STUDY OF MEDICARE HOME HEALTH PRACTICE VARIATIONS

CARE PROVIDER QUESTIONNAIRE (CPQ)
Start of Care/Readmission to Agency/Resumption of Care

Conducted by:
The Center for Health Services and Policy Research

for:

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

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Use this CPQ for:
(DCC: Please mark one of the following:)

☐ **Start of Care** (new admission to the agency - complete this CPQ based on the comprehensive assessment).

OR

☐ **Readmission to Agency within 14 days of an agency discharge** (study patient was discharged by the agency and is being readmitted to home health care within 14 days of discharge - complete this CPQ based on the new readmission comprehensive assessment).

Note: Patient MUST be readmitted to the study and tracked. He/she continues with the original file key number.

OR

☐ **Resumption of Care** (study patient was admitted to inpatient facility but **NOT** discharged from the agency and is now resuming care, also with the original file key number - complete this CPQ based on the first visit upon resumption of care).

CARE PROVIDER QUESTIONNAIRE (CPQ)
Start of Care/Readmission to Agency/Resumption of Care

OVERVIEW/PROTOCOL

PURPOSE: This information is collected to obtain data on patient characteristics, informal assistance received, the physician, agency, and Care Provider. This information will be used for descriptive purposes and for various analyses involving these factors.

HOW COLLECTED: This questionnaire is completed by the Care Provider providing direct care to the study patient.

WHEN COLLECTED: The CPQ should be completed at admission to the agency for each study patient. Completion of the instrument should occur within 24 hours of the comprehensive assessment.

This form also needs to be completed if a patient is readmitted to home care within 14 days of being discharged. In that case, the form should be based on the patient's new start of care visit and should be completed by the Care Provider within 24 hours of the new comprehensive assessment.

This form will also be completed when a patient resumes home care following an inpatient facility stay of more than 24 hours (where the patient was not discharged from the agency). The form should be based on the patient's first home care visit after the inpatient facility stay and should be completed by the Care Provider within 24 hours of that visit.

INSTRUCTIONS: The Care Provider completes the CPQ her/himself, recording answers directly on the questionnaire. 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. Please mark the correct response as follows:

■ Acceptable

☑ ☒ ⓞ Not Acceptable

Study of Medicare Home Health Practice Variations

CARE PROVIDER QUESTIONNAIRE (CPQ)
Start of Care/Readmission to Agency/Resumption of Care

File Key: **(C010)** Agency ID | **(C020)** Patient ID

Patient Name: (C040) Last | **(C045)** First

Patient State of Residence: (C050)

Agency Name: (C060)

Questionnaire Completed By: (C070) Last | **(C075)** First

Start Of Care Date: (C030) Month / day / year

Date CPQ Completed: (C090) Month / day / year

Responses to this questionnaire are based on a home visit conducted on: (C080) Month / day / year

1. **(C098)** This assessment is currently being completed for the following reason:

   Note to Care Provider: Mark the same response that is marked on the cover page.

   - ❑ 1 - Start of Care
   - ❑ 2 - Readmission to agency within 14 days of agency discharge
   - ❑ 3 - Resumption of care following inpatient admission (no agency discharge)

Now that you have completed the visit, we have some questions about this patient. ***Please mark only one answer per item unless "Mark all that apply" appears next to the question.***

Patient Information

2. **(C100) Medicaid Enrollment:** Is this patient currently enrolled in a Medicaid program (e.g., traditional fee-for-service, HMO/managed care, waiver program)?

   - ❑ 0 - No
   - ❑ 1 - Yes

3. **(C110) Private Insurance:** Does this patient currently have supplemental insurance (e.g., private third-party insurance, private third-party HMO/managed care, or Medigap)?

   - ❑ 0 - No
   - ❑ 1 - Yes

4. **(C120) Complex Management:** Does this patient require complex management (e.g., procedures at least two times daily; patient teaching/education needs requiring more than 15 minutes per visit or need to repeat instructions at almost every visit; coordination of services between multiple internal and/or external participants)?

