated with better patient outcomes and higher patient satisfaction rates (Beach, 2010).

Regrettably, providers have had suboptimal performance in communicating with patients. Reasons for ineffectual communication are varied and can include language and cultural differences between the provider and patient, patient disabilities, and low health literacy (Wilson-Stronks, 2013). Of these barriers, providers are least likely to recognize a patient with low health literacy since it is not easily identifiable (Powell & Kripalani, 2005). Therefore, the key to improving provider-patient communication is for providers to understand the issue of health literacy and employ strategies to overcome this barrier. When providers understand how
to best communicate with patients, patients are more likely to become engaged in their health care, and engaged patients have better outcomes and are less recurring hospitalizations (Divi, Koss, Schmaltz, & Loeb 2007).

Providers at St. Francis Medical Center, an acute care hospital in Lynwood, CA, raised concerns regarding their inability to effectively manage patients with atrial fibrillation and other chronic diseases (J. Smith, personal communication, January 27, 2013). Patients with atrial fibrillation were poorly managing their care; this resulted in repeat hospitalizations and incidents of preventable stroke. Similar trends could be seen in other chronic illnesses as well. Providers expressed frustration with the lack of patient engagement and accountability. Hospital leaders recognized an immediate need for improvement in patient engagement in order to advance the quality of care being delivered both within the hospital and self-care after discharge.

Local Problem

Health literacy is defined as “the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (US Department of Health and Human Services, 2013). The issue of health literacy is not only an individual problem, but also a systemic issue, prevalent throughout the healthcare industry and facing local communities all over the country. It is an important component of a patient’s ability to learn and involves much more than the ability to read and write, as demonstrated by 45% of high school graduates having limited health literacy (Kutner, Greenberg, Jin, & Paulsen, 2006). Health literacy “requires a complex group of reading, listening, analytical, and decision-making skills, and the ability to apply these skills to health situations” (National Network of Libraries of Medicine, 2013). This issue is so critical; it is in fact a greater predictor of health than age, income, race, education level, and employment status (Weiss, 2007).
Health literacy actually involves the ability to follow directions, fill out forms, calculate medication dosages, and make sense of medical jargon. The incidence of health illiteracy affects nearly 90 million American adults (Vernon, Trujillo, Rosenbaum, & DeBuono, 2007). It is more pervasive in individuals of a non-white ethnicity, those with lower education and socioeconomic backgrounds, with physical and mental disabilities, or with low English proficiency (Somers & Mahadevan, 2010). Health literacy is rarely recognizable and often masked. It is common for patients to pretend to understand, nod their head in agreement and fail to ask clarifying questions for fear of embarrassment.

Each day, individuals are being asked to make vital decisions that directly affect the status of their health. Patients must weigh the risks and benefits of a myriad of health care matters such as medications and their side effects, chemotherapy, surgery, or diet regulation. These choices are never easy, require a great deal of comprehension and discernment, and each decision has an effect on individual patient outcomes. Studies show patients with low health literacy are more likely to skip necessary medical tests, have more recurring Emergency Department visits, and have a harder time managing their chronic illnesses (Rudd, Anderson, Oppenheimer, & Nath, 2007).

Health literacy is just as much about the provider and healthcare system as it is the patient. Healthcare leaders must begin to examine how providers communicate with patients, assess health literacy and accommodate for patients and families with low health literacy. When considering the vast amount of sources providing patients with health information, it is understandable for patients to be confused. Health information is provided by friends, internet sites, news, books, radio, pharmacists and other providers. Sometimes the information is contradictory, and depending on the delivery is presented with no opportunities to clarify or
question the content. Patients are left to their own devices to make sense of the health information they receive.

In the state of California there are two programs designed to improve public health literacy (Centers for Disease Control, 2013). The Institute for Healthcare Advancement offers educational programs for providers and educators to raise awareness and teach best practices in educating persons with low health literacy. Services also include review and revision of educational material to assure it meets the needs of low health literacy individuals (Institute for Healthcare Advancement, 2013).

Health Research for Action is another program in California aimed at reducing health disparities by improving health literacy. The program operates out of the University of California Berkeley, School of Public Health. A team of researchers and public health professionals manage this consulting service. Health Resource for Action offers a variety of services to combat low health literacy. Services include educating the public, research, public health policy and planning (Health Research Action, 2013).

This paper is based on a quality improvement activity, which centered on the community of Lynwood, California. As such, the city’s demographics were analyzed. Lynwood is a small city in south Los Angeles County, just east of Compton, California. In Lynwood there is one 384-bed, community hospital that contains a busy trauma center, high-risk obstetrics and a large population of patients with chronic diseases, including heart disease, diabetes and renal failure (J. Smith, personal communication, January 27, 2013). Overall readmissions are high, many patients have difficulty managing their chronic diseases and normally suffer from harmful, yet preventable complications as a result of poorly home-managed care. As previously stated, low health literacy is found more often in certain demographics (non-white, over age 65, low
education and English as a second language). In an effort to comprehend health literacy in Lynwood, demographic data from the US Census Bureau (2012) was evaluated and compared to all of Los Angeles County (see Table 1). In Los Angeles County an estimated 33.5% of the population, age 16 years and older, lack basic literacy skills (National Center for Education and Statistics, 2003). For the city of Lynwood the demographics were analyzed to understand the population at risk for low health literacy. In 2010, 86.6% of the population in Lynwood was Hispanic or Latino, in comparison to 48.2% in all of Los Angeles County. Forty-one percent of the residents are foreign born and 83.6% speak a language other than English at home. Only 4.6% of the adults in Lynwood have Bachelor degrees while 29.2% in Los Angeles County have degrees.

Table 1

*Comparison Demographics, Lynwood, CA and Los Angeles County*

<table>
<thead>
<tr>
<th>People Quick Facts</th>
<th>Lynwood, CA</th>
<th>Year</th>
<th>Los Angeles County</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>70,709</td>
<td>2012</td>
<td>9,962,789</td>
<td>2012</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>86.6%</td>
<td>2010</td>
<td>48.2%</td>
<td>2012</td>
</tr>
<tr>
<td>Foreign-born persons</td>
<td>41%</td>
<td>2007-2011</td>
<td>35.6%</td>
<td>2007-2011</td>
</tr>
<tr>
<td>Language other than English spoken at home</td>
<td>83.6%</td>
<td>2007-2011</td>
<td>56.6%</td>
<td>2007-2011</td>
</tr>
<tr>
<td>Bachelor’s degree or higher</td>
<td>4.6%</td>
<td>2007-2011</td>
<td>29.2%</td>
<td>2007-2011</td>
</tr>
<tr>
<td>Persons below poverty level</td>
<td>21.6%</td>
<td>2007-2011</td>
<td>16.3%</td>
<td>2007-2011</td>
</tr>
<tr>
<td>Age 65 and over</td>
<td>5.4%</td>
<td>2010</td>
<td>11.5%</td>
<td>2012</td>
</tr>
</tbody>
</table>

US Census Bureau, 2012
Purpose of Change

The specific aim of this project was to influence healthcare providers to change their communication style. The reason for this change was to close the gap between clinical practice and evidenced-based practice relative to provider communication. In doing so, providers would be able to effectively converse with patients and their families. This practice change initiative was provided with the overarching intent for providers to affect patient engagement and ultimately improve quality outcomes. The success of this initiative would be measured by the number of providers who reported changes in how they communicated with patients.

Review of Evidence

There is evidence that suggests hospital readmissions and quality of care can be significantly reduced with effective provider communication and patient education (Robert Wood Johnson Foundation, 2013). One method for improvement involves use of the “teach back” method (Schillinger et al., 2003). There have been multiple sources advocating use of teach back as an effective strategy to enhance provider communication when conducting patient education (DeWalt et al., 2010; Institute for Healthcare Improvement, 2013; Oh, 2011).

Teach back involves the patient stating back to the clinician, in their own words, what they know and understand about their health condition (Schillinger et al., 2003). It is publicized as being an effective method of patient education since it allows the clinician to validate learning (DeWalt et al., 2010; Institute for Healthcare Improvement, 2013; Oh, 2011). Unlike traditional education, which involves post-education questions such as “do you have any questions” or “what questions do you have regarding your medication”, teach back asks, “can you please tell me how you will take your medications” (Schillinger et al., 2003). During teach back, if a patient incorrectly states any part of the information the clinician will reinstruct the patient. This
process will continue until the “feedback loop is closed” meaning until the patient correctly, states the information that was originally provided by the clinician (see Appendix A).

A literature review was done to evaluate the evidence (using Johns Hopkins Evidence and Quality Rating Scale) and to determine if patients understood health information better with teach back in comparison to simply providing information alone. All databases were searched for keywords “teach back” and “reducing readmissions”. The literature review was filtered to search for scholarly peer-reviewed journals published between 2007-2013. The search returned 54 documents. The remaining searches were once again filtered, this time to exclude non-research articles. This writing discusses the ten remaining articles and recommendations for practice change based on the evidence (see Appendix B).

In 2013, authors Kornburger, Gibson, Sadowski, Maletta and Klingbeil published their work on pediatric nurses and their use of teach back. This was a qualitative study assessing nurses’ pre and post knowledge, use, and perceived value of teach back. The findings revealed most nurses found value in teach back and had realized opportunities to clarify information regarding medication administration and follow-up appointments. The largest perceived barrier was time. Nurses responded it took more time to provide education with this method. The study was limited in that it looked only at nurse perceptions of the efficacy of teach back and did not actually assess the patient or family’s healthcare knowledge.

Another qualitative study investigated pharmacists’ perceived value while using teach back in the medication reconciliation process (Haynes, Oberne, Cawthon & Kripilani, 2012). The research found pharmacists believed they could improve patient outcomes by using teach back during medication reconciliation and patient education. The study was limited since it did not address the efficacy of teach back, but simply surveyed pharmacists for their perceptions.
Wilson, Baker, Nordstrom and Legwand (2008) examined the efficacy of teach back while educating mothers on the use of vaccines. In this study, researchers discovered women with low literacy failed to benefit from teach back. However, the writing did not indicate if the researchers retaught the material until learning was achieved (full use of the feedback loop). The authors noted the small sample size limited the study, and greatly cautioned against generalizing findings.

In separate, but similar study, Wilson, Peart, Webster and Nordstrom (2012) evaluated the use of teach back with low income women and their knowledge of the benefits and risks of vaccines. This quantitative/qualitative study found teach back was effective among women with higher health literacy rates. The women with low health literacy had minimal knowledge gain with teach back. The researchers acknowledged their sample size was small which hindered their ability to produce statistically significant results. In addition, it was not reported if the full teach back process had been applied because there was no indication the mothers were retaught when they stated incorrect information. True teach back involves closing the feedback loop or reteaching until the learner is able to correctly state the information (Schillinger et al., 2003).

