STUDY OF MEDICARE HOME HEALTH PRACTICE VARIATIONS

CARE PROVIDER QUESTIONNAIRE (CPQ)
Recertification/Discharge

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:)

☐ **Discharge** (complete this CPQ based on the discharge visit or the last skilled visit prior to agency discharge).

OR

☐ **60-Day Interval Follow-up** (complete this CPQ based on the recertification visit). For which 60-day period is this CPQ being completed?

Circle one: 60 180

120 240

CARE PROVIDER QUESTIONNAIRE (CPQ)
Recertification/Discharge

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 when a study patient is recertified by or discharged from the agency. The questionnaire should be completed within 24 hours of the recertification/discharge visit. If the patient is discharged and there was no discharge visit, the CPQ should be completed, as soon as possible, based on the last skilled 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)
Recertification/Discharge

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

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.

   - ❑ 4 - Discharge from agency (patient was discharged from all home health services for any of the following reasons: met goals, moved, expired, refused further services, entered nursing home, hospital or hospice, etc.)
   - ❑ 5 - 60-day follow-up
   - ❑ 6 - 120-day follow-up
   - ❑ 7 - 180-day follow-up
   - ❑ 8 - 240-day follow-up

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. **(C160) Ability to Learn:** The patient'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

7. **(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

8. **(C180) Compliance:** The patient's assessed level of compliance is:

- ❑ 1 - Excellent; patient adheres to home care regimen almost all (76% - 100%) of the time
- ❑ 2 - Good; patient adheres to home care regimen most (51% - 75%) of the time
- ❑ 3 - Fair; patient adheres to home care regimen some (26% - 50%) of the time
- ❑ 4 - Poor; patient rarely (0-25%) adheres to home care regimen

9. **(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.

10. **(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

11. **(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.

12. **(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
- ❑ 4 - None of the above

13. **(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

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

- ❑ 0 - No
- ❑ 1 - Yes

15. **(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)

Family/Support System Information

16. **(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 34, “Unmet Needs”]**
- ❑ 1 - Yes

Family/Support System ADL Assistance

17. **(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 20]**
- ❑ 1 - Yes

18. **(C511) ADL Assistance:** Which of the following person(s) assist the patient with ADLs (e.g., bathing, dressing, toileting, bowel/bladder, 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)

19. **(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

Family/Support System IADL Assistance

20. **(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 23]**
- ❑ 1 - Yes

21. **(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)

22. **(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

Family/Support System Specialized Care Assistance

23. **(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 26]**
- ❑ 1 - Yes

24. **(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)

25. **(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

Family/Support System Psychosocial Support

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

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

27. **(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)

28. **(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

Family/Support System Advocacy for Medical Care

29. **(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 31]**
- ❑ 1 - Yes

30. **(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)

Family/Support System Transportation Assistance

31. **(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 34]**
- ❑ 1 - Yes

32. **(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)

33. **(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

Unmet Needs

34. **(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 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

35. **(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 40]**
- ❑ 0 - No one person **[If No one person, go to Question 40]**
- ❑ 1 - Spouse or significant other
- ❑ 2 - Daughter or son
- ❑ 3 - Other family member
- ❑ 4 - Friend, neighbor, or community/church member
- ❑ 5 - Paid help

36. **(C610) Primary Caregiver's Care Plan Involvement:** To what extent was the primary caregiver involved in developing the ongoing 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)

37. **(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)

38. **(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

39. **(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

Physician Information

40. **(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)

41. **(C740) Physician's Input:** Given this patient's needs, the amount of physician input around case management has been:

- ❑ 1 - Not enough, more input was needed
- ❑ 2 - Just the right amount of input
- ❑ 3 - More input than was needed

42. **(C750) Physician's Awareness of Services Provided by Your Agency:** In your opinion, the physician's awareness of the home care services provided by your agency has been:

- ❑ 1 - More than adequate (he/she always has been aware of the care being provided)
- ❑ 2 - Adequate (he/she usually has been aware of the care being provided)
- ❑ 3 - Inadequate (he/she rarely has been aware of the care being provided)

Care Provision Features

43. **(C800) Skilled Services Provided:** Please mark the skilled services you provided during the most recent 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) ____________________________

44. **(C810) Care Coordination:** Since the last time a Care Provider Questionnaire was completed on this patient, with whom have you spoken to coordinate care? **Mark all that apply.**

- ❑ 1 - No one at this point **[If No one at this point, go to Question 47]**
- ❑ 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) ________

45. **(C820) Number of Care Coordination Communications:** How many verbal communications have there been since the last time a Care Provider Questionnaire was completed on this patient? 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 #44 (do not specify a range, please provide one number).

_____ communications

46. **(C830) Time Spent on Care Coordination Communications:** What is the total amount of time you spent on the verbal communications you noted in item #45?

_____ minutes

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:** On average, how long does it take to get to the patient's home either from the home health agency or from another home visit?

- ❑ 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

Care Provider Information

49. **(C960) SOC Assessment:** Did you do the comprehensive assessment for this patient at start of care?

