The HCAHPS Breakthrough Series™ Webinars

Custom Learning Systems

#7 Discharge Information

Discharge Satisfaction Guaranteed™

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Discharge Satisfaction Guaranteed™

How to prepare every patient for safe, continued recovery at home… every time!

Satisfactory Discharges Not Guaranteed: Patients Reported:

- They did **not understand** the discharge instructions
- Care instructions were **too general**
- **New prescriptions** posed special challenges
- **PCP's missing** from the picture
- Had only **limited support** at home
- Had **chronic** health condition, but they were **not educated** about it

-Robert Wood Johnson Foundation, February, 2013

"Getting out of the hospital is a lot like resigning from a book club… You're not out of it until the computer says you're out of it."

-Erma Bombeck, American Humorist

HCAHPS Domain – Communication with Nurses

Survey Question #1: *Help at Home*

*During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether **you would have the help you needed when you left the hospital**?*

Survey Question #2: *Written Counselling*

*During this hospital stay, did you get information **in writing** about **what symptoms or health problems** to look out for after you left the hospital?*

Domain Owners:
CEO, CNO, CME, all Nurse Managers, Nursing Directors and Supervisors

Domain Staff Owners:
Nursing Staff, Case Managers, and all team members engaged in assisting the Discharge process: from RN's to Transporters to Parking Attendants, starting with Admitting

Current National Threshold is;

(Rated a 4 – "Always")

84%

What's yours? _____%

There are Seven Reasons Why Poorly-Managed Discharges Matter

For the Family:

1 Pain and suffering (because patient lacks strategies for life after hospital)
2 Needless Stress (family not prepared to manage home care)
3 Unnecessary additional patient/family costs (time away from work to care for patient)
4 Patient/Family dissatisfaction (they feel lost or abandoned by hospital)

For Our Hospital:

5. Poor outcomes (longer recovery time)
6. Adverse events (effects 1 in 5 patients within three weeks)
7. Unnecessary readmissions. Cost: $26 billion per year (with 75% potentially avoidable)

Readmission Facts:
The facts are awful, a survey of discharged patients showed:

- Only **41% knew** their **diagnosis**
- Only **37%** were able to **state the purpose** of their medication
- Only **14%** knew the **common side-effects** of all their medications

*"It's not the re-admissions that are the problem… It's the **avoidable** re-admissions!"*
-A hospital administrator

Readmission Penalties:
Those in the bottom quartile from prior year will have percentage of Medicare payments withheld
FY 2013: up to 1% (2200 Hospitals at Risk)
FY 2015: up to 3%

Why a Caring Discharge Matters

"How patients leave is as important as how they came in."
-Stella Fitzgibbons, M.D., Houston, Texas

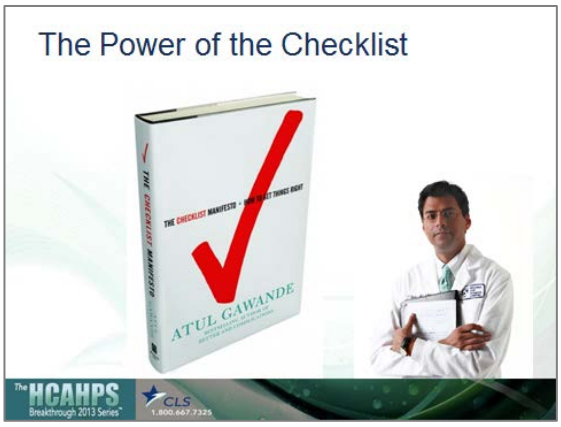
"We remember the most what we experience last."
-Brian Lee, CSP