Kripalani, Bengtzen, Henderson and Jacobson (2008) conducted a study to understand patients’ comprehension of informed consents. The findings were particularly disturbing because although the informed consent was written at grade school level, researchers found participants with limited health literacy could not fully comprehend the information. The study concluded low health literacy creates such a learning barrier, even use of the teach back could not overcome this obstacle.

Teach back was examined with patients and their respiratory inhaler techniques (Press, et al., 2012). This was a quantitative, randomized study with one group of patients being provided
brief instructions and the second group being provided instructions using teach back or teaching until learning goal was met. Researchers found teach back, described as “teach to goal”, was more effective. This was demonstrated by teach back patients exhibiting appropriate use of their inhalers and fewer hospital readmissions in comparison to those patients that did not receive education with teach back.

Few researchers were found to have examined knowledge retention and teach back. One study was located which studied teach back effectiveness over time. Kandula, Malli, Zei, Larson and Baker (2011) tested patients’ ability to recall health information related to diabetes. Teach back was utilized and found to be effective during immediate recall. However, researchers determined teach back did not have the same effectiveness for knowledge retention. Participants in the study were not able to recall the same level of information after two weeks. Therefore, it is recommended to provide educational resources for patient review over long periods of time.

Mahramus, et al. (2012) studied teach back while educating nurses on the management of congestive heart failure (CHF). Their findings concluded teach back was a valuable technique for instructing nurses. Unlike nurses, patients and families often times have low health literacy (National Center for Education Statistics, 2013). As a result, a patient’s ability to comprehend health information with teach back may have varying results in comparison to healthcare professionals.

Farrell, Kuruvilla, Eskra, Christopher and Brienza (2009) evaluated transcripts from 68 records. The examination focused on transcripts containing one of four “assessments for understanding” types, (a) open ended questions, (b) closed ended questions, (c) teach back and (d) asking “okay”. The analysis was limited and researchers pointed out many transcripts lacked any assessment of patient’s understanding and those that did were often phrased ineffectively or
initiated with poor timing. The authors concluded that many patients may not understand clinicians, and the clinicians many times are unaware of patients’ confusion. The research was further limited for the purposes of this evaluation since it did not focus on the effectiveness of the assessments of understanding.

In 2010 a meta-analysis of quantitative studies relative to patient comprehension of informed consents was performed (Schenker, Fernandez, Sudore & Schillinder). Researchers reviewed a total of 44 studies with one or more of the following teaching techniques, (a) written information, (b) audiovisual/multimedia, (c) extended discussions and (d) teach back. Researchers concluded all teaching techniques were effective, and did not determine if one was more superior to the other. They did suggest clarity regarding key elements of the informed consent in an effort to standardize the evaluation of patient comprehension. The analysis was limited because many studies did not include an adequate description of the study population, and there was considerable variety of outcomes making it difficult to surmise findings. However, the meta-analysis included promising results utilizing teach back.

Overall, the evidence to date supports the use of teach back as a communication strategy to assist with understanding new and unfamiliar concepts. However, teach back is not only a process, but involves a supportive approach that is necessary and involves clinicians creating a shame free environment so patients do not feel threatened (Weiss, 2007). It is important for clinicians to not only use teach back, but in conjunction provide educational materials based on the patient’s preferred learning style. These additional resources would be given to the patient so that over time the patient can refer back to the information.
Conceptual/Theoretical Framework

Theories and conceptual frameworks are often used to explain the foundation for which principles lie. Both Orem’s Self Care Theory and Kurt Lewin’s Change Theory were used as the foundation from which this practice change project was built. Orem’s Self Care Theory was used to develop an understanding of the importance of patients being partners in their own care, and having more accountability in that care. Kurt Lewin’s Change Theory was used to guide the project and create a format for motivating providers to change.

Orem’s Self Care Theory was first published in 1971 by Dorthea Orem and is built on the following basic assumptions: (a) people should be self-reliant and responsible for their own care, (b) a person’s knowledge of health and illness is necessary for promoting self-care behaviors and (c) self-care is a behavior learned within a socio-cultural context (Orem, 1991). Orem’s Self Care Theory maintains the basic premise that individuals are physically and cognitively able to regulate their own self-care, when they are unable to do so, persons experience a self-care deficit. Individuals suffering from a self-care deficit require assistance from a self-care agent to meet their health and human needs (Denyes, Orem & SozWiss, 2001).

There are numerous change theories available, and one may argue several are more relevant to clinical practice change. However, Kurt Lewin’s Change Theory is remarkably applicable, it is concise, simple and useful with non-complex change. Lewin’s Change Theory explains how behavior is associated both to an individual’s personal characteristics as well as the social situation in which one exists (Lewin, 1947). With this premise in mind, the change project was created with a basic assumption that providers want to provide the best care for their patients, and once they became aware of the clinical evidence supporting a new approach to communication, providers would be motivated to change (see Figure 1).
The practice change project first involved commentary to challenge the current beliefs and values around provider communication and patient comprehension; this stage is what Lewin referred to as unfreezing the mind. At the conclusion of the project, providers were asked about their intent to change their practice. It is at this point where change is intended to take place. Several weeks after the project, providers were mailed a follow-up survey to inquire about their commitment to change, to assess if they had changed their practice as intended. Lewin refers to this stage as refreezing. The providers are adapting to the new communication strategies and are forming a new way to communicate with patients.

Figure 1 Lewin’s Change Model

Methods

Ethical Issues

In May 2013 this quality improvement project was submitted to the University of San Francisco (USF) Institutional Review Board (IRB) for consideration. The USF IRB responded in confirmation, that the project was indeed quality improvement in nature and did not require an
informed consent (see Appendix C). The sponsors of this project at St. Francis Medical Center did not require an IRB review. It was well known and understood as a performance improvement initiative designed to improve care delivery within accepted evidenced-based standards. There was not, and is not, any intent to use this data for research purposes. This project did not involve any patients- all participants were clinical providers. As a result of this project, any changes in clinical practice will result in patients receiving the standard of care.

Setting

The setting for this project took place in Lynwood, CA in the auditorium of the medical center. The providers were from the acute, community-based and ambulatory care settings. Participants were informed that providers in attendance were from all over south Los Angeles County and were a mix of registered nurses, physicians and pharmacists. It was unclear if the providers had received any prior training regarding communication for patient engagement.

Planning the Intervention

In prior months primary care physicians raised concerns regarding quality and outcomes for patients with cardiac diseases. As a result, when the opportunity arose, a decision was made to pursue an educational, grant-funded project. The available grant offered funds for an educational project related to improving the quality of care in the management of patients with atrial fibrillation. In addition to medical treatments to prevent strokes, the grantor recommended projects to also include education on techniques to improve communication with patients. The grantor recognized in order to achieve quality, provider communication had to be addressed. The grant was pursued and ultimately awarded.

Once the organization received an announcement of the grant award, this author formed a team to create an educational project that would capture a multidisciplinary audience. In
addition to the author, team members included a cardiologist who also serves as the Director of Electrophysiology, a pharmacist, hematologist, nurse clinical educator, and librarian (see Appendix D). Each member was assigned a role in preparing educational content. The librarian was responsible for scheduling meetings, facilitating transactions and other administrative tasks. Clinical members conducted research and prepared content for their assigned area of education. The team was led by this author, and met routinely to discuss and review project plans. In addition to the educational program, planning was done to arrange for the venue, promotional advertisements, catering and audiovisual recording.

Although the grant funding was targeted towards a physician educational project, this author recognized an opportunity to involve other providers as well. There was no language in the grant precluding other disciplines from participating; as a result, the author made a decision to target key providers who could impact patient outcomes. Three provider types were determined to have the greatest influence on patient outcomes: physicians, pharmacists and nurses. There was agreement that these three disciplines would be the target audience, however the event would be open to all clinical providers.

The total budget for the project was approximately $11,000. The largest expense was $7,000 for the speakers (see Appendix E). The greatest variance between the proposed costs and actual costs were audiovisual fees. In the planning phase the project team anticipated providing the project online. This would have allowed the content to be accessible to anyone, and participants would pay only when requesting continuing education credits. In the final stages of planning, it was discovered the I.T. department could not support a web-based program of this scale. The $2,000 originally allocated for this ended in being a positive variance line item.
A communication plan was developed to strategize the most effective way to advertise internally and within the community (see Appendix F). Factors such as professional background, practice area and affiliation with the medical center were considered. Strategies consisted of communication posters within the medical center, save-the-date postcards and mailed brochure invites (see Appendix G, H, & I). Invitations were also sent electronically with a link for online registration at https://a-fib.eventbrite.com (see Appendix J). The website served as both an advertisement and registration tool. Persons looking for an educational activity or conference could search for and find the program using selected key words. The website also provided key information, which was used to evaluate traffic on the site (Appendix K).

**Implementation**

This project was implemented by a team of clinical professionals, who together had an overarching goal of improving the care and treatment of patients with atrial fibrillation. A cardiologist (who is also the Director of Electrophysiology) reviewed epidemiology and pathophysiology of atrial fibrillation and therapeutic implications. He also discussed the concept of rate versus rhythm control and ablation therapy. A Clinical Pharmacist discussed the role of antiarrhythmic therapy and warfarin use. An Oncologist/Hematologist educated the providers on new and emerging anticoagulant therapies. While the Clinical Nurse Educator reviewed safety concerns for patients. Lastly, this author discussed how to coordinate safe transitions of care and improve quality with enhanced provider communication. While there were several lecturers and topics, this writing is focused exclusively on the content presented by this author, and the endeavor of invoking change in how providers communicate with patients.

A total of 92 providers participated in the daylong educational event. This project was planned as a multidisciplinary educational event, and as such, attendees included registered
nurses, advanced practice nurses, physicians, pharmacists, one respiratory therapist and one technician. Of those in attendance, there were 60 providers who completed the post event evaluation (see Figure 2). Thirty-two remaining providers left before the event ended or failed to complete an evaluation, and as a result, are not captured in the data.

**Figure 2 Breakdowns of Evaluation Respondents**

<table>
<thead>
<tr>
<th>Label</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>15</td>
<td>25.00</td>
</tr>
<tr>
<td>NP</td>
<td>2</td>
<td>3.33</td>
</tr>
<tr>
<td>Nurses</td>
<td>41</td>
<td>68.33</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>3.33</td>
</tr>
<tr>
<td>Total Valid</td>
<td>60</td>
<td>100</td>
</tr>
</tbody>
</table>

**Planning the Study of the Intervention**

The event topic was designed to influence providers to adopt new communication strategies. Accordingly, success was measured based on providers’ intent to change and self-reported changes in the area of communicating with patients. Communication was considered an essential component of the project since literature supports the concept of effective communication leading to patient engagement and improved outcomes.

