

NYSNA MEMBER LOBBY PACKET

SAFE STAFFING LOBBY DAY

MAY 20, 2014



NAME: _____ BUS CAPTAIN NAME: _____

BUS#: _____ BUS PICKUP TIME: _____ BUS CAPTAIN PHONE#: _____

IN THIS PACKET

PAGE #

Itinerary for MAY 20.....	2
Safe Staffing Fact Sheet.....	3
Myths & Facts about Safe Staffing.....	5
Responding to Tough Questions about Safe Staffing.....	7
Workplace Violence Fact Sheet.....	9
Sample Mini Agenda For Legislative Meeting.....	10
Legislator Visit Report Form.....	12
CE Eval - Politically Active RN - Legislative Priorities.....	14
CE Eval - Politically Active RN - Impact of Advocacy.....	16

ITINERARY FOR MAY 20

CATCH YOUR BUS & GET TRAINED

- Get breakfast and lobby day orientation.
- Bus departure times vary. Contact your NYSNA rep.
- Register on the bus
- The Politically Active Nurse: PT1 (2.0 CH)

FOR THOSE NOT ON THE BUS, Lobby Day Training (2.0 CH), breakfast and supplies will be in the meeting room 2 from 8:30am-10:00am E Then you'll go to Lobby Visits F from 10:00am-12:00pm.

THOSE NOT TAKING A BUS must go to "Politically Active Nurse Part II" training in meeting room 2 H immediately after lunch.

A NYSNA LEGISLATIVE PRIORITIES DISCUSSION CHECK-IN (9:30AM ON BUSEN ROUTE TO ALBANY)

B BUS DROP-OFF (11:30AM)

C CHECK-IN (11:45AM) MEETING ROOM 2

- Get supplies
- Get T-shirt
- Get bandana
- Get additional CE booklet

D MULTI UNION PROGRAM (12:15PM - 1:30PM)

- Walk to Convention Center.
- Eat lunch.
- Sit at a table for your union
- Meet your team leader.
- Hear from union speakers
- Plan lobby visits

E LOBBY (1:15PM - 3:00PM)

- Go with your group to lobby Assembly person or Senator. Check in through security and then go to either the Legislative Office Building or the Capitol.
- One or more visit per team - Focus on the talking points.

F DEBRIEF (1:15PM - 4:00PM)

FOR THOSE DOING ALL VISITS

- Return to meeting room 2 immediately after visits.
- Those who did morning visits will debrief immediately after lunch.
- Make sure you report and especially note follow-up assignments.
- Snack provided.
- Overview of legislative priorities.
- Learn tips for follow up with legislators.

G BUS (4:00PM - 4:30PM)

- Return to Bus that dropped you off. Roll call.
- Get final training: Politically Active Nurse Part II (1.0 CH)
- Get your CE certificates.
- Next steps - Sign up for biennial conference.
- Sign up for other actions.

*** UP TO 6.5 CONTACT HOURS will be awarded for the day.**



SAFE STAFFING FACT SHEET



New York patients are at risk. Healthcare administrators are forcing nurses to take on 9, 10, or even more patients at once.

There is a solution: legislated safe nurse-to-patient ratios. Safe nurse ratios save lives – and can help save money for our healthcare system. NYSNA supports legislation that will require all acute care facilities to meet minimum nurse-to-patient staffing ratios. The bill would also require all residential healthcare facilities to comply with minimum care hours for registered nurses, licensed practical nurses and certified nurse aides.

1 Safe Staffing Saves Lives

- The number of patients assigned to a nurse has a direct impact on our ability to appropriately assess, monitor, care for and safely discharge our patients.
- Outcomes are better for patients when staffing levels meet those established in California. Research demonstrates lives are saved, quality of care is improved and hospital stays are shorter in other states, when hospitals meet the CA staffing benchmarks (*Health Services Research*, 2010).
- Hospitals which routinely staff with 1:8 nurse-to-patient ratios experience five additional deaths per 1,000 patients than those staffing with 1:4 nurse-to-patient ratios (*Journal of the American Medical Association*, 2002).
- The odds of patient death increases by 7% for each additional patient the nurse must take on at one time (*Journal of the American Medical Association*, 2002).

