Board Quality Committee

Apr 14, 2015 at 12:00 PM - 01:30 PM

Eskridge Conference Room
AGENDA

5. APPROVAL OF MINUTES

a) Board Quality Committee Charter

6.1. Quality Committee Goals 2015 & Charter

b) Board Quality Committee DRAFT Goals

6.2. TFHS Quality Strategic Plan Goals

a) 2015-17 Strategic Plan

6.3. Patient Satisfaction Survey

a) Ambulatory Surgery - Sample Survey
b) Emergency Dept IVCH - Sample Survey
c) Emergency Dept TFH - Sample Survey
d) Inpatient - Sample Survey
e) Medical Practice (MSC) - Sample Survey
f) Outpatient - Sample Survey

6.4. Patient & Family Centered Care (PFCC)

6.4.1. Patient Advisory Council Update

6.4.2. Patient Family Story Presentation at Board Meeting

6.5. Lean Training Program

6.6. Board Quality Education

ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

2015 Apr 14 Board Quality_Agenda Page 3

ITEMS 1 - 4 See Agenda

02/10/2015 Board Quality Committee_DRAFT Minutes Page 5

No related materials
QUALITY COMMITTEE
AGENDA
Tuesday, April 14, 2015 at 12:00 p.m.
Eskridge Lobby Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. CALL TO ORDER

2. ROLL CALL
   Greg Jellinek, M.D., Chair; John Mohun, Board Member

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

4. INPUT – AUDIENCE
   This is an opportunity for members of the public to address the Committee on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Committee cannot take action on any item not on the agenda. The Committee may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

5. APPROVAL OF MINUTES OF: 2/10/2015 .............................................................ATTACHMENT

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION
   6.1. Quality Committee Goals 2015 & Charter..........................................................ATTACHMENT
   Committee will review and discuss updated goals and charter.

   **Staff Recommendation:** Committee recommendation to the full board for approval of the Quality Committee Charter and 2015 Goals.

   6.2. TFHS Quality Strategic Plan Goals........................................................................ATTACHMENT
   Committee will review and provide update related to the Tahoe Forest Health System strategic goals related to quality.

   6.3. Patient Satisfaction Survey ..................................................................................ATTACHMENT
   Sample patient satisfaction survey templates will be reviewed and discussed.

   6.4. Patient & Family Centered Care (PFCC)
       6.4.1. Patient & Family Advisory Council Update
               An update will be provided related to the activities of the Patient and Family Advisory Council (PFAC).
6.4.2. **Patient Family Story Presentation at Board Meeting**
A review of the Stanford University Patient Liaison presentation scheduled on April 27, 2015 at the BOD meeting. She will be sharing her personal healthcare story and the importance of a Just Culture philosophy and error disclosure.

6.5. **Lean Training Program**
An update will be provided about the Lean training program in which TFHD staff has been participating and funded through a grant from the National Rural Health Resource Center. A review of plans for future education will also be discussed.

6.6. **Board Quality Education**
The committee will review and discuss topics for future Board quality education.

7. **REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS**

8. **NEXT MEETING DATE**
The date and time of the next committee meeting will be proposed and/or confirmed.

9. **ADJOURN**

*Denotes material (or a portion thereof) may be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions.

Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District’s public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.
QUALITY COMMITTEE
DRAFT MINUTES
Tuesday, February 10, 2015 at 12:00 p.m.
Eskridge Lobby Conference Room, Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA

1. **CALL TO ORDER**
   Meeting called to order at 12:06 p.m.

2. **ROLL CALL**
   Greg Jellinek, M.D., Chair; John Mohun, Board Member

3. **CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA**
   None.

4. **INPUT – AUDIENCE**
   None.

5. **APPROVAL OF MINUTES OF: 10/22/2014**
   Director Mohun requested clarification related to the Meaningful Use reference on page 2 of the minutes. Minutes will be corrected to reflect 2015 as the attestation year rather than 2014.

   **ACTION:** Motion made by Director Mohun, seconded by Director Jellinek, to approve minutes with noted correction. Approved unanimously.

6. **ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION**
   6.1. **Quality Committee Goals 2015 & Charter**
   
   *Topic moved after item 6.5 at the request of Director Mohun.*
   
   Committee reviewed the 2015 Quality Committee goals. The goals identified are the same as those identified for 2014.

   Discussion took place regarding consideration for developing more clearly defined goals.

   Discussion took place regarding the frequency of meetings for the Quality Committee and potential for increasing the number of meetings to six per year. The focus on quality oversight needs to be stronger by the Board.

   Discussion took place regarding the role of the Quality Committee related to oversight of organizational processes. The Interim CEO shared that the committee is charged with advising over clinical quality. It was agreed that the Committee’s goals need to be sharply defined.

   The Interim CEO shared that a mechanism is being developed and will be put in place to capture the findings of the Just Culture assessments completed by the organization.
Director of Quality provided a review of the root cause analysis process.

It was recommended that it would be a good idea to center the Committee’s goals around the QA/PI plan. The addition of improved communication to the priority index was recommended.

Discussion took place related to decreasing costs and work being done by the process improvement team and their engagement of physicians related to reduction in costs in the operating room.

Discussion took place related to the principle of LEAN management and providing education to staff and physicians. Director of Quality indicated that she has submitted an application for a program that provides free LEAN training and will report back if TFH is selected. Dr. Shawni Coll provided a summary of a LEAN project she is currently involved through a USC course in which she is participating.

Director of Quality was directed to rework the committee goals based on feedback provided.

A decision was made to move the committee meetings to every other month; the date for next meeting will be determined.

