STUDY OF MEDICARE HOME HEALTH PRACTICE VARIATIONS

CARE PROVIDER PROFILE

Conducted by: The Center for Health Services and Policy Research

for:

Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation

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Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used only for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or establishment. Responses to the collection of the information are voluntary.

CARE PROVIDER PROFILE OVERVIEW/PROTOCOL (CPP)

PURPOSE: This information is being collected in order to obtain demographic

data on Care Providers participating in the data collection of the OASIS and Care Provider Questionnaire. This information will be used for descriptive purposes and for various analyses

involving Care Provider characteristics.

HOW COLLECTED: This questionnaire will be completed by each Care Provider

participating in the study.

WHEN COLLECTED: The CPP should be completed <u>only once</u> by <u>each</u> Care Provider

participating in the study. This should be done by the Care Provider at the onset of the study prior to completion of any other study questionnaires. As new Care Providers join the study, after the study has begun, they will need to complete the CPP

prior to completion of any other study questionnaires.

INSTRUCTIONS: The Care Provider completes the CPP her/himself, and answers

are to be recorded directly on the instrument. The Care Provider should mark the correct response as appropriate or print numbers/answers where requested. All questions should be answered unless specifically directed to skip questions based on

a previous answer.

Study of Medicare Home Health Practice Variations

CARE PROVIDER PROFILE

Care	Provider Name:
Last	First
Agen	ncy Name:
Agen	rcy ID: Today's Date: month day year
1.	Discipline: What is your discipline? ☐ 1 - RN ☐ 4 - SLP/ST ☐ 2 - LPN ☐ 5 - OT
	□ 3 - PT □ 6 - MSW
2.	Years of Home Health Experience: How many years have you been providing home health care? Please mark one answer.
	 □ 1 - Less than 2 years □ 2 - 2 to 5 years □ 3 - 6 to 10 years □ 4 - More than 10 years
3.	Specific Areas of Expertise: Do you have <u>specific</u> areas of expertise in any of the following? Mark all that apply. (NOTE : Areas of expertise can mean specific certifications, e.g., enterostomal therapist, or simply a strong interest and experience with any of the categories listed below.)
	□ 1 - Cardiovascular □ 9 - Psychiatric □ 2 - Diabetes □ 10 - Rehabilitation □ 3 - Infectious Diseases □ 11 - Respiratory □ 4 - IV Therapy □ 12 - Speech □ 5 - Medical/Surgical □ 13 - Strength/Endurance Training □ 6 - Neurology □ 14 - Wound Management □ 7 - Nutrition/Diet □ 15 - Other: (specify) □ 8 - Orthopedic □ 16 - None of the above
4.	Level of Education: What is your <u>highest</u> level of education?
	□ 1 - LPN/LVN Education □ 4 - Bachelor's degree □ 2 - Diploma □ 5 - Master's degree □ 3 - Associate's degree □ 6 - Other: (specify)
5.	Part-Time/Full-Time Status: Are you a part-time or full-time employee?
	□ 1 - Part time □ 2 - Full time
6.	Contract Status: Do you work for this agency as a contractor?
	□ 0 - No □ 1 - Yes
7.	Productivity Standards: Does your agency have productivity standards for you (for example, you are required to make five visits a day)?
	□ 0 - No [If No, you may skip Question 8.]□ 1 - Yes
8.	On average, how many visits are you required to make each day (do not specify a range, please provide one number)?
	visits per day