2 Safe Staffing Reduces Adverse Patient Outcomes in Hospitals and Nursing Homes

- When registered nurse staffing is increased by only 5%, the number of adverse events, including pressure ulcers, catheter-associated urinary tract infections, hospital-acquired injuries, air embolism, blood incompatibilities, vascular catheter-associated infections and mediastinitis following coronary bypass graft, are reduced by 15.8% (*Quality Management in Health Care*, 2010).
- Hospitals with lower nurse staffing levels have higher rates of pneumonia, shock, cardiac arrest, urinary tract infections and upper gastrointestinal bleeds; all leading to longer hospital stays, increased post-surgical 30-day mortality rates and increased rates of failure-to-rescue, i.e. death of a surgical patient following a hospital-acquired complication (*Agency for Healthcare Research and Quality Pub. No. 04-0029*, 2004).
- In nursing homes, safe nurse staffing levels have a positive impact on both facility processes and on resident outcomes, for example, fewer facility deficiencies for poor quality and improved functional status of the residents (*Health Services Research*, 2012).
- There is a correlation between unsafe staffing and high nurse turnover and in nursing homes, research has also shown that as nurse turnover increases, the quality of resident care declines which results in more frequent use of restraints, urinary catheterization, and psychoactive drugs; increased risk of contractures, pressure ulcers and other adverse patient outcomes (*Gerontological Nursing*, 2008).

3 Safe Staffing is a Cost-Effective Way to Improve Patient Care and Can Lead to Savings for Hospitals and our Healthcare System

- In California, hospital income rose dramatically after ratios were implemented, from \$12.5 billion from 1994 to 2003, to more than \$20.6 billion from 2004 to 2010. Not one California hospital closed because of ratio implementation.
- When compared to other 'life-saving' interventions, nurse staffing is a cost-effective way to improve patient care (*Nursing Administration Quarterly*, 2011).
- Safe nurse staffing reduces turnover in hospitals. Inadequate staffing levels are correlated with nursing turnover and poor patient satisfaction. These costs and the negative consequences of poor staffing increase the cost of care (*Nursing Administration Quarterly*, 2011).
- The average cost to replace an RN ranges from approximately \$82,000 (if turnover vacancies are filled by experienced RNs who need fewer hours of training) to \$88,000 (if vacancies are filled by new RNs who need more hours of training) (*The Journal of Nursing Administration*, 2008).
- Nurse understaffing in hospital intensive care units increases the risk of pneumonia and other preventable infections that can add thousands of dollars to the cost of care and may lead to avoidable deaths. Hospital-acquired pressure ulcers alone are estimated to cost \$8.5 billion per year. (*Agency for Healthcare Quality and Research Pub. No. 04-0029*, 2004).
- The Centers for Medicare and Medicaid Services is reducing or eliminating payments for care after adverse events including: hospital-acquired infections, pressure ulcers, falls and avoidable re-admissions. This year, hospitals begin experiencing the effect of Medicare's new Value-Based Purchasing program, with more than 1,400 getting penalized based on quality of care (CMS.gov, 2013).

4 Research Establishes Ratios and Hours of Care

- The hospital nurse-to-patient ratios specified in the Safe Staffing for Quality Care Act are based on peer-reviewed academic research, evidence-based recommendations from scholarly entities and lessons learned from California's experience implementing nurse staffing ratios. The minimum care hours specified for nursing homes are also based on research evidence and the recommendations of the Institute of Medicine's report, *Keeping Patients Safe: Transforming the Work Environment of Nurses* (2004).

Proposed Ratios

These ratios were specified in last year's version of the Safe Staffing for Quality Care Act. We expect the same language to be introduced this year.

All intensive care	1:2
Emergency critical care	1:2
Trauma emergency unit	1:1
Operating room	1:1
Post-anesthesia care	1:2
Labor – stage 1	1:2
Labor – stages 2 & 3	1:1
Antepartum	1:3
Non-critical antepartum	1:4
Newborn nursery	1:3
Intermediate care nursery	1:3
Postpartum couplets	1:3
Postpartum mother-only	1:4
Well-baby nursery	1:6
Pediatrics	1:3
Emergency department	1:3
Step-down & telemetry	1:3
Medical/surgical	1:4
Acute care psychiatric	1:4
Rehabilitation units	1:5

MYTHS & FACTS

ABOUT SAFE STAFFING



There is a crisis in New York patient care - a staffing crisis.

