

STUDY OF MEDICARE HOME HEALTH PRACTICE VARIATIONS

ADMINISTRATOR QUESTIONNAIRE

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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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.

ADMINISTRATOR QUESTIONNAIRE (AQ) OVERVIEW/PROTOCOL

- PURPOSE:** This information is being collected in order to obtain current data on an agency's characteristics and environment (e.g., agency type and services provided). This information will be used for descriptive purposes and for various analyses involving agency characteristics.
- HOW COLLECTED:** This questionnaire will be completed by the Administrator on the form provided.
- WHEN COLLECTED:** The AQ should be completed only once. This should be done at some point between the administrator's decision to participate in the study (i.e., after the Research Center has received the signed study contract) and agency training on remaining study protocols. The Research Center should receive the completed Administrator Questionnaire prior to agency training for the study.
- INSTRUCTIONS:** The administrator completes the Administrator Questionnaire her/himself, and answers are to be recorded directly on the instrument. The administrator 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.

2. **Agency Control:** Please indicate your agency's type of control:
- 1 - Proprietary (for-profit)
 - 2 - Government
 - 3 - Private not-for-profit
3. **Chain Membership:** Is your agency part of a chain?
- 0 - No [If No, go to Question 5]
 - 1 - Yes
4. How many agencies are in the chain?
5. **Hospital Affiliation:** Is your agency affiliated with (e.g., owned by, contracted with) a hospital, SNF, or rehabilitation center?
- 0 - No
 - 1 - Yes
6. **Certificate of Need:** Does your agency hold a Certificate of Need?
- 8 - Not applicable, Certificate of Need not needed in this state
 - 0 - No
 - 1 - Yes
7. **Licensure:** Is your agency licensed by the state?
- 8 - Not applicable, no licensure needed in this state
 - 0 - No
 - 1 - Yes
8. **Accreditation:** Who is your agency currently accredited by? **Mark all that apply.**
- 1 - JCAHO
 - 2 - CHAP
 - 3 - Other (specify) _____
 - 4 - None of the above [If None of the above, go to Question 10]
9. When was your most recent accreditation survey?
- ____ / ____ / ____
- Month Day Year
10. **Years in Operation:** How long has the Medicare component of your agency been in operation?
- 1 - Less than 1 year
 - 2 - 1 to 2 years
 - 3 - 3 to 5 years
 - 4 - 6 to 8 years
 - 5 - More than 8 years (specify) _____

11. **Medicare Per-Visit Cost Limit:** Is your agency currently operating over the Medicare per-visit cost limits?

- 0 - No
- 1 - Yes

12. **Per-Beneficiary Cost Limit:** Is your agency currently operating over the new per-beneficiary annual limit?

- 0 - No
- 1 - Yes

13. **Percent of Caseload That is Medicare:** Approximately what percent of your agency's caseload is Medicare?

_____ %

14. **Current Reimbursement Rate:** List the current reimbursement amount per visit you receive from Medicare (averaged across all disciplines).

Amount per visit \$ _____ .

15. **Employee Compensation For Home Care Visits:** When making home care visits, what percent of your employees are paid hourly, by salary, or by the visit? Percentages should equal 100% for each discipline. (Exclude contract employees. These are people who are not on your payroll and are not directly employed by your agency. In many instances, contract employees have been hired through temporary placement agencies.)

Discipline	Hourly	Salary	By Visit
Registered Nurses	%	%	%
Physical Therapists	%	%	%
Home Care Aides	%	%	%

16. **Third Party Control Over Number of Visits for Entire Caseload:** In 1998, for what percent of your agency's caseload was the number of visits overseen by a third party payer source?

_____ %

17. **Third Party Control Over Number of Visits for Medicare Patients:** In 1998, for what percent of your agency's Medicare caseload was the number of visits managed by a third party payer source?