The project was designed using questionnaires to capture provider responses via evaluations and follow-up surveys. Educational content was presented, immediately afterwards providers were instructed to complete an evaluation. The evaluation queried the providers’ intent to change and perceptions of being more effective in their practice. Six weeks after the event, providers were mailed a follow-up survey. The follow-up survey asked if the provider actually changed their practice as they originally intended. The success of the project was determined by three factors, all targeted at 90% or greater: (a) provider perceptions of being more effective in practice, (b) intent to change, and (c) actual change.
During the planning phase, several milestones were identified to assist the author with staying on track with timelines of tasks due (see Appendix L). Some important timelines included mailing advertisements, along with the review of draft and final presentation materials. Moreover, the grantor required submission of preliminary outcomes and final reports. These were tasks considered high priorities because since funding was contingent on reports being turned in timely.

During the event, this author discussed how providers could improve quality, and safely transition patients using improved communication (see Appendix M). This topic is of great interest to the health professional community because there is a strong assumption that patients want to improve their health, yet often times they are not engaged in their own health regimen. The industry is finally shifting from providers being all knowing and delegating regimens to patients, to providers partnering with patients and collaborating on how to best achieve health. At the event, providers were introduced to all of the reasons why leaving the hospital can be a dangerous time for patients. Communication failures result in misunderstandings of discharge appointments, medications, and disease processes. The presentation briefly reviewed the definition of care transitions as defined by Coleman and Boult (2003) and providers were shown data reflecting hospital readmissions. Data was an essential component and used to raise awareness with the audience and invoke a desire to change.

The vast majority of the presentation entailed strategies for effective communication. Providers were made aware of how technology is being used to enhance communication with patients. Examples included health information exchanges with patient portals that allow email communication between the patient and providers. There was emphasis placed on the involvement of families. The audience was informed that often times family are facilitators of
care and consequently providers must engage families in the health discussions when necessary.

The author focused most of the presentation on teach back as a strategy for effective communication (Schillinger et al., 2003). Providers were shown the Closing the Feedback Loop diagram, which was used to illustrate the teach back method in practice (see Appendix A). The importance of following-up with patients was another communication strategy emphasized and encouraged for use. Providers were advised some form of follow-up with their patients was necessary to ensure patients had no additional questions and remained on track on the road to achieving health.

Towards the end of the presentation, audience members were given two real life stories as told from an emergency department physician. The first story recounts what happened when there was lack of communication with the primary provider, and how the patient required a visit to the emergency department after getting confused with the medications. The second story envisions the same patient except this time the provider is utilizing the communication strategies including teach back. The patient fully understands the medications and is subsequently discharged without further event. The stories are quite revealing and serve as an example of how healthcare could function with proper communication. Provider beliefs and assumptions are challenged and they are asked to rethink the idea of labeling a patient as “non-compliant” and instead view these issues as patients non-engaged, often times as a result of having little to no rapport with their provider. When the presentation comes to completion, providers are left with the data that demonstrate a need for a change, given strategies on how to create change, provided an example of what change could look like in clinical practice.

**Methods of Evaluation**

The purpose of this quality initiative was to influence health care providers to adopt new,
evidence-based approaches when communicating with patients. Six weeks after the event, self-reported surveys were administered to determine if providers had actually changed how they communicated. Only self-reported change was examined to determine if change had occurred. The degree of that change was neither identified nor measured. The Physicians’ Institute provided the survey tools and established validity and reliability for both tools.

Two surveys were administered to the providers participating in the event (see Appendix N & O). The first survey was an evaluation given to providers at the conclusion of the event. The evaluation contained questions to assess comprehension of content, perceived increase in practitioner effectiveness and intent to change. Six weeks later, participants were mailed follow-up surveys. The follow-up surveys asked providers if they had in fact changed as they previously committed to doing. It also specifically asked which communication strategies had been adopted and put into use with patients.

A SWOT analysis was done to develop a full awareness of the environment for this event and help with both planning and decision-making. (see Appendix P). The author determined strengths within the medical center included motivated physician providers. Many of the medical staff had already voiced a concern with wanting to improve patient outcomes, this was a good sign the group was already committed to learning new information. In addition, it could be argued, any provider registering for the event was already open to some level of change. In that regard, half of the battle had already been won. There was a team of experienced, clinical professionals available to teach content, so there was no need to hire an outside lecturer. Z

Weaknesses were also analyzed and revealed historically these types of events at the medical center had a low turn out. In addition, the organization did not routinely train physicians and nurses together. These two factors were considered weaknesses. In consideration of these
weaknesses, speakers were purposefully comprised of disciplines similar to the target audience members. Having two nurses, two physicians, and a pharmacist deliver the content, was intentionally designed to increase the turnout for these disciplines.

The team also explored opportunities and threats related to the event. Opportunities external to the organization included grant funding to support the event and an abundance of literature available to assist speakers with developing content. Threats to the success of the event involved a short deadline to return preliminary analysis reports to the grantor. The event had been pushed back a month later to accommodate one speaker’s vacation. This subsequently created a short turn around time for the first report. The author kept a chart with deadlines as a reference to assure all tasks were completed on time. The other threat was the potential difficulty with recruiting providers from outside of the organization. Providers in clinics and from Los Angeles County Department of Health were invited. The objective of inviting outside participants was to influence change with acute, ambulatory and community setting providers. Without having any professional relationships with these other providers, there was no guarantee they would attend. However, opportunities available to overcome this included having funding necessary to distribute repeat, professional advertisement to the invitees. The event offered was free to all attendees and continuing education units were provided for all physicians, nurses and pharmacists. These factors were considered critical for attracting providers to the event.

Again, the entire event was grant funded, and as a result, did not require a return on investment analysis. However, the total costs for the event were $10,993.75 (see Appendix E). If the medical center wanted to replicate a similar program, with a return on investment, it could offer an event for less cost if standard hourly labor wages were used to pay employed speakers
(nurses and pharmacists). The return would be realized through reduced length of stay and readmissions with actual savings calculations based on Medicare’s value based purchasing.

Analysis

There were a total of 92 participants, 60 of who responded to the evaluation on the day of the activity. Of the 60 respondents, there were 15 MDs, 2 Nurse Practitioners, 41 RNs, and 2 Others. Participants were asked to rate the entire event, encompassing all content. The majority of respondents reported the activity was appropriate for their practice, with 75% in strong agreement (see Figure 3). Ninety percent reported the activity met the course objectives with 85% in strong agreement (see Figure 4).

Figure 3 Content Appropriate to Practice

![Figure 3 Content Appropriate to Practice](image)

<table>
<thead>
<tr>
<th>Label</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>6</td>
<td>10.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Disagree</td>
<td>0</td>
<td>0.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Neutral</td>
<td>2</td>
<td>3.33</td>
<td>13.33</td>
</tr>
<tr>
<td>Agree</td>
<td>7</td>
<td>11.67</td>
<td>25.00</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>45</td>
<td>75.00</td>
<td>100.00</td>
</tr>
<tr>
<td>Total Valid</td>
<td>60</td>
<td>100.00</td>
<td></td>
</tr>
</tbody>
</table>

Figure 4 Met Course Objectives

![Figure 4 Met Course Objectives](image)

<table>
<thead>
<tr>
<th>Label</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>6</td>
<td>10.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Disagree</td>
<td>0</td>
<td>0.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Neutral</td>
<td>0</td>
<td>0.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Agree</td>
<td>3</td>
<td>5.00</td>
<td>15.00</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>51</td>
<td>85.00</td>
<td>100.00</td>
</tr>
<tr>
<td>Total Valid</td>
<td>60</td>
<td>100.00</td>
<td></td>
</tr>
</tbody>
</table>
Eighty-eight percent reported the activity was likely to make them more effective in their practice (see Figure 5). This scoring was lower than the targeted goal of 90%.

**Figure 5 Activity Will Make Me More Effective in My Practice**

<table>
<thead>
<tr>
<th>Activity Day %</th>
<th>0%</th>
<th>10%</th>
<th>2%</th>
<th>15%</th>
<th>73%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>0%</td>
<td>10%</td>
<td>2%</td>
<td>15%</td>
<td>73%</td>
</tr>
<tr>
<td>Disagree</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
<td>15%</td>
<td>73%</td>
</tr>
<tr>
<td>Neutral</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
<td>15%</td>
<td>73%</td>
</tr>
<tr>
<td>Agree</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
<td>15%</td>
<td>73%</td>
</tr>
<tr>
<td>Strongly Agree</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
<td>15%</td>
<td>73%</td>
</tr>
</tbody>
</table>

Throughout the event every attempt was made to keep the content unbiased. Each speaker had to attest to several items, including not having a conflict of interest (see Appendices Q, R, & S). All but one respondent expressed the activity was free from commercial bias (see Figure 6).

**Figure 6 Free from Commercial Bias**

<table>
<thead>
<tr>
<th>The activity was free of commercial bias:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Label</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Total Valid</td>
</tr>
<tr>
<td>Total Missing</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Ninety-three percent of respondents felt the activity had influenced them to change and reevaluate their approach (see Figure 7). Areas identified most often as commitment to change included use of teach back and overall communication with patients (see Figure 8).
The commitment to change responses showed 93% of respondents committed to change after attending this activity. This was above the targeted goal of 90%. After six weeks, the follow-up survey revealed 92% remained influenced to change (see Figure 9). This too, was above the goal of 90%. In most cases, percentage results demonstrated minimal differences in the areas respondents identified as intending to change in comparison to actual changes (see Figure 10).
Results

Program Evaluation/Outcomes

Of the 92 attendees, 60 completed the evaluation the day of the activity, of those, 25 responded for the follow-up survey. There was a significant reduction in respondents during the follow-up survey, in comparison to the number of respondents on the day of the activity. Only
25 people responded during the follow-up, of those 11 were physicians, 13 nurses, and 1 other (see Figure 11). While the follow-up responses are low, those that submitted data demonstrated the activity was successful. On the activity day, 93% of respondents reported the activity had caused them to intend on changing how they communicate. This percentage remained relatively unchanged, with 92% of respondents reporting the same during the follow-up evaluation (see Figure 9). A higher percentage of providers actually changed how they communicate with patients, 77% indicated they intended to change, whereas 84% reported actual change (see Figure 9). A significant decline in provider responses was seen with encouraging patients to use communication tools. On the day of the activity, 70% of the respondents reported their intent to encourage patients to use communication tools, but six weeks later, only 44% of the had actually done this.