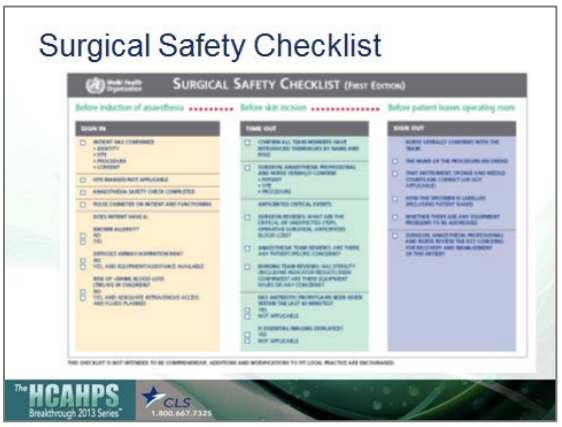
***Question**:*
Whether you're a **Patient**, Family Member, or Hospital Staff, **why** does an effective discharge process matter **to you**?

***Observation**:*
Discharge accountability is the new measuring stick.

Crucial Leadership Engagement Best Practice

*"If you have a problem, make it a **procedure,** and it **won't be a problem** anymore."*
-Wayne Cotton





Airline Six Sigma Safety "1,000,001"

***The Point is**:*

- *The HOPE Plan for this Webinar is a **series of checklists***
- *Start using these lists **NOW!***
- *Then add to them!*

***Recommendation:* A Very Personal Checklist**:
Create your own team based ***Discharge Mission Statement*** based on your team's shared goals.

Team Discharge Mission Statement *Examples*
"A safe discharge every time"
"No adverse events"
"Excellence in recovery at home!"
"We empower self-reliance in every patient!"

***Question**:*
When and who will create your department's Mission Statement for Discharge?

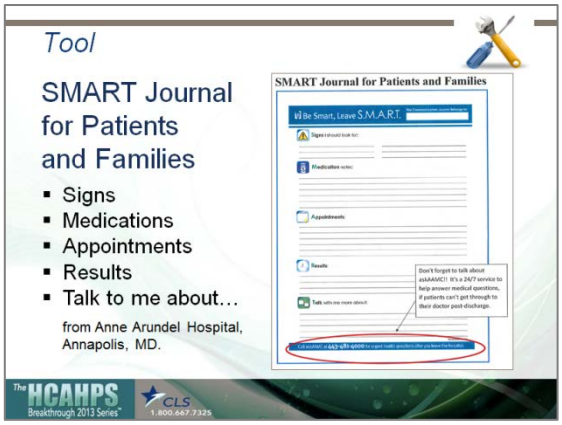
1 Specific Best Practices

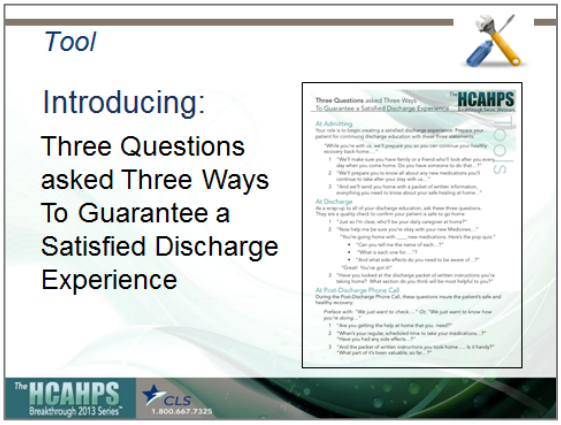
Best Practice Step #1: *First things first,* ***Discharge Starts at Admitting!***

- At CLS, we believe that "discharge information" is **not** something that happens at the **end of a stay**
- It's an on-going process… *and it all starts at Admitting!*

A Great Admitting Staff:

- Informs the patient that a well-planned discharge is a hospital priority. *"We'll start preparing/educating you to go home long before we say 'good-bye…'"*
- Engages **active participation of patient & family** as partners with clinical staff
- **Documents** patient's functional status – risk at home?
- Introduces **Discharge Coordinator**
- "**Manages Up**" the nursing staff





Three Critical Statements to Guide You:

1 *"We'll make sure* ***you have family or a friend*** *who'll look after you every day when you come home. Do you have someone to do that?"*

2 *"We'll prepare you to know all about* ***any new medications*** *you'll continue to take after your stay with us"*

3 *"And we'll send you home with a* ***packet of written information,*** *everything you need to know about your safe healing at home"*

Use variations of these three statements/questions at key 'touch-points' in a stay:

- at Admitting
- at actual Discharge
- and at Post-Discharge phone call

Specific Best Practices (cont'd)

Best Practice Step #2: ***Daily Coaching for "When You Get Home"***

Question
On a daily basis, how are you preparing patients for going home?