_____ %

Familiarity with Fiscal Intermediary:

18. Who is your agency's Medicare fiscal intermediary?
-
19. How long has this been your FI?
- 1 - Less than 1 year
 - 2 - 1 to 3 years
 - 3 - More than 3 years
20. In the past 12 months, have you or anyone in your agency attended an information session and/or presentation led by your FI?
- 0 - No
 - 1 - Yes
21. In the past 12 months, have you or anyone in your agency attended a training/in-service conducted by your FI medical reviewer?
- 0 - No
 - 1 - Yes
22. How consistent is your fiscal intermediary in approving Medicare claims?
- 1 - Highly consistent (FI almost always makes the same decision across similar patient conditions)
 - 2 - Somewhat consistent (FI usually makes the same decision across similar patient conditions)
 - 3 - Minimally consistent (It is difficult to predict the FI's decisions across similar patient conditions)

Policies/Standards/Organization:

23. **Nurse Productivity Standards:** Is there a standard, written or otherwise, about the number of visits a nurse should complete in a given day/week?
- 0 - No written or unwritten standards **[If No, go to Question 25]**
 - 1 - Yes, there are unwritten standards
 - 2 - Yes, there are written standards
24. On average, how many visits do you require in a day? (NOTE: This average should reflect all days worked, not just days making home visits.) (Please provide the number.)
-
25. **Standardized Care Plans/Critical Paths:** Does your agency utilize a standardized care plan approach like critical paths/clinical pathways/diagnosis-specific care plans?
- 0 - No **[If No, go to Question 28]**
 - 1 - Yes

26. Who developed these pathways? **Mark all that apply.**

- 1 - Your agency
- 2 - A group of agencies
- 3 - A commercial group
- 4 - A corporation
- 5 - HMO or managed care
- 6 - Other (specify) _____

27. For which of the following diagnoses/problems does your agency currently use standardized care plans or critical pathways? **Mark all that apply.**

- | | |
|-----------------------------------|--------------------------------|
| 1 - COPD | 9 - Total knee |
| 2 - CHF | 10 - CVA |
| 3 - MI | 11 - Diabetes mellitus |
| 4 - Other cardiac (specify) _____ | 12 - Osteoarthritis |
| 5 - Pressure ulcers | 13 - HIV/AIDS |
| 6 - Other wounds | 14 - Other infectious diseases |
| 7 - Fractured hip | 15 - Other (specify) _____ |
| 8 - Total hip | 16 - Other (specify) _____ |

28. **Venipuncture:** In what ways has the delivery of services in your agency changed now that venipuncture is no longer a qualifying home health service? For each of the following items, please mark if there has been an increase, decrease, or no change.

	Increase	Decrease	No Change
a. Service area	_____	_____	_____
b. Number of home visits per patient	_____	_____	_____
c. Time spent on patient care planning	_____	_____	_____
d. Other: _____	_____	_____	_____
e. Other: _____	_____	_____	_____
f. Other: _____	_____	_____	_____

29. **Agency Standard for Number of SN Visits for Post Hospital Discharge Patients:** Is there a standard, written or otherwise, about the number of SN visits a post hospital discharge patient will receive (e.g., patient receives daily skilled nurse visits for three days followed by one visit per week for four weeks)?

- 0 - No written or unwritten standard [If No, go to Question 31]
- 1 - Yes, there is an unwritten standard
- 2 - Yes, there is a written standard

30. Please describe this standard (or enclose a written copy of the standard).

31. **Agency Standard for Number of SN Visits for CHF Patients:** Is there a standard, written or otherwise, about the number of SN visits a CHF patient will receive (e.g., a patient with the primary diagnosis of CHF receives daily skilled nurse visits for three days followed by one visit per week for four weeks)?

- 0 - No written or unwritten standard [If No, go to Question 33]
- 1 - Yes, there is an unwritten standard
- 2 - Yes, there is a written standard

32. Please describe this standard (or enclose a written copy of the standard).

33. **Agency Standard for Number of SN Visits for Diabetic Patients:** Is there a standard, written or otherwise, about the number of SN visits a diabetic patient will receive (e.g., a patient with the primary diagnosis of diabetes receives daily skilled nurse visits for three days followed by one visit per week for four weeks)?

- 0 - No written or unwritten standard [If No, go to Question 35]
- 1 - Yes, there is an unwritten standard
- 2 - Yes, there is a written standard

34. Please describe this standard (or enclose a written copy of the standard).

35. **Staff Determining Number of Visits:** What percent of the time is the start of care nurse (the nurse who makes the initial assessment visit) responsible for the initial decision regarding the number of visits a patient will receive?

_____ %

36. **Provider-Patient Assignment:** Do you assign patients a primary nurse/therapist (a designated person who coordinates care and may make most of the skilled visits to the patient)?

