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Custom Learning Systems

#10 Transition of Care

# Care Transitions Done Right™

*To engage staff and patients in creating a seamless care transition experience.*

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# Care Transitions Done Right™

*To engage staff and patients in creating a seamless care transition experience.*

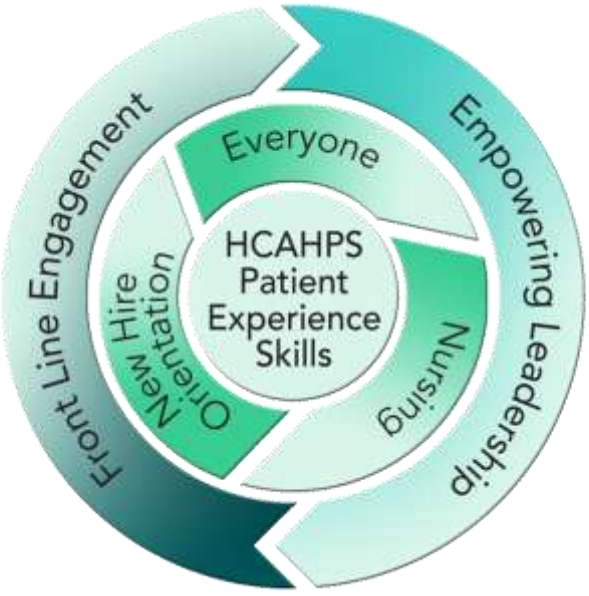
**Everyone is a Caregiver. We're all First Responders.**

**Question:** *Are you playing a form of 'telephone' with care transitions at your facility? Healthcare isn't a game…*
*The poor communication of meaningful information is inefficient, expensive – and potentially life-threatening for patients and families.*

**Care Transitions Defined:**

- Within a facility, where care is transferred from one setting to another
- From hospital to home, where care is transferred to the patient, family, or other home caregivers
- From one healthcare facility to another,
  where care responsibilities are transferred from providers at one facility to another. These include Assisted Living, Skilled Nursing, or Long-Term Care residences

**The Custom Learning Systems HCAHPS Transformation Model**



# HCAHPS Domain – Transition of Care

**Survey Question #1:** *Patient Preferences*

*The hospital staff **took my preferences and those of my family or caregiver into account** in deciding what my healthcare needs would be when I left the hospital.*
*("Always" is the response you need)*

**Survey Questions #2:** *Patient Responsibility*

*When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.*

**Survey Question #3:** *Patient Medication Education*

*When I left the hospital, I **clearly understood the purpose** of taking each of my medications.*

**Domain Leadership Owners**
CEO, CMO, CNO, Physicians, Nurse Managers and Case Workers, Pharmacists

**Domain Staff Owners**
Case Managers, Nurses, Transitional Care Manager, Social Worker, Transition Coach, Staff Members

**Current National Threshold is:**
(Rated a 4 – "Always")

**66%**

What's yours? _____%

**Some Facts about Responsiveness:**

- "Handoffs and Transitions" was consistently the second-lowest-scoring area in a survey of over 1000 hospitals nationwide. -AHRQ Pt. Safety, 2011

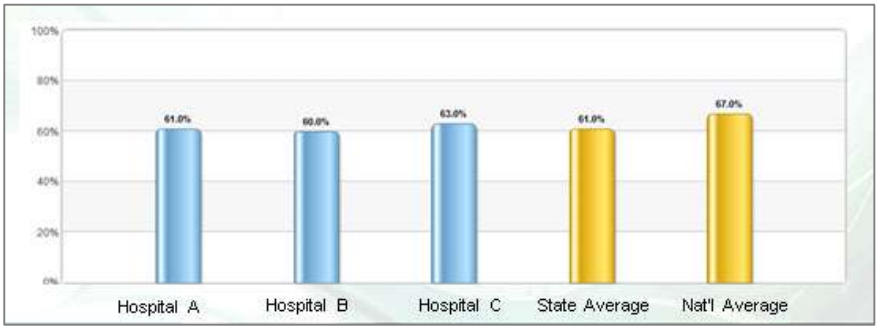
**In this same survey, caregivers said:**

- *"Things 'fall between the cracks' when transferring patients between units…"*
- *"Important patient care information is often lost during shift changes…"*

## Why Effective Care Transitions Matters:

**Got Ineffective Care Transitions? Here's What You're Looking at:**

1. Adverse Events. About 1 in 5 patients suffer an adverse event during the care transition period. Medication-related events are the most common
2. Unnecessary Readmissions. About 1 in 5 patients are re-hospitalized within 30 days of discharge. Of these readmissions, 75% are potentially avoidable
3. **Unnecessary Pain and Suffering** often occurs when patients are **not properly educated** about how to successfully manage pain at home
4. **Poor HCAHPS Scores and Financial Penalties**. Patients who suffer from poorly-managed discharges and care transitions **reflect their dissatisfaction on their HCAHPS** survey. Poor scores lead to unnecessary financial penalties for the hospital
5. **Transitions of Care Ratings Are Public Sample:** Patients who reported that they "Always" understood the purpose of taking each of their medications




**Ineffective Care Transitions – You are looking at:**

6. "In the second year of the HRRP, beginning October 1, 2013, CMS estimates **2,225 hospitals** will be penalized a total of **$227 million** because of excess readmissions."