6.2. **Patient & Family Centered Care (PFCC)**

*Topic moved after item 6.3 to accommodate presenters’ anticipated presentation start time.*

6.2.1. **Patient Advisory Council Update**
Trish Foley and Eileen Knudson provided an update related to the PFCC program. Staff has assisted with recruitment following an education program presented to each department. Patient and/or patient family member have expressed an interest in volunteering in the PFCC. The first person was identified through a recommendation from Dr. Taylor, another from OB and a third through the Cancer Center.

Trish Foley provided background related to the beta program from which this council has been designed. The PFCC, through the eyes of the patient, will help to identify priorities on which to focus to improve the patient experience at TFH.

6.2.2. **Patient Family Story Presentation**
Director of Quality shared that discussions have taken place with different organizations regarding how patient stories are shared. An individual from the Reno area, who now works as a patient advocate at Stanford, has been identified as a speaker. Discussion took place regarding whether this individual should address the full board or Quality Committee only. Consideration will be given to having this speaker present following the PFCC presentation to the full board at the January 24, 2015 meeting. The topic will be included for the agenda review with the Board Chair before confirming.

The referenced presenter participated in the recent Just Culture training and expressed that she was pleased with what TFH is doing with Just Culture.
6.3. **Board Quality Education**  
Director of Quality provided a review of the expectations related to Board education. Areas of education focus include:

6.3.1. **Baldridge Performance Excellence Education**: Interim CEO provided a summary of the Baldridge program and made a recommendation to include education funding in the 2016 fiscal year budget for related future board education in Q1 2016. Discussion took place regarding whether there was intent for TFHD to participate in the Baldridge program. The initial intent is to explore the tenants related to Baldridge without formally participating in the program which may be too burdensome for an organization of our size. Staff directed to move forward with identifying Baldridge education options for future education session.

6.3.2. **Other recommendations**: Discussion took place regarding options for quality education at the 2/12/15 special meeting of the Board. Additional consideration was given to IHA board on board training.

6.4. **Quality Assurance/Performance Improvement Plan**  
Director of Quality provided background related to the presentation of the Quality Assurance/Performance Improvement (QA/PI) plan to the full board. The report would normally be reviewed first by the Quality Committee but timing of meetings resulted in the need to present to the Board in advance of the Committee. The QA/PI was reviewed and approved by the Board of Directors at the January 27, 2015 board meeting.

Discussion took place regarding the different components included in the QA/PI and related board responsibilities outlined in the policy.

Director Mohun presented concerns related to page 1 of 4 of Attachment B pertaining to the reference to CEO responsibility for operations of the hospital; inquiring as to how this is being monitored. Discussion took place related to the compliance oversight/auditing process related to this policy. Request for staff to bring back a review of how items identified in the policy are monitored for compliance.

Discussion took place related to the language pertaining to telemedicine and a need to revisit this along with the language referencing the “COO” as this position has been suspended with the appointment of the *interim* CEO.

Discussion took place related to reporting measures identified in Attachment C. Discussion took place related to CAH hospital participation in core data collection.

6.5. **Service Excellence**  
Director of Quality reported that the Service Excellence report is shared with the full Board on a quarterly basis and is scheduled to come to the full board this month.

Discussion took place related to looking at the regional market either in place of, or in addition to, the markets current included in the data. Not all hospitals use Press Ganey and may not be included in the regional market data; including this data may only be worthwhile if a sufficient number of regional facilities participate. *Interim* CEO shared other options available to review the regional data.
sought. Data can be accessed through CMS, and though the data available is delayed it is still useful for trending purposes.

Discussion took place related to the value of using Press Ganey. *Interim* CEO provided an overview of the tools accessible for management through Press Ganey. IVCH Administrator/CNO provided a review of how Press Ganey was selected for use.

Discussion took place related to Medical Staff’s work in evaluating and responding to the Press Ganey data.

6.5.1. **Patient Satisfaction Survey Benchmarking Comparisons**
Committee reviewed the HCAHP Top Box Results for Q2 and Q3 2014.

7. **REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS**

8. **NEXT MEETING DATE**
The date and time of the next committee meeting will be proposed and/or confirmed by the Director of Quality.

9. **ADJOURN**
Meeting adjourned at 1:48 p.m.
Quality Committee Charter

Tahoe Forest Hospital District is committed to performance excellence, to delivering the highest quality care and service, and to exceeding the expectations of our patients, physicians, employees, and community. This committee will provide leadership, oversight, and accountability for organization wide quality improvement processes and programs. We will regularly assess the needs of our stakeholders, evaluate proposed quality initiatives, openly debate options, and assure the production of an organization wide strategic plan for quality. We will set expectations, facilitate education, and support the monitoring of the quality of care, service excellence, risk reduction, safety enhancement, performance improvement, and healthcare outcomes. Because of our efforts Tahoe Forest Hospital District will be the best place to receive care, the best place to work, the best place to practice medicine, and a recognized asset to all in our community.

Approved January 22, 2014
Board Quality Committee Goals 2015

1. Establish a Patient & Family Advisory Council, including development of council charter, initial participant selection, and suggested topics. Develop a framework for reviewing and addressing input from the council.

2. Advance quality and patient safety metrics based on best practice including review of performance against benchmarks and the organization's participation in various reporting initiatives.

3. Using STEEEP (safe, timely, effective, efficient, equitable and patient-centered) and the Triple Aim as the organization's rubric for approaching quality, review and provide direction on the Quality and Service elements of the Health System strategic plan and the Quality Assurance Performance Improvement Plan.