As nurses, we see every day how this crisis hurts our patients. But hospital administrators are trying to stop us from solving the crisis, by campaigning against safe staffing ratios.

That's because hospital administrators are used to having all the power over staffing. Putting safe minimum staffing levels into law will take some of that power out of their hands. Most managers will eventually come to see how safe staffing saves lives, but many are spreading myths now to try to stop us – the nurses of New York State – from taking power into our own hands and protecting our patients with safe staffing ratios.

Here are some of the myths they are spreading. We need to be prepared to counter those myths with the truth – our

MYTH #1: There is no direct link between mandated nurse staffing ratios and improved patient outcomes.

FACT: The number of patients assigned to a nurse has a direct impact on our ability to appropriately assess, monitor, care for, and safely discharge our patients.

- Hospitals which routinely staff with 1:8 nurse-to-patient ratios experience five additional deaths per 1,000 patients than those staffing with 1:4 nurse-to-patient ratios (Journal of the American Medical Association, 2002).
- The odds of patient death increases by 7% for each additional patient the nurse must take on at one time (Journal of the American Medical Association, 2002).
- Outcomes are better for patients when staffing levels meet those established in California. Research demonstrates that lives are saved, quality of care is improved and hospital stays are shorter in other states, when hospitals meet the CA staffing benchmarks (*Health Services Research*, 2010).

MYTH #2: Mandated staffing ratios could force hospitals to close or cut services, which could compromise access to care

FACT: Not one California hospital closed because of ratio implementation.

- In California, hospital income rose dramatically after ratios were implemented, from \$12.5 billion from 1994 to 2003, to more than \$20.6 billion from 2004 to 2010.
- There was no evidence that linked changes in hospital finances to the implementation of Safe Staffing Ratios after the law was enacted in California. In fact, some managers reported that the staffing legislation made it easier to secure funding. (*California Health Care Foundation*)
- When compared to other 'life-saving' interventions, nurse staffing is a cost-effective way to improve patient care (*Nursing Administration Quarterly*, 2011).

MYTH #3: Safe staffing ratios would cost New York's hospitals and nursing homes too much

FACT: Safe Staffing is a cost-effective way to improve patient care and can lead to savings for hospitals and our healthcare system.

- Safe nurse staffing reduces turnover in hospitals. Inadequate staffing levels are correlated with nursing turnover and poor patient satisfaction. These costs and the negative consequences of poor staffing increase the cost of care (*Nursing Administration Quarterly*, 2011).
- Turnover is expensive. The average cost to replace an RN ranges from approximately \$82,000 (if turnover vacancies are filled by experienced RNs who need fewer hours of training) to \$88,000 (if vacancies are filled by new RNs who need more hours of training) (*The Journal of Nursing Administration*, 2008).
- Nurse understaffing in hospital intensive care units increases the risk of pneumonia and other preventable infections that can add thousands of dollars to the cost of care and may lead to avoidable deaths. Hospital-acquired pressure ulcers alone are estimated to cost \$8.5 billion per year. (*Agency for Healthcare Quality and Research Pub. No. 04-0029*, 2004).

MYTH #4: Hospitals need flexibility in staffing - fixed ratios won't meet the needs of patients.

FACT: The ratios set a minimum standard based on research evidence, best practices and the experience in California.

- Ratios will provide a safe minimum level of staffing. Hospitals and nursing homes will still have flexibility in staffing – but they cannot go below the levels that the research demonstrates are safe.
- The bill requires facilities to use an acuity system to determine the care needs of particular patients. They must also take into consideration other activities on the unit such as admissions and discharges, and equipment and administrative needs.
- Based on all of these considerations, the facilities have the flexibility to assign nurses fewer patients than the set ratios if they determine that is appropriate.

MYTH #5: Hospitals will have to lay off other caregivers if safe staffing ratios are implemented.

FACT: Non-nurse staffing levels at hospitals increased after safe staffing ratios were implemented in California.