"The more patients are involved in their care, the higher is their adherence to the treatment, and their satisfaction with their care and outcome."
-Rydeman & Tornkvist, 2010

Every day of the hospital stay, teach Patients and families essential home-care skills:
- ❑ Guidelines for **proper medication** & **diet.**
- ❑ Techniques for **changing dressings**, **wound-care hygiene.**
- ❑ A variety of **pain-control strategies.**
- ❑ Are coached to **ask questions** of bedside caregivers.

Education for life-at-home is on-going. Coach daily about possible new, lifestyle changes at home. Examples:
- ❑ **Coach** adjustments needed to manage new health realities, make new lifestyle decisions.
- ❑ **Remind** patient he/she will move from a **hospital cocoon** – where everything's done for him – to home, where a certain degree of independence is required for healthy recovery.

Everyone's Challenge: To make education for post-discharge life part of your daily routine.

When teaching aftercare strategies:
- ❑ Eliminate distractions
  - Close the room's doors.
  - Draw curtains for privacy if necessary.
- ❑ Make giving information a **Very Big Deal.**
- ❑ If it looks/sounds routine and unimportant – your teaching won't sink in.

Keep it Simple:
- ❑ Sit close to the patient. Make good eye contact.
- ❑ Avoid unnecessary medical jargon, wordy explanations.
- ❑ Be sure instructions are clear and easy to understand.
- ❑ Use an interpreter when necessary. Have communication devices for the hearing and visually-impaired.

***"93%** of what you learn in a classroom is forgotten within 14 days."*
-Dr. Tony Buzan, *The Mind Map Book*

Beware of information overload!
- ❑ Limit number of topics for education.
  "Information in small bites beats a big banquet of facts"
- ❑ Best strategy: Start the education process in advance of discharge, not last-minute.
- ❑ Overload results in **poor retention.**

Specific Best Practices (cont'd)

Best Practice Step #3: ***The Day Prior***

"If you're not certain they're ready to pack, ask your patient to teach back!"
-Brian Lee, CSP

Please Answer These Questions:

1 How do you check for a patient's *"independence readiness"*?

_____

2 How do you provide a needed *"independence awareness heads-up"* for the patient and their family?

_____

_____

The Pre-Discharge Checklist

- ❑ 1. Supply patient/family with **list of post-hospital care services.**
  Also*:* Where to access home health equipment and supplies.
- ❑ 2. Wisely counsel patients/family again (and again) about **new lifestyle changes at home**, along with possible adjustments necessary to manage new health realities.
- ❑ 3. Give written home-care instructions to patient in a well-organized packet (with a brightly-colored, can't-lose-it cover), in multiple languages.
- ❑ 4. Six critical steps to remove the root cause of adverse events:
  - ❑ Review written information with patient & caregiver:
  - ❑ Who to contact if questions or problems arise.
  - ❑ Signs/symptoms of recurring poor health to watch for.
  - ❑ Medications – and how to safely take them.
  - ❑ Safe and effective management of pain.
  - ❑ How to perform self-care.
  - ❑ Possible exploration of end-of-life options.
    -Hospice services to help patients manage care at home, rather than return to hospital

Best Practice Step #4: ***Medication Reconciliation***

Medication Reconciliation is:
The process of **comparing** a patient's medications ***prior*** *to* **hospital admission**, *and* ***during the hospital stay***, with ***discharge*** *or transfer medication orders.*

Your Pharmacist is Key!

- As performed by a pharmacist, Medication Reconciliation provides a checkpoint to ensure that any medication **discrepancies are correctly resolved.**
- Accuracy and **patient safety** is the goal.