4. Engage the communities we serve through appropriate sharing and public reporting of quality and service metrics.

5. Review how the Health System reports to the community on quality and service excellence through the website, community report and other media.

6. Review the annual Quality Plan and assure that objectives, action plans and key measures are aligned with Quality and Service Foundations of Excellence and the organizational strategic plan.

7. Assess and recommend quality education programs to advance the performance of the committee and the district board.


9. Assures community needs are met through compliance to regulatory and accreditation standards.
1. **Goal**: Management and Health Staff will develop an annual quality and safety plan to be approved by the Board of Directors.

**Measurement**: Submit a completed annual Quality and Safety Plan for Board of Directors approval.

2. **Goal**: Conduct patient satisfaction surveys, reports, and outcomes and develop action plans in accordance with the state-mandated survey (in order to maintain HCAHPS 90% top box).

**Measurement**: Achieve HCAHPS 90% top box for “patients recommend this hospital” and “patients rate this hospital a 9 or 10.”

3. **Goal**: Achieve Home Health HCAHPS 90% top box for “patients recommend your home health agency” and “patients rate this home health agency a 9 or 10.”

**Measurement**: Under the supervision of the Quality Committee, develop a customer service improvement initiative that will include the creation of a patient advisory council.

**Measurement**: The Quality Committee adopts a customer service improvement initiative and appoints a patient advisory council.

4. **Goal**: Maintain accreditation with HFAP Health Facilities Accreditation Program.

**Measurement**: Maintain deemed accreditation status.

5. **Goal**: The medical staff will develop a quality improvement plan and appoint a patient satisfaction improvement team.

**Measurement**: Medical staff produces patient satisfaction improvement plans and appoints a patient advisory council.

6. **Goal**: Medical staff develops quality and patient satisfaction improvement program, reports outcomes and collaborates with staff on initiating plans for improvement.

**Measurement**: Medical staff produces patient satisfaction improvement plans and maintains its medical leadership to optimize medical staff, community advisory council and foundation meetings.

7. **Goal**: Conduct two-way communication with employees about health system goals, projects and priorities.

**Measurement**: Conduct annual Town Hall employee focus group and annual employee Town Hall Meetings.

8. **Goal**: Implement the next level of Just Culture training for organizational-wide implementation.

**Measurement**: Completed Just Culture Training. The Just Culture training will be ongoing to ensure employees and medical staff are informed of the principles of Just Culture and how it benefits the organization.

9. **Goal**: Regularly communicate system-wide services, priorities, projects and activities to health system community advisory groups and agencies that represent the demographic interests of the community.

**Measurement**: Report out progress on health system programs and initiatives at community advisory council and foundation meetings.

10. **Goal**: Maintain external communication through the available media such as the Tahoe Forest Health System Magazine as a primary communication tool.

**Measurement**: Maintain active communication on behalf of the health system and community development department.

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**QUALITY AND SERVICE LEADER**

1. **Goal**: Establish a formal system of communication and feedback with the medical staff organization and maintain its medical leadership to optimize medical staff, community advisory council and foundation meetings.

**Measurement**: Medical staff approval.

2. **Goal**: Director of Medical Practice will develop and maintain senior management meetings to review progress against specific programs, initiatives and priorities identified in the strategic plan.

**Measurement**: Benchmark operating costs by department and service lines and initiate specific operational improvement initiatives to meet the desired benchmark.

3. **Goal**: Develop a plan with assistance of Jacobus and the Finance Committee to finalize a pricing plan.

**Measurement**: Approval by Board of Directors of an IT EMR strategic plan.

4. **Goal**: Develop and deploy short-term IT EMR plan to optimize use of current CPSI software to meet Meaningful Use stage one and ICD-10.

**Measurement**: Short-term IT EMR plan is developed, communicated and deployed.

5. **Goal**: Develop an accountable care organization (ACO) model of care.

**Measurement**: Approve by Board of Directors to the Truckee Surgery Center Board.

6. **Goal**: Implement the Tahoe Forest PPO and assess opportunities for direct contracting with local employers.

**Measurement**: Management will provide a contracting update as part of the Finance Committee report.

7. **Goal**: Engage the community through the health system’s Foundation and Advisory Councils.

**Measurement**: The Board of Director representative will report periodically the activities of the Foundation and Advisory Councils.

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**ADVANCEMENT THROUGH PARTNERSHIPS**

1. **Goal**: Develop a three-year business development plan to align the strategic priorities and opportunities for the organization.

**Measurement**: Present of the IT EMR strategic plan to the Board of Directors with the assistance of IT EMR strategic plan.

2. **Goal**: Develop a long-range IT EMR strategic plan to the Board of Directors about relevant potential collaboration opportunities.

**Measurement**: Presentation of the IT EMR strategic plan to the Board of Directors.

3. **Goal**: Explore opportunities to expand the GUMITCC Cancer Care Network through informational and educational initiatives.

**Measurement**: Management will periodically report to the Board of Directors the progress of the Cancer Foundation.

4. **Goal**: Explore the health system Facilities Development Plan and expansion plan to account for the needs of primary care medical office expansion.

**Measurement**: Report quarterly on progress to the Board of Directors and COC on Measure C projects.

5. **Goal**: Appoint a collaborative team to stop process improvement teams in clinical service areas where operating efficiency exceeds 75% of the benchmark for our hospital cohort.

**Measurement**: Engage with facility planners to develop medical office space plan for primary care.

6. **Goal**: Evaluate success of prior plan and financing requirements with the Board of Directors.