- The number of total nursing assistive personnel increased by 64% in California hospitals since 2005, after the ratios were implemented. That is a rate 59% higher than the rate of increase of hospital nursing assistive personnel nationally. (*Institute for Health & Socio-Economic Policy*)
- Ancillary staff continue to be vital to the healthcare team after safe RN staffing ratios are implemented. In fact, the bill requires hospitals to maintain appropriate level of all caregiver staff.

RESPONDING TO TOUGH QUESTIONS

ABOUT SAFE STAFFING

The Hospital Association of NYS (HANYS) and the Greater NY Hospital Association (GNYHA) have been spreading myths and lies to legislators about the cost of Safe Staffing. You may get questions from your legislator based on their misinformation.

Here's a proven method to handle tough questions:

1. **Acknowledge** the question as valid;
2. **Answer** the question;
3. **Get back to the core issue of Safe Staffing** – the key to safe patient care.

QUESTION 1: “The Hospitals and nursing homes say that it will cost \$3 Billion to implement these staffing ratios. How can they afford to pay that much money?”

ANSWER: We share your concerns about healthcare funding – and we have fought alongside you to get New York State the \$8 Billion in Medicaid waiver funds.

The \$3 billion cost being claimed by the hospital industry is exaggerated. They have given no data to support this claim. But even if the number were true, it is only 1.8% of the revenue of hospitals and nursing homes – that's a very small cost for quality patient care. They can come up with that cost by cutting excessive management salaries and other non-patient care overhead expenses. (See: http://www.ahd.com/states/hospital_NY.html; http://www.ahcancal.org/research_data/trends_statistics/Documents/ST_rpt_STStats2011_20110906_FINAL_web.pdf) Actually, safe staffing will help hospitals save money – savings that can offset the cost of increased staffing.

Safe Staffing will help hospitals save money from re-admission penalties. About 86% of NYS hospitals evaluated will be penalized in 2014 by Medicare for high re-admission rates. In California, where Safe Staffing ratios are set by law, only 33% of hospitals had a re-admissions penalty, and the average penalty amount is **half** what the NYS average penalty will be. (See: <http://www.kaiserhealthnews.org/stories/2013/november/14/value-based-purchasing-medicare.aspx>)

Hospitals will also save money with reduced turnover of staff RNs and lower costs for lawsuits. When all these savings are factored in, it will cost hospitals less than one percent of their budget to implement staffing ratios.

Get back to the core issue: Hospitals' top priority should always be quality patient care – especially when budgets are tight. Hospital executives might have to take a hard look at their spending on luxury buildings, exorbitant technology and their own executive salaries, in order to ensure safe care for patients. That would be a good thing for New York's health – and the long-term health of our healthcare institutions.

QUESTION 2: “Maybe the big hospitals can afford Safe Staffing. But won’t this bill shut down the struggling community hospital in my district?”

ANSWER:

We share your commitment to stop hospital closings. NYSNA nurses have stood with you and many others to keep hospitals open for care. If we thought Safe Staffing would harm hospitals, we would not support it.

More than two dozen hospitals have closed in New York since 2000, and many more that are in bad shape. Not one of those hospitals closed because of Safe Staffing.

Hospitals don’t close because they have good staffing and good quality patient care. Hospitals close because they don’t get reimbursed enough for the cost of providing care to Medicaid and uninsured populations in their districts.

Unsafe staffing only makes it more likely that hospitals will close. The hospitals with the best staffing are actually the ones doing the best financially.

Struggling hospitals often give millions of dollars to “consultants” who promise to save the facility, then leave it deeper in debt. Investing those same funds in Safe Staffing would improve the hospital’s quality of care and community reputation – and might help avoid deaths and the malpractice lawsuits that really can kill a community hospital.

We want to join with you to reform Medicaid reimbursement and fairly allocate the Medicaid Waiver funds to keep those hospitals open in the short-term. And we hope you will support the NY Health bill to fairly fund hospitals in the long-run.