- 0 - No
- 1 - Yes

37. What percent of the time does the person who completes the start of care visit become the primary nurse/therapist?

_____ %

38. **Verifying Patient Eligibility:** Aside from the nurse providing visits to the patient, is there anyone in your agency who regularly assesses whether the patient is still eligible for home health visits (e.g., reviews clinical records, consults with the visiting nurse)?

- 0 - No
- 1 - Yes

39. **Home Health Aide Assignment:** Is there a standard, written or otherwise, for assigning a home care aide to a patient based on functional status and/or symptomatology (e.g., all patients dependent in bathing get a home care aide)?

- 0 - No written or unwritten policies or protocols [If No, go to Question 41]
- 1 - Yes, there are unwritten policies or protocols
- 2 - Yes, there are written policies or protocols

40. Please describe this standard (or enclose a written copy of the standard).

41. **Home Health Aide Assignment - CHF:** Is there a standard, written or otherwise, for assigning a home care aide to CHF patients at start of care (e.g., all CHF patients get a home care aide)?

- 0 - No written or unwritten policies or protocols [If No, go to Question 43]
- 1 - Yes, there are unwritten policies or protocols
- 2 - Yes, there are written policies or protocols

42. Please describe this standard (or enclose a written copy of the standard).

43. **Home Health Aide Assignment - Diabetes:** Is there a standard, written or otherwise, for assigning a home care aide to diabetic patients at start of care (e.g., all diabetic patients get a home care aide)?

- 0 - No written or unwritten policies or protocols [If No, go to Question 45]
- 1 - Yes, there are unwritten policies or protocols
- 2 - Yes, there are written policies or protocols

44. Please describe this standard (or enclose a written copy of the standard).

45. **Procedures Performed by Home Care Aides:** Beyond the basic personal care services, what nursing procedures are home care aides allowed to perform in your agency, according to your State Nursing Practice Act?

46. **Supervision:** For a typical Medicare patient in your agency, how often do direct care providers meet with their supervisor (either face-to-face or by telephone) to discuss patient issues? We are not interested in agency policy per se; please tell us about what normally occurs. **Please circle one response.**

Nurse/Supervisor Meetings:

- 1 - More than once a week
- 2 - Weekly
- 3 - Twice monthly
- 4 - Monthly
- 5 - Quarterly
- 6 - Less than quarterly

Therapist/Supervisor Meetings:

- 1 - More than once a week
- 2 - Weekly
- 3 - Twice monthly
- 4 - Monthly
- 5 - Quarterly
- 6 - Less than quarterly

47. **Interdisciplinary Communication:** For a typical Medicare patient in your agency, how often do interdisciplinary case conferences occur (including both face-to-face and phone conferencing)? **Please circle one response.**

- 1 - More than once a week
- 2 - Weekly
- 3 - Twice monthly
- 4 - Monthly
- 5 - Quarterly
- 6 - Less than quarterly

48. **HCFA-485:** Who most frequently completes the 485?

- 1 - Staff nurse or therapist who admits patient
- 2 - Supervisory or QA staff
- 3 - Case Manager other than admitting nurse
- 4 - Other (specify) _____

49. **Payer Source Contact:** For Medicare-risk patients, what percent of the time is the SOC nurse (or primary care nurse) responsible for contacting payer sources to negotiate visits?

_____ %

50. What are the key patient factors that are used to negotiate the number of visits?

51. **Recertification Decision:** Who in your agency most frequently decides whether or not to recertify a patient?

- 1 - Nurse or therapist who is the primary care provider
- 2 - Supervisory or QA staff who is not the primary care provider

Environmental Factors:

52. **Alternative Services Provided in the Community:** Excluding the services your agency offers, please tell us about the services other organizations provide in your community. Also, if your agency uses a service not on this list, please tell us about it in the "Other" spaces provided (r & s).