   ❑ 0 - No
   ❑ 1 - Yes

5. **(C130) Functional Assistance Needs:** Compared to your average Medicare patient, does this patient require greater assistance with activities of daily living (e.g., requires assistance with transferring, bathing, feeding/eating)?

   ❑ 0 - No
   ❑ 1 - Yes

6. **(C140) Willingness and Need for Aide Services:** Is this patient in need of and willing to have a home health aide?

   ❑ 1 - Patient <u>needs</u> aide and is <u>willing</u> to receive aide services
   ❑ 2 - Patient <u>needs</u> aide but is <u>not</u> willing to receive aide services
   ❑ 3 - Patient does <u>not need</u> aide services

7. **(C150) Care Plan Involvement:** To what extent was the patient involved in developing the initial care plan?

   ❑ 1 - Very/somewhat involved (e.g., showed interest by asking questions, offering suggestions, stating needs)
   ❑ 2 - Minimally involved (e.g., showed little or no interest, left it up to you and the physician or you and the primary caregiver)
   ❑ 8 - Not applicable (patient is comatose or cognitively incapable of involvement)

8. **(C160) Ability to Learn:** The <u>patient's ability</u> to learn is:

   ❑ 1 - Excellent; able to quickly demonstrate or verbalize what you teach after hearing it explained once
   ❑ 2 - Good; able to demonstrate or verbalize what you teach after hearing it explained two to three times
   ❑ 3 - Fair; able to demonstrate or verbalize what you teach after hearing it explained four or more times
   ❑ 4 - Poor; unable to follow directions and/or remember information

9. **(C170) Knowledge of the Medicare Home Health Benefit**: Does the patient demonstrate or verbalize understanding of the home health benefit (including services available to the patient and patient eligibility requirements such as being homebound)?

   ❑ 0 - No
   ❑ 1 - Yes
   ❑ 9 - Unknown

10. **(C190) Nutrition:** Which response best describes the patient's usual food intake pattern?

    ❑ 1 - **Excellent** - Eats most of every meal. Never refuses a meal. Usually eats a total of four or more servings of meat and dairy products per day. Occasionally eats between meals. Does not require supplementation.
    ❑ 2 - **Adequate** - Eats over half of most meals. Eats a total of four servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered, OR is on a tube feeding or TPN regimen that probably meets most of nutritional needs.
    ❑ 3 - **Probably Inadequate** - Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only three servings of meat or dairy products per day. Occasionally will take a dietary supplement, OR receives less than optimum amount of liquid diet or tube feeding.
    ❑ 4 - **Very poor** - Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats two servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement, OR is NPO and/or maintained on clear liquids or IVs for more than five days.

11. **(C200) Alternative Services Patient is Currently Receiving:** Which of the following alternative services, outside your agency, is the patient currently receiving? **Mark all that apply.**

- ❑ a. Meals on Wheels
- ❑ b. Food bank/meal services (other than Meals on Wheels)
- ❑ c. Outpatient rehab
- ❑ d. Transportation assistance
- ❑ e. Assisted living facility
- ❑ f. Foster care services
- ❑ g. Respite services
- ❑ h. Homemaker services
- ❑ i. Personal care services
- ❑ j. Friendly visitor/companion services
- ❑ k. Adult day care
- ❑ l. Mental health services
- ❑ m. Legal/protective services
- ❑ n. Emergency response services
- ❑ o. Case management (such as placement or referral services)
- ❑ p. Environmental/home modifications
- ❑ q. Volunteer services
- ❑ r. Other: (specify) _____
- ❑ s. Other: (specify) _____
- ❑ t. **NONE OF THE ABOVE**
- ❑ u. Unknown

12. **(C210) Alternative Services Being Coordinated:** Which of the following alternative services, outside your agency, have you tried to coordinate for this patient (e.g., you discussed with the patient the possibility of getting alternative services, you spoke with someone at your agency to get information, you contacted an outside agency to arrange services)? **Mark all that apply.**

