Timeline of Health Literacy at Staten Island University Hospital

2007- Formed Health Literacy Committee

2009- Received NNLM Funding for Community Health Literacy Program

2010- Started SI Health Literacy Collaborative

2011- Hosted NYC's 1st Health Literacy Conference

2008-2015:

- Served as community hospital partner for ESL + Health Literacy classes
- Hospital host of community 'Health Literacy Navigational Tours'

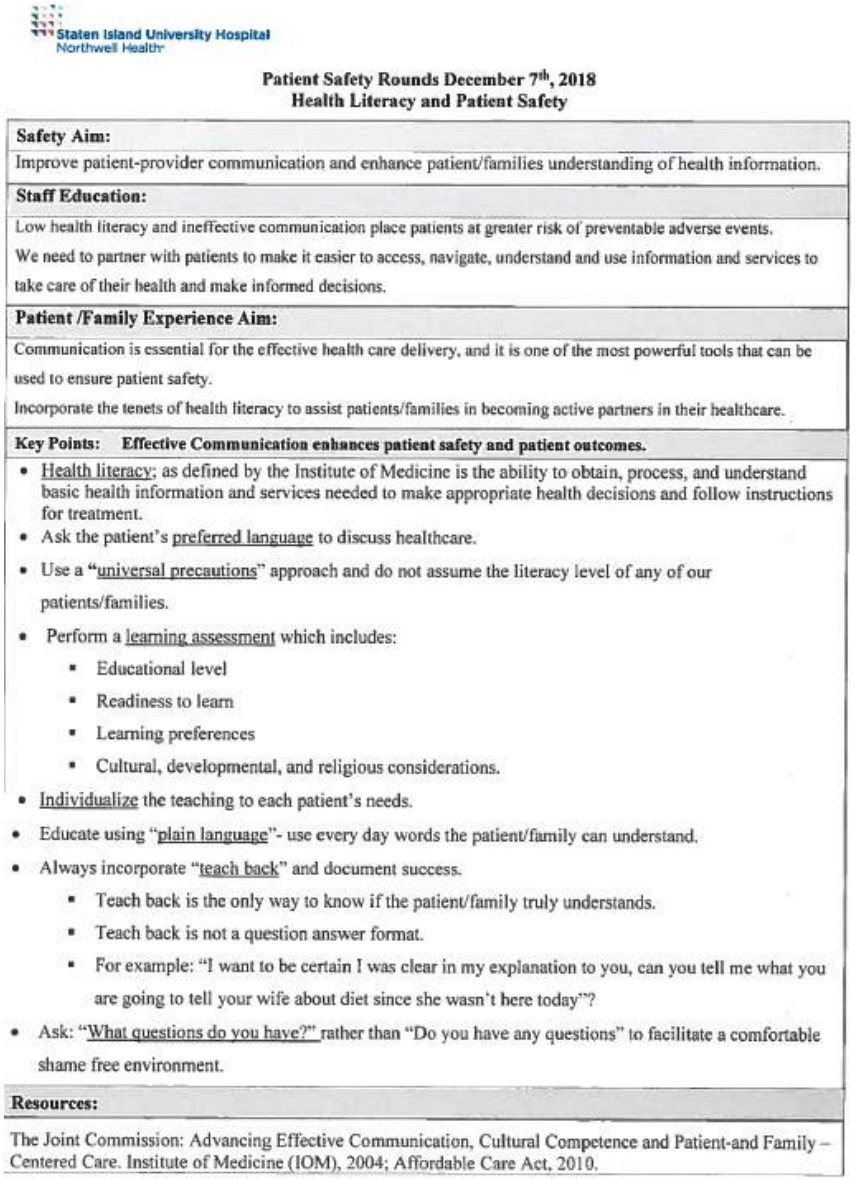
AHRQ Tool 3: Raise Awareness

Ensuring that all staff members, all at levels of the organization, understand how health literacy affects our patients and their families. Placing an emphasis on providing clear and easy to understand health information to our patients.

Raise Awareness

Patient Safety Rounds is a weekly platform where Administrative Leaders round in all hospital, clinical and non-clinical, areas to discuss important topics related to patient safety and patient experience.

- An in person brief training was provided to all hospital departments using the Health Literacy Communication Tool.
- The tool, along with the fact sheet, were distributed as reference materials for all staff.
- Administrative debrief is held immediately following rounds to share feedback and areas for continued education.



Staten Island University Hospital
Northwell Health

Patient Safety Rounds December 7th, 2018
Health Literacy and Patient Safety

Safety Aim:

Improve patient-provider communication and enhance patient/families understanding of health information.

Staff Education:

Low health literacy and ineffective communication place patients at greater risk of preventable adverse events.

We need to partner with patients to make it easier to access, navigate, understand and use information and services to take care of their health and make informed decisions.

Patient /Family Experience Aim:

Communication is essential for the effective health care delivery, and it is one of the most powerful tools that can be used to ensure patient safety.

Incorporate the tenets of health literacy to assist patients/families in becoming active partners in their healthcare.

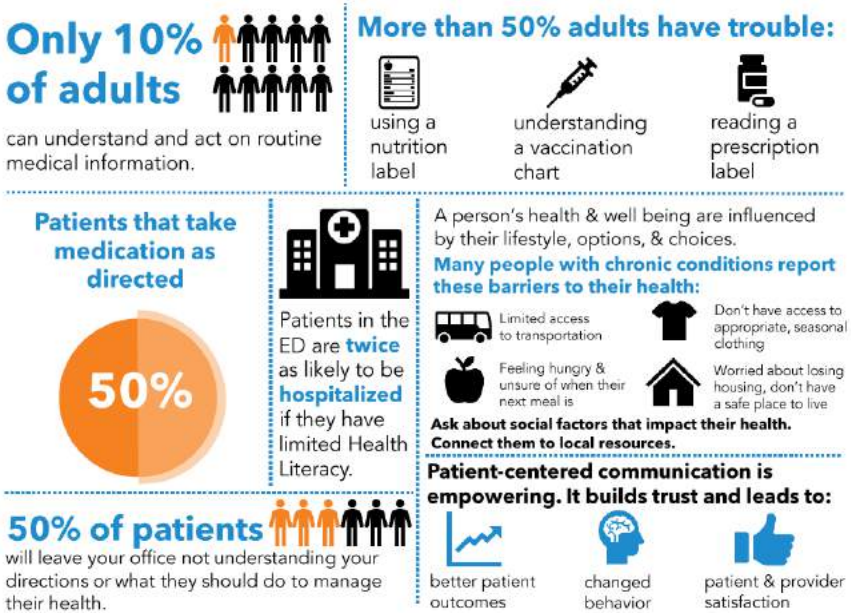
Key Points: Effective Communication enhances patient safety and patient outcomes.