-Source: Health Affairs Journal, November 12, 2013

## Crucial Leadership Engagement Best Practice

**The Million Dollar Transition Question:**

How to seamlessly handoff the patient between:

- Different Departments
- Different Shifts
- Different Healthcare Institutions
- Different Home settings

…without dropping the ball because of poor communication, weak collaboration, and listless coordination of care?

**Answer:**

*Empower **everyone** to manage your patients' **Moments of Truth**.*

**Definitions:**

**Moment of Truth**

Any interaction in which a patient comes in contact with the care transition process

**A Reward Strategy**

Pays off each Moment of Truth, allows patient to have the very best experience at each point of contact

**Cycle of Service**

Any combination of Moments of Truth

**Same Day Surgery Cycle of Service**


**Every "Moment of Truth" Involves a Hand-Off**

*"**Hand-offs occur** any time there is a transfer of responsibility for a patient from one caregiver to another..."*

*"**The goal of the handoff** is to provide timely, accurate information about the patient's care plan, treatment, current condition, and any recent or anticipated changes."*

-Lee Ann Runy, *Hospitals & Health Networks*, 2008


**The Top Ten Care Transition Cycles you must Successfully Manage:**

1. Admitting (manage expectations, assess patient, explain process)
2. Medication Education (especially around new meds + MedRec)
3. Pt. Participation and Commitment to Care Plan
4. Self-responsibility (include awareness of risks, pitfalls at home)
5. Self-care (wound care, dressing change, PT regimen, etc.)
6. Med Rec (pharmacist with patient + family caregivers)
7. Transition readiness for at-risk patients (to SNF, home)
8. Hand-off to next caregivers (whether family or new facility)
9. The actual day of discharge (is everyone ready for transition?)
10. Post-discharge diligence (home visits/check-ups, new appointments)

**Team *DO IT* Recommendations:**

1. Back in your department, **pick any Care Transition dissatisfier** and do the **"Cycle of Service" exercise**. Ferret out "Moments of Truth" that are going awry.
2. Devise **creative and lasting improvements** to eliminate each dissatisfier.
3. **Hardwire by making a checklist** of essential actions from each Cycle of Service.
4. **Involve your team** in developing the checklist! Then each staffer can **teach anyone else** who's new in the department.
5. If you haven't done so already, engage your staff to conduct the Cycle of Service exercise and create an **SOP checklist of best practices** to ensure your patients' **Medication Mastery**?

*What would be the value of conducting this "**Cycle of Service**" for each "**dissatisfier**" in your care transition process?*

Benefits:

- Involves all staff (everybody contributes!)
- Creates ownership (if they create it – they'll own it!)
- Sets norms for staff behavior (no fear of missteps)
- Empowers all staff as educators
- Gives patients reliable road maps to recovery
- Prepares family as confident support team
- Assures timely healing at home or care facility
- Reduces unnecessary readmissions
- Creates satisfied patients. Fewer CMS penalties

**Team *DO IT* Recommendations:**

1. Prepare to lead this exercise with everyone in your work group
2. Look for ways to improve each Moment of Truth
3. Brainstorm on "Reward Strategies"
4. Create new systems for consistent service
5. Document your *progress – and keep improving*

**Question:**
When and how will you use the Cycle of Service and Reward Strategy exercise to engage your staff in managing your patients' Moments of Truth?

**Transition of Care Survey Question #2:** Patient Accountability
When I left the hospital, I had a **good understanding of the things I was responsible** for in managing my health.