Figure 11 Activity Day and Follow-Up Respondent Demographics

![Respondent Demographics](chart.png)

Tables 12 and 13 reveal a more detailed analysis of responses separated by physicians and nurses (the two largest groups of providers). Overall, relatively the same percentage of providers who intended to use teach back, actually utilized it. However, when you evaluate the physicians and nurses separately, the data shows more nurses reported they had used teach back in their clinical practice than the physicians (see Tables 12 &13).
Table 12

Nurses Intent to Change

<table>
<thead>
<tr>
<th>Answer</th>
<th>Activity Day</th>
<th>1st Follow-up</th>
<th>Activity Day %</th>
<th>1st Follow-up %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicating with patients</td>
<td>37</td>
<td>12</td>
<td>90%</td>
<td>92%</td>
</tr>
<tr>
<td>Using teach back with education</td>
<td>35</td>
<td>13</td>
<td>85%</td>
<td>100%</td>
</tr>
<tr>
<td>Following up with patients</td>
<td>22</td>
<td>6</td>
<td>54%</td>
<td>46%</td>
</tr>
<tr>
<td>Use of communication tools</td>
<td>32</td>
<td>6</td>
<td>78%</td>
<td>46%</td>
</tr>
</tbody>
</table>

Table 13

Physicians Intent to Change

<table>
<thead>
<tr>
<th>Answer</th>
<th>Activity Day</th>
<th>1st Follow-up</th>
<th>Activity Day %</th>
<th>1st Follow-up %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicating with patients</td>
<td>7</td>
<td>9</td>
<td>54%</td>
<td>82%</td>
</tr>
<tr>
<td>Using teach back with education</td>
<td>8</td>
<td>4</td>
<td>62%</td>
<td>36%</td>
</tr>
<tr>
<td>Following up with patients</td>
<td>8</td>
<td>7</td>
<td>62%</td>
<td>64%</td>
</tr>
<tr>
<td>Use of communication tools</td>
<td>7</td>
<td>4</td>
<td>54%</td>
<td>36%</td>
</tr>
</tbody>
</table>

During the follow-up evaluation, participants were asked to share examples of when they utilized information from the activity with their patients.

- Cirrhosis patient with atrial fibrillation
- Easy to understand as RN what the needs are of patients
- Elderly frail debilitated male-used AJA and beta blocker
- I gave materials to patients and faculty in the Coumadin Clinic
- I was able to effectively teach a patient with new onset A-Fib about treatment options
• Able to use content with my mother-in-law

• Patient had nonchalant attitude towards his risk factors of A-Fib. I increased education and conversation of therapy and risks

• Teach back verification of understanding

The comments shared by the participants demonstrated appropriate use of teach back and an overall conscious effort to improve the communication process with patients.

**Discussion**

**Summary**

Less than 50% of the original 60 reporting providers responded to the six-week follow-up survey. Of the 25 follow-up surveys received, the breakdown was as follows: 73% physicians, 32% nurses, 0% nurse practitioners, and 50% others. In the future, more strategies will need to be employed to capture a higher number of overall provider responses. It is possible, a higher number of physicians responded to the follow-up survey since they understood the event had been funded from the Physicians’ Institute. As a result, physicians may have felt more obligated to report their changes. Follow-up surveys were mailed to the addresses provided by the participants. This likely caused confusion since the initial evaluation asked for both an email and US mail address. Some respondents may have only included their email address. Unfortunately, we were unable to solicit responses via emails. The low follow-up responses may demonstrate U.S. mail is not the most effective way to receive responses to surveys. There should be a strong consideration for soliciting future responses via email.

The content of the findings also suggest other factors. Providers intended to encourage patients and families to use electronic communication tools. However, in practice, it perhaps was not as feasible as initially thought. Providers may not have all of the tools and resources in
place today to direct patients. The lower findings may also represent patients who had little interest in using these tools. Other data showed a higher percentage of nurses used teach back than originally intended, whereas the opposite was seen with physicians. More physicians planned on using teach back, but only half of those responding actually integrated teach back into their clinical practice. This may be due to physicians’ limited time constraints to “close the feedback loop” with patients or perhaps another clinical provider, for example nurses, were more available to teach patients.

**Relation to Other Evidence**

Evidence in the literature showed providers were less inclined to use teach back given that it was perceived as being time consuming (Kornburger et al., 2013). This is understandable for those patients that may require multiple reteaching sessions in order to close the feedback loop. Press et al. (2012) determined that using teach back required three times as much time educating patients. While the approach may require more time, it can be argued, if this is what is required to generate comprehension, than this is the right approach for the patient.

During the event, providers were given information to assist with communicating with patients. Providers were informed how technology could be used to enhance communication. One example shared with the group involved electronic care plans that could be maintained and shared across care settings and with the patient. Providers were also given information regarding electronic healthcare information exchanges and patient electronic personal records or patient portals. Providers were advised to encourage their patients to use electronic records as a means to improve communication and ultimately quality.

At the time of the event, 70% of respondents expressed intent to encourage patients to use electronic communication tools. However, following the event, only 44% reported they had
actually encouraged patients to use these communication tools. These results are comparable to outcomes provided in literature. There is literature that suggests patients fail to participate in electronic patient portals because they lack interest or motivation (Goel, et al., 2011). Still, others report nurses have struggled with these new forms of communication because it is perceived as being additional work (Rodriguez, 2011). Lastly, while providers expressed intent to use communication tools, Emont (2011) found sometimes it is the organization that is reluctant to embrace these technologies due to concerns regarding costs, reimbursements and liability.

**Barriers To Implementation/Limitations**

Barriers and limitations of this quality initiative were centered on the lack of direct observations. Although the intent of this quality initiative was to change how providers communicated with patients, the event did not include observed knowledge and behavior assessments. During the event providers were given examples of how to incorporate teach back into their clinical practice and only received a short, written assessment of their knowledge. At the six-week follow-up assessment, providers self reported all data. As a result, there was no ability to objectively monitor if providers had in fact changed their practice. Without observations, the author also could not discern how effective providers were in their change.

Additional limitations included the low response rate. With only 27% of the 92 attendees participating in the follow-up survey, attempts to measure success were problematic. The author relied on limited data to analyze outcomes. While the reported change percentages are high, it is important to caution against concluding most providers in attendance changed their practice. The data was calculated using the number of responders as the denominator and not the number of attendees.
Limitations with Information Technology (I.T.) proved to be significant as it greatly impacted the ability to provide the event online. During the planning phase, the intent had been to video record the event and offer the educational program online via a link on the hospital’s website. The online feature would have the ability to collect participant information and issue continuing education credits at completion. However, the hospital’s I.T. department advised they were unable to create this function and would need to spend costly dollars outsourcing the labor. In the future, this issue could be resolved by uploading the video content on an external website with a link from the hospital’s company website. While not recommended, another alternative could exist by providing the content online, exclusively in written format.

**Interpretation**

Leading change is an arduous process and rarely can be achieved in a one-day training. The results of this initiative were promising, yet extremely limited, since everyone did not respond, there was no clear indication of how many of the total participants were influenced to change. This event could have been more substantial with more responses and the incorporation of role-play to assess levels of competency. However, the author recognizes observations during training sessions and in clinical practice were not feasible for this audience. If the physicians’ patients could be studied, patient outcomes could have been used to measure change. Measurements such as reducing acute care length of stay and 30-day readmissions would have served as possible outcome metrics for large-scale training limited to inpatient and emergency department providers. Still, the focus of this event was to engage providers throughout the healthcare continuum (acute, ambulatory and community) with the intent of improving communication at multiple health care entry points. Future events could focus on the acute care
or ambulatory settings only, which would allow better control of those being trained, observed and measured.

**Conclusions**

Effective provider communication certainly serves as a tactic to enhance patient understanding and engagement. At a minimum, health care providers have a responsibility to ensure their patients can process information given to them. It is well established, that many people suffer from low health literacy. Providers must be prepared to modify their communication techniques to create better patient-provider partnerships.

Earlier, this document discussed how provider communication is linked to patient engagement and ultimately improved outcomes. Details were provided that described a quality improvement, educational event, aimed at raising awareness and influencing providers to adopt change in communication with patients. The results were promising, and most responding providers indicated they had incorporated new communication strategies with their patients. There is confidence that these providers will positively transform their patient relationships with all patients, not just those diagnosed with atrial fibrillation. This document should serve as a catalyst, for both healthcare providers and leaders, to stimulate conversations regarding patient communication. There should be thoughtful consideration for how to establish, manage and sustain change in other settings.

**Other Information**

**Funding**

This quality initiative was grant funded by the Physicians’ Institute. The design and implementation schedule was crafted to adhere to the guidelines of the grantor. The Physicians’
Institute provided funding through commercial support from the Bristol-Myers Squibb/Pfizer Pharmaceuticals Partnership.
References


Oh, J. (September 21, 2011). 10 proven ways to reduce hospital readmissions. *Becker’s Hospital Review.*


Schillinger, D., Piette, J., Grumbach, K., Wang, F., Wilson, C., Daher, C., …Bindman, A. (January 13, 2003). Closing the loop physician communication with diabetic patients who have low health literacy. *Archives of Internal Medicine, 163*.


Appendix A

Teach Back: Closing the Feedback Loop Diagram

Appendix B

Evidence Table (Evaluated using Johns Hopkins Evidence and Quality Rating Scale)