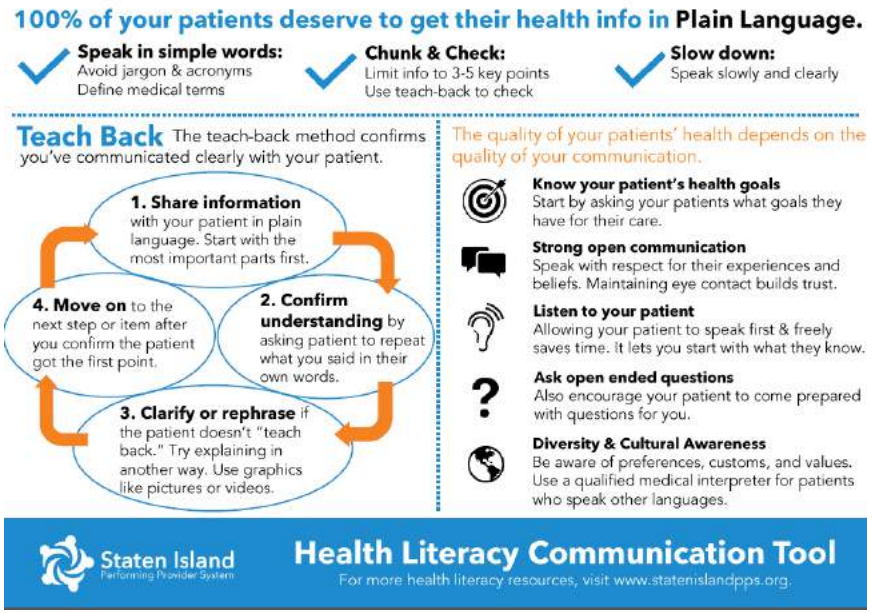
- Health literacy: as defined by the Institute of Medicine is the ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions and follow instructions for treatment.
- Ask the patient's preferred language to discuss healthcare.
- Use a "universal precautions" approach and do not assume the literacy level of any of our patients/families.
- Perform a learning assessment which includes:
  - Educational level
  - Readiness to learn
  - Learning preferences
  - Cultural, developmental, and religious considerations.
- Individualize the teaching to each patient's needs.
- Educate using "plain language"- use every day words the patient/family can understand.
- Always incorporate "teach back" and document success.
  - Teach back is the only way to know if the patient/family truly understands.
  - Teach back is not a question answer format.
  - For example: "I want to be certain I was clear in my explanation to you, can you tell me what you are going to tell your wife about diet since she wasn't here today"?
- Ask: "What questions do you have?" rather than "Do you have any questions" to facilitate a comfortable shame free environment.

Resources:

The Joint Commission: Advancing Effective Communication, Cultural Competence and Patient-and Family – Centered Care. Institute of Medicine (IOM), 2004; Affordable Care Act, 2010.

Health Literacy Communication Tool





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AHRQ Tool 14 & 16:
Encourage Questions & Help Patients Remember How and When to Take Their Medicine

Statement of Need: To improve patient experience, improve compliance with Medication Adherence and decrease polypharmacy in the ambulatory care setting

- Create a shame-free environment that encourages patients to ask questions. An emphasis is placed on helping patients to prioritize questions and remind patients to bring their questions with them.

- Helping patients understand and remember what medicines they need and how to take them. An emphasis is places on clear verbal and written communication.

Encourage Questions & Help Patients Remember How and When to Take Their Medicine

Plan:

- **Introduction of the Medication Reconciliation Communication Tool**
  - Provided to patients during their Medication Reconciliation along with their medication list as a tool to assist in communication and provide an outline and direction for future conversations.

- **Integration of an Ambulatory Care Pharmacist**
  - To provide education and medication management services to Physicians and Patient.

Medication Reconciliation Communication Tool

What you talk to your doctor about matters.

Your doctor should:

- ✔ know your health goals
- ✔ be kind
- ✔ look you in the eyes
- ✔ speak slow and clear
- ✔ let you ask questions without interrupting
- ✔ make you feel comfortable and calm
- ✔ check if you understand
- ✔ teach you in a different way if you don't understand
- ✔ give you easy steps on what to do

Do you know what your medical diagnosis (health issue) is?

Most people forget what their doctor tells them after their visit.
The next sections can help you remember important things about your health care.

Prepare for your next doctor's visit:

- Bring a list of questions to your visit
- Have a list of your medicines ready
- Be honest and share your story
- Bring a family member or friend with you for support
- Ask questions if you don't understand
- Take notes on what your doctor said

Questions to ask about my medicine:

- Why should I take this?
- How do I take this medicine?
- Can you show me how to take it?
- What time of day should I take it?
- How many times a day do I take it?
- What are the side effects?
- How long do I need to take it?
- Am I worried about how much it costs?

Staten Island Performing Provider System
www.statenislandpps.org

Do:

My medicines:

What I'm taking	How much	Dosage	How often	When and how	Why
Aspirin	*1 pill*	*325 mg*	*Once a day*	*8 a.m. with food*	*Headache*

Important things my doctor said:

1. _____
2. _____
3. _____
4. _____

The Communication tool is being distributed by the Ambulatory Care Pharmacist, Pharmacy Medical Students and the Nursing Staff in the Ambulatory Care Clinic.

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Pharmacy Provided Services

- **Drug Information Resources for Patients and Medical staff**
- **Provide Comprehensive Medication Management**
- **Patient Education**

- Reduction in Polypharmacy
- Transition of Care
- Immunizations
- Assist in Care Management
- Chronic disease state management
  - Hypertension, Diabetes, COPD / Asthma, Heart Failure, Smoking cessation , Anticoagulation , HIV, Hepatitis , Pharmacotherapy

What is Ambulatory Care Pharmacy?

"The provision of **integrated, accessible** health care services by **pharmacists** who are accountable for **addressing medication needs, developing sustained partnerships with patients**, and practicing in the context of family and community. This is accomplished through **direct patient care and medication management** for ambulatory patients."