Get back to the core issue: There is one state where these safe ratios are law: California. Not one hospital close because of the ratio law. In fact, hospital income rose dramatically after ratios were implemented. Before ratios (1997 to 2003) hospital income was \$12.5 billion. After ratios (2004-2010), it jumped to \$20.6 billion. Safe staffing is good for patients and good for healthcare institutions. (See: <http://www.chcf.org/publications/2009/02/assessing-the-impact-of-californias-nurse-staffing-ratios-on-hospitals-and-patient-care>)

WORKPLACE VIOLENCE

FACT SHEET

- Studies show a direct correlation between the level of violence against nurses and understaffing.
- Up to 80% of nurses report being assaulted on duty during the course of their careers. Nurses are three times more likely to be victims of violence than any other professional group.
- In 2006, the Bureau of Labor reported 60% of workplace assaults occurred in health care setting. Among health care workers, nurses and patient care assistants (PCAs) experience the highest rates of violence.
- According to a Dept. of Justice Report, between 1993 and 1999 an average of 1.7 million incidents of workplace violence occurred annually in the United States. 25% of the victims (430,000) were nurses.
- In a 2008 study of 1,377 nurses, nearly 80% of respondents reported having experienced some form of violence within the work setting.
- 53% of assaults in health care settings are perpetrated by patients and 47% by visitors.
- Nurses are subject to repeated assault and violence over the course of their careers. Approximately 25% of respondents reported experiencing physical violence more than 20 times in the past 3 years, and almost 20% reported experiencing verbal abuse more than 200 times during the same period.”
- Workplace violence is costly to employers in the following ways:
 - **Decreased Productivity:** increased turnover, absenteeism
 - **Direct Economic Loss:** property damage, increased security, litigation, workers’ compensation, medical and psychological care
 - **Job dissatisfaction and decreased morale**
- The cost per case for assaults to registered nurses has been estimated at \$31,643 and \$17,585 for licensed practical nurses.
- In a sample of 110 nurses from five institutions, 80% of the nurses were assaulted, 65% had been injured and 26% had been seriously injured. Injuries included fractures, eye injuries and permanent disability.
- Up to 50% of assaults and violent incidents against nurses are never reported.

SAMPLE MINI AGENDA

FOR LEGISLATIVE MEETING

(A 20 MINUTE MEETING)

- 1 Introduce everyone in the room**, name, where you live in the district and your job and that you are members of NYSNA– 5 minutes
- 2 Explain why you are there** – what is the topic and provide background. - 3 minutes
- 3 Have one or two nurses tell a story** to highlight the need for change. – 4 minutes
- 4 Provide an ask to the legislator** – 5 minutes (most of this should be the legislator talking)
- 5 Conclude the meeting** by clarifying what you heard and what everyone’s roles are: “you agreed to support the bill...” or “we have agreed to look up that piece of information you asked about and to provide that to you by next week...” – 3 minutes
- 6 Thank the legislator and depart.** – 1 minute

**LEGISLATOR VISIT
 REPORT FORM
 LOBBY DAY, MAY 20, 2014**

Please tell us about your lobbying experience...

YOUR NAME (PLEASE PRINT LEGIBLY!)		NYSNA MEMBER?	<input type="checkbox"/> YES <input type="checkbox"/> NO
CHAMBER AND NAME OF LEGISLATOR:	<input type="checkbox"/> ASSEMBLY <input type="checkbox"/> SENATE	LEGISLATOR PRESENT?	<input type="checkbox"/> YES <input type="checkbox"/> NO
NAME(S) OF LEG. STAFF:		LEG. STAFF PRESENT?	<input type="checkbox"/> ALSO <input type="checkbox"/> ONLY
OTHERS IN YOUR GROUP:			

I. INDICATE LEGISLATIVE PRIORITIES DISCUSSED (and Legislator's Position)

<input type="checkbox"/> Establish Safe Nurse Staffing	<input type="checkbox"/> Agrees	<input type="checkbox"/> Neutral/Undecided	<input type="checkbox"/> Disagrees
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Agrees	<input type="checkbox"/> Neutral/Undecided	<input type="checkbox"/> Disagrees

II. NOTABLE STATEMENTS BY OFFICIAL/STAFF:

III. RECOMMENDATIONS FOR FOLLOW-UP (Questions Raised or Information Requested of NYSNA):

IV. COMMENTS (Your Additional Observations, Questions, Concerns. Use reverse side if needed):

****PLEASE GIVE TO ONE OF THE POLITICAL & COMMUNITY ORGANIZING STAFF MEMBERS OR YOUR PROGRAM REP****

EMAIL: legislative@nysna.org
 FAX: (518) 782-9532
 MAIL: NYSNA – 11 CORNELL RD – LATHAM, NY 12110-1499

Name: _____ Facility: _____

Title of Workshop: The Politically Active Nurse: Advocating for Nurses Legislative Priorities Date: May 20, 201

Are you a NYSNA member? Yes No Location: Empire State Plaza, Albany, NY

Program Evaluation

Thank you for attending this program. We hope that you found the course interesting and that we met your expectations. Please take a moment to complete this program evaluation form. Your comments will assist us in improving existing programs and in developing future programs.