<table>
<thead>
<tr>
<th>Study</th>
<th>Method</th>
<th>Sample</th>
<th>Intervention</th>
<th>Outcomes Recommendations</th>
<th>Strength rating</th>
<th>Quality (a-c) rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kornberger, Gibson, Sadowski, Maletta &amp; Klingbel (2013)</td>
<td>Qualitative study with post intervention surveys.</td>
<td>Convenient sample of 74 nurses</td>
<td>Nurses were instructed on how to use the teach back method. Following this instruction nurses were surveyed to assess their perceptions of the effectiveness of teach back with patients/families.</td>
<td>This educational intervention improved the nurses' use and understanding of the “teach-back” process. The findings specifically demonstrated the importance that “teach-back” can have on preventing medication errors. The identified barriers need to be addressed in order to support the use of teach back in practice (nurses’ lack of time or patient/family lack of interest).</td>
<td>3</td>
<td>A</td>
</tr>
<tr>
<td>Haynes, Oberne, Cawtho n &amp; Kripilani (2012)</td>
<td>Qualitative study. Pharmacist s were interviewed to determine if their use of the teach back method in the medication reconciliation process was effective.</td>
<td>Convenient sample of 79 patients</td>
<td>Eleven pharmacists at 2 hospitals participated in the Pharmacist Intervention for Low Literacy in Cardiovascular Disease (PILL-CVD) study and completed semistructured one-on-one interviews. Pharmacists provided their perspectives on admission and discharge medication reconciliation, in-hospital patient counseling, provision of simple medication adherence aids (eg, pill box, illustrated daily medication schedule), and telephone follow-up.</td>
<td>Pharmacists are well positioned to participate in hospital-based medication reconciliation, identify patients with poor medication understanding or adherence, and provide teach back patient counseling to improve transitions of care. Additional studies are needed to confirm these findings in other settings.</td>
<td>2</td>
<td>C</td>
</tr>
<tr>
<td>Mahramus, Frewin, Chamberlain, Wilson, Penoyer &amp; Sole (2012)</td>
<td>The study used a quasi-experimental, pre-test, post-test design involving nurses and their knowledge of CHF.</td>
<td>Convenient sample of 158 nurses</td>
<td>Nurses completed a CHF pretest, were instructed on CHF competency using simulation models and were assessed post-test using the teach back methodology. Competency was reassessed 3 months later to test knowledge retention.</td>
<td>Teach back competency assessment scores showed that 97.8% were correct although 44% of these needed some remediation. Based upon findings, this educational intervention has shown effectiveness.</td>
<td>2</td>
<td>C</td>
</tr>
<tr>
<td>Press, Arora, Shah, Lewis,</td>
<td>Quantitative, randomized study used</td>
<td>Convenient sample of 50</td>
<td>Fifty patients were enrolled and randomized into teach back group (n=24) or</td>
<td>Teach back appears to be more effective compared with brief instructions. Patients over-estimate their inhaler technique, emphasizing the need for hospital-based</td>
<td>1</td>
<td>A</td>
</tr>
<tr>
<td>Authors</td>
<td>Study Design</td>
<td>Setting/Population Description</td>
<td>Participants/Methodology</td>
<td>Findings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------</td>
<td>---------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charbonneau, Naurekas &amp; Krishna (2012)</td>
<td>To compare two educational interventions to instruct hospitalized patients with asthma or COPD on respiratory inhaler technique.</td>
<td>Patients were instructed on respiratory inhaler technique.</td>
<td>Brief instruction group (n=26).</td>
<td>Interventions to correct inhaler misuse.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wilson, Peart, Webster &amp; Nordström (2012)</td>
<td>Two community health centers in Jamaica were selected for this study. Both served predominately low-income patients.</td>
<td>A descriptive, nonexperimental research design to both quantitatively/qualitatively report maternal health literacy and use of the teach-back method.</td>
<td>Convenient sample of 34 pregnant women. Researchers implemented the teach back, which consisted of teaching each participant about the benefits, risks, and safety issues of the BCG and hep B vaccines using information from the two pamphlets. After the teaching, the researcher asked the participants to repeat in their own words their understanding of what they were taught; these responses were audio-recorded. An analysis was done of each mother’s responses to the teach back, with the response data coded and measured as correct (1), partially correct (0.5), or incorrect (0). Although in this study the teach-back method may have been beneficial in the knowledge and communicative abilities of women with higher literacy level, there was only a modest gain for women with lower literacy, and these gains were not statistically significant. However, these results indicate the need for future research that tests education strategies targeting parents who have difficulty understanding immunization instructions.</td>
<td>2 B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kandula, Malli, Zei, Larson &amp; Baker (2011)</td>
<td>Experimental study with surveys used to assess knowledge.</td>
<td>Participants were tested on recall of health information related to diabetes. There were 113 participants in Group 1 who did not have teach back and 58 participants in Group 2 who used teach back.</td>
<td>After 2 weeks, all participants, regardless of their literacy levels, forgot approximately half the new information they had learned. Adding a teach-back protocol did improve immediate recall but did not improve knowledge retention at 2 weeks. Health education interventions must incorporate strategies that can improve retention of health information and actively engage patients in long-term care.</td>
<td>1 C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Author(s)</td>
<td>Methodology</td>
<td>Sample Size</td>
<td>Key Findings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
<td>-------------</td>
<td>--------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schenker, Fernandez, Sudore &amp; Schillinger (2010)</td>
<td>Meta-analysis of randomized controlled trials and controlled trials with nonrandom allocation were reviewed. Only studies that used a quantitative, objective measure of understanding were included.</td>
<td>44 studies</td>
<td>Forty-four studies were eligible. Intervention categories included written information, audiovisual-multimedia, extended discussions, and test/feedback techniques. The majority of studies assessed patient understanding of procedural risks; other elements included benefits, alternatives, and general knowledge about the procedure. Only 6 of 44 studies assessed all 4 elements of understanding. A wide range of communication interventions, including teach back, improve comprehension in clinical informed consent. Decisions to enhance informed consent should consider the importance of different elements of understanding, beyond procedural risks, as well as feasibility and acceptability of the intervention to clinicians and patients. Conceptual clarity regarding the key elements of informed consent knowledge will help to focus improvements and standardize evaluations.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farrell, Kuruvilla, Eskra, Christopher &amp; Brienza (2009)</td>
<td>Data abstraction using a data dictionary for 4 assessment of understanding types (open ended questions, closed ended questions, teach back and okay)</td>
<td>Conveniant sample of 86 transcripts</td>
<td>Transcripts were reviewed to assess teaching methods and assessments of understanding. Definite criteria for at least one assessment of understanding were found in 68/86 transcripts (79%). Of these, 2 transcripts contained a request for a teach-back (&quot;what is your understanding of this?&quot;), 2 contained an open-ended question, 46 (54%) contained only a close-ended question, and 18 (21%) only contained an &quot;OK?&quot; question. Many transcripts lacked clinicians' assessments of understanding, and those that included assessments of understanding were often ineffectively phrased or inefficiently timed. Many patients may not understand clinicians, and many clinicians may be unaware of patients' confusion.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kripalani, Bengtzen, Henders &amp; Jacobson (2008)</td>
<td>Quantitative study where researchers used teach-back to assess comprehension of informed consent and privacy information for patients participating</td>
<td>Conveniant sample of 435 patients</td>
<td>Patients 1) received written informed consent and HIPAA forms and were prompted to look over them; 2) heard a scripted study overview; and 3) were assessed regarding comprehension of study information using “teach-back” techniques. Literacy was significantly associated with comprehension of consent and privacy information, even when recommended steps were taken to simplify the information and a verbal study description was provided. Findings suggest that individuals with limited literacy skills should be considered a vulnerable population. Special consideration should be given to their protection in clinical research studies, as is currently done for children, prisoners, and other at-risk groups.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wilson, Baker, Nordstrom &amp; Legwand (2008)</td>
<td>Quantitative-qualitative research design where mothers were tested on recall of vaccine information using the teach back methodology.</td>
<td>The Rapid Estimate of Adult Literacy (REALM) was used to assess literacy level. Vaccine information statements on inactive poliovirus (IPV) and pneumococcal conjugate vaccine (PCV) were instructional materials used in the teach back procedure.</td>
<td>There was inconsistency of the mothers’ responses to communicate critical immunization information about vaccines. Higher levels of correct responses were found in mothers with higher literacy rates. This indicates the need to further assess how best to increase parents’ vaccine knowledge and communication skills.</td>
<td>2</td>
<td>C</td>
<td></td>
</tr>
</tbody>
</table>

Newhouse R, Dearholt S, Poe S, Pugh LC, White K. Johns Hopkins Evidence-Based Practice Research Evidence Appraisal. The Johns Hopkins Hospital/Johns Hopkins Evidence and Quality Rating Scale
To: Ceonne Raasikh  
From: Terence Patterson, IRB Chair  
Subject: Protocol #92  
Date: 05/23/2013  

The Institutional Review Board for the Protection of Human Subjects (IRBPHS) at the University of San Francisco (USF) has reviewed your request for human subjects approval regarding your study.

Your research (IRB Protocol #92) with the project title Providing Education Updates to Physicians and Nurses Re: Treatment and Management of Patients with A-Fib has been verified by the University of San Francisco IRBPHS as a Quality Improvement Project, and accordingly does not meet the definition of "research" at to 45CFR46.102(d). Your protocol is thus exempt from IRB review.

Please note that changes to your protocol may affect its exempt status. Please submit a modification application within ten working days, indicating any changes to your research. Please include the Protocol number assigned to your application in your correspondence.

On behalf of the IRBPHS committee, I wish you much success in your research.

Sincerely,

Terence Patterson,  
Chair, Institutional Review Board for the Protection of Human Subjects  
IRBPHS - Univeristy of San Francisco  
Counseling Psychology Department  
Education Building - Room 017  
2130 Fulton Street  
San Francisco, CA 94117-1080  
(415) 422-6091 (Message)  
IRBPHS@usfca.edu
Appendix D

Project Team Members

Ceonne Raasikh, RN
Project Team Leader

Medical Director for EP Cardiology

Librarian

Clinical Pharmacist

Hematologis/Oncologist

Clinical Educator
Appendix E

Project Budget

<table>
<thead>
<tr>
<th>Budget Item</th>
<th>Proposed Costs</th>
<th>Actual Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speakers</td>
<td>$5,000.00</td>
<td>$7,000.00</td>
</tr>
<tr>
<td>Travel</td>
<td>$300</td>
<td>$0</td>
</tr>
<tr>
<td>Food and Beverage</td>
<td>$1,000</td>
<td>$1,408.55</td>
</tr>
<tr>
<td>Audiovisual</td>
<td>$2,000</td>
<td>$0.00</td>
</tr>
<tr>
<td>Hotel/Rental Space</td>
<td>$500</td>
<td>$-</td>
</tr>
<tr>
<td>Printing/copying</td>
<td>$400</td>
<td>$1,034.02</td>
</tr>
<tr>
<td>Mail House/Postage</td>
<td>$50</td>
<td>$50.00</td>
</tr>
<tr>
<td>Marketing</td>
<td>$550</td>
<td>$0</td>
</tr>
<tr>
<td>Data Collection</td>
<td>$375</td>
<td>$471.68</td>
</tr>
<tr>
<td>Supplies</td>
<td>$250</td>
<td>$438.50</td>
</tr>
<tr>
<td>Administrative</td>
<td>$500</td>
<td>$591.00</td>
</tr>
<tr>
<td>Total Expenses</td>
<td>$10,925.00</td>
<td>$10,993.75</td>
</tr>
</tbody>
</table>
Appendix F