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Board of Pharmacy Specialties. Ambulatory Care. Available at: https://www.bpsweb.org/bps-specialties/ambulatory-care. Accessed on January 7, 2019.

Staten Island University Hospital

1 full time pharmacist add to the ambulatory care clinic staff starting February 2017

Hours – Monday through Friday 8 AM to 4 PM

	Monday	Tuesday	Wednesday	Thursday	Friday
AM Clinic	Student day	Primary Care	Geriatrics	Inpatient	Primary Care
PM Clinic		Pulmonary	Geriatrics / Paperwork	Geriatrics	Paperwork/ Students

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Objectives of Pharmacy Services at SIUH

1. **Integrate in to the ambulatory care team and provide drug information resources to physicians, medical residents, medical students and nursing staff**

2. **Provide comprehensive medication management to ambulatory care patients to reduce the potential for medication adverse events, drug- drug interactions, drug – disease interactions, prescribing and administration errors and inappropriate medication use**

3. **Ensure proper patient counseling and education on each medication to increase adherence and prevent hospital admissions**

4. Optimize diabetes, asthma, chronic pulmonary obstructive disease, cardiovascular disease, and preventive care in the ambulatory care populations through the optimal use of medications and patient counseling

5. Reduce polypharmacy in the ambulatory care population

Encourage Questions & Help Patients Remember How and When to Take Their Medicine

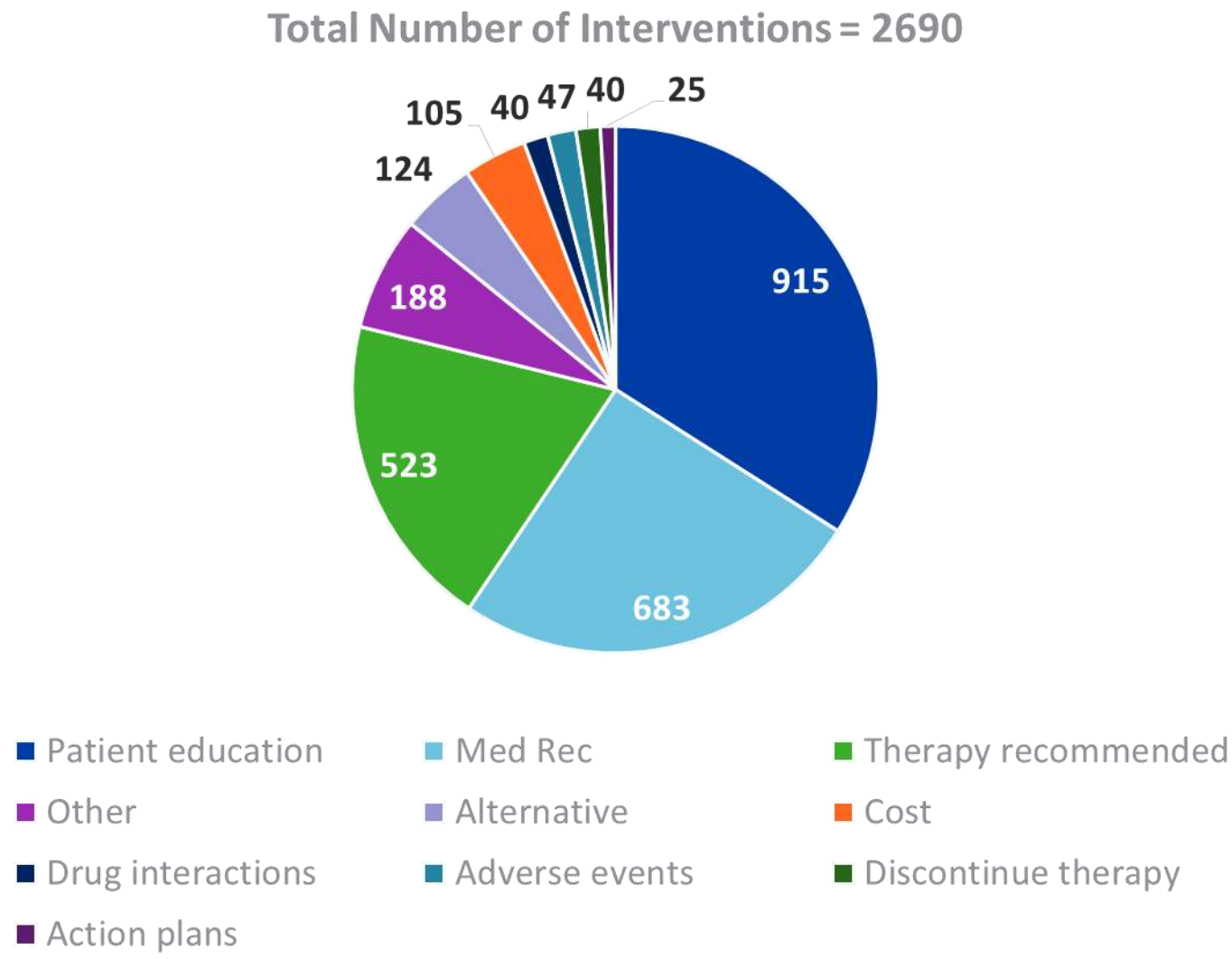
PDSA Cycle 1: We distributed HL Med Rec cards to all patients but identified that more than just distributing cards was needed to effect change

PDSA Cycle 2: We provided information plus health literacy communication cards to all staff in patient and outpatient areas to educate on the importance of health literacy and plain language. We identified a need for direct explanation/communication to patients on health literacy when the med rec cards were given out

PDSA Cycle 3: We assigned a pharmacy medical student the task of sitting eith patients who were newly diagnosed or with high # of prescriptions and reviewing their med rec card with them. They also attached the card with their full medication reconciliation list