**Measurement**: Continue to work with the Orthopedic, UC Davis leadership.

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**PROMOTE COMMUNITY HEALTH IMPROVEMENT**

1. **Goal**: Implement the sustainable implementation of the high-value programs and initiatives that achieve the goals identified in the strategic plan.

**Measurement**: Conduct a market study to inform ongoing and potential service line investments.

2. **Goal**: Maintain accreditation with COC on Measure C projects.

**Measurement**: Conduct two-way communication with employees about quality and safety initiatives.

3. **Goal**: Develop two-way communication with employees about health system goals, projects and priorities.

**Measurement**: Implement CPSI version 19 to enable ICD-10 compliance.

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**Tahoe Forest Health System STRATEGIC INITIATIVES**

1. **Goal**: Continue our health system collaboration with UC Davis and explore potential enhancements to that collaboration.

**Measurement**: Management will report periodically to the Board of Directors on continued ongoing plans for joint clinical meetings with UC Davis leadership.

2. **Goal**: Explore partnering opportunities with local health systems to improve efficiency and effectiveness of care delivery.

**Measurement**: Management will periodically report to the Board of Directors about dialogue with local and regional hospital providers on potential collaboration opportunities for enhancing efficiency in operations.

3. **Goal**: Explore potential opportunities to expand the GUMITCC Cancer Care Network through informational and educational initiatives.

**Measurement**: Management will periodically report to the Board of Directors about relevant potential collaboration opportunities.

4. **Goal**: Develop and deploy a strategic plan to optimize use of current CPSI software to meet Meaningful Use stage one and ICD-10.

**Measurement**: Short-term IT EMR plan is developed, communicated and deployed.

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**MEASURABLE GOALS**

1. **Goal**: Continue our health system collaboration with UC Davis and explore potential enhancements to that collaboration.

**Measurement**: Management will provide a contracting update as part of the Finance Committee report.

2. **Goal**: Engage the community through the health system’s Foundation and Advisory Councils.

**Measurement**: The Board of Director representative will report periodically the activities of the Foundation and Advisory Councils.

3. **Goal**: Develop and expand philanthropy and volunteer services congruent with the five-year Foundation Development Plan.

**Measurement**: Report progress against goals quarterly of the Foundation Development Plan.

4. **Goal**: Communicate specific information to the community about TAHOMA or any other information.

**Measurement**: Publish a health system informational communications focusing on health system programs, services and community benefit three times per year.

5. **Goal**: Develop a community benefit report that highlights key accomplishments and areas for improvement, and gap analysis between 2011 and 2014 assessments.

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**Tahoe Forest Health System 3 Year Plan Fiscal 2015/2017**

**11 of 23**

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3 Year Plan FINAL
AMBULATORY SURGERY SURVEY

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed envelope.

THE SERVICE YOU RECEIVED (fill in one circle only - for example ●)
Please select the last outpatient surgery or procedure you received. Rate only that service and visit.

- Ophthalmology (eye)
- Ear, Nose, Throat
- Orthopedics
- Gynecology
- G.I. Procedures
- Dermatology
- Urology
- Dental/Oral
- Cosmetic Surgery
- General Surgery
- Other: (specify)

BACKGROUND QUESTIONS (write in answer or fill in circle as appropriate)

1. Date of procedure:

   [ ] month [ ] day [ ] year

2. Was this your first visit as a patient to our Ambulatory Surgery Center? [ ] Yes [ ] No

3. Patient’s sex [ ] Male [ ] Female

4. Patient’s age [ ] years

INSTRUCTIONS: Please rate the outpatient surgery you received from our facility. Rate only the service you selected above. Fill in the circle that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to you.

A. REGISTRATION

1. If you spoke with the Surgery Center by phone, helpfulness of the person you spoke with: [ ] very poor [ ] poor [ ] fair [ ] good [ ] very good

2. Ease of getting an appointment for surgery when you wanted: [ ] very poor [ ] poor [ ] fair [ ] good [ ] very good

3. Information you received prior to surgery (i.e., time of surgery, how to prepare): [ ] very poor [ ] poor [ ] fair [ ] good [ ] very good

4. Helpfulness of the person at the registration desk: [ ] very poor [ ] poor [ ] fair [ ] good [ ] very good

Comments (describe good or bad experience):

B. FACILITY

1. Comfort of the registration waiting area: [ ] very poor [ ] poor [ ] fair [ ] good [ ] very good

2. Comfort of your room or resting area in the Center: [ ] very poor [ ] poor [ ] fair [ ] good [ ] very good

3. Comfort of the waiting area for your family: [ ] very poor [ ] poor [ ] fair [ ] good [ ] very good

4. Attractiveness of the Surgery Center: [ ] very poor [ ] poor [ ] fair [ ] good [ ] very good

5. Cleanliness of the Surgery Center: [ ] very poor [ ] poor [ ] fair [ ] good [ ] very good

Comments (describe good or bad experience):

continued...
### C. BEFORE YOUR SURGERY OR PROCEDURE

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Comments (describe good or bad experience):

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Comments (describe good or bad experience):

### E. PERSONAL ISSUES

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Comments (describe good or bad experience):

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Comments (describe good or bad experience):

Patient's Name: (optional)

Telephone Number: (optional)
EMERGENCY DEPARTMENT SURVEY

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed envelope.