- ❑ a. Meals on Wheels
- ❑ b. Food bank/meal services (other than Meals on Wheels)
- ❑ c. Outpatient rehab
- ❑ d. Transportation assistance
- ❑ e. Assisted living facility
- ❑ f. Foster care services
- ❑ g. Respite services
- ❑ h. Homemaker services
- ❑ i. Personal care services
- ❑ j. Friendly visitor/companion services
- ❑ k. Adult day care
- ❑ l. Mental health services
- ❑ m. Legal/protective services
- ❑ n. Emergency response services
- ❑ o. Case management (such as placement or referral services)
- ❑ p. Environmental/home modifications
- ❑ q. Volunteer services
- ❑ r. Other: (specify) _____
- ❑ s. Other: (specify) _____
- ❑ t. **NONE OF THE ABOVE**
- ❑ u. Unknown

Homebound Status

It is not required that all of the following be true in order for a patient to be eligible for home care. We are interested in knowing which are true for this patient.

13. **(C300) Absences from Home:** Absences from the home are: **Mark all that apply.**

- ❑ 1 - Infrequent
- ❑ 2 - For periods of relatively short duration
- ❑ 3 - Attributable to the need to receive medical treatment

14. **(C310) Requirements to Leave Home:** In order to leave her/his place of residence, the patient requires: **Mark all that apply.**

- ❑ 1 - Aid of supportive devices
- ❑ 2 - Use of special transportation
- ❑ 3 - Assistance of another person
- ❑ 4 - None of the above

15. **(C320) Medical Contraindication:** Is leaving the home medically contraindicated for this patient (e.g., patient has unstable symptoms or is bedbound, ventilator dependent, immunosuppressed)?

- ❑ 0 - No
- ❑ 1 - Yes

16. **(C330) Difficulty Receiving Services:** How difficult is it for the patient to receive services outside of the home?

- ❑ 1 - Very difficult (e.g., leaving the home requires a considerable and taxing effort)
- ❑ 2 - Somewhat difficult (e.g., leaving the home requires some effort)
- ❑ 3 - Not at all difficult (e.g., leaving the home presents no difficulty)

Managed Care

17. (**C400) Managed Care:** Is this a managed care patient (e.g., Medicare HMO)?

- ❑ 0 - No **[If No, go to Question 22]**
- ❑ 1 - Yes

18. **(C410) Authorization of Skilled Nurse Visits:** Did the managed care company authorize the number of SN visits requested?

- ❑ 0 - No, they authorized fewer visits than requested
- ❑ 1 - Yes, they authorized the number of visits requested
- ❑ 2 - No, they authorized more visits than requested
- ❑ 6 - Not applicable (agency uses a pre-approved standard formula to determine the number of visits [e.g., Milliman – Robertson])
- ❑ 8 - Not applicable (patient will not receive SN services)

19. **(C420) Number of Skilled Nurse Visits Requested:** Were fewer skilled nurse visits allowed than what would have been if this had been a non-managed care patient?

- ❑ 0 - No
- ❑ 1 - Yes
- ❑ 8 - Not applicable (patient will not receive SN services)

20. **(C430) Authorization of Aide Services:** Did the managed care company authorize the assignment of a home health aide?

- ❑ 0 - No, request was denied **[If No, go to Question 22]**
- ❑ 1 - Yes, request was approved
- ❑ 8 - Not applicable (aide services were not requested for this patient) **[If NA, go to Question 22]**

21. **(C440) Authorization of Home Health Aide Frequency:** Did the managed care company authorize the number of home health aide visits requested?

- ❑ 0 - No, they authorized fewer visits than requested
- ❑ 1 - Yes, they authorized the number of visits requested
- ❑ 2 - No, they authorized more visits than requested

Family/Support System Information

22. **(C500) Family/Support System:** Does this patient have a family/support system other than the home health agency (e.g., spouse, child, other family member, friend or neighbor, paid help)?

- ❑ 0 - No **[If No, go to Question 40, "Unmet Needs"]**
- ❑ 1 - Yes
- ❑ 9 - Unknown **[If Unknown, go to Question 40, "Unmet Needs"]**

Family/Support System ADL Assistance

23. **(C510) ADL Assistance Received**: Does the patient receive ADL assistance (e.g., bathing, dressing, toileting, bowel/bladder, eating/feeding) from the family/support system?