**This stage is still in progress

Pharmacy Data



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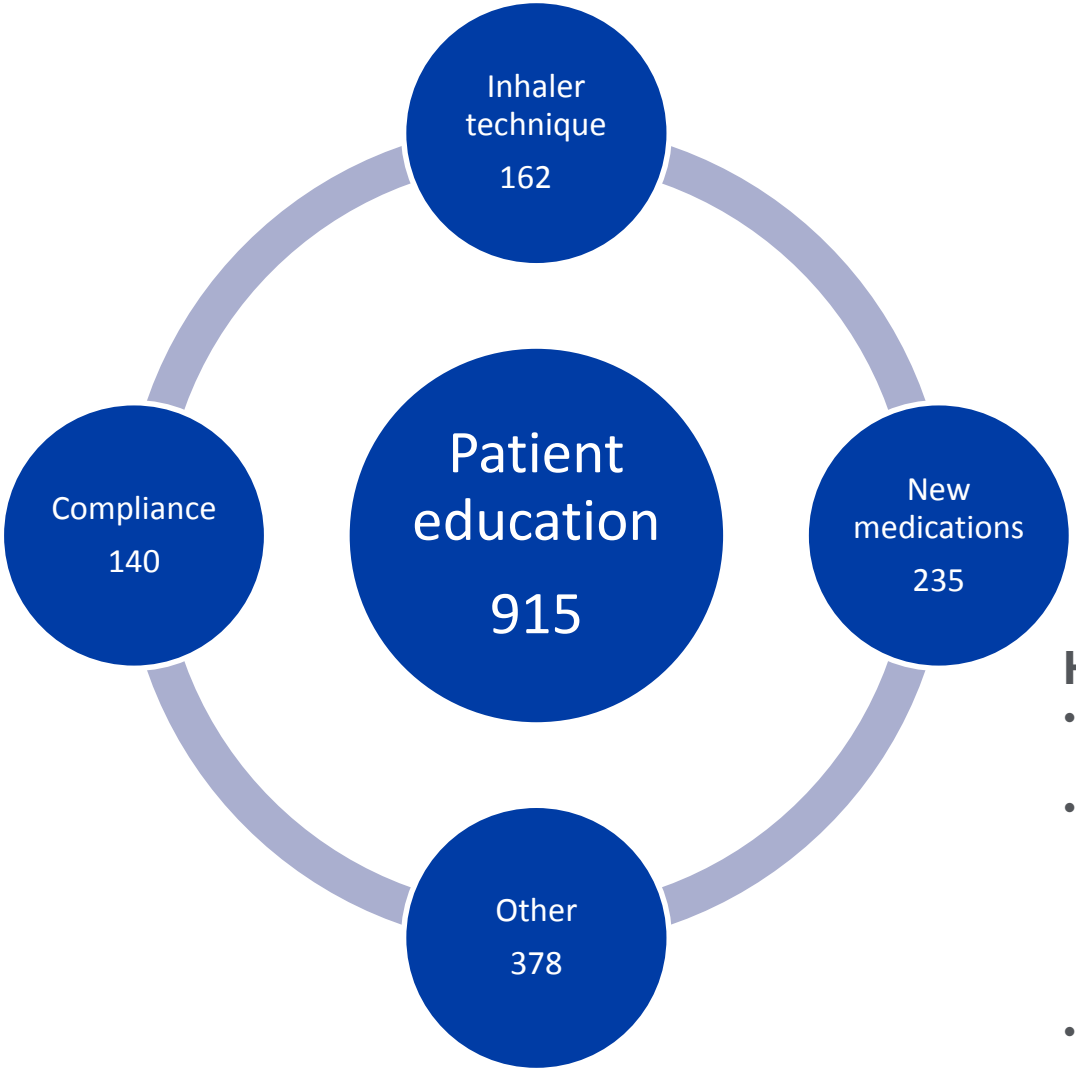
Ensure proper patient counseling and education on each medication to increase adherence and prevent hospital admissions



HEDIS/QARR

- PCP discussed Rx drugs
- Compliance to diabetic, cholesterol and hypertension medication
- All- cause admission

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Let's bring it back to the patients…

ES is a 62 year old male who presented to clinic after a recent hospitalization due to weakness for hyperglycemia. Throughout the visit he reports he no longer cares about life, that it is currently too hard.

He is non-compliant to this medication leading to a FBG ~350 mg/dL. During the visit he experiences an episode of incontinence which his daughter reports is common

Labs A1c = 14.3 % SCr 1.4 GFR 62 ml/min

Medication List

COPD
- Montelukast 10 mg PO daily
- Sprivia Respimat 1.25 mcg 2 Inh daily
- Symbicort 160/4.5 mcg 2 Inh BID

Benign Prostate Hyperplasia
- Finasteride 5 mg PO daily
- Tamsulosin 0.4 mg PO daily

Diabetes Mellitus
- Jardiance 10 mg PO daily
- Lantus 50 units SC daily
- Pioglitazone 30 mg PO daily

Hypertension
- Losartan 25 mg PO daily

Cholesterol
- Atorvastatin 40 mg PO daily

Other
- Pantoprazole 40 mg PO daily
- Aspirin 81 mg PO daily
- Docusate 100 mg 2 tablets PO daily
- Gabapentin 300 mg PO BID

Pharmacy Intervention

- Patient educated using **PLAIN LANGUAGE** on all medications indications, mechanism and proper administration
- **Medication chart** created **for the patient**
- Blister packets requested from pharmacy
- **Patient educated** on diabetes and **appropriate time** to measure SMBG
- **Educated** on proper use of inhalers, **using teach back**, as patient reports frequent shortness of breath

Medication changes:

- Discontinue Jardiance – add Ozempic
- Insulin titration – patient contacted weekly
- Immunizations recommended

Three months later

ES has all of the appropriate contact information for his health team. **He has taken control of his health and reaches out to staff when additional help is needed. Reports compliance to all medications and health goals.**

Diabetes

- A1c trended down to 7.5%
- Pt currently check SMBG twice daily and presents with blood glucose logs
- Reports he no longer feels weak and has less frequent incontinence episodes, which has significantly improved his quality of life, and therefore, his mood

COPD/Asthma

- Pt is now using maintenance medications daily and only using his rescue when needed
- Reports shortness of breath has improved, less frequent hospitalization