	Is this service available in your community?	Is this service easy to obtain in your community (e.g., most patients can receive service right away w/o being placed on a waiting list)?	Is this service covered by Medicaid?	Is this service covered by a payer other than Medicaid?	Please place a \checkmark next to the 5 alternative services to which your agency most frequently refers patients.
a. Food Banks/Meal Services (excluding Meals-on-Wheels)	0 = No 1 = Yes	0 = No 1 = Yes	0 = No 1 = Yes 9 = Don't know	0 = No 1 = Yes 9 = Don't know	
b. Outpatient rehab (other than agency PT/OT)	0 = No 1 = Yes	0 = No 1 = Yes	0 = No 1 = Yes 9 = Don't know	0 = No 1 = Yes 9 = Don't know	
c. Transportation Assistance	0 = No 1 = Yes	0 = No 1 = Yes	0 = No 1 = Yes 9 = Don't know	0 = No 1 = Yes 9 = Don't know	
d. Assisted Living Facility	0 = No 1 = Yes	0 = No 1 = Yes	0 = No 1 = Yes 9 = Don't know	0 = No 1 = Yes 9 = Don't know	
e. Foster Care Services	0 = No 1 = Yes	0 = No 1 = Yes	0 = No 1 = Yes 9 = Don't know	0 = No 1 = Yes 9 = Don't know	
f. Respite Services	0 = No 1 = Yes	0 = No 1 = Yes	0 = No 1 = Yes 9 = Don't know	0 = No 1 = Yes 9 = Don't know	
g. Homemaker Services	0 = No 1 = Yes	0 = No 1 = Yes	0 = No 1 = Yes 9 = Don't know	0 = No 1 = Yes 9 = Don't know	
h. Personal Care Services	0 = No 1 = Yes	0 = No 1 = Yes	0 = No 1 = Yes 9 = Don't know	0 = No 1 = Yes 9 = Don't know	
i. Friendly Visitor/Companion Services	0 = No 1 = Yes	0 = No 1 = Yes	0 = No 1 = Yes 9 = Don't know	0 = No 1 = Yes 9 = Don't know	
j. Adult Day Care	0 = No 1 = Yes	0 = No 1 = Yes	0 = No 1 = Yes 9 = Don't know	0 = No 1 = Yes 9 = Don't know	
k. Mental Health Services	0 = No 1 = Yes	0 = No 1 = Yes	0 = No 1 = Yes 9 = Don't know	0 = No 1 = Yes 9 = Don't know	
l. Legal/Protective Services	0 = No 1 = Yes	0 = No 1 = Yes	0 = No 1 = Yes 9 = Don't know	0 = No 1 = Yes 9 = Don't know	
m. Emergency Response Services	0 = No 1 = Yes	0 = No 1 = Yes	0 = No 1 = Yes 9 = Don't know	0 = No 1 = Yes 9 = Don't know	
n. Case Management (such as placement or referral services)	0 = No 1 = Yes	0 = No 1 = Yes	0 = No 1 = Yes 9 = Don't know	0 = No 1 = Yes 9 = Don't know	
o. Environmental/Home Modifications	0 = No 1 = Yes	0 = No 1 = Yes	0 = No 1 = Yes 9 = Don't know	0 = No 1 = Yes 9 = Don't know	
p. Meals on Wheels	0 = No 1 = Yes	0 = No 1 = Yes	NA	0 = No 1 = Yes 9 = Don't know	
q. Volunteer Services	0 = No 1 = Yes	0 = No 1 = Yes	NA	NA	
r. Other (specify) _____	0 = No 1 = Yes	0 = No 1 = Yes	0 = No 1 = Yes 9 = Don't know	0 = No 1 = Yes 9 = Don't know	
s. Other (specify) _____	0 = No 1 = Yes	0 = No 1 = Yes	0 = No 1 = Yes 9 = Don't know	0 = No 1 = Yes 9 = Don't know	

53. **Location:** Are the majority of your patients located in a rural, urban, or rural/urban mix location?

- 1 - Rural
- 2 - Urban
- 3 - Mix

General Agency Information:

54. **Numbers of Agency Personnel:** For each discipline listed, indicate the numbers of agency personnel who are hired as Employees (full or part time) or on a Contract basis. (Exclude any personnel who occupy management positions exclusively.)

Discipline	Employees	Contract
Registered Nurses		
Licensed Practical/Vocational Nurses (LPN/LVN)		
Physical Therapists		
Occupational Therapists		
Speech Therapists		
Social Workers		
Home Care Aides		

Comments:

55. **Number of Visits:** For the most recent month for which you have complete data, please indicate the number of Medicare visits your Medicare-certified agency provided by the disciplines listed below.