- ❑ 0 - No **[If No, go to Question 26]**
- ❑ 1 - Yes
- ❑ 9 - Unknown **[If Unknown, go to Question 26]**

24. **(C511) ADL Assistance:** Which of the following person(s) assist the patient with ADLs (e.g., bathing, dressing, bowel/bladder, transferring, eating/feeding)? **Mark all that apply.**

- ❑ 1 - Spouse or significant other
- ❑ 2 - Daughter or son
- ❑ 3 - Other family member
- ❑ 4 - Friend, neighbor, or community/church member
- ❑ 5 - Paid help (other than the home health agency)
- ❑ 9 - Unknown

25. **(C512) ADL Assistance Frequency:** Taking into account all the people who assist, how often is the patient receiving ADL assistance per week? (Determine cumulative frequency. For example, if the daughter helps 2x week and the son helps 1x week, choose option 4 "Three or more times per week.")

- ❑ 1 - Several times during day and night
- ❑ 2 - Several times during day
- ❑ 3 - Once daily
- ❑ 4 - Three or more times per week
- ❑ 5 - One to two times per week
- ❑ 6 - Less often than weekly
- ❑ 9 - Unknown

Family/Support System IADL Assistance

26. **(C520) IADL Assistance Received:** Does the patient receive IADL assistance (e.g., medications, meals, housekeeping, laundry, telephone, shopping, finances) from the family/support system?

- ❑ 0 - No **[If No, go to Question 29]**
- ❑ 1 - Yes
- ❑ 9 - Unknown **[If Unknown, go to Question 29]**

27. **(C521) IADL Assistance:** Which of the following person(s) assist the patient with IADLs (e.g., medications, meals, housekeeping, laundry, telephone, shopping, finances)? **Mark all that apply.**

- ❑ 1 - Spouse or significant other
- ❑ 2 - Daughter or son
- ❑ 3 - Other family member
- ❑ 4 - Friend, neighbor, or community/church member
- ❑ 5 - Paid help (other than the home health agency)
- ❑ 9 - Unknown

28. **(C522) IADL Assistance Frequency:** Taking into account all the people who assist, how often is the patient receiving IADL assistance per week? (Determine cumulative frequency. For example, if the daughter helps 2x week and the son helps 1x week, choose option 4 "Three or more times per week.")

- ❑ 1 - Several times during day and night
- ❑ 2 - Several times during day
- ❑ 3 - Once daily
- ❑ 4 - Three or more times per week
- ❑ 5 - One to two times per week
- ❑ 6 - Less often than weekly
- ❑ 9 - Unknown

Family/Support System Specialized Care Assistance

29. **(C530) Specialized Care for Wounds and/or Equipment:** Does the patient receive specialized care for wounds and/or equipment from the family/support system?

- ❑ 0 - No **[If No, go to Question 32]**
- ❑ 1 - Yes
- ❑ 9 - Unknown **[If Unknown, go to Question 32]**

30. **(C531) Specialized Care Assistance:** Which of the following person(s) assist the patient with specialized care for wounds and/or equipment? **Mark all that apply.**

- ❑ 1 - Spouse or significant other
- ❑ 2 - Daughter or son
- ❑ 3 - Other family member
- ❑ 4 - Friend, neighbor, or community/church member
- ❑ 5 - Paid help (other than the home health agency)
- ❑ 9 - Unknown

31. **(C532) Specialized Care Assistance Frequency:** Taking into account all the people who assist, how often is the patient receiving specialized care for wounds and/or equipment per week? (Determine cumulative frequency. For example, if the daughter helps 2x week and the son helps 1x week, choose option 4 "Three or more times per week.")

- ❑ 1 - Several times during day and night
- ❑ 2 - Several times during day
- ❑ 3 - Once daily
- ❑ 4 - Three or more times per week
- ❑ 5 - One to two times per week
- ❑ 6 - Less often than weekly
- ❑ 9 - Unknown

Family/Support System Psychosocial Support

32. **(C540) Psychosocial Support**: Does the patient receive psychosocial support (socialization, companionship, recreation) from the family/support system?