Thank You

2.Health Literacy PDSA Case Study

Community Based Organization

COMMUNITY HEALTH ACTION OF STATEN ISLAND

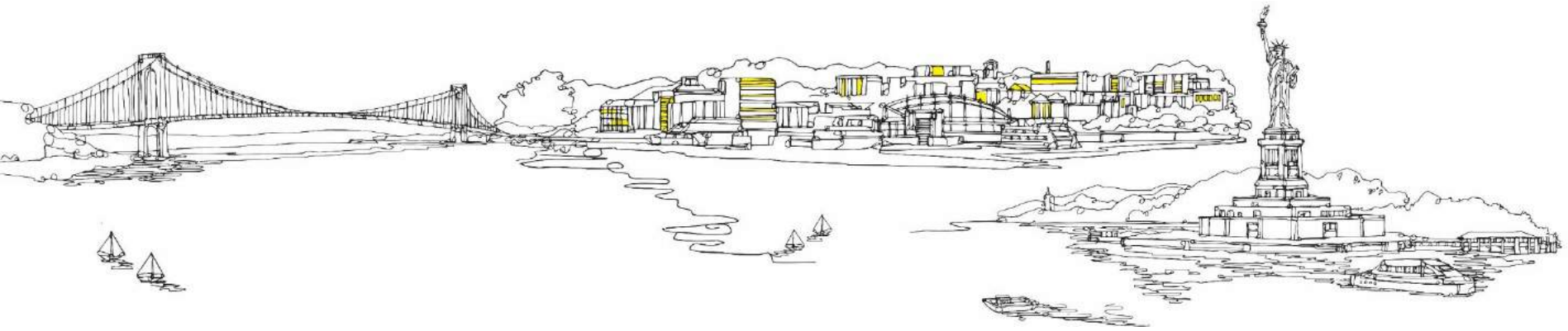
A member of **Hudson River Health Care**

WELCOME TO WELLNESS

Case study: Improving Health Literacy in Community-Based Organization

Community Health Action of Staten Island

A Member of Hudson River Health Care



A brief history of CHASI…

1988 - **Staten Island AIDS Task Force**

2004 - **Community Health Action of Staten Island**

2015 - **Community Health Action of Staten Island**

a member of Brightpoint Health

2018 - **Community Health Action of Staten Island**

a member of HRHCare

Community Health Action drives dramatic improvements in the health of Staten Islanders

COMMUNITY HEALTH ACTION OF STATEN ISLAND
A member of Hudson River Health Care

Current Services Offered

- Medicaid **Health Home**
- **AIDS care** and **health management** services
- **HIV & hepatitis C Care** Management, Testing and Prevention
- Community **Food Pantry**
- **Mobile Food Pantry**
- **Harm Reduction Health Hub/ Program** for people who use drugs, including workshops and syringe exchange
- **Chronic Disease Self Management** Workshops (including diabetes, high blood pressure, and other chronic diseases)
- **Next Step Resource & Recovery Center**, a 24/7 Center for people and families affected by substance use
- **Learning Lab** at the Food Pantry
- **Mobile Health Unit** screenings, outreach, and services
- Peer Training Institute for people in recovery

Current Services Offered

- **Domestic Violence program** (and supplemental DV program in partnership with the SI Family Justice Center
- **HIV programs in prisons**, including Queensboro, Lincoln, & Edgecombe correctional facilities
- Assistance with **Insurance** and **SNAP Benefits** (food stamps)

Through Brightpoint Health and our partners

- **Outpatient Substance Abuse-822** (on site at 56 Bay Street)
- **Primary Care** – Federally Qualified Health Center (FQHC)
- **Behavioral Health** – Article 31
- **Dental Services**
- **Adult Day Health Center** (ADHC)
- **Pediatrics**, specialty medicine, **OB/GYN** services

Pride Center of Staten Island, a spin-off organization that provides direct local access to LGBTQ-welcoming services and programs.

CHASI staff work at the Center to provide HIV testing, Information & Referral services, and to connect LGBTQ seniors to food pantry and help for chronic health conditions.

CHASI Health Literacy Team

John Mastellone

DSRIP Program Manager

Maureen Nembhard

RN, HIV Care Coordination Department

Gary Chin

Harm Reduction counselor
EMT

Emilie Tippins

Communications/ Resource Development Director

Mary Beshai

Communications/ Resource Development Assistant

Some Health Literacy considerations

- Much of our work happens face to face, one on one, but follow up visits can happen in client homes or by phone. As a community-based network of wraparound services addressing SDOH, we also get to work with people *after* their presenting issue or problem has been addressed.

- We measure our effectiveness in part by our clients' engagement in their health care and their follow-through on treatment plans.

- A primary goal as an organization is to remove barriers between clients and improved health – to help them heal, over time, from the conditions and illnesses that get in the way of them leading healthy and full lives.

Our Health Literacy Plan

We wanted to focus on the topics that would leverage the most results for our clients.

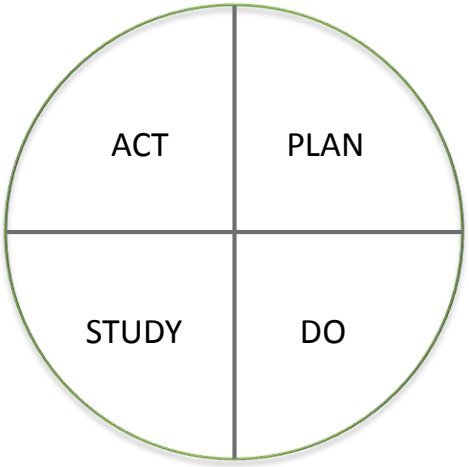
We identified 3 pieces of the Communication Tool that would focus our work with staff training related to communication (by department):

- Improve spoken communication
- Revamp written materials for marketing and health education
- Use graphics to improve understanding with clients and staff

Using PDSA for Tool 4: Communicate Clearly

Improving Communication

Health Literacy training incorporated into routine staff development

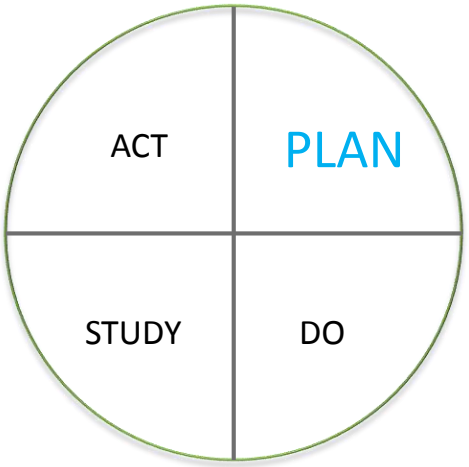


Developed Health Literacy training plan for agency

- Managers summarized findings
- HL team found surprises

- Trained 120 employees (in groups)
- Observed and documented communication

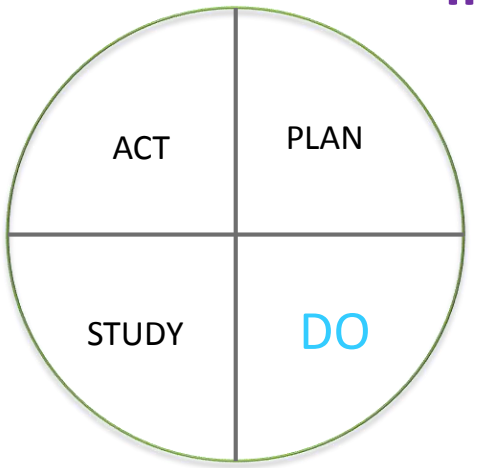
Using PDSA for Tool 4: Communicate Clearly