**The *Key* to getting an "*Always*" on Question #2:**
**Accountability for Self-Management** - Teach patient and family to be *active, responsible participants* in the self-management of the healing process

**Teach what's Needed for a Safe Transition:**

- Education for life after a hospital stay should not begin two hours before discharge
- Let patients/family know that when they leave the hospital they become, by default, their own Care Coordinator
- Encourage patients to assert that role, and tell health professionals what they need
- Teaching about diet, exercise, following med. regimens, etc. should be ongoing, daily

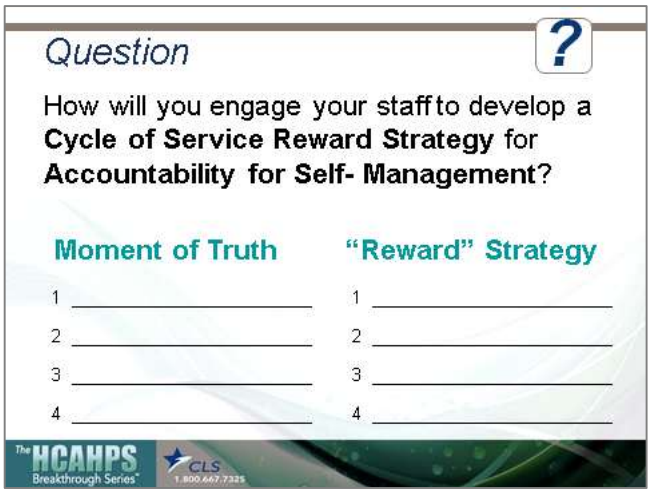
**You'll know patients are self-reliant and ready for discharge when they:**

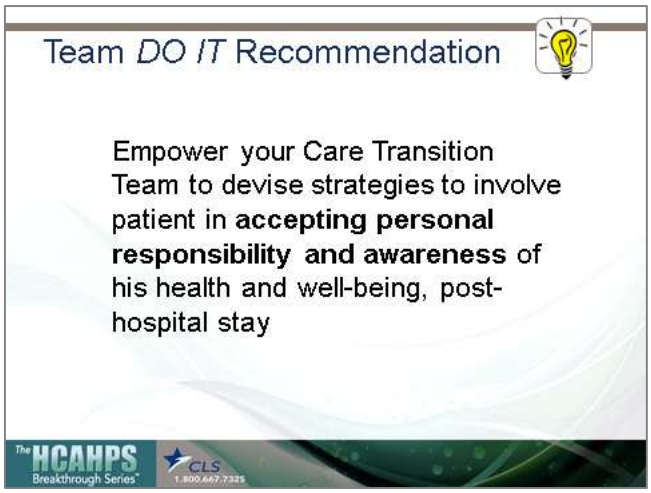
- Participate actively in their care plan
- Know their diagnosis and prognosis
- Speak confidently about meds – aware of side effects
- Working with determination at PT, other therapies
- Have already set goals for rehab, recovery
- Are supported by knowledgeable family caregivers

**Have you reason to believe patient will need extra care post-discharge?**
Your responsibility is to alert:

- Attending physician
- Case Manager
- Social Worker
- Next care facility (if transitioning to SNF, etc.)
- Patient's family
- Or other home caregivers

… to the fact this patient is potentially "at risk" and will need supervision



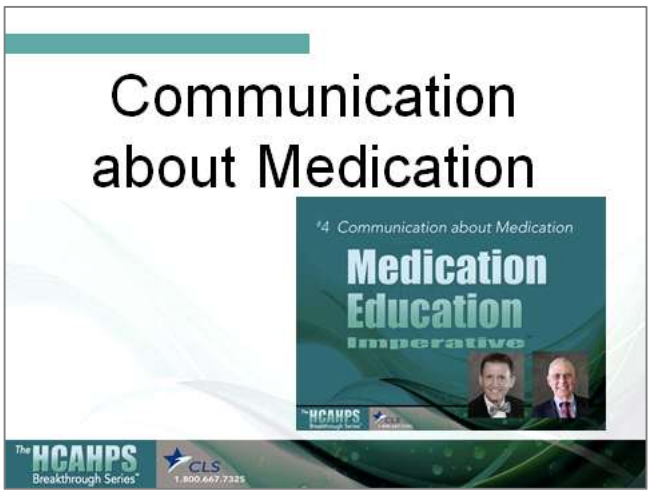




**Medication Self Mastery**

**Transition of Care Survey Question #3:** *Patient Medication Education*
When I left the hospital, I clearly **understood the purpose of taking each of my medications**.

**The *Key* to earing an *"Always"*on Question #3:**

- We call it "Medication Self Mastery"
- Ensure a safe transition home by skillfully teaching patients about their meds, when to take them, and what to do if potential adverse effects occur




**The Morisky Scale Promotes Medication Discussion with the patient:**

1. Do you ever forget to take your medicine?
2. Are you careless at times about taking your medicine?
3. When you're feeling better, do you sometimes stop taking your medicine?
4. Sometimes if you feel worse when you take your medicine, do you **stop taking it**?
5. Do you know the **long-term benefit** of taking your medicine as explained by your doctor or pharmacist?
6. Sometimes do you **forget to refill** your prescription on time?