BACKGROUND QUESTIONS [write in answer or fill in circle (for example ●) as appropriate]

1. Date of visit:
   - [ ] month
   - [ ] day
   - [ ] year

2. Time of day you arrived: (fill in one circle only)
   ○ 7:01 am - 11:00 am
   ○ 11:01 am - 3:00 pm
   ○ 3:01 pm - 7:00 pm
   ○ 7:01 pm - 11:00 pm
   ○ 11:01 pm - 3:00 am
   ○ 3:01 am - 7:00 am

3. Time spent in the Emergency Department:
   - [ ] hours
   - [ ] minutes

4. Patient’s sex ………… ○ Male ○ Female

5. Patient’s age …………………… years

6. Who is filling out this survey?
   ○ Patient ○ Friend
   ○ Parent ○ Other
   ○ Family

INSTRUCTIONS: Please rate the Emergency Department services you received from our facility. Fill in the circle that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to you.

Please use black or blue ink to fill in the circle completely. Example: ●

A. ARRIVAL

1. Waiting time before staff noticed your arrival …………………… ○ ○ ○ ○ ○
2. Helpfulness of the person who first asked you about your condition ………… ○ ○ ○ ○ ○
3. Comfort of the waiting area ……………………………………… ○ ○ ○ ○ ○
4. Waiting time before you were brought to the treatment area …………………… ○ ○ ○ ○ ○
5. Waiting time in the treatment area, before you were seen by a doctor …………………… ○ ○ ○ ○ ○

Comments (describe good or bad experience):

B. NURSES

1. Courtesy of the nurses …………………………………………… ○ ○ ○ ○ ○
2. Degree to which the nurses took the time to listen to you ……………………… ○ ○ ○ ○ ○
3. Nurses’ attention to your needs …………………………… ○ ○ ○ ○ ○
4. Nurses’ concern to keep you informed about your treatment …………………… ○ ○ ○ ○ ○
5. Nurses’ concern for your privacy ………………………………… ○ ○ ○ ○ ○

Comments (describe good or bad experience):

C. DOCTORS

1. Courtesy of the doctor ……………………………………… ○ ○ ○ ○ ○
2. Degree to which the doctor took the time to listen to you …………………… ○ ○ ○ ○ ○
3. Doctor’s concern to keep you informed about your treatment …………………… ○ ○ ○ ○ ○
4. Doctor’s concern for your comfort while treating you ……………………… ○ ○ ○ ○ ○

Comments (describe good or bad experience):

9312959

continued ...

123456789

14 of 26
D. TESTS
(Please answer only those questions that apply to you.)

Lab
1. Courtesy of the person who took your blood........................................... O O O O O
2. Concern shown for your comfort when your blood was drawn................... O O O O O
3. Extent to which nurses checked ID bracelets before giving you medications..... O O O O O

Radiology (X-ray, ultrasound, CAT scan, MRI)
1. Waiting time for radiology test.............................................................. O O O O O
2. Courtesy of the radiology staff............................................................. O O O O O
3. Concern shown for your comfort during your test.................................... O O O O O

Comments (describe good or bad experience):

E. FAMILY OR FRIENDS
(If you came alone, please skip this section.)

1. Courtesy with which family or friends were treated ................................ O O O O O
2. Staff concern to keep family or friends informed about your status during your course of treatment ......................................................... O O O O O
3. Staff concern to let a family member or friend be with you while you were being treated ................................................................. O O O O O

Comments (describe good or bad experience):

F. PERSONAL/INSURANCE INFORMATION

1. Courtesy of the person who took your personal/insurance information.......... O O O O O
2. Privacy you felt when asked about your personal/insurance information......... O O O O O
3. Ease of giving your personal/insurance information................................... O O O O O

Comments (describe good or bad experience):

G. PERSONAL ISSUES

1. How well you were kept informed about delays....................................... O O O O O
2. Degree to which staff cared about you as a person................................ O O O O O
3. How well your pain was controlled......................................................... O O O O O
4. Information you were given about caring for yourself at home (e.g., taking medications, getting follow-up medical care)................................. O O O O O

Comments (describe good or bad experience):

H. OVERALL ASSESSMENT

1. Overall rating of care received during your visit ..................................... O O O O O
2. Likelihood of your recommending our Emergency Department to others........ O O O O O

Comments (describe good or bad experience):

Patient’s Name: (optional)

Telephone Number: (optional)
EMERGENCY DEPARTMENT SURVEY

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed envelope.

BACKGROUND QUESTIONS [write in answer or fill in circle (for example ●) as appropriate]

1. Date of visit:
   - [ ] month
   - [ ] day
   - [ ] year

2. Time of day you arrived. (Fill in one circle only)
   - ○ 7:01 am - 11:00 am
   - ○ 11:01 am - 3:00 pm
   - ○ 3:01 pm - 7:00 pm
   - ○ 7:01 pm - 11:00 pm
   - ○ 11:01 pm - 3:00 am
   - ○ 3:01 am - 7:00 am

3. Time spent in the Emergency Department:
   - [ ] hours
   - [ ] minutes

4. Patient’s sex ............ ○ Male ○ Female

5. Patient’s age .................... years

6. Who is filling out this survey?
   - ○ Patient
   - ○ Friend
   - ○ Parent
   - ○ Other
   - ○ Family

INSTRUCTIONS: Please rate the Emergency Department services you received from our facility. Fill in the circle that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to you.

A. ARRIVAL

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<thead>
<tr>
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<tr>
<td>1. Waiting time before staff noticed your arrival</td>
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<td>○</td>
<td>○</td>
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</tr>
<tr>
<td>2. Helpfulness of the person who first asked you about your condition</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3. Comfort of the waiting area</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>4. Courtesy of the triage exam and interview</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>5. Waiting time before you were registered</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>6. Waiting time before you were brought to the treatment area</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>7. Waiting time in the treatment area, before you were seen by a doctor</td>
<td>○</td>
<td>○</td>
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Comments (describe good or bad experience):


继续...