Improving Communication

- Train employees on plain language
- Identify jargon by department
- Evaluate written materials

Using PDSA for Tool 4: Communicate Clearly



Improving Communication

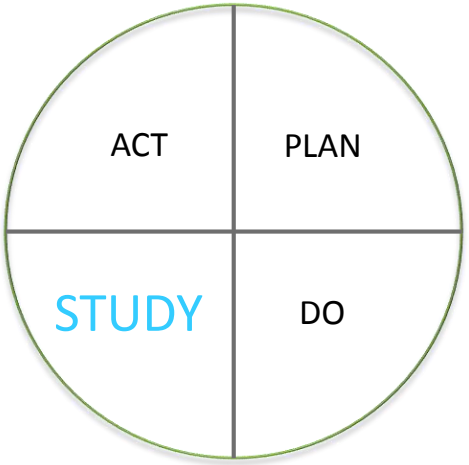
Trained 120 employees (in groups)

Observed and documented communication in

- Domestic Violence
- HIV Care Coordination
- HIV Prevention

Using PDSA for Tool 4: Communicate Clearly

Improving Communication



- Managers summarized findings and shared with the HL team
- HL team made recommendations to senior leadership for changes

Surprises:

- Identified high-performing team for one indicator (graphics)
- Evaluated their strengths in order to replicate with other teams and projects

Counseling, Testing, & Referral Health Literacy assessment

Highlights:

Testers were culturally sensitive and provided information to take home in a variety of languages (this was in a majority-immigrant community setting on our Mobile Health Unit).

Staff demonstrated good use of eye contact and used motivational interviewing techniques.

Key finding:

Too much information was given at once and complicated terms were used in the screening/ counseling process. Testers have a small window of time to screen and identify risks and then conduct HIV/HEP C testing. Testers have to complete a comprehensive CTR packet comprised of more than 30 forms.

There was also a lot HIV-specific terminology that was used when screening clients.

DV Health Literacy assessment

Domestic Violence and Trauma Services

- CHASI provides client-centered, trauma-informed, strength-based services to individuals and families affected by domestic violence.

Key findings:

- Although the DV counselors were well-versed in motivational interviewing, **they did not maximize the use of simple diagrams, graphics or models to illustrate explanations, and there were not a lot of educational materials used.**
- The DV team did not have a jargon problem like some other of our departments, primarily because they're not relaying a lot of specific medical information. (*Note that these observations were conducted in Spanish.)

HIV Care Coordination Health Literacy assessment

Our **HIV Care Coordination** Department connects HIV+ individuals to quality health care, addresses treatment adherence barriers to Viral Load Suppression, and focuses on self-management of their care and treatment by providing client-centered, strength-based services.

Indicators	Number Conducted
Self- Assessments	1
Client- Assessments	7
Staff Observations	1

Indicators	Number Conducted
Self- Assessments	12
Client- Assessments	12
Staff Observations	9

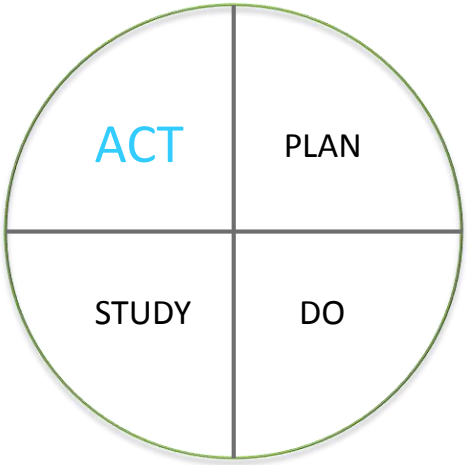
Findings:

Some of the clients answered **all** the questions on the survey with a "Yes." This made the reviewer question the accuracy of the feedback and whether they read and/or understood what was being asked of them. It was consistent with the write-in sections where most clients wrote in how grateful they were for services and appreciation for their case worker.

Other write-in feedback indicated that clients' understanding was greater after attending workshops where visual aids and diagrams were used to explain how HIV behaves in the body and the impact of treatment on HIV transmission.

Using PDSA for Tool 4: Communicate Clearly

Improving Communication



- Trained all employees on plain language
- Simplified our intake packets
- Modified design templates
- Next: Start training cycle

Counseling, Testing, & Referral Action

Too much information was given at once and often complicated terms were used in the screening and prevention counseling process.

One ACT action was to incorporate new HL training and observation into the work of a form-review team. That team evaluated intake paperwork for a number of departments and reduced the redundant questions while still hitting all required data points for quality tracking.

Intake packet was reduced by **40%**!