**An Easy Way to Understand Meds**

- ❑ Proper written description of all new medications *(as provided by Pharmacy)* must be handed out
- ❑ Available from your EMR
- ❑ Can a Pharmacist teach an in-service on your floor about a new medication, just released?

**Take Home Information Pages**

- ❑ Support all verbal education about medications with take-home, printed information sheets
- ❑ Have these available for print-out on nurse's station computer
- ❑ Review them with the patient and family

**Patient Engagement at Home**

- ❑ Ask for a commitment of support from family
- ❑ Follow up with at-risk cases
- ❑ Create a web-portal for continuous communication
- ❑ Utilize smart Apps

**The 5 Step DEATS Process for Education about Meds**

**D –** Draw Curtain
**E –** Engage Patient
**A –** Adapt Communication
**T –** Translate if Necessary
**S –** Side Effects

**Team *DO IT* Recommendations:**

***Step #1:*** Review the HBS **Communication about Medication Module**, if you haven't done so already. Take action as recommended.

***Step #2:*** Schedule a 30 min. nursing lunch-and- learn or incorporate a **Medication Mastery segment** in an annual 3 hour Nursing seminar/webinar.

**Ensure patients know their meds. Use *"Teach Back"***

***Confirm they've "got it"*** *by asking patients to teach-back or restate to you in their own words how they'll perform their medication regimen*

- ***Reason why*** *he/she is taking each medication*
- ***Positive effects*** *of taking the medication(s)*
- ***Cite symptoms/side effects*** *– and what to do should they occur. Refill dates?*
- ***How long*** *to remain on the medication(s)*

**Follow Up on Medication Compliance**

1. Care Transition Team phone call or home visit needs to take place within 36 hours of discharge of all at-risk patients
2. The call is to the patient – or RN in the transition facility if patient has not gone home
3. Check on patient's status, esp. medications
4. Answer questions regarding medication regiment, and any signs, symptoms, reactions, to the meds

***Recommendation:*** Care Team Transition

**The team also functions as educators for all clinical staff**
Care Transition Team members can share their unique skills in visits to Huddles, or via a "**guest shot**" **at a monthly Staff Meeting,** or in working with a process improvement team that's momentarily stuck in solving a transition problem.


**Team *DO IT* Recommendation:**
If you haven't done so already, how soon can you engage your staff in creating a checklist of best practices to ensure your patients' Medication Mastery?

***Question:***
When and how will you organize and see to the creation of this checklist?

## 2 Tools, Equipment and Resources

**The Journey Home White Board:**
In-room white boards are re-titled
***"The Journey Home"***
They contain all pertinent care transition data

**Agenda-Setting Cards** Improve Transition Communication

- Each card in the deck has a question frequently asked by patients with Heart Failure
- Questions were gathered from patients by HF nurses
- Patients are given the card deck to keep and are encouraged to choose 2-3 cards for discussion at each learning opportunity across care settings
- The agenda-setting cards reduce patients' hesitation to ask questions and assist them with driving the learning agenda
- The cards have been very successful at Cedars Sinai Hospital in Los Angeles

**Source**: *Effective Interventions to Reduce Rehospitalizations;* Institute for Healthcare Improvement, 2009

***Question:***
How skillful are you and your team at using **Teach-Back** whenever educating patients?
When was the last time you held a Teach-Back role-play to test staff competency with this tool?

A great online resource that helps patients understand their meds: www.mypicturerx.com

Another information-rich Transition website: www.nextstepincare.org

### Discharge Preparation Checklist

***Before I leave the care facility, the following tasks should be completed:***

- ❑ I have been involved in decisions about what will take place after I leave the facility.
- ❑ I understand where I am going after I leave this facility and what will happen to me once I arrive.
- ❑ I have the name and phone number of a person I should contact if a problem arise during my transfer.
- ❑ I understand what my medications are, how to obtain them and how to take them.
- ❑ I understand the potential side effects of my medications and whom I should call if I experience them.
- ❑ I understand what symptoms I need to watch out for and whom to call should I notice them.
- ❑ I understand how to keep my health problems from becoming worse.
- ❑ My doctor or nurse has answered my most important questions prior to leaving the facility.
- ❑ My family or someone close to me knows that I am coming home and what I will need once I leave the facility.
- ❑ If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.