Specific Best Practices (cont'd)

It is vital to include all medications in the reconciliation process:

- All over-the-counter and prescription medications
- Vitamins
- Herbal supplements
- Patches
- Creams and ointments
- As well as dose, frequency, and route
- And an awareness of patient's drug allergies

Medication Reconciliation saves lives By preventing such medication errors as:

- Omissions
- Duplications
- Interactions
- Name, dose, and route confusion

If discrepancies are noted, they *must be clarified* with the prescriber before discharge

Empower Your Pharmacists! Engage them in overseeing the medication reconciliation process

- They are a superb resource for expert patient and family education, especially when complex medications are involved

Best Practice Step #5: ***Going Home Day***

Checklist at Discharge:

- ❑ Co-ordinate/arrange all discharge elements with Case Worker.
- ❑ Check all initial go-home prescriptions filled.
- ❑ Alert/book transporter. They'll double-check patients have all the information they need before they leave.
- ❑ Inform patient/family they'll receive a follow-up call at home within 48 hours.

Revisit the medication safety points:

Your focus: Convey a clear understanding of all medications to be taken, including:

- ❑ **New** medications.
- ❑ **Continuing** medications.
- ❑ Previously **discontinued** home medications that *are* to be resumed.
- ❑ And which previously discontinued home medications are **not to be resumed.**

The **Discharge Coordinator** avoids delays:

- ❑ Medication reconciliation done; go-home Rx's filled.
- ❑ Final test results available from Lab.
- ❑ Next appointment with PT, OT, etc. made.
- ❑ Transporters alerted, provide escort to car.
- ❑ Patient/family knows they'll receive a follow-up call within 48 hours.

Staff Skills and Behaviors (cont'd)

Three Critical Questions to Ask:

1. *"Just so I'm clear, **who'll be your daily caregiver** at home?"*
2. *"Now help me be sure you're okay with your new medicines"*
   - *"You're going home with ____ new medications."*
   - *"Here's the **pop quiz**: Can you tell me the **name of each**?"*
   - *"What is **each one for?**" "And what **side effects** you need to be aware of?" "Great! You've got it!"*
3. *"Have you looked at the **discharge packet of written instructions** you're taking home?"*
   - *"What section do you think will **be most helpful** to you…?"*

Best Practice Step #6: ***The Post Discharge Phone Call***

Who should make the Post Discharge Phone Call?

- Ideally, call should come from a **nurse who cared for the patient.**
- When that isn't possible, call must come from someone who **can answer questions about medications** and health concerns.
- Or a call center.
- Or a hospital volunteer (must be trained/skilled at answering patient questions).

Call within 48 hours:

Make calls from private location. Have at hand:

- ❑ The **patient's chart**/discharge information
- ❑ **Resources** to answer questions re: medications and health conditions
- ❑ Resources to answer questions about **out-of-hospital** services

The genius is the process:

- Establish **protocols** for the follow-up call Check for: Wellness – Safety - Service - *and any questions?*
- Harvest patient satisfaction comments, complaints and **share immediately with relevant staff.**
- Systematically use **'lessons learned'** from post-discharge calls to improve caring service to patients.
- Quickly provide **Service Recovery** as needed.

Essential elements of an effective post-discharge call:

- ❑ Identify yourself.
- ❑ Explain why you are calling.
- ❑ Ask about safety, care, and comfort.
- ❑ Check for follow-up MD & other appointments.
- ❑ Assess satisfaction with service during stay using the "Three Thoughtful Questions."
- ❑ Express thanks.

Staff Skills and Behaviors (cont'd)

Be sure to spend extra time with patients:

- With cognitive impairments.
- The elderly.
- Social issues: A history of abuse, neglect, no known social support, or patients who live alone.
- Poor nutritional status.
- Financial issues.

Listen carefully for challenges needing help!

2 Tools, Equipment and Resources

Communication Resources in the Patient's Room - Tools, Equipment and Resources for a Flawless Discharge Experience!