DV & Trauma Action

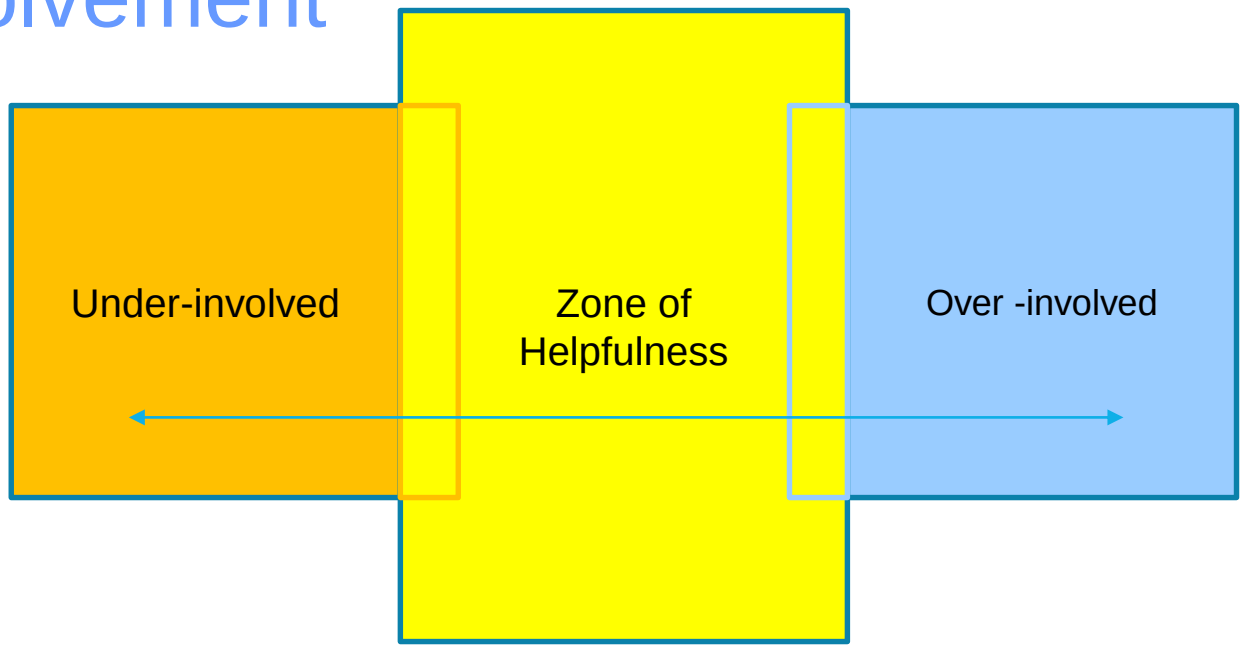
Main challenge to the communications tool was incorporating graphics in counseling sessions.

This is an area we're still working to improve. Due to time and resource limitations with trauma care, the team has instead incorporated HL lessons into a new series for women – Healthy Relationships (Women Up!). In partnership with the project leader, the communications team advised and helped design a curriculum that incorporates visual aids, hands-on learning, and role playing to emphasize the main themes of the workshop series. (more in next slide)

Counselors decided to focus on

- **Focus on no more than 3 topics per session**
- **Review key points each session to check understanding**
- **Use charts, graphics, and videos to confirm learning (as seen on next slide as an example)**

Peer Boundaries: degree of involvement



From WOMEN UP! Curriculum. Leaders use this graphic to lay out Dos and Don’ts of peer work in the community.

HIV Care Coordination Action – Survey changes

As a result of many people answering "YES" to all questions on our surveys, the team made the following changes:

- Implemented the surveys in workshop and group settings.
- Combined this survey with a client satisfaction survey to allow them to praise their workers.

HIV Care Coordination Action - Design

Consistent with other programs, we found that **design changes** could improve client retention of health information.

This part of the project would not have been possible without finding allocated to materials for this program.

With new funding specific to Health Education materials from the CDC, we were able to review their flip chart materials and upgrade to laminated posters to ensure consistency and incorporate graphics and diagrams that clients said in surveys were helpful.

Other Changes

An example of outreach material over time

What is Naloxone (Narcan)?

Naloxone (also known as Narcan) is a medication that can reverse an opioid overdose by blocking the opioids and restoring normal breathing. It is safe and has no potential for overuse. Upon Completion you will be certified to administer NARCAN and will receive a rescue kit. All trainings are provided by certified/qualified professionals and last approximately 90 minutes.

Date: Wednesday April 23, 2014 – Sponsored by South Beach ATC

Time: 10:00am and 2:00pm
Location: South Beach ATC, Building #3 - Seaview Avenue
Staten Island, New York 10305
RSVP by: April 16, 2014 to Denise Debrato at (718) 667-2776

Date: Tuesday, April 29, 2014 – Sponsored by CHASI

Time: 7:00pm
Location: Community Health Action
56 Bay Street, 6th Floor Conference Room
Staten Island, New York 10301
RSVP to: Angela Attanasio at angela.attanasio@chasiny.org or (718) 808-1428

Date: Wednesday, April 30, 2014 – Sponsored by CHASI

Time: 7:30pm
Location: Our Lady Star of the Sea
5371 Amboy Road
Staten Island, New York 10312
RSVP to: Angela Attanasio at angela.attanasio@chasiny.org or (718) 808-1428

For registration or additional information please contact:
Angela.Attanasio@chasiny.org (718) 808-1428 or (718) 808-1439

COMMUNITY HEALTH ACTION OF STATEN ISLAND
A member of Hudson River Health Care

HIV Prevention through PEP/ PrEP (STUDY)

More than other teams we observed, this group was using visual aids with more consistency.

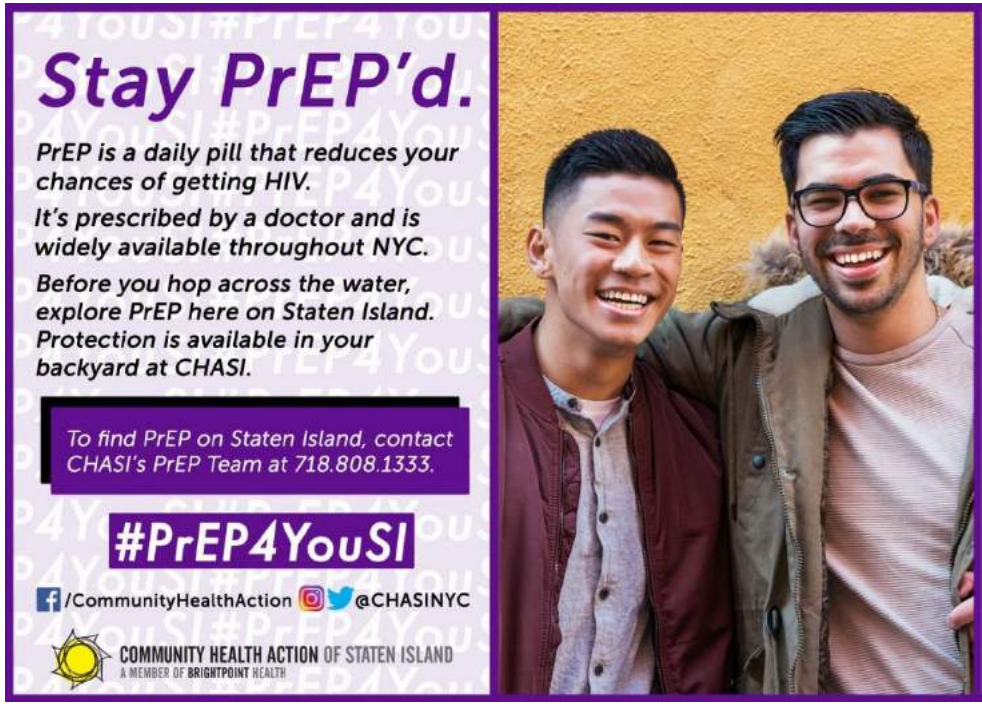
WHY?