- ❑ 0 - No **[If No, go to Question 35]**
- ❑ 1 - Yes
- ❑ 9 - Unknown **[If Unknown, go to Question 35]**

33. **(C541) Psychosocial Support Assistance:** Which of the following person(s) assist the patient with psychosocial support (socialization, companionship, recreation)? **Mark all that apply.**

- ❑ 1 - Spouse or significant other
- ❑ 2 - Daughter or son
- ❑ 3 - Other family member
- ❑ 4 - Friend, neighbor, or community/church member
- ❑ 5 - Paid help (other than the home health agency)
- ❑ 9 - Unknown

34. **(C542) Psychosocial Support Assistance Frequency:** Taking into account all the people who assist, how often is the patient receiving psychosocial support per week? (Determine cumulative frequency. For example, if the daughter helps 2x week and the son helps 1x week, choose option 4 "Three or more times per week.")

- ❑ 1 - Several times during day and night
- ❑ 2 - Several times during day
- ❑ 3 - Once daily
- ❑ 4 - Three or more times per week
- ❑ 5 - One to two times per week
- ❑ 6 - Less often than weekly
- ❑ 9 - Unknown

Family/Support System Advocacy for Medical Care

35. **(C550) Advocacy for Medical Care**: Is there someone in the family/support system who advocates or facilitates the patient's participation in appropriate medical care (e.g., someone who makes sure patient goes to scheduled appointments, someone who advocates or facilitates medical care when needed)?

- ❑ 0 - No **[If No, go to Question 37]**
- ❑ 1 - Yes
- ❑ 9 - Unknown **[If Unknown, go to Question 37]**

36. **(C551) Advocacy Assistance:** Which of the following person(s) advocates or facilitates the patient's participation in appropriate medical care? **Mark all that apply.**

- ❑ 1 - Spouse or significant other
- ❑ 2 - Daughter or son
- ❑ 3 - Other family member
- ❑ 4 - Friend, neighbor, or community/church member
- ❑ 5 - Paid help (other than the home health agency)
- ❑ 9 - Unknown

Family/Support System Transportation Assistance

37. **(C560) Providing Transportation**: Is there someone in the family/support system who provides needed transportation (e.g., to and from the doctor's office or other medical care)?

- ❑ 0 - No **[If No, go to Question 40]**
- ❑ 1 - Yes
- ❑ 9 - Unknown **[If Unknown, go to Question 40]**

38. **(C561) Transportation Assistance:** Which of the following person(s) provide the patient with needed transportation? **Mark all that apply.**

- ❑ 1 - Spouse or significant other
- ❑ 2 - Daughter or son
- ❑ 3 - Other family member
- ❑ 4 - Friend, neighbor, or community/church member
- ❑ 5 - Paid help (other than the home health agency)
- ❑ 9 - Unknown

39. **(C562) Transportation Assistance Frequency:** Taking into account all the people who assist, how often is the patient receiving transportation per week? (Determine cumulative frequency. For example, if the daughter helps 2x week and the son helps 1x week, choose option 4 "Three or more times per week.")

- ❑ 1 - Several times during day and night
- ❑ 2 - Several times during day
- ❑ 3 - Once daily
- ❑ 4 - Three or more times per week
- ❑ 5 - One to two times per week
- ❑ 6 - Less often than weekly
- ❑ 9 - Unknown

Unmet Needs

40. **(C570) Unmet Needs:** Considering all sources from which the patient currently receives assistance (e.g., family/support system, home care agency), for which of the following services does this patient require additional help? **Mark all that apply.**

- ❑ 1 - ADL assistance
- ❑ 2 - IADL assistance
- ❑ 3 - Specialized care for wounds and/or equipment
- ❑ 4 - Psychosocial support
- ❑ 5 - Advocacy for medical care
- ❑ 6 - Transportation
- ❑ 7 - None of the above

Primary Caregiver

41. **(C600) Primary Caregiver:** Who in the family/support system takes the lead responsibility for providing or managing the patient's care, providing the most frequent assistance, etc. (other than home care agency staff)?