This tool was developed by Dr. Eric Coleman, UCHSC, HCPR, with funding from the John A. Hartford Foundation and the Robert Wood Johnson Foundation

**VA Home Telehealth Monitoring Service**

- For Veterans who have a health problem like diabetes, chronic heart failure, chronic obstructive pulmonary disease (COPD), depression or post-traumatic stress disorder, getting treatment can be complex and inconvenient
- VA technology makes it possible to check on symptoms and measure vital signs in the home using regular telephone lines

***Question*:**
Which Care Transition tool *(or combination)* would benefit your patients?

- Dedicated White Boards
- Discharge Packet
- Internet applications
- Agenda-setting cards
- Discharge Checklist
- Discharge Satisfaction Guaranteed
- Telehealth Monitoring Service

***Recommendation***
Share this helpful tool-kit for smoother Care Transitions with your colleagues.
Each tool is easily taught at a Morning Huddle or in a Staff Meeting

| Communicate | Collaborate | Coordinate |
|---|---|---|

The Five P's streamline transfer of responsibility *via* communication, collaboration, & coordination

- **Patient** (name, identifiers, age, sex, location)
- **Plan** (diagnosis, treatment plan, next steps)
- **Purpose** (provide a rationale for the care plan)
- **Problems** (explain what's different/unusual about patient)
- **Precautions** (explain what's *expected* to be different)

-Source: Sentara Health Care, Norfolk, VA

**Communicate:** M.D.'s + RN's + Patient + Family

- The essential connection
- Physicians and Nurses in a busy facility don't know all of a patient's history (People are pushed through the system so quickly). Time must be made for this conversation
- Caregivers need to know their patient's back-story

**Collaborate:** between various disciplines and family

- A patient may present as being alert and oriented upon initial assessment – but cognitive deficits are not immediately noticed
- Inter-disciplinary collaboration allows second and third "looks" and the sharing of informed perceptions re: cognition, etc.

**Coordinate:** all players in the transition

- Transition planning must begin with family included. Not just the patient
- Case Managers/Transition Team need to meet early on with family to look at proper arrangements which need to be met to keep a patient safe after discharge

**The Critical Transition Skill:** Managing Patient's Expectations

- Life changes dynamically after discharge: patients must go from being passive recipients to being responsible, active, and outspoken about their well-being
- Teach patients and families how to take an active role in care transition and how to manage predictable post-discharge events
- They'll be less likely to be re-admitted

**Team *DO IT* Recommendations:**
How soon will you draw up a checklist of skills for managing patient expectations?
*For example:*

1. **Managing expectations about discomfort**
   *How will you ready patients about what to expect regarding pain, discomfort, and energy levels after surgery, anesthesia, and illness?*

2. **Managing expectations around communication between various care-givers, post-discharge**
   *How will you make patients aware of this (and what to do about it?)*

3. **Manage expectations about resuming normal activities**
   *How will you teach family caregivers to help patients get their bearings back before engaging in activities such as driving?*

**Words That Win:** A working model for feedback
*"Please do me a favor and explain, in your own words, what I said… I want to make sure you have a good understanding of the signs and symptoms to watch for at home, since you'll be responsible for monitoring them."*

**Words to ensure understanding and self-care at home:** Use teach-back and show-back
*"So that I'm sure you know how to change your dressing… will you please show me how you'd remove and replace it?"*
*"Your new prescriptions are important. Can you tell me what the two medications are for, when you'll take them, and what to do if you miss a dose?"*
*"Here's a quick quiz: how will you apply your blood pressure cuff?"*

**Words to use when explaining the Care Transition Take-Home Packet**
*"We've put a good deal of thought into this packet.*
*It contains your medication information, upcoming appointments, emergency names and numbers 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."*

**Words to help set goals for recovery at home:**
*"What else do you need in order to feel safe during your recovery at home?"*
*"What's the most important thing I can do for you as you prepare to go home?"*
*"What's something you really want to accomplish in your first week at home, and how can I help you reach that goal?"*

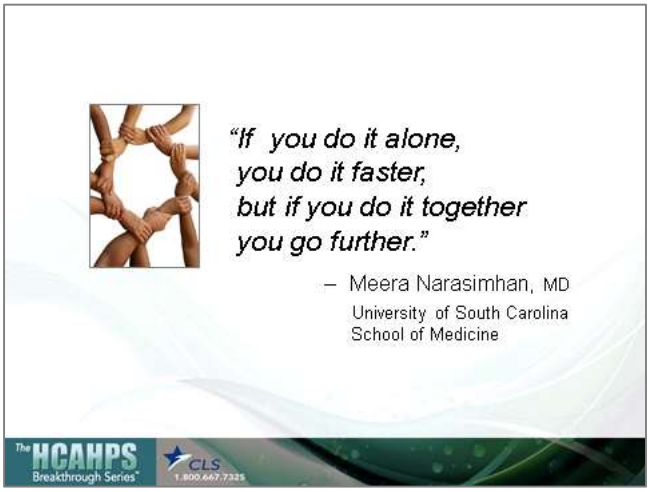
***Sentence Starters to support a patient's positive outlook***
*"It won't be long before you'll…"*
*"I like the way you listen to your body and what it needs..."*
*"People like you don't usually take any longer than they need… (in order…) to…"*
*"Slow but sure is often best… as you continue to recover."*
*"Your wound is healing. The tissue is a pink and clean."*