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CL#6805-ER101-01-11/06

123456789
B. NURSES

1. Courtesy of the nurses ................................................................. 0 0 0 0 0
2. Degree to which the nurses took the time to listen to you .................................................. 0 0 0 0 0
3. Nurses' attention to your needs ................................................................................... 0 0 0 0 0
4. Nurses' concern to keep you informed about your treatment ........................................ 0 0 0 0 0
5. Nurses' concern for your privacy .................................................................................. 0 0 0 0 0
6. How clearly discharge instructions were explained ....................................................... 0 0 0 0 0
7. Technical skill of nurses ............................................................................................... 0 0 0 0 0

Comments (describe good or bad experience): _______________________________________

C. DOCTORS

1. Courtesy of the doctor ................................................................................................. 0 0 0 0 0
2. Degree to which the doctor took the time to listen to you .............................................. 0 0 0 0 0
3. Doctor's concern to keep you informed about your treatment ..................................... 0 0 0 0 0
4. Doctor's concern for your comfort while treating you ................................................... 0 0 0 0 0
5. Adequacy of time doctor spent with you ................................................................. 0 0 0 0 0

Comments (describe good or bad experience): _______________________________________

D. TESTS

(Please answer only those questions that apply to you.)

Lab
1. Courtesy of the person who took your blood .............................................................. 0 0 0 0 0
2. Concern shown for your comfort when your blood was drawn ................................ 0 0 0 0 0

Radiology (X-ray, ultrasound, CAT scan, MRI)
1. Waiting time for radiology test ..................................................................................... 0 0 0 0 0
2. Courtesy of the radiology staff ..................................................................................... 0 0 0 0 0
3. Concern shown for your comfort during your test ....................................................... 0 0 0 0 0

Comments (describe good or bad experience): _______________________________________

E. FAMILY OR FRIENDS

(If you came alone, please skip this section.)

1. Courtesy with which family or friends were treated ...................................................... 0 0 0 0 0
2. Staff concern to keep family or friends informed about your status during your course of treatment .................................................................................... 0 0 0 0 0
3. Staff concern to let a family member or friend be with you while you were being treated .............................................................................................................. 0 0 0 0 0

Comments (describe good or bad experience): _______________________________________

F. PERSONAL/INSURANCE INFORMATION

1. Courtesy of the person who took your personal/insurance information ........................................ 0 0 0 0 0
2. Privacy you felt when asked about your personal/insurance information ............................... 0 0 0 0 0
3. Ease of giving your personal/insurance information ...................................................... 0 0 0 0 0

Comments (describe good or bad experience): _______________________________________

G. PERSONAL ISSUES

1. How well you were kept informed about delays ...................................................................... 0 0 0 0 0
2. Degree to which staff cared about you as a person ............................................................. 0 0 0 0 0
3. How well your pain was controlled ................................................................................. 0 0 0 0 0
4. Information you were given about caring for yourself at home (e.g., taking medications, getting follow-up medical care)........................................................................................................ 0 0 0 0 0

Comments (describe good or bad experience): _______________________________________

H. OVERALL ASSESSMENT

1. Overall rating of care received during your visit ..................................................................... 0 0 0 0 0
2. Likelihood of your recommending our Emergency Department to others ...... 0 0 0 0 0
3. Overall satisfaction with the emergency department ............................................................. 0 0 0 0 0

Comments (describe good or bad experience): _______________________________________

Patient's Name: (optional) _______________________________________________________

Telephone Number: (optional) _____________________________________________________
# SURVEY INSTRUCTIONS

You should only fill out this survey if you were the patient during the hospital stay named in the cover letter. Do not fill out this survey if you were not the patient. Answer all of the questions honestly. Remember, this survey is anonymous, so you do not need to fill it out completely.

Please answer the questions in this survey about your stay at Tahoe Forest Hospital District. Do not include any other hospital stays in your answers.

## YOUR CARE FROM NURSES

1. During this hospital stay, how often did nurses treat you with courtesy and respect?
   - Never
   - Sometimes
   - Usually
   - Always

2. During this hospital stay, how often did nurses explain things in a way you could understand?
   - Never
   - Sometimes
   - Usually
   - Always

3. During this hospital stay, how often did nurses explain things in a way you could understand?
   - Never
   - Sometimes
   - Usually
   - Always

4. During this hospital stay, how often did nurses explain things in a way you could understand?
   - Never
   - Sometimes
   - Usually
   - Always

5. During this hospital stay, how often did nurses explain things in a way you could understand?
   - Never
   - Sometimes
   - Usually
   - Always

## YOUR CARE FROM DOCTORS

6. During this hospital stay, how often did doctors treat you with courtesy and respect?
   - Never
   - Sometimes
   - Usually
   - Always

7. During this hospital stay, how often did doctors explain things in a way you could understand?
   - Never
   - Sometimes
   - Usually
   - Always

8. During this hospital stay, how often did doctors explain things in a way you could understand?
   - Never
   - Sometimes
   - Usually
   - Always

9. During this hospital stay, how often did doctors explain things in a way you could understand?
   - Never
   - Sometimes
   - Usually
   - Always

10. During this hospital stay, how often did doctors explain things in a way you could understand?
    - Never
    - Sometimes
    - Usually
    - Always

11. During this hospital stay, how often did doctors explain things in a way you could understand?
    - Never
    - Sometimes
    - Usually
    - Always

12. During this hospital stay, how often did doctors explain things in a way you could understand?
    - Never
    - Sometimes
    - Usually
    - Always