- ❑ 0 - No
- ❑ 1 - Yes

50. **(C970) Familiarity with Patient:** Including today, how many times have you seen this patient?

- ❑ 1 - Once
- ❑ 2 - Two to five times
- ❑ 3 - Six to ten times
- ❑ 4 - More than ten times

If the patient is being discharged, please skip this section and go to item 66.

DATA ITEMS COLLECTED AT RECERTIFICATION ONLY

Please complete data on items 51-65 if the patient is being recertified.

Patient Information

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

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

52. **(C150) Care Plan Involvement:** To what extent was the patient involved in updating the care plan for the next certification period?

- ❑ 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)

<u>Primary Caregiver Information</u>

53. **(C650) Primary Caregiver's Agreeableness to Continuing Home Care:** Upon discussing the continuation of home health care services with the primary caregiver:

- ❑ 1 - The primary caregiver <u>is not</u> agreeable to the continuation of home health care services
- ❑ 2 - The primary caregiver <u>is</u> agreeable to the continuation of home health care services
- ❑ 8 - Not applicable (no primary caregiver or primary caregiver is cognitively incapable of involvement)
- ❑ 9 - Unknown (Unable to discuss with primary caregiver at recertification)

<u>Managed Care</u>

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

- ❑ 0 - No **[If No, go to Question 59]**
- ❑ 1 - Yes

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

- ❑ 0 - No, they authorized <u>fewer</u> visits than requested
- ❑ 1 - Yes, they authorized the number of visits requested
- ❑ 2 - No, they authorized <u>more</u> 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)

56. **(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)

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

- ❑ 0 - No, request was <u>denied</u> **[If No, go to Question 59]**
- ❑ 1 - Yes, request was <u>approved</u>
- ❑ 8 - Not applicable (aide services were not requested for this patient) **[If NA, go to Question 59]**

58. **(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 <u>fewer</u> visits than requested
- ❑ 1 - Yes, they authorized the number of visits requested
- ❑ 2 - No, they authorized <u>more</u> visits than requested

Physician Information

When answering questions 59-61, please consider the patient's physician only. Do not consider other individuals.

59. **(C710) Evaluation of Need for Aide Services:** Prior to writing up the recert paperwork, did the physician request an evaluation of need for home health aide services?

    ❑ 0 - No
    ❑ 1 - Yes

60. **(C720) Home Health Aide Services:** Prior to writing up the recert paperwork, were aide services ordered by the physician?

    ❑ 0 - No
    ❑ 1 - Yes

61. **(C760) Recommendation for Recertification:** Prior to writing up the recert paperwork, did the physician recommend that the patient be recertified?

    ❑ 0 - No
    ❑ 1 - Yes

Agency Information

62. **(C900) Feedback from Other Agency Personnel About Frequency of SN Visits:** Since the last time a Care Provider Questionnaire was completed on this patient, have you received feedback from other agency personnel (e.g., case manager, supervisor, other discipline) about the frequency of SN visits needed for this patient for this recertification period?

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

63. **(C910) Feedback from Other Agency Personnel About Home Health Aide Services:** Since the last time a Care Provider Questionnaire was completed on this patient, have you received feedback from other agency personnel (e.g., case manager, supervisor, other discipline) about whether or not an aide should be assigned to this patient for this recertification period?

    ❑ 0 - No
    ❑ 1 - Yes

64. **(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

65. **(C940) Feedback from Other Agency Personnel About Recertifying:** Did you receive feedback from other agency personnel (e.g., case manager, supervisor, other discipline) about recertifying this patient?

    ❑ 0 - No
    ❑ 1 - Yes

> ***If the patient is being recertified, please skip this section. Thank you for completing this questionnaire.***

DATA ITEMS COLLECTED AT DISCHARGE ONLY

Please collect data on items 66-72 only when the study participant is discharged from your agency.

66. **Discharge Date: (C038)**

		/			/		
Month			day			year	

Patient Information

67. **(C230) Patient Agreeableness to Discontinuing Home Care:** Upon discussing the discontinuation of home health care services with the patient:

- ❑ 1 - The patient is not agreeable to the discontinuation of home health care services
- ❑ 2 - The patient is agreeable to the discontinuation of home health care services
- ❑ 8 - Not applicable (patient is comatose or cognitively incapable of involvement)
- ❑ 9 - Unknown (Unable to discuss with patient prior to discharge)

68. **(C240) Discharge Planning Involvement:** To what extent was the patient involved in planning for his/her discharge?

- ❑ 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)

Primary Caregiver Information

69. **(C660) Primary Caregiver's Agreeableness to Discontinuing Home Care:** Upon discussing the discontinuation of home health care services with the primary caregiver:

- ❑ 1 - The primary caregiver is not agreeable to the discontinuation of home health care services
- ❑ 2 - The primary caregiver is agreeable to the discontinuation of home health care services
- ❑ 8 - Not applicable (no primary caregiver or primary caregiver is cognitively incapable of involvement)
- ❑ 9 - Unknown (