**Question:**
What sentence-starters do you routinely use to:

- set expectations
- encourage a positive outlook in patients and family
- appreciate patient progress
- motivate patients to change to more healthy and productive behaviors

*When will you share your Words that Win with fellow team members?*

## Collaborating for Care Transitions




**Collaboration:** The Art of Going Further
*"Effective care transitions take advantage of the complementary skills and talents of all team members, from inpatient care to every other supportive resource, when needed."*
– American Medical Association, 2013 from *"There and Home Again, Safely"*

**Collaborations:**

- Admitting Staff Collaborates with Patients
- Physicians Collaborate on how to improve the transition
- Pharmacists collaborate to provide Medication Reconciliation
- RN/MD/PharmD. Collaborate
- Timely Lab Reports at Transition
- Case Managers or M.D. collaborate with patient and family caregivers
- Case Managers Collaborate with PCP
- Collaboration with Transporters
- Partner with Home Health

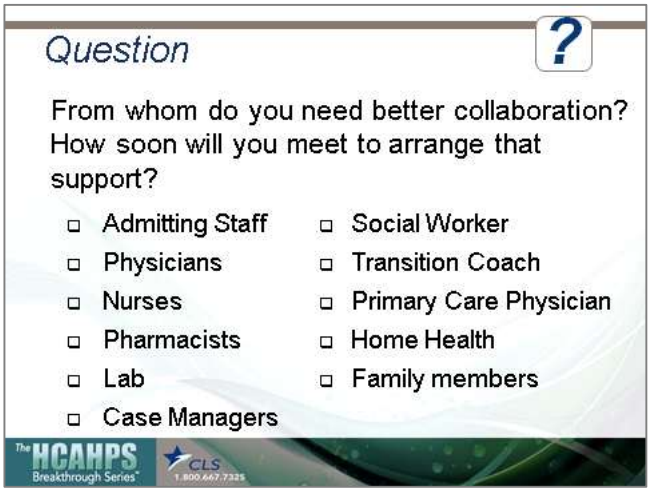
**Above all, integrate family as active collaborators in recovery**
They're closest to the patient and deserve your best energies to educate, encourage, and empower them as vital caregivers

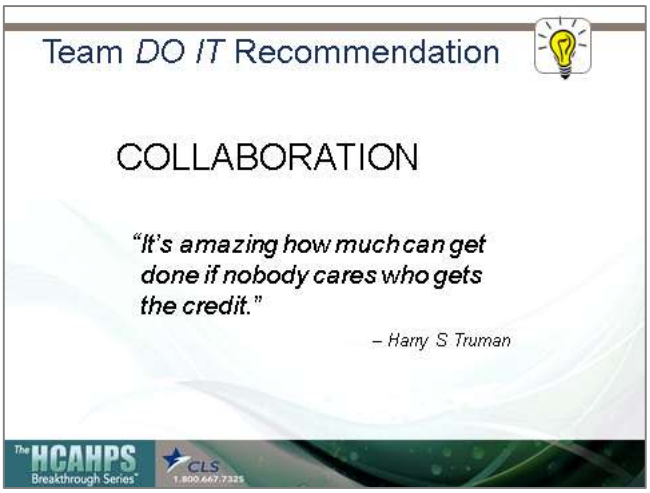
**Question:**
Who's the quarterback, calling the collaborative signals?

It's not always clear who's in charge of a patient when they're transitioning **out** of the hospital…
Collaboration is critical at this point

***Lead the decision to choose the quarterback of this team*** *S*uggestion: ***Choose the PCP***

**Involve the Primary Care Physician**
Lack of oversight by PCP's is a big part of early readmissions
Yet they're the ones who generally know patient and family best
Invite them to take the role as quarterback




**Care Transition Team**
Everything You Always
Wanted to Know about Smoother Care Transitions
(but were afraid to ask)

## 3 Words that Win "*Conversation Starters*"

**A Working Model for Teach Back**
*"Please do me a favor and explain, in your own words, what I said… I want to make sure you have a good understanding of the signs and symptoms to watch for at home, since you'll be responsible for monitoring them."*