Communication Plan Matrix

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Audience(s)</th>
<th>Timing</th>
<th>Message</th>
<th>Method</th>
<th>Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have potential participants mark their calendars to plan for attendance</td>
<td>Physicians, nurses and pharmacists</td>
<td>Twice, April and May 2013</td>
<td>Event name, date, place and time</td>
<td>US mailing of postcards</td>
<td>B. Araya</td>
</tr>
<tr>
<td>Raise awareness of event</td>
<td>Physicians and nurses</td>
<td>Once, May 2013</td>
<td>Event name, date, place, time, objectives and speakers</td>
<td>Posters placed throughout walls of hospital</td>
<td>M. Van Leeuwen</td>
</tr>
<tr>
<td>Online advertisement and registration</td>
<td>Physicians, nurses, pharmacists and others</td>
<td>Ongoing, May 2013 until event</td>
<td>Event name, date, place, time, objectives and speakers</td>
<td>Online</td>
<td>C. Raasikh</td>
</tr>
<tr>
<td>Extend invitations and raise awareness</td>
<td>Physicians</td>
<td>April, May and June 2013</td>
<td>Event name, date, place, time, objectives</td>
<td>Medical staff meetings</td>
<td>Dr. A. Singh</td>
</tr>
<tr>
<td>Extend invitations and raise awareness</td>
<td>Pharmacists</td>
<td>May and June 2013</td>
<td>Event name, date, place, time, objectives and speakers</td>
<td>Face to Face one-on-one meetings</td>
<td>Dr. P. Ty</td>
</tr>
</tbody>
</table>
INFLUENCING CHANGE IN HEALTH CARE PROVIDERS

Appendix G

Poster Advertisement

CURRENT MANAGEMENT OF ATRIAL FIBRILLATION

EVENT DATE: SATURDAY, JUNE 22, 2013
TIME: 8:30 AM - 4:00 PM
LOCATION: St. Francis Medical Center Auditorium
3630 E. Imperial Highway
Lynwood, CA 90262

CME Hours: 6.0 AMA PRA Category 1 Credit(s)
CEUs: 6.5 contact hours

Register online at www.a-fib.eventbrite.com or contact CME department at (310) 900-8671 or 8672.

TARGET AUDIENCE
Target audience members will include frontline healthcare workers who manage the care of patients with Atrial Fibrillation, and include: 1) Physicians with specialties in: Primary Care, Internal Medicine, Family Practice, Cardiology, and Emergency; 2) Pharmacists; and 3) Registered Nurses. This CME will also address the interaction between disciplines as associated with the care of Atrial Fibrillation, and how the team can collectively work to improve patient outcomes.

OBJECTIVES
- Demonstrate knowledge of current methods for managing atrial fibrillation.
- Identify new oral anticoagulant therapies currently being trialed for treatment of atrial fibrillation.
- Determine risk stratification for complications of atrial fibrillation.
- Determine the relative risk and benefit of antithrombotic therapy for a given patient.
- Determine which patients are best managed with a rate-control versus rhythm-control strategy.
- Discuss options for maintaining sinus rhythm including anti-arrhythmic drug therapy and the role of ablation.

- Free self-parking in parking structure
- Continental breakfast, lunch and refreshments will be served

FACULTY
- Anantjit Singh, MD Cardiology
  Project Medical Director, St. Francis Medical Center
- Peter Ty, Pharm.D., BCPs
  Clinical Pharmacist Specialist, St. Francis Medical Center
- Christopher Ho, MD Oncology-Hematology
  St. Francis Medical Center

MARLENE VANLIEUWEN, RN, MSN
Clinical Educator, St. Francis Medical Center

CÉONNE HOUSTON-RASIAK, RN, DNPC, CPHQ, NEA-BC
Nurse Executive Leadership, University of San Francisco

COMMERCIAL SUPPORT
This activity is funded through an educational grant from Bristol-Myers Squibb/Pfizer Pharmaceuticals Partnership to the TEAM-A Collaborative to support activities that improve the treatment of patients with Atrial Fibrillation. The Physicians’ Institute is a member of TEAM-A and retains full control over the distribution of individual grants under this collaborative grant program.

DISCLOSURE STATEMENT
Everyone in a position to control the content of this educational activity will disclose to the CME provider and to attendees all relevant financial relationships with any commercial interest. They will also disclose if any pharmaceuticals or medical procedures and devices discussed are investigational or unapproved for use by the U.S. Food and Drug Administration (FDA). Determination of educational content for this program and the selection of speakers are responsibilities of the program director. Firms providing financial support did not have input in these areas.

St. Francis Medical Center is accredited by the Institute for Medical Quality/California Medical Association to provide CME for physicians. St. Francis Medical Center takes responsibility for the content, quality and scientific integrity of this CME activity. St. Francis Medical Center designates this educational activity for a maximum of 6.0 AMA PRA Category 1 Credit(s) TM. Physicians should only claim credit commensurate with the extent of their participation in the activity. This credit may also be applied to the OMA Certification in Continuing Medical Education.
Appendix H

Save the Date Postcard Advertisement

Physicians-Nurses-Clinicians

SAVE THE DATE

ATRIAL FIBRILLATION
A CLINICAL UPDATE

DATE Saturday, June 22, 2013
TIME 8:30 AM - 4:00 PM
LOCATION St. Francis Medical Center Auditorum
3630 E. Imperial Highway
Lynwood, CA 90262

CME Hours 6.0 AMA PRA Category 1 Credit(s)

*This activity is funded through an educational grant from Bristol-Myers Squibb/Pfizer Pharmaceuticals Partnership to the TEAM-A Collaborative to support activities that improve the treatment of patients with Atrial Fibrillation. The Physicians’ Institute is a member of TEAM A and retains full control over the distribution of individual grants under this collaborative grant program.*
Appendix I

Advertisement Brochures
INFLUENCING CHANGE IN HEALTH CARE PROVIDERS

TARGET AUDIENCE

Target audience members will include frontline health care workers who manage the care of patients with Atrial Fibrillation, and include: 1) Physicians with specialties in: Primary Care, Internal Medicine, Family Practice, Cardiology, and Emergency; 2) Pharmacists; and 3) Registered Nurses. This CME will also address the interaction between disciplines as associated with the care of Atrial Fibrillation, and how the team can collectively work to improve patient outcomes.

OBJECTIVES

- Demonstrate knowledge of current methods for managing Atrial Fibrillation.
- Identify new oral anticoagulant therapies currently being trialed for treatment of Atrial Fibrillation.
- Determine risk stratification for complications of Atrial Fibrillation.
- Determine the relative risk and benefit of antithrombotic therapy for a given patient.
- Determine which patients are best managed with a rate-control versus rhythm-control strategy.
- Discuss options for maintaining sinus rhythm including anti-arrhythmic drug therapy and the role of ablation.
- Free self-parking in parking structure
- Continental breakfast, lunch and refreshments will be served

AGENDA

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 AM</td>
<td>Registration and Continental Breakfast</td>
</tr>
<tr>
<td>9:10 AM</td>
<td>Welcome and Reflection</td>
</tr>
<tr>
<td>9:30 AM</td>
<td><strong>IDENTIFICATION</strong></td>
</tr>
<tr>
<td></td>
<td>Epidemiology and Pathophysiology of Atrial Fibrillation and the Therapeutic</td>
</tr>
<tr>
<td></td>
<td>Implications.</td>
</tr>
<tr>
<td></td>
<td>Risk Assessment in Atrial Fibrillation: Anantjiti Singh, MD</td>
</tr>
<tr>
<td>10:30 AM</td>
<td>Break</td>
</tr>
<tr>
<td>10:45 AM</td>
<td><strong>TREATMENT</strong></td>
</tr>
<tr>
<td></td>
<td>Rate vs. Rhythm Control in Atrial Fibrillation: Anantjiti Singh, MD</td>
</tr>
<tr>
<td>11:15 AM</td>
<td>Role of Antiarrhythmic Therapy and Warfarin in Atrial Fibrillation: Peter</td>
</tr>
<tr>
<td></td>
<td>Ty, Pharm.D.</td>
</tr>
<tr>
<td>11:50 AM</td>
<td>Lunch</td>
</tr>
<tr>
<td>12:30 PM</td>
<td>New and Emerging Anticoagulant Therapy for Atrial Fibrillation: Christopher</td>
</tr>
<tr>
<td></td>
<td>Ho, MD</td>
</tr>
<tr>
<td>1:00 PM</td>
<td>Ablation Therapy for Atrial Fibrillation Past, Present and Future: Anantjiti</td>
</tr>
<tr>
<td></td>
<td>Singh, MD</td>
</tr>
<tr>
<td>1:35 PM</td>
<td>CARE</td>
</tr>
<tr>
<td></td>
<td>Keeping Patients Safe</td>
</tr>
<tr>
<td></td>
<td>Marleno Vanloucouen, RN</td>
</tr>
<tr>
<td>2:00 PM</td>
<td>Break</td>
</tr>
<tr>
<td>2:15 PM</td>
<td>Coordinating Safe Transitions of Care: Ceme Houston-Rassikh, RN</td>
</tr>
</tbody>
</table>

INTERACTIVE LEARNING

2:45 PM  Case-Based Examples

QUESTIONS AND ANSWERS/ADJOURNMENT

REGISTRATION

Register online at www.a-fib.eventbrite.com or complete and mail REGISTRATION FORM to:
St. Francis Medical Center
Attention: Medical Staff Services
CME Department
3630 E. Imperial Highway
Lynwood, CA 90262

Name: __________________________________________
Address: ________________________________________
City/State/Zip Code: ______________________________
Phone (Daytime): _________________________________
Fax: ____________________________________________
Please check: ______ MD ______ DO ______ Pharm.D
______ PA/NP ______ RN ______ LVN ______ OTHER

OTHER (Please Specify): __________________________
Specialty (if physician): __________________________
Email: _________________________________________

COMMERCIAL SUPPORT

In order to promote the educational goals of this activity, the activity will include discussions of commercially available products. The Physician Institute is a member of TEAM-A and may solicit feedback from companies on medical issues and educational content of this activity.

DISCLOSURE STATEMENT

Disclosures in education are consistent with the content of this educational activity. All faculty have no conflict of interest to disclose. The Physician Institute has no financial interest in any of the products or services referred to in this activity.