Month covered by the visit data: $\frac{\text{--}}{\text{M}} \frac{\text{--}}{\text{M}} / \frac{\text{--}}{\text{Y}} \frac{\text{--}}{\text{Y}} \frac{\text{--}}{\text{Y}} \frac{\text{--}}{\text{Y}}$

Visit Discipline	Number of Medicare Visits provided by each discipline for most recent month with complete data
a. Skilled nursing	_____
b. Physical therapy	_____
c. Occupational therapy	_____
d. Speech therapy	_____
e. Medical social services	_____
f. Home care aide	_____

56. **Total Admissions for 1998:** Please provide the total number of admissions in 1998 for your agency's provider number:

57. **Total Medicare Admissions for 1998:** Please provide the total number of Medicare admissions in 1998 for your agency's provider number:

58. **Employee Retention:** Approximately what percentage of your nursing, therapy, and aide personnel (employees or contractual) have been with your agency for more than one year? (Leave blank if you have no personnel in a particular category.)

- a. Nursing personnel (RNs and LPNs/LVNs) _____ %
- b. Therapists (physical, occupational, or speech/language pathologists) _____ %
- c. Social workers _____ %
- d. Home care aides _____ %

59. **Change of Payment Source:** If skilled services are needed and there is a change in payment source from Medicare to some other source (e.g., private insurance or self-pay), does the patient automatically get discharged and then readmitted under the new payor source?

- 0 - No
- 1 - Yes

60. **Discharge Policy for Change in Primary Diagnosis While in an Inpatient Facility:** If there is a change in primary diagnosis and/or the plan of care during an inpatient facility stay, is the patient automatically discharged from your agency?

- 0 - No
- 1 - Yes

61. **Discharge Policy for Admission to Inpatient Facility:** How long must a patient stay in a hospital or other inpatient facility before being discharged from your agency? **Mark all that apply.**

- 1 - Patients are not routinely discharged when admitted to an inpatient facility
- 2 - Patients are discharged when admitted if the admission coincides with the recertification
- 3 - Patients are routinely discharged if the inpatient facility stay is _____ hours (*specify the number of hours*) or _____ days (*specify the number of days*)

62. **Recertification:** When do most recertifications take place? For example, No Name Home Health completes their 60-day recertification visit at approximately day 50. They would circle the following:

25 30 35 40 45 50 55 60

Please circle the time period when most of your agency's recertifications take place:

25 30 35 40 45 50 55 60

63. **Admission Nurse:** Do "Admission Only" nurses open/admit all patients?

- 0 - No
- 1 - Yes [If Yes, go to Question 66]

64. **Staff Conducting SOC Visit:** At your agency, which staff conduct the admission/start of care visit? **Mark all that apply.**

- 1 - RN
- 2 - PT
- 3 - ST

65. **Evening/Weekend Staff Conducting SOC:** Which staff conduct admission/start of care visits on evenings, nights, and weekends? **Mark all that apply.**

- 1 - RN
- 2 - PT
- 3 - ST

66. What is your agency's current Medicare annual per beneficiary limit?

\$ _____ per beneficiary

67. Was your agency considered an "old" or a "new" agency for the purposes of the per beneficiary limit calculation?

- Old
- New

68. Has your agency undergone a change in ownership or been involved in a merger since the Interim Payment System (IPS) went into effect in late 1997?

- No
- Yes (if yes, when did the change in ownership or the merger occur?)

_____/_____
Month Year

Study Organization:

69. **Study Training Session:** For each discipline listed, indicate the number of agency personnel who will attend the EPIC training session.

Discipline	Number of Persons
Nurses	
Physical Therapists	
Occupational Therapists	
Speech Therapists	
Management Personnel	
Others: (specify)_____	

70. **Data Collection Coordinator:** We need one person from your agency to be a Data Collection Coordinator (DCC). Please choose a person who is very organized and who you believe will be with your agency for the next two years. The following tasks are typically the responsibility of the DCC:

- identifying all incoming referrals as eligible or ineligible for the study;
- supplying primary care providers with appropriate study materials;
- notifying (via fax) the Research Center of all study admits and discharges within 24 hours;
- tracking all patients admitted to the study;
- receiving completed forms from care providers, checking for completeness and mailing to the Research Center weekly;
- coordinating the copying of billing records (UB92) for each study patient and mailing these to the Research Center when patients are discharged;
- maintaining communication between the agency and the Research Center; and
- ordering new forms/supplies as needed.

Please indicate the name, title, and phone number of the person who will be the DCC.

Name
Phone Number: _____

Title

Thank you.