## THE HOSPITAL ENVIRONMENT

13. During this hospital stay, how often was your room and bathroom kept clean?
    - Never
    - Sometimes
    - Usually
    - Always

14. During this hospital stay, how often was the area around your room kept clean?
    - Never
    - Sometimes
    - Usually
    - Always

15. During this hospital stay, how often was the area around your room kept clean?
    - Never
    - Sometimes
    - Usually
    - Always

16. During this hospital stay, how often was the area around your room kept clean?
    - Never
    - Sometimes
    - Usually
    - Always

17. During this hospital stay, how often was the area around your room kept clean?
    - Never
    - Sometimes
    - Usually
    - Always

## YOUR EXPERIENCES IN THE HOSPITAL

18. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a treadmill?
    - Yes
    - No

19. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a treadmill?
    - Yes
    - No

20. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a treadmill?
    - Yes
    - No

21. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a treadmill?
    - Yes
    - No

22. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a treadmill?
    - Yes
    - No

23. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a treadmill?
    - Yes
    - No

24. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a treadmill?
    - Yes
    - No

25. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a treadmill?
    - Yes
    - No

26. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a treadmill?
    - Yes
    - No

27. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a treadmill?
    - Yes
    - No

## About You

- **Gender:**
- **Patient’s Age:**
- **Patient’s Race/Ethnicity:**
- **Patient’s Language:**
- **Patient’s Income Level:**
- **Education Level:**
- **Employment Status:**
- **Insurance Status:**
- **Relationship to Hospital Staff:**
- **HCAHPS Score:**

---

**THANK YOU.** Please return the completed survey in the postage-paid envelope.
OVERALL RATING OF HOSPITAL
Please answer the following questions about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.

21. Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?
   0 | Very poor hospital possible
   1
   2
   3
   4
   5
   6
   7
   8
   9
   10 | Best hospital possible

22. Would you recommend this hospital to your friends and family?
   Yes
   No

23. During this hospital stay, staff took my precautions and told me about ‘do not resuscitate’ if I had another heart attack.
   Strongly disagree
   Disagree
   Agree
   Strongly agree

24. When I left the hospital, I had a good understanding of things I was responsible for in managing my health.
   Strongly disagree
   Disagree
   Agree
   Strongly agree

25. When I left the hospital, I clearly understood the purpose for taking each of my medications.
   Strongly disagree
   Disagree
   Agree
   Strongly agree

26. I was not given any medication when I left the hospital.
   Yes
   No

ADDITIONAL QUESTIONS ABOUT YOUR STAY
Now that we have asked you to tell us about what happened during your stay, we want to ask you about how well we met your needs.

INSTRUCTIONS: Fill in the circle that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on your experiences.

ROOM
1. Pleasiveness of room decor.
2. Room cleanliness.
3. Courtesy of the person who cleaned your room.
4. Room temperature.
5. Noise level in and around room.

COMMENTS (Please describe your good or bad experience)

MEALS
1. Temperature of the food (cold foods cold, hot foods hot).
2. Quantity of the food.
3. Courtesies of the staff who served your food.

COMMENTS (Please describe your good or bad experience)

NURSES
1. Friendliness/courtesy of the nurses.
2. Promptness in responding to the call button.
3. Nurse’s attitude toward your requests.
4. Amount of attention paid to your special or personal needs.
5. How well the nurses kept you informed.
6. Skill of the nurses.

COMMENTS (Please describe your good or bad experience)

TESTS AND TREATMENTS
1. Timing of tests or treatments.
2. Explanations of what would happen during tests or treatments.
3. Courtesies of the staff who took your blood.
4. Courtesies of the staff who treated you.

COMMENTS (Please describe your good or bad experience)

VISITORS AND FAMILY
1. Accommodations and comfort for visitors.
2. Staff attitude toward your visitors.

COMMENTS (Please describe your good or bad experience)

PHYSICIAN
1. Time physician spent with you.
2. Physician’s concern for your questions and worries.
3. How well physician kept you informed.
5. Skill of physician.

COMMENTS (Please describe your good or bad experience)

DISCHARGE
1. Fears for which you felt ready to be discharged.
2. Speed of discharge process after you were told you could go home.
3. Instructions given about how to care for yourself at home.

COMMENTS (Please describe your good or bad experience)
M EDIC AL  PRACTICE SURVEY

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed envelope.

Please rate your appointment with: Precode 3  On: Precode 4

BACKGROUND QUESTIONS

1. If someone other than the patient is completing this survey, please fill in circle:  O

2. Was this your first visit here?.... O Yes  O No

3. How many minutes did you wait after your scheduled appointment time before you were called to an exam room?........................ minutes

4. How many minutes did you wait in the exam room before you were seen by a doctor, physician assistant (PA), nurse practitioner (NP), or midwife?……………… minutes

INSTRUCTIONS: Please rate the services you received from our practice. Select the response that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to you.

ACCESS

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</tr>
</tbody>
</table>

1. Ease of getting through to the clinic on the phone.................................
2. Convenience of our office hours ................................................................
3. Ease of scheduling your appointment ......................................................
4. Courtesy of staff in the registration area ..............................................
5. Length of time between your call and seeing a care provider..................

Comments (describe good or bad experience):

MOVING THROUGH YOUR VISIT

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<td>2</td>
<td>3</td>
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<td>5</td>
</tr>
</tbody>
</table>

1. Degree to which you were informed about any delays............................
2. Wait time at clinic (from arriving to leaving)......................................
3.Courtesy of front office staff ............................................................