Visual tools and props patients have different learning styles:
Accelerate learning with visual tools and props

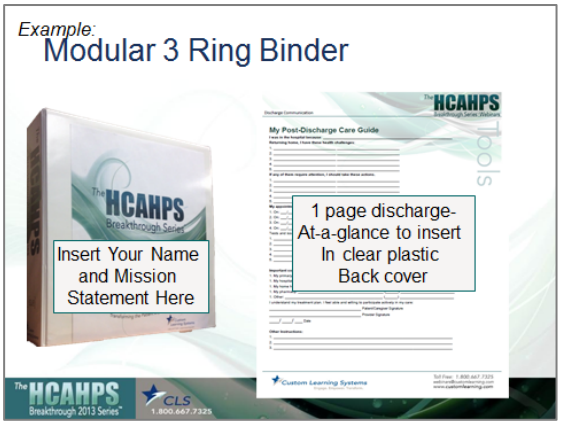
- Graphics
- Diagrams
- Scale models
- A white board
- Handy drawing paper ***A quick sketch is worth 1000 words!***

Best Practice Step #7: ***An Invaluable Discharge Packet***

An invaluable Discharge Packet to accompany patient home should include:

- Education handouts.
- Hospital contact info.
- A medication list including potential side effects.
- A follow-up appointment schedule.

*"Don't make your discharge packet valuable, make it **invaluable!**"*
-Brian Lee, CSP



Tools, Equipment and Resources (cont'd)

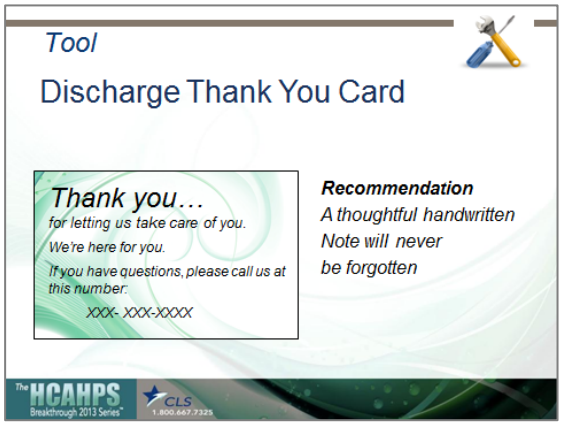
The Discharge Packet: W*ritten words the patient takes home*:

- Lists are helpful.
- Sentences are kept simple and short.
- Highlight important elements in **bold type.**
- Print is large enough for easy reading.
- Avoid using all capital letters and italics.
- Avoid jargon, tech words, & medical abbreviations.

Tool: **Patient's Post-Discharge Care Guide** - "To Do's" at a Glance

Tool: **Your Hospital Discharge Document should contain a line or two which says**:

- *"I've been given instructions on all my medications and understand how to take them."*
- *"I also understand my responsibilities for my aftercare."*
- Patient or caregiver is asked to initial these lines to indicate their preparedness for home.



Tool: **Four Excellent Online Discharge Resources**:

1. The Discharge Planning List - From CMS http://www.medicare.gov/Pubs/pdf/11376.pdf
2. The SHM BOOST Project - For Care Transitions http://www.hospitalmedicine.org/AM/Template.cfm?Section=home&template=/CustomSource/ondemand/2013-05- 28_15_03_Project_BOOST_Informational_Webinar.cfm
3. Project Red – Boston University Re-Engineered Discharge http://www.ahrq.gov/professionals/systems/hospital/toolkit/index.html
4. SMART Discharge Protocol - Anne Arundel Medical Center, Annapolis, MD http://www.aahs.org/aamcnursing/wp-content/uploads/SMART-Discharge-Protocol.pdf

Tool: **A Master, Must-Do Discharge Checklist** - that is developed and approved and updated by your Discharge Satisfaction Team

Which tools do you need to add to enhance your discharge satisfaction professional practice?