- ❑ 8 - Not applicable, patient does not have any caregivers **[If NA, go to Question 46]**
- ❑ 0 - No one person **[If No one person, go to Question 46]**
- ❑ 1 - Spouse or significant other
- ❑ 2 - Daughter or son
- ❑ 3 - Other family member
- ❑ 4 - Friend, neighbor, or community/church member
- ❑ 5 - Paid help
- ❑ 9 - Unknown **[If Unknown, go to Question 46]**

42. **(C610) Primary Caregiver's Care Plan Involvement:** To what extent was the primary caregiver involved in developing the initial care plan?

- ❑ 1 - Very/somewhat involved (e.g., showed interest by asking questions, offering suggestions, stating needs)
- ❑ 2 - Minimally involved (e.g., showed little or no interest, left it up to you and the physician or you and the patient)
- ❑ 8 - Not applicable (primary caregiver is cognitively incapable of involvement)

43. **(C620) Primary Caregiver's Willingness and Patient's Need for Aide Services:** Is the primary caregiver willing to have a home health aide for the patient?

- ❑ 1 - Primary caregiver is willing to have aide for the patient and the patient needs aide services
- ❑ 2 - Primary caregiver is unwilling to have aide for the patient though the patient needs aide services
- ❑ 3 - Patient does not need aide services
- ❑ 8 - Not applicable (primary caregiver is cognitively incapable of communicating willingness)

44. **(C630) Primary Caregiver's Ability to Learn:** The primary caregiver's ability to learn is:

- ❑ 1 - Excellent; able to quickly demonstrate or verbalize what you teach after hearing it explained once
- ❑ 2 - Good; able to demonstrate or verbalize what you teach after hearing it explained two to three times
- ❑ 3 - Fair; able to demonstrate or verbalize what you teach after hearing it explained four or more times
- ❑ 4 - Poor; unable to follow directions and/or remember information
- ❑ 9 - Unknown

45. **(C640) Primary Caregiver's Knowledge of the Medicare Home Health Benefit**: Does the primary caregiver demonstrate or verbalize understanding of the home health benefit (including services available to the patient and patient eligibility requirements such as being homebound)?

- ❑ 0 - No
- ❑ 1 - Yes
- ❑ 9 - Unknown

Care Provision Features

46. **(C800) Skilled Services Provided:** Please mark the skilled services you provided during this visit. **Mark all that apply.**

- ❑ 1 - Skilled observation and assessment (e.g., listened to breath sounds, took blood pressure, checked pulses)
- ❑ 2 - Procedures (e.g., dressing changes, chest physiotherapy, strengthening exercises, administration of medications)
- ❑ 3 - Teaching (e.g., dietary instructions, safety precautions, signs and symptoms of complications)
- ❑ 4 - Coordination of care (e.g., spoke with supervisor, spoke with physician, arranged for delivery of supplies)
- ❑ 5 - Care planning (e.g., decided on frequency of visits, disciplines to involve)
- ❑ 6 - Management and evaluation of care plan (e.g., developed and assessed a plan of care for unskilled services)
- ❑ 7 - Other: (specify) _____

47. **(C840) Standardized Care Plan:** Did you follow a standardized care plan for this visit (e.g., clinical pathway)?

- ❑ 0 - No
- ❑ 1 - Yes

48. **(C850) Travel Time:** How long did it take you to get to the patient's home?

- ❑ 1 - 10 minutes or less
- ❑ 2 - 11-20 minutes
- ❑ 3 - 21-30 minutes
- ❑ 4 - 31-40 minutes
- ❑ 5 - 41-50 minutes
- ❑ 6 - 51-60 minutes
- ❑ 7 - Over one hour

49. **(C730) Care Plan Role:** How much of a role has the physician played in developing the care plan?