- availability of visual supplements related to PEP/PrEP
- variety and scope of visual subjects
  - and –
- **two CRITICAL ELEMENTS:**

Success: HIV Prevention through PEP/PrEP

Input

The OCP team worked with our communications team on designs for their own program. We created materials that are specific to our borough, our agency, and their program, so the team is **proud** of the messaging and **likes to use the materials** with clients.



Money

The OCP team had money in their grant from the CDC that allowed us to bring in an extra person for the design team for a limited amount of time.

This team beat all their targets in 2018 for recruitment and retention in the PrEP program.

Results & Recommendations

Our Health Literacy assessment

- Health Literacy interventions are successful at our organization when they are combined with other evaluation methods (like client satisfaction).

- The more time and investment we have in becoming a health literate organization, the better our clients' outcomes will be. When we have funding to support our recommendations about materials and design, we can be successful.

- Finding ways to incorporate Health Literacy and improve workflow at the same time make work less labor-intensive (like reducing redundant forms).

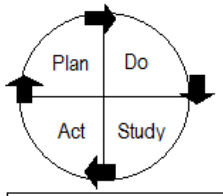
- Staff training about Health Literacy is effective, especially with plain language. Staff need continued refreshers and observations in order to implement new ways of communicating. When teams are stretched for time and resources, they revert back to old patterns of communicating.

3. Impact Performance Measures

PDSA Activity

Data Source	Relationship	Performance Measure
C&G CAHPS	Health Literacy	Someone from providers office usually or always talked about all prescription medications being taken
C&G CAHPS	Health Comm	Someone from providers office usually or always followed up with you to give you results of blood test, x-ray or other test
C&G CAHPS	Health Comm	Provider usually or always listened carefully to you
C&G CAHPS	Health Comm	Provider usually or always showed respect for what you had to say
C&G CAHPS	Health Comm	Usually or always got answer to medical question the same day you contacted provider's office
C&G CAHPS	Health Literacy	Provider usually or always gave easy to understand instructions for caring for illness or health condition
C&G CAHPS	Health Literacy	Provider usually or always explained things in way that was easy to understand
C&G CAHPS	Health Comm	Provider usually or always spent enough time with you
C&G CAHPS	Health Literacy	Provider usually or always asked you to describe how you would follow instructions for caring for illness or health condition
C&G CAHPS	Health Literacy	Provider usually or always explained what to do if illness or health condition got worse or came back
DOH Claims	Health Literacy	Adult Access to Preventive or Ambulatory Care - 20 to 44 years
DOH Claims	Health Literacy	Adult Access to Preventive or Ambulatory Care - 45 to 64 years
DOH Claims	Health Literacy	Adult Access to Preventive or Ambulatory Care - 65 and older
C&G CAHPS	Health Comm	Care Coordination with provider up-to-date about care received
DOH Claims	Health Literacy	Children's Access to Primary Care - 12 to 19 years
DOH Claims	Health Literacy	Children's Access to Primary Care - 12 to 24 months
DOH Claims	Health Literacy	Children's Access to Primary Care - 25 months to 6 years
DOH Claims	Health Literacy	Children's Access to Primary Care - 7 to 11 years
DOH Claims	Health Literacy	PDI 90 - Composite of all measures (per 100,000 members)
DOH Claims	Health Literacy	PQI 90 - Composite of all measures (per 100,000 members)
DOH Claims	Health Literacy	Potentially Avoidable ER Visits (per 100 members)[HP]
DOH Claims	Health Literacy	Potentially Avoidable Readmissions (per 100,000 members)[HP]
NYS w/SPARCS	Health Literacy	ED use by uninsured
DOH Claims	Health Literacy	Non-use of primary and preventive care services
DOH Claims	Health Comm	Adherence to Antipsychotic Meds for People w Schizophrenia
DOH Claims	Health Comm	Follow up for children prescribed ADHD meds - continuation
DOH Claims	Health Literacy	Potentially Preventable ER Visits (people w/ BH diagnosis per 100 members)HP
DOH Claims	Health Literacy	PQI 1 - Diabetes ST Complications (per 100,000 members)
Med Rec Review	Health Literacy	Comprehensive Diabetes Care- Poor A1C control
Med Rec Review	Health Literacy	Comprehensive Diabetes Care- A1c, eye, LDL, nephropathy screen
C&G CAHPS	Health Comm	Medical Assistance with Smoking Advised to Quit
C&G CAHPS	Health Comm	Medical Assistance with Smoking Discussed Cessation Medication
C&G CAHPS	Health Comm	Medical Assistance with Smoking Discussed Cessation Strategies
IPOS	Health Comm	Advanced Directives- Talked about appointing for health decisions
C&G CAHPS	Health Comm	Hospital Stay- Staff took my preferences and those of my family or caregiver into account in deciding my health care needs
C&G CAHPS	Health Literacy	Hospital Stay- When I left the hospital I had a good understanding of the things I was responsible for in managing my health
C&G CAHPS	Health Literacy	Hospital Stay- When I left the hospital, I clearly understood the purpose for taking each of my medications

PDSA Cycle



PDSA WORKSHEET

Team Name:	Date of test:	Test Completion Date:
Overall team/project aim:		
What is the objective of the test?		

PLAN:
Briefly describe the test:

How will you know that the change is an improvement?

What driver does the change impact?

What do you predict will happen?

PLAN

List the tasks necessary to complete this test (what)	Person responsible (who)	When	Where
1.			
2.			
3.			
4.			
5.			
6.			

Plan for collection of data:

DO: Test the changes.

Was the cycle carried out as planned? Yes No

Record data and observations.

What did you observe that was not part of our plan?

STUDY:
Did the results match your predictions? Yes No

Compare the result of your test to your previous performance:

What did you learn?

ACT: Decide to Adopt, Adapt, or Abandon.

☐ Adapt: Improve the change and continue testing plan.
Plans/changes for next test:

☐ Adopt: Select changes to implement on a larger scale and develop an implementation plan and plan for sustainability

☐ Abandon: Discard this change idea and try a different one

Questions?