**Words to Ensure Understanding of Meds & Self-Care at Home**
**Use "teach-back" and "show-back"**
*"So that I'm sure you know how to change your dressing… will you please show me how you'd remove and replace it?"*
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- motivate patients to change to more healthy and productive behaviors
  *When will you share your Words that Win with fellow team members?*

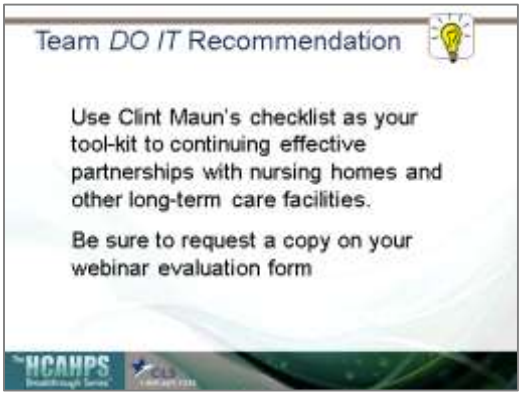
**The ReHospitalization Partnership** -Clint Maun, CSP
The following checklist details the important components that must be up and running in a Skilled Nursing Organization, from a Hospital's perspective

**Skilled Nursing Organization:**

1. Keeps score on ReHospitalizations in sync with Hospital/Health System measurements and CMS surveys.
2. Has a specific approach to prevent ReHospitalization and specific protocols/tools to assist in that effort.
3. Looks at each ReHospitalization as a Risk Event. It proactively checks on the status of the client in the Emergency Room and makes every effort to take the client back before ReHospitalization occurs.
4. Makes great first impressions and proactive admissions to insure client/family satisfaction.
5. Ensures that all necessary information (medications, equipment needs, required treatments, current client status, medical history, etc) is received at admission to successfully transition the new resident.
6. Has superior Physician and/or Mid-Level involvement to assist in preventing ReHospitalization.
7. Has the correct number of professionals with the correct clinical training to provide excellent care for clients.
8. Works as an active partner in the new transition business of QST.
9. Can effectively handle ReHospitalization Prevention on nights and weekends.
10. Proactively publishes their ReHospitalization numbers and their successes. They also meet regularly with the Hospital/Health system to develop improvement strategies as needed.

**The QST Factor**

Clint is a knowledgeable resource for all your questions about long term care & reducing readmissions. Reach him at 1.800.356.2233
Customerservice@maunlemke.com



**Question:**

How will you improve your continuing alliances with the long-term care facilities in your community?
How can you both be better partners to each other?

**To Summarize**
**Three Thoughtful Questions that ensure Improved HCAHPS Scores**

The hospital staff **took my preferences and those of my family or caregiver into account** in deciding what my healthcare needs would be when I left the hospital.

1. *"Did we take all of your personal preferences into account in designing your plan of care for when you go home?"*
   *"What did we miss that we should include?"*

When I left the hospital, I had a **good understanding of the things I was responsible** for in managing my health.

2. *"What do you see as any potential barriers to your ability to be responsible for managing your health at home?"*

3. *"What's a question about home care you never got to ask us?"*

When I left the hospital, I clearly **understood the purpose of taking each of my medications**.

*"Just for my benefit, can you tell me about the meds you're taking?"*
*"Can you tell me what the possible side effects are for the two medications you're going home with?"*
*"And what do you do if you experience those side effects?"*
*"What meds already at home are you to stop taking and throw away?"*

Adapt and personalize these three questions in a way that will work best for your team.

**Frontline Educational Imperative**

**Make sure your staff understand the following:**
The three TOC questions in this HCAHPS domain, and the skills to:

- help devise personal care plans
- teach effective self-care and self-management
- assure patient knows medication management
- use Teach-Back to guarantee lessons are learned
- be adept as communicator, collaborator, and coordinator

**Team *DO IT* Recommendation:**
*"You've got to keep innovating your initiatives"*
This quote reminds us that any improvement plan is only as good as it is kept fresh in the hearts and minds of the people executing it every day
The vital DO IT behavior here is: keep innovating and suggesting fresh best practice points that will drive continually improved Care Transitions. *Keep it new!*