- ❑ 1 - A major role (physician is actively involved in making suggestions about the care that should be provided)
- ❑ 2 - A moderate role (physician functions primarily by responding to suggestions made by home care staff as to the care that should be provided)
- ❑ 3 - A minor role (aside from signing the HCFA-485 and other orders, there is no involvement in care planning)

DATA ITEMS COLLECTED AT START OF CARE OR READMISSION ONLY

Please complete items 50-59 if this is a start of care visit or the patient has been readmitted to your agency within 14 days of agency discharge. DO NOT complete this section if the patient is resuming care with your agency following an inpatient stay (and was not discharged from your agency).

Physician Information

When answering questions 50-52, please consider the patient's physician. Do not consider a discharge planner or other individual.

50. **(C700) Frequency of SN Visits:** Prior to the start of care visit, was a suggested frequency of SN visits specified by the patient's physician?

- ❑ 0 - No
- ❑ 1 - Yes
- ❑ 8 - Not applicable (SN not ordered)

51. **(C710) Evaluation of Need for Aide Services:** Prior to the start of care visit, did the physician request an evaluation of need for home health aide services?

- ❑ 0 - No
- ❑ 1 - Yes

52. **(C720) Home Health Aide Services:** Prior to the start of care visit, were aide services ordered by the patient's physician?

- ❑ 0 - No
- ❑ 1 - Yes

Agency Information

53. **(C900) Feedback from Other Agency Personnel About Frequency of SN Visits:** Between the time the referral for home health care came in and the completion of the comprehensive assessment, did you receive feedback from other agency personnel (e.g., case manager, supervisor, other discipline) about the frequency of SN visits needed for this patient?

- ❑ 0 - No
- ❑ 1 - Yes
- ❑ 8 - Not applicable (this patient will not receive SN visits)

54. **(C910) Feedback from Other Agency Personnel About Home Health Aide Services:** Between the time the referral for home health care came in and the completion of the comprehensive assessment, did you receive feedback from other agency personnel (e.g., case manager, supervisor, other discipline) about whether or not an aide should be assigned to this patient?

- ❑ 0 - No
- ❑ 1 - Yes

55. **(C920) Home Health Aide Availability:** Regardless of whether or not this patient will receive home health aide services, is there an aide available to assign to this patient?

- ❑ 0 - No
- ❑ 1 - Yes

56. **(C930) Guideline/Protocol Specifying Aide Visits**: Does your agency have a guideline or protocol that specifies the number of aide visits for the primary diagnosis this patient has (e.g., critical paths/diagnosis-specific care plan)?

- ❑ 0 - No
- ❑ 1 - Yes

Care Provision Features

57. **(C810) Care Coordination:** Between the time the referral for home health care came in and the completion of the comprehensive assessment, with whom have you spoken to coordinate care for this patient? **Mark all that apply.**

- ❑ 1 - No one at this point **[If No one at this point, you have completed this form]**
- ❑ 2 - Agency case manager
- ❑ 3 - Agency supervisory nurse
- ❑ 4 - Dietary Services
- ❑ 5 - Durable medical equipment representative
- ❑ 6 - Family/support system
- ❑ 7 - Home health aide
- ❑ 8 - Hospital discharge planner
- ❑ 9 - IV equipment/supplies representative
- ❑ 10 - Lab Services
- ❑ 11 - Occupational therapist
- ❑ 12 - Patient's physician
- ❑ 13 - Payer case manager
- ❑ 14 - Pharmacist
- ❑ 15 - Physical therapist
- ❑ 16 - Primary care nurse
- ❑ 17 - Psychiatric nurse
- ❑ 18 - Respiratory therapist
- ❑ 19 - Social worker
- ❑ 20 - Speech therapist
- ❑ 21 - Staff nurse in your agency
- ❑ 22 - Other: (specify) _____

58. **(C820) Number of Care Coordination Communications:** How many verbal communications have there been since the referral for home health care came in? Count all formal and informal conversations pertaining to this patient including conferences and other communications regarding care coordination with the people you mentioned in item #57 (do not specify a range; please provide one number).

_____ communications

59. **(C830) Time Spent on Care Coordination Communications:** What is the total amount of time you spent on the verbal communications you noted in item #58?

_____ minutes

Thank you for completing this questionnaire