The Physician Institute is accredited by the Institute for Medical Education (IME) and is approved to provide continuing medical education (CME) for physicians. The Physician Institute designates this educational activity for a maximum of 5.5 AMA PRA Category 1 Credit(s)™. Physicians should only claim credit commensurate with the extent of their participation in the activity. This course may also be applied for opioids CME credit (ILEX) in continuing education.
Appendix J

Online Event Advertisement & Registration

Atrial Fibrillation: A Clinical Update
Saturday, June 22, 2013 from 9:00 AM to 3:30 PM (PDT)
Lynwood, CA | Main Tower, 1st Floor Auditorium

Main Tower, 1st Floor Auditorium
St. Francis Medical Center,
3630 E. Imperial Highway
Lynwood, CA 90262
Saturday, June 22, 2013 from 9:00 AM to 3:30 PM (PDT)
Add to my calendar
Appendix K

Online Page Views

![Online Page Views Graph](image-url)
Appendix L

Project Timeline

<table>
<thead>
<tr>
<th>Action</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meet with AV Technician to discuss needs</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meet with I.T. Director to discuss needs</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meet with Marketing Director to create ads</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team Content Planning Meeting</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Confirm Caterer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mail Save-the-Date Postcards</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mail Ad Brochures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>Project Implementation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>22-Jun</td>
</tr>
<tr>
<td>Follow-up Surveys Mailed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Preliminary Report Due</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>19-Jul</td>
</tr>
<tr>
<td>Final Reports Due Aug 31</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

*** Intent to Change Practice responses are mailed to participants
Appendix M

Event Presentation Slides

Safe Transitions of Care
Communication Strategies to Improve Patient Outcomes
Ceeonne Houston-Raasikh, RN

Overview
- Transitions of care
- Reasons for poor care coordination
- Creating safe transitions of care with improved provider communication

What are transitions...
...a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location. Transitional care is based on a comprehensive plan of care and the availability of health care practitioners who are well-trained in chronic care and have current information about the patient’s goals, preferences and clinical status. It includes logistical arrangements, education of the patient and family, and coordination among the health professionals involved in the transition. Transitional care, which encompasses both the sending and the receiving aspects of the transfer, is essential for persons with complex care needs.


Effects of Poor Care Coordination
- One-third of patients discharged from hospitals have at least one medication discrepancy that could negatively affect outcomes.
- Approximately 1 out of every 5 Medicare patients are readmitted within 30 days.
- One-third of patients are readmitted within 90 days.
- One-half of patients readmitted within 30 days did not see a provider after discharge.

Health Policy Brief: Care Transitions, Health Affairs, Sept. 13, 2012

Why is This Important?
- CMS payments for core measure data (FNA, CHF, MI) ...list to expand
- Get With The Guidelines [CMS stroke registry]
- IJC Certified Stroke Center
- SIR Meaningful Use [stroke data]
- Physician Quality Reporting Initiative (PQRI) eligibility for bonus dollars

Focus on Quality
Influencing Change in Health Care Providers

Engaging Patients for Safe Transitions of Care

Best Practice Areas of Communication
- Discharge
- Medication Reconciliation
- Communication Tools
- Patient Education
- Follow up

Heart Rhythm Society Available at http://www.hrsonline.org/Patient-Resources/Heart-Diseases-Disorders/Atrial-Fibrillation-AFib/AFib-Transitions-of-Care/Information-for-Care-Providers

From Med Wreck to Med Rec

- Are you certain patients understand the importance of taking medications?
  - Patients need to fully understand
    - Why?
    - How?
    - When?
    - Side effects?
  - Specially trained Admissions Nurse
  - Expand the role of the pharmacist during medication reconciliation
  - Multidisciplinary medication reconciliation

AHRQ Available at http://www.ahrq.gov/professionals/institutions/initiative-appreciation/0-124105271-0-9538A14168F.html

Communication

“The problem with communication is the illusion that it has occurred.”
- George Bernard Shaw

Communication Tools
- Develop a care plan that is maintained and shared across care settings
- Establish a HIE (healthcare information exchange)
- Each provider must have information regarding the patient's anticoagulation therapy
- Encourage patients to maintain an electronic personal health record
  - WebMD, Mayo Clinic, Mymedconnect, Practice Fusion etc.

Discharge
- In 2005 85% of Emergency Room visits ended up in discharges\(^1\)
  - Is the focus on effective discharges the same as inpatient areas?
  - ED Case Managers and Discharge Planners
  - Give patient a copy of reports including lab and radiography
  - Ensure full understanding of discharge instructions with patient and/or family
  - Upon discharge encourage patients to establish their own personal “health goals”
  - Patient maintained Discharge Checklist, empowers patients and families to be responsible for their own care

\(^1\) Hsueh, R.N. et al., "National hospital Ambulatory Medical Care Survey: 2005 Emergency Department Summary," Advance Data from Vital and Health Statistics, June 2007

The problem with communication is the illusion that it has occurred.
- George Bernard Shaw

Discharge

- In 2005 85% of Emergency Room visits ended up in discharges\(^1\)
  - Is the focus on effective discharges the same as inpatient areas?
  - ED Case Managers and Discharge Planners
  - Give patient a copy of reports including lab and radiography
  - Ensure full understanding of discharge instructions with patient and/or family
  - Upon discharge encourage patients to establish their own personal “health goals”
  - Patient maintained Discharge Checklist, empowers patients and families to be responsible for their own care

\(^1\) Hsueh, R.N. et al., "National hospital Ambulatory Medical Care Survey: 2005 Emergency Department Summary," Advance Data from Vital and Health Statistics, June 2007
What Is My Main Problem?
What Do I Need to Do?
Why Is It Important for Me to Do This?

Teach Back Method
- 40-80% of the information patients receive is forgotten immediately.
- Ensures the healthcare professional that the patient understands.
- Provides an opportunity to identify knowledge gaps.
- Do NOT ask patients “Do you understand?”
- This is not a test for the patient, but instead a technique to understand how well YOU explained the topic.
- “Mrs. Smith, I want to make sure I explained everything clearly. In your own words, what can you tell me about your condition?”
- “Mrs. Garcia, please explain how you will administer your mother’s medication when you go home.”


Innovative Mobile Applications
- Monitor heart rate
- A-Fib reference guide for healthcare professionals
- iStand Fall Prevention

3 Things Every Patient Must Know

Patient Education
- As much as possible, educate family members and patients
- Patient and family should understand A-Fib
- Use the “teach back” method

Teach back: Closing the loop

Innovative Mobile Applications
- Monitor heart rate
- A-Fib reference guide for healthcare professionals
- iStand Fall Prevention
Follow up

- Coordinate discharge care with all providers
- Schedule follow up appointments before the patient leaves
- Ensure there is a follow up call to the patient

Story of what happened...

Care Transitions Program Available at http://www.caretransitions.org

Story of what should have happened...

Care Transitions Program Available at http://www.caretransitions.org

Paradigm shift

- Remove patient labels of “non-compliant”, instead drill down on root causes...
- Build effective patient relationships, offer positive reinforcement, communicate to understand patient concerns
- Empathize with patient concerns related to anticoagulants and risk of bleeding, cost of medications, drug interactions etc.
- Explore reasons why patients do not follow up with providers upon discharge, lack of access, insurance, transportation, healthcare system failures
- Other factors, mental illness, substance abuse, lack of social support, illiteracy, negative attitudes, financial restrictions- are we dismissing these patients or offering them resources...

Communication for Coordination

- Know that care transitions can be dangerous for patients, invest time in properly coordinating care.
- Explore new ways to collaborate with other disciplines to improve the transition process.
- Develop or utilize predictive models to identify patients at risk for experiencing complicated care transitions.
- Empower patients to be self-advocates of their personal health
  - Maintain personal health record
  - Patient maintained Discharge Checklist
  - Use of mobile apps or websites to motivate patients
  - Teach Back method- the patient teaches YOU, not the other way around.
  - Encourage patients to develop their own personal health goals
- Recognize that patients and families have challenges with coordinating care within a complex and complicated healthcare system.

Thank you

“Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution; it represents the wise choice of many alternatives.” William Foster
Appendix N

Participant Evaluation

Improving the Primary Care Treatment of Atrial Fibrillation

The Evolution of Anticoagulation Management (TEAM-A) is a strategic, multi-institution educational initiative designed to prevent and reduce the serious complications associated with thrombus formation. TEAM-A is an innovative educational collaboration among ten organizations committed to improving patient outcomes through clinician education. This activity is funded through an educational grant from Bristol-Myers Squibb/Pfizer Pharmaceuticals Partnership.

As part of your participation in this CME activity, it is important for you to complete the activity evaluation form and agree to complete a post activity questionnaire. Note: Only aggregate reports will be produced; physician and organization-specific information is considered confidential and will not be disclosed.

Atrial Fibrillation: A Clinical Update
June 22, 2013

Please complete the following information, if you agree to complete the evaluations associated with this CME activity:

****PLEASE write clearly*****

<table>
<thead>
<tr>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Practice</td>
</tr>
<tr>
<td>Street Address</td>
</tr>
<tr>
<td>City, State Zip Code</td>
</tr>
<tr>
<td>Email/Phone</td>
</tr>
</tbody>
</table>

What is the best way to reach you for the post activity questionnaire? ☐ Email ☐ Mailing Address

1. What is your degree?
☐ Physician ☐ NP ☐ PA ☐ Nurses (RN, LPN, APN) ☐ Other

2. What is your specialty?
☐ Cardiology ☐ Hospitalist ☐ Family Practice ☐ Internal Medicine ☐ Other
3. Please indicate the extent to which you agree with the following statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>1=Strongly Disagree</th>
<th>2=Disagree</th>
<th>3=Neutral</th>
<th>4=Agree</th>
<th>5=Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. This activity met the course objectives.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The content was appropriate to my practice.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. This activity will make me more effective in my practice.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. The activity was free of commercial bias.  
   $$\square$$ Yes  $$\square$$ No

If no, please explain________________________________________________________

**Commitment to Change Questions**

5. Thinking back to the last 10 patients you saw with this condition, will this educational activity influence you to reevaluate your approach?
   $$\square$$ Yes  $$\square$$ No  $$\square$$ Not sure at this time

6. Based on this activity, I intend to make changes regarding: (select all that apply)

- Assessing and documenting risk of stroke for patients with AF
- Weighing the risk/benefit of treatment
- Communicating with patients
- Selecting appropriate antithrombotic therapy (aspirin, warfarin, dabigatran, rivaroxaban, etc.)
- Checking warfarin levels
- Monitoring patient adherence to anticoagulation therapy
- Managing anticoagulation through medical procedures and special situations
- Educating patients using the teach back method
- Following up with patients
- Encouraging patient/family use of communication tools
- Other: ___________________________________________________________________
Knowledge and Competency Questions

A 77 year old man presents with permanent non-valvular atrial fibrillation of three years duration. He has a history of stroke, hypertension and mild congestive heart failure. He complains of frequent headaches, is moderately obese and has type II diabetes mellitus well controlled on an oral regimen.

7. What in his history would indicate a higher risk for stroke? (Select all that apply)
- Age
- Duration of atrial fibrillation
- Previous stroke
- Hypertension
- Congestive heart failure
- Frequent headaches
- Obesity
- Diabetes

A 50 year old man without past medical history has intermittent episodes of atrial fibrillation which he controls with episodic doses of oral metoprolol. The episodes typically last for less than one hour and resolve spontaneously. They occur less than once per year. He has been evaluated in the past with a normal chest xray, a normal echocardiogram, and normal thyroid function tests. He has no history of stroke, diabetes, hypertension, or congestive heart failure.