Please complete the form and return to the instructor.

PROGRAM CONTENT AND ORGANIZATION

SCALE: 1- STRONGLY DISAGREE 2 – DISAGREE 3 – NEUTRAL 4 –AGREE 5 – STRONGLY AGREE

	1	2	3	4	5	Comments
1. The program met the stated objectives.	<input type="checkbox"/>					
2. The program material was presented in a clear and organized manner.	<input type="checkbox"/>					
3. The presenter(s) were well prepared.						
a.	<input type="checkbox"/>					
b.	<input type="checkbox"/>					
c.	<input type="checkbox"/>					
d.	<input type="checkbox"/>					
4. The presenter(s) responded to questions/provided feedback in an informative, appropriate and satisfactory manner.						
a.	<input type="checkbox"/>					
b.	<input type="checkbox"/>					
c.	<input type="checkbox"/>					
d.	<input type="checkbox"/>					
5. The program was paced appropriately.	<input type="checkbox"/>					
6. The teaching strategies were appropriate.	<input type="checkbox"/>					
7. Overall, the program was informative and valuable.	<input type="checkbox"/>					
8. Was this program fair, balanced and free of commercial bias?						<input type="checkbox"/> Yes <input type="checkbox"/> No

Continued on back.

REFLECTING ON THE PROGRAM

SCALE: 1 - STRONGLY DISAGREE 2 – DISAGREE 3 – NEUTRAL 4 –AGREE 5 – STRONGLY AGREE
 Please provide feedback in the comments box.

	1	2	3	4	5	Comments
9. The program facilities were appropriate and satisfactory.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. The program registration was efficient.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. What aspect(s) of the program, if any, would you change in future? Why?						
12. Which element(s) of the program did you find most useful? Why?						
13. What new skill(s) have you learned from the program that you think you will be able to put into practice?						
14. Would you recommend this or a similar program to a colleague?						<input type="checkbox"/> Yes <input type="checkbox"/> No
15. What type of programs would you like to see NYSNA offer in the future?						
16. How would you prefer to participate in continuing education activities?	<input type="checkbox"/> Live and in person <input type="checkbox"/> Webinar <input type="checkbox"/> Online & self-paced <input type="checkbox"/> Booklet					
17. For purposes of being released to attend educational programs, which do you need:	<input type="checkbox"/> Certification of Completion <input type="checkbox"/> Contact Hour/CEU Certificate					
18. Additional comments...						

Thank you for completing the program evaluation. *Please return to the presenter when you are finished.*

Name: _____ Facility: _____

Title of Workshop: The Politically Active Nurse: The Impact of Advocacy at Lobby Day Date: May 20, 2014

Are you a NYSNA member? Yes No Location: Empire State Plaza, Albany, NY

Program Evaluation

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Please complete the form and return to the instructor.

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	1	2	3	4	5	Comments
1. The program met the stated objectives.	<input type="checkbox"/>					
2. The program material was presented in a clear and organized manner.	<input type="checkbox"/>					
3. The presenter(s) were well prepared.						
a.	<input type="checkbox"/>					
b.	<input type="checkbox"/>					
c.	<input type="checkbox"/>					
d.	<input type="checkbox"/>					
4. The presenter(s) responded to questions/provided feedback in an informative, appropriate and satisfactory manner.						
a.	<input type="checkbox"/>					
b.	<input type="checkbox"/>					
c.	<input type="checkbox"/>					
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7. Overall, the program was informative and valuable.	<input type="checkbox"/>					
8. Was this program fair, balanced and free of commercial bias?						<input type="checkbox"/> Yes <input type="checkbox"/> No

Continued on back.

REFLECTING ON THE PROGRAM

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 Please provide feedback in the comments box.

	1	2	3	4	5	Comments
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