Comments (describe good or bad experience):

NURSE/ASSISTANT

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</tr>
</tbody>
</table>

1. Friendliness/courtesy of the nurse/assistant...........................................
2. Concern the nurse/assistant showed for your problem..........................

Comments (describe good or bad experience):

continued…
**CARE PROVIDER**

DURING YOUR VISIT, YOUR CARE WAS PROVIDED PRIMARILY BY A DOCTOR, PHYSICIAN ASSISTANT (PA), NURSE PRACTITIONER (NP), OR MIDWIFE. PLEASE ANSWER THE FOLLOWING QUESTIONS WITH THAT HEALTH CARE PROVIDER IN MIND.

1. Friendliness/courtesy of the care provider
2. Explanations the care provider gave you about your problem or condition
3. Concern the care provider showed for your questions or worries
4. Care provider's efforts to include you in decisions about your treatment
5. Information the care provider gave you about medications (if any)
6. Instructions the care provider gave you about follow-up care (if any)
7. Degree to which care provider talked with you using words you could understand
8. Amount of time the care provider spent with you
9. Your confidence in this care provider
10. Likelihood of your recommending this care provider to others

Comments (describe good or bad experience):

---

**PERSONAL ISSUES**

1. How well staff protected your safety (wearing gloves, etc.)
2. Our sensitivity to your needs
3. Our concern for your privacy
4. Cleanliness of our practice
5. Waiting time before having testing done
6. Ease of obtaining referrals for specialty care
7. Ease of obtaining test results

Comments (describe good or bad experience):

---

**OVERALL ASSESSMENT**

1. How well the staff worked together to care for you
2. Likelihood of your recommending our practice to others
3. Accuracy of billing statements
4. Promptness with which questions or problems about your bill were resolved (if you had any)
5. Courtesy of insurance/billing personnel
6. Degree to which your mailed bill was clear and understandable

Comments (describe good or bad experience):

Patient's Name: *(optional)*

Telephone Number: *(optional)*
OUTPATIENT SERVICES SURVEY

We thank you in advance for completing this questionnaire. When you have finished, please mail it in the enclosed envelope.

THE SERVICE YOU RECEIVED (fill in one circle only - for example ●)
Please select the last outpatient test or treatment you received. Rate only that service and visit.

- Ultrasound
- Nuclear Scan
- Orthopedics
- Mammography
- X-Ray
- Lab
- CT Scan
- MRI
- Other: ______________ (specify)

BACKGROUND QUESTIONS (write in answer or fill in circle as appropriate)

1. Date of visit:
   month  day  year

2. Patient's first visit to our Outpatient Center............ ○ Yes  ○ No

3. Patient's sex............ ○ Male  ○ Female

4. Patient's age......................... years

5. How many minutes did you wait after your scheduled appointment time before you were called to the test or treatment area?............ minutes

6. How many minutes did you wait in the test or treatment area before your test or treatment began?............ minutes

7. On what day was your most recent visit?
   ○ Monday  ○ Thursday  ○ Saturday
   ○ Tuesday  ○ Friday  ○ Sunday
   ○ Wednesday

8. At what time of day was your most recent visit?
   ○ 6:00 am - 8:00 am  ○ 2:01 pm - 4:00 pm
   ○ 8:01 am - 10:00 am  ○ 4:01 pm - 6:00 pm
   ○ 10:01 am - Noon  ○ 6:01 pm - 8:00 pm
   ○ 12:01 pm - 2:00 pm  ○ 8:01 pm - 10:00 pm

INSTRUCTIONS: Please rate the outpatient service you received from our facility. Rate only the service you selected above. Fill in the circle that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on good or bad things that may have happened to you.

A. REGISTRATION

   1. Helpfulness of the person at the registration desk ........................................................ ○ ○ ○ ○ ○
   2. Ease of the registration process ......................................................................................... ○ ○ ○ ○ ○
   3. Waiting time in registration ............................................................................................... ○ ○ ○ ○ ○

Comments (describe good or bad experience):

______________________________________________________________________________________

continued...
B. FACILITY

1. Comfort of the waiting area ................................................................. ○ ○ ○ ○ ○
2. Ease of finding your way around ......................................................... ○ ○ ○ ○ ○
3. Cleanliness of the facility ................................................................. ○ ○ ○ ○ ○

Comments (describe good or bad experience):


C. YOUR TEST OR TREATMENT

1. Friendliness/courtesy of the staff who provided your test or treatment ................................................................. ○ ○ ○ ○ ○
2. Explanations from the staff about what would happen during your test or treatment ........................................ ○ ○ ○ ○ ○
3. Skill of the staff who provided your test or treatment ................................................................. ○ ○ ○ ○ ○
4. Staff's concern for your comfort ................................................................. ○ ○ ○ ○ ○
5. Staff's concern for your questions and worries ................................................................. ○ ○ ○ ○ ○

Comments (describe good or bad experience):


D. PERSONAL ISSUES

1. Our concern for your privacy ................................................................. ○ ○ ○ ○ ○
2. Our sensitivity to your needs ................................................................. ○ ○ ○ ○ ○
3. Response to concerns/complaints made during your visit ................................................................. ○ ○ ○ ○ ○

Comments (describe good or bad experience):


E. OVERALL ASSESSMENT

1. How well staff worked together to provide care ................................................................. ○ ○ ○ ○ ○
2. Overall rating of care received during your visit ................................................................. ○ ○ ○ ○ ○
3. Likelihood of your recommending our facility to others ................................................................. ○ ○ ○ ○ ○

Comments (describe good or bad experience):


Patient's Name: (optional) ________________________________

Telephone Number: (optional) ________________________________