8. Which of the following therapies would you select initially for this patient? (Select all that apply)
- No therapy or aspirin
- clopidogrel (Plavix®)
- dabigatran (Pradaxa®)
- rivaroxaban (Xarelto®)
- warfarin

A 78 year old woman with a history of hypertension and diabetes has permanent atrial fibrillation. She has dialysis-dependent renal failure due to diabetic nephropathy. There is no history of prior stroke, congestive heart failure, or left ventricular dysfunction. There is no history of valvular heart disease.

9. Which of the following therapies would you select initially for this patient? (Select all that apply)
- No therapy or aspirin
- clopidogrel (Plavix®)
- dabigatran (Pradaxa®)
- rivaroxaban (Xarelto®)
- warfarin

An 80 year old man with a history of hypertension and type II diabetes (orally controlled) has permanent atrial fibrillation and a pacemaker. He is active and fit. There is no history of prior stroke, congestive heart failure, or left ventricular dysfunction. There is no history of valvular heart disease.
10. Which of the following therapies would you select initially for this patient? (Select all that apply)
- No therapy or aspirin
- clopidogrel (Plavix®)
- dabigatran (Pradaxa®)
- rivaroxaban (Xarelto®)
- warfarin

A 55 year old female with hypertension and diabetes with chronic atrial fibrillation is planning to undergo an elective cholecystectomy. She takes dabigatran 150 mg twice daily.

11. How should her dabigatran be managed pre-procedurally?
- Stop the dabigatran the evening before the procedure
- Continue dabigatran throughout the procedure
- Stop the dabigatran a day before the procedure
- If the creatinine clearance is normal, stop the dabigatran 48 hours before the procedure

A 78 year old male with a history of permanent atrial fibrillation, CHF, and prior stroke maintained on warfarin presents to the hospital with confusion, and is found to have an intracranial hemorrhage. INR is 4.0.

12. The next course of action is:
- Continue warfarin
- Allow the INR to drift down to 2.0 and resume warfarin
- Administer vitamin K
- Start subcutaneous heparin

13. Approximately what percentage of time are patients taking warfarin at target INR levels?
- 25%
- 50%
- 75%
- 90%

14. Approximately what percent of patients will discontinue warfarin therapy for atrial fibrillation within the first year of treatment?
- 10%
- 25%
- 50%
- 75%

15. Which set of strategies can serve as an effective technique for communicating with patients?
- teach back, speaking loudly for non-English speakers, distribution of written materials
- ignoring non-compliant patients, electronic patient portals
- teach back, follow-up calls to patient, electronic patient portals
- distribution of written material, speaking quickly, follow-up phone calls to patients
Appendix O

Follow Up Survey

Improving the Primary Care Treatment of Atrial Fibrillation

The Evolution of Anticoagulation Management (TEAM-A) is a strategic, multi-institution educational initiative designed to prevent and reduce the serious complications associated with thrombus formation. TEAM-A is an innovative educational collaboration among ten organizations committed to improving patient outcomes through clinician education. This activity is funded through an educational grant from Bristol-Myers Squibb/Pfizer Pharmaceuticals Partnership.

As part of your participation in this CME activity, it is important for you to complete the activity evaluation form and agree to complete a post activity questionnaire. Note: Only aggregate reports will be produced; physician and organization-specific information is considered confidential and will not be disclosed.

Atrial Fibrillation: A Clinical Update
June 22, 2013

1. What is your degree?
- [ ] Physician
- [ ] NP
- [ ] PA
- [ ] Nurses (RN, LPN, APN)
- [x] Other

2. What is your specialty?
- [ ] Cardiology
- [ ] Hospitalist
- [ ] Family Practice
- [ ] Internal Medicine
- [x] Other

Commitment to Change Questions

3. Thinking back to the last 10 patients you saw with this condition, did this educational activity influence you in your approach?

- [ ] Yes
- [ ] No
- [ ] Not sure at this time

4. Based on this activity, I made changes regarding: (select all that apply)

- [x] Assessing and documenting risk of stroke for patients with AF
- [x] Weighing the risk/benefit of treatment
- [x] Communicating with patients
- [x] Selecting appropriate antithrombotic therapy (aspirin, warfarin, dabigatran, rivaroxaban, etc.)
- [x] Checking warfarin levels
- [x] Monitoring patient adherence to anticoagulation therapy
- [x] Managing anticoagulation through medical procedures and special situations
- [x] Educating patients using the teach back method
- [x] Following up with patients
- [x] Encouraging patient/family use of communication tools
- [ ] Other:
Appendix P

SWOT Analysis

**Strengths**
- Motivated providers
- Onsite speakers

**Opportunities**
- Grant funding
- Literature easily accessible

**Weaknesses**
- Historically low turn out to events
- Physicians and nurses are not normally trained together

**Threats**
- Short deadline from event to reports due to grantor
- Potential challenge with community attendance
Faculty Disclosure Form

It is the policy of St. Francis Medical Center to ensure balance, objectivity, independence, and scientific rigor in all CME activities. Anyone engaged in activity content development, planning, or presentation must complete this form. “A commercial interest is any proprietary entity producing, marketing, re-selling, distributing or otherwise participating in or profiting from the distribution, promotion or sale of health care goods or services consumed by, or used on, patients.”

Name: Ceonne Houston-Raasikh, RN, MSN, NEA-BC
Activity title: “Atrial Fibrillation: A Clinical Update”
Live presentation date: June 22, 2013
Role in this activity: ☐ Presenter ☐ Author ☐ Course director ☐ Moderator ☐ Planner

DISCLOSURE
☐ Yes ☐ No Have you (or your spouse/partner) had a personal financial relationship in the last 12 months with the manufacturer of the products or services that will be discussed in this CME activity?

If no, sign just below this box. If yes, please list your disclosures and approaches to resolution below and sign at the bottom.

<table>
<thead>
<tr>
<th>Commercial Interest</th>
<th>Nature of Relevant Financial Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Company</td>
<td>Employee, grants/research support recipient, board member, independent contractor, stock shareholder (excluding mutual funds), speaker's bureau, honorarium recipient, royalty recipient, holder of intellectual property rights, other</td>
</tr>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
</tbody>
</table>

Signature: C. Raasikh Date: June 21, 2013

If you checked “YES” above, we have to resolve the conflict of interest; the following mechanisms have been identified to resolve conflicts of interest. Please check all that apply and sign the declaration below:

Presenters/authors
☐ I will support my presentation and clinical recommendations with the “best available” evidence from the medical literature. See suggested sources of best evidence at www.aafp.org/x3139.xml
☐ I will refrain from making recommendations regarding products and services, e.g., limit presentation to pathophysiology, diagnosis, and/or research findings.
☐ I will recommend an alternative presenter for this topic for the planning committee’s consideration.
☐ I will submit my presentation in advance to allow for adequate peer review.
☐ I will or have divested myself of this financial relationship.

DECLARATION
1. I attest that I will comply with ACCME Standards for Commercial Support of Continuing Medical Education to ensure that this CME activity is free of commercial bias or the appearance thereof.
2. I will base all clinical recommendations on evidence that is accepted within the profession of medicine as adequate justification in the care of patients.
3. All scientific research referred to in support of a patient care recommendation will conform to generally accepted standards of experimental design, data collection, and analysis.
4. I will not discuss any unlabeled uses of products.

Signature: Date:
**Appendix R**

Content Validation Form

<table>
<thead>
<tr>
<th>Title</th>
<th>&quot;Atrial Fibrillation: A Clinical Update&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speaker</td>
<td>Ceonne Houston-Raasikh, RN, MSN, NEA-BC</td>
</tr>
<tr>
<td>Date</td>
<td>June 22, 2013</td>
</tr>
</tbody>
</table>

Please read the accreditation standard we are accountable to meet:

<table>
<thead>
<tr>
<th>IMQ Standard on Content Validation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. All the recommendations involving clinical medicine in a CME activity must be based on evidence that is accepted within the profession of medicine as adequate justification for their indications and contraindications in the care of patients.</td>
</tr>
<tr>
<td>2. All scientific research referred to, reported or used in CME in support of justification of a patient care recommendation must conform to the generally accepted standards of experimental design, data collection and analysis.</td>
</tr>
<tr>
<td>3. Providers are not eligible for ACCME or CMA/MQ accreditation or reaccreditation if they present activities that promote recommendations, treatment or manners of practicing medicine that are not within the definition of CME, or known to have risks or dangers that outweighs the benefits or known to be ineffective in the treatment of patients.</td>
</tr>
</tbody>
</table>

Please check off the appropriate statements, sign and return to the Medical Staff Services Department:

| The above-mentioned CME lecture does not contain any recommendations in the diagnosis or management of patient care. |
| X I have read the above standard on content validation and understand that non-compliance of this standard will disqualify me as a speaker. |
| X My presentation contains recommendations, diagnosis and treatment in the care of patients and the following sources were used for content validation (please check-off all applicable references) |
| Cochrane Collaboration or other evidence-based reviews (list below) |
| Journals and all literature review (list below) |
| Standard textbook of medicine/surgery (not including holistic health/alternative medicine – list below) |
| X National Practice Guidelines |
| Other (list below) |

References: AHRQ, CMS, Joint Commission

Signature: C. Raasikh

Date: June 21, 2013
INFLUENCING CHANGE IN HEALTH CARE PROVIDERS

Appendix S

Cultural and Linguistics Competency Form

CULTURAL & LINGUISTICS COMPETENCY FORM

Date: June 22, 2013
Topic: "Atrial Fibrillation: A Clinical Update"
Faculty: Ceonne Houston-Raasikh, RN, MSN, NEA-BC

The California legislature has passed AB 1195 which states that as of July 1, 2006 all Category 1 CME activities that relate to patient care must include a cultural diversity/linguistics component.

DEFINITIONS: Cultural competency means a set of integrated attitudes, knowledge, and skills that enables a health care professional or organization to care effectively for patients from diverse cultures, groups, and communities. Linguistic competency means the ability of a physician and surgeon to provide patients who do not speak English or who have limited ability to speak English, direct communication in the patient’s primary language.

We believe there is relevant cultural diversity information relating to one or more of the following: age, gender, race, socio-economics, sexual orientation, religion, language, ethnicity, etc. that impacts the care of patients and you are required to include it in your presentation.

Therefore, the following objective will be added to the activity publicity to potential attendees and also to the attendee evaluation form:

Utilize the information learned relative to cultural diversities to better care for patients.

I have read this form and will comply with AB 1195 as outlined above.

Signature: 
Date: June 21, 2013

Listed below is Cultural/Linguistic Competency (CLC) information collected from the internet, which may help you in meeting the AB1195 requirement. This may not fully represent the CLC information available on this topic.