- ❑ Visual tools and props
- ❑ Discharge Packet
- ❑ Post Discharge Care Guide – at-a-glance
- ❑ Hospital discharge document
- ❑ Thank you card
- ❑ Master Discharge Checklist

3 Staff Skills and Behaviors

How important is good communication — especially about Discharge?

- #1 predictor of HCAHPS success
- #1 factor re: patients' non-compliance
- #1 reason 50% of meds taken incorrectly
- #1 cause of preventable medical errors
- #1 cause of malpractice litigation
- #1 cause of re-admits

-Source: Customer Focus, Inc., 2012

Best Practice Step #8: ***Mastering Teach Back***

The vital importance of "Teach Back" for Medications

Ask for a "**Teach Back**" to determine patients/families have a working knowledge of all facets of their care once home

Inquire what he/she understands about a specific topic:

- What a medication is prescribed for.
- When to call the doctor about a symptom.

Here's a sample "Teach-Back" role-play:

"Do me a favor and explain back to me, in your own words, what I said to you…"

"I want to be sure I got across what I wanted to say…"

Make 'Teach Back' a Core Competency

- Strengthen your ability to **form questions and sharpen the skills** needed to teach patients the information necessary for their self-care.
- **Regular practice** will give you the confidence to send patients home well-prepared to take charge of their recovery.

Recommendation

What would be the value in continually improving skills, ie "Teach Back", to increase patient "going home" preparedness?

4 Staff Scripting Recommended "Conversation Starters" Examples

***Questions**:*
What would be the value of using **key words at key times**? We call them:

- *Empathizers, or*
- *Sentence Starters, or*
- *Conversation Starters*

To make sure the patient understands their medications and self-care at home.

Teach Back:
"So that I'm sure you know how to change your dressing… (take your medications, monitor your blood pressure, etc.)"

"Will you please show me how you'd remove and replace your dressing?"
Or:
"Explain what the two medications are for, and when you'll take them, and what to do if you miss a dose?"
Or:
"How will you apply your blood pressure cuff?"

Utilize Take-Home Discharge Information Packet
How will you review the take-home information packet*?* Here's how:
Put the Packet in their hands

- *"We've put a good deal of thought into this packet. It contains the names, numbers and e-mail addresses of everyone you'll need to contact if you have questions or need help."*
- *"It's divided into five sections."*
- *"Let me show you how they're arranged and what's in each one."*

***Question**:*
How will you manage unrealistic expectations about recovery at home?
(Including responses to questions the patient may be reluctant to ask?)

Coaching Our Concerns
"What else do you need in order to feel safe during your recovery at home?"
"I've had many patients who worry about _____. Do you have any of the same concerns? I'm happy to share what I know!"
"Frequently, when going home, patients ask me about _____. How can I be of help to you in that area?"

Attitude is everything!
Encourage a positive outlook and promote patient's sense of being in control.

Staff Scripting Recommended "Conversation Starters" Examples (cont'd)

Ego-Boosting Encouragement
"It won't be long before you'll…"
"People like you don't usually take any longer than they need… in order to…"
"Slow but sure is often best, as you continue your recovery…"

Two Questions:
- Which conversation-starters do **you** want to put to work as soon as possible?
- What other **"words that work"** are you successfully using, that you could share with team members?

5 Collaboration Required from other Leaders/Departments

❑ **Role of Admitting Staff**
1. Let patients know that preparation for successful discharge is a top priority at your hospital.
2. Gives patient a Post-Discharge Care Guide.
3. Utilize the "Three Thoughtful Statements."

❑ **Role of Physicians**
1. Confirms that discharge summaries are recorded and transferred to follow-up providers within 24 hours of discharge.
2. Sets win-win expectations for discharge timeliness.

Physician *ALERT*!!
Major roadblock to patient satisfaction:
Such well-meaning discharge promises as…
"We'll get you discharged right away."
"You'll go home early today."