Tools

# Team DO IT Plan

- ☐ 1. Appoint and charter a Care Transition Team charged with leading effective discharges – not discharges that turn into a 'revolving door'
- ☐ 2. Enlist physicians and RN's to create and implement a Personalized Care Plan Checklist that prepares patients for discharge
- ☐ 3. Conduct a one-hour "refresher" workshop on the teaching skills necessary to educate patients and their caregivers to prepare patient to thrive after discharge through their own self management
- ☐ 4. Train all caregivers to eliminate patient "dissatisfiers" by identifying clear "Moments of Truth," and deciding on "Reward Strategies" for each one
- ☐ 5. Use weekly Service Huddles or monthly DO IT Meeting to link the successful "Moments" together in a positive "Cycle of Service" and hardwire by creating an SOP Checklist for key areas such as: Managing Expectations about discomfort, Managing expectations around communication between various care-givers, post-discharge, Management expectations about resuming normal activities
- ☐ 6. Schedule a visit to your Nursing Home(s)/partners to which you most regularly refer patients and utilize the Clint Maun ReHospitalization Checklist, as the agenda for future collaboration expectations
- ☐ 7. Review the HBS Relationship-Based Nurse Communication Module and schedule a 30 min. nursing lunch-and-learn or incorporate a Bedside Report Module in an annual 3 hour Nursing seminar/webinar
- ☐ 8. Review the HBS Communication about Medication Module, if you haven't done so already. Take action as recommended
- ☐ 9. If you haven't done so already, engage your staff to conduct the Cycle of Service exercise and create an SOP Checklist of best practices to ensure your patients' Medication Mastery
- ☐ 10. Engage your staff to utilize the sentence-starters provided to routinely: Set expectations, encourage a positive outlook in patients and family, appreciate patient progress, and motivate patients to change to more health and productive behaviors
- ☐ 11. Make sure your staff understand the following…The three TOC questions in this HCAHPS domain, and the skills to set expectations. Help devise personal care plans, teach effective self-care and self-management, ensure patient knows medication management, use teach-back to guarantee lessons are learned, and be adept as communicator, collaborator, and coordinator
- ☐ 12. Make the minutes from your review of this Team DO IT Plan, your "Care Transitions Strategic Plan," and forward to your Executive Team and managers

# 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.*

- ☐ One Hour *(Free)* Coaching Call
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- ☐ HCAHPS Performance Improvement E-learning Series
  10 Module Online Interactive Education Series that enables all staff be HCAHPS competent.
- ☐ The Frontline Culture of Engagement Initiative™
  Create a sustainable culture of employee empowerment as an Employer of Choice
- ☐ The DO IT Implementation Meeting™ – Train-the-Trainer Course
  A "How-To" System to engage everyone in continuously improving HCAHPS and the Patient Experience.
- ☐ HCAHPS based Patient Experience Skills for Everyone
- ☐ Relationship based HCAHPS Skills for Nursing
- ☐ The Annual HealthCare Service Excellence - www.HealthCareServiceExcellenceConference.com
  - National Symposium on HCAHPS Success
- ☐ Brian Lee, CSP, Onsite Keynote Presentation
  - The Magic of Engagement™
  - The Six Secrets of a World Class Patient Experience™
  - The HCAHPS Hospital of Choice™

# Frequently Asked Questions *(and Answers)*

FAQ

**1. How Do I Log-in?**

If you have already registered for the series, please go to: **www.telenect.com/u/7tkyhxk56u** and at the bottom of the screen you will see an *'Already Registered'* button. Login using your email address and the password you previously created. If you have forgotten your password please click *'I forgot my password'* and you will receive an email from Telenect asking you to reset your password.

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**2. I don't know my Sponsor Code so what do I put in the field?**

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**4. Can I get CEU's from the HCAHPS Breakthrough Webinar Series?**

No. Unfortunately we do not issue CEU's for this webinar series. You can contact your governing organization to see if they are able to issue them for you.

**5. I'm going to be late for the webinar or miss it entirely, can I still watch it? How long do I have to watch it?**

Yes, you can begin the webinar any time after it begins at its set time. We don't want you to miss it so if you join late it will take you right to the beginning as we are recording it for the archive file. If the entire webinar has passed you can log-in to your account and access it anytime. You will have access to the webinar series for 1 year from the date the webinar originally aired.

**6. How do I access the tools mentioned in the webinar including the certificate?**

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6. Check that the system volume in your operating system is turned up.
7. Some sound cards are only able to play audio from one source at a time, so make sure no other applications are using your sound card.
8. If your audio is not working in any other application, try restarting the system before turning to your computer manufacturers' support.

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V1-R2

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-Gayle Moses, Safety & Security Manager, Lodi Health, CA

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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. **Skilled Nursing Organization** Tool
   Yes B. **Personal Care** Plan Checklist
   Yes C. Please send the Case Study "**Swank Healthcare's HCAHPS Performance Improvement Series drives improved patient experience scores**"
   Yes D. **Care Transition** Team Charter
   Yes E. Team ***DO IT*** Plan
   Yes F. Interested in Scheduling Our Team **Coaching Call**

6. **P.S. – My Best Tip**: _____
   _____
   _____ ❑ More on Reverse

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