When they turn sour because of unavoidable delays, we're all in a pickle. Instead…
MD's need to manage patients' discharge expectations:
- *"We'll make every effort to see you're discharged today. Please know it can be a slow process."*
- *"So stay relaxed and stay comfortable. Your team will be doing everything necessary to see you discharged safely."*
- *"That's the key to your healthy recovery."*

❑ **Pharmacy's Role**
1. Medication Education (for RN's as well as patients)
2. Medication Reconciliation

❑ **Social Worker's Role**
1. Check patient readiness for daily living activities:
   Bathing, dressing, and grooming, meal preparation, household chores, caring for dependents
2. Equipment, and Supplies?
   Prescriptions, Home Oxygen, a walker, bedside commode, scales, bandages, syringes, and compression stockings

Collaboration Required from Other Leaders/Departments (cont'd)

- **Case Manager's & Discharge Planner's Role**
  1 Information
  2 Appointments clarified complications resolved(meds, equipment, follow-ups)

- **PTO & Ancillary Staff Role**
  Collaborate with other care-givers. They look to you to ready patients for discharge with needed new life-skills

- **Collaborative Role with Home Health**
  Ensures follow-up appointments & care.

- **Role of the Transporters**
  Asks patients if they have their Take-Home Information Packet

- **Role of the Valet Parking Attendant**
  1. Are the patients' last contact with hospital
  2. Skilled with helping into car, & with farewell:
     "*Thank you for letting us take care of you!"*
     Not *"Good luck!"*

Best Practice Step #9: ***The Discharge Satisfaction Team***

Discharge is a team activity! (No Lone Rangers Allowed)

The Power of the Team
Especially with a complex discharge, you'll want a **multi-disciplinary** group to plan a streamlined exit in advance.

Discharge Satisfaction Team Stakeholders would include reps from:
- Administration (as Exec Sponsor)
- Key MD's involved in the discharge process
- Clinical nursing staff
- Social Workers, Case Managers, Geriatricians
- Pharmacists
- ED
- Medical Records Dep't
- Nutrition / Dietary
- Home Health
- Call Center

Discharge Satisfaction Team Mission:
To continuously improve the process of prepare every patient for a safe, continued recovery at home, and improve HACHPS scores.

Discharge Satisfaction Team Mission

To continuously improve the process of: ***Prepare every patient for a safe, continued recovery at home, and improve HACHPS scores***

Team Charter -

The Team maintains accountability for discharge Best Practices

1. Send everyone to 'lunch 'n learn' classes to role-play discharge processes
2. Spread latest discharge information
3. Educate & remind Managers to model and monitor behavior
4. Author a Master Discharge Checklist process with input from everyone
   (Preferably using LEAN/SIX SIGMA)
5. Continually create awareness around discharge skills.
6. Improve inter-departmental collaboration and hand-offs
7. Monitor HCAHPS scores, and improve
8. Acknowledge and recognize progress

And most importantly….

The Discharge Satisfaction Team is chartered to meet with:

The Med Exec Committee and appear at a Med Staff Meeting to assure all physicians are aligned with hospital discharge procedures

Question:
Would a Discharge Satisfaction Team ensure better **transition** of patients from your hospital to their homes?

Recommendation:
The CNO to Create a **Discharge Satisfaction Team** to continually improve skills and increase patient "going home" preparedness. *(It'll work… if you work it!)*

6 Three Questions asked three ways to guarantee a Satisfied Discharge Experience

Tool:
Introducing *"**Three Questions asked Three Ways to Guarantee a Satisfied Discharge Experience**"*
Be sure to request your Copy of this **Discharge Tool**.

Question:
If you were consistent about **using** these home-preparedness questions, at

- **Admitting**
- **Discharge**
- **Post Discharge call**

How positive an impact would they have improving the patient experience & HACHPS scores?

Engage Your Front Line

The Vital Importance of Front Line Education & Engagement
Until your **front line staff own the Discharge Satisfaction process,** you'll never achieve excellence in the patient's experience

Question:
How will you educate and engage your team to implement an improved Discharge Process?

Thank you to our Nurse Advisors:
Tammy Elliott, Holton Community Hospital, KS
Beverly Martinez, Rio Grande Hospital, CO
Kathy Vern, Matagorda Regional Medical Center, TX
Rebecca Smallwood, Lubbock, TX

Tools

Team DO IT Plan

- ☐ 1. Request your CNO to charter a "Discharge Satisfaction Team" to champion the cause. Their first assignment: enlist physicians in managing realistic patient expectations around discharge
- ☐ 2. Challenge each nursing unit to author and post a Discharge Mission Statement that reflects their collective commitment to a safe transition to recovery at home
- ☐ 3. Request your pharmacy director to take the lead to implement an effective, systematic process for medication reconciliation. They are your Med Rec Guru's
- ☐ 4. Appoint a sub team to conduct a critical review of your current Discharge packet. Compare best practices with other facilities in your state. Schedule one or more focus groups with recently discharged patients. Seek input from home health to add value to the packet.

  Your goal: Make it the best! (& send us a copy when you're done)
- ☐ 5. Schedule a 30 minute workshop to provide nurses, admitting and your discharge phone call team an opportunity to learn about and buy into utilizing the "Three Discharge Questions"

  Engage Admitting Staff to immediately use the "Three Statements". Admitting Staff are essential First Educators in your Discharge process

  Make sure the manager in charge of your post-discharge phone calls begins implementing "The Three Questions" ASAP
- ☐ 6. Make "Teach Back' skills a vital competency for all bedside care-givers. Include this skill-set in your workshop on "The Three Discharge Questions"
- ☐ 7. Enhance your current discharge system by conducting a review of the forms and checklists we have recommended in this webinar's "Four Resources: CMS, BOOST, RED, and Anne Arundel Medical Center" and develop your own master checklist system for your entire discharge process.
- ☐ 8. Using the PDCA, LEAN and or Six Sigma quality improvement model, conduct a role review of all Discharge Players identified in the collaboration section
- ☐ 9. Design and implement a patients' Care Guidance
- ☐ 10. Add a section to your patients discharge document that asks them to indicate their personal preparedness for life at home
- ☐ 11. Phase in a discharge thank you card, (if you have not done so already) that includes space for a handwritten, personal note from the patients' nurse
- ☐ 12. Empower the Discharge Satisfaction team, carefully monitor your readmission rates, and taken timely action to continuously reduce them.

The HCAHPS Breakthrough Leadership Series™

Tools & Resources

Tools

To support your team to achieve its HCAHPS performance improvement goals, we are pleased to offer these value added Educational Resources and Implementation Tools. For more information give us a call at 800-667-7325, or email webinars@customlearning.com.

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  - February 6 - 8, 2017, Hilton Long Beach, Long Beach, CA
  - National Symposium on HCAHPS Success – February 6, 2017

- ☐ **Brian Lee, CSP, Onsite Keynote Presentation**
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You've just heard from us, now we'd like to hear from you. Thank you.

We **totally employ** about #_____ full and part time staff, at _____ facilities.

1. **For me, the most valuable idea I learned and intend to use is**: _____

   _____

   _____

2. **What I would tell others about the quality of the speakers and value of the content**:_____

   _____

   _____

   _____ O.K. to quote me: YES NO

3. **Presentation improvements I would suggest**: _____

   _____

   _____

4. **On a scale of 1 - 5, this presentation:** (Met My Expectations) 5 4 3 2 1 (Did Not)

5. ***Featured Implementation Tool:***

   Yes A. Three Questions asked Three Ways to Guarantee a Satisfied Discharge Experience
   Yes B. Interested in scheduling our **Team Coaching Call**
   Yes C. I plan to apply for my "Certified HCAHPS Practicing Professional" designation at the conclusion of this service

6. **P.S. – My Best Tip**: _____

   _____

   _____

   _____ ❑ More on Reverse

PLEASE PRINT

First/Last Name:_____
Organization: _____ Position:_____
Address:_____ Zip: _____
Bus. Phone:(_____) _____ Extension:_____ Cell: (_____)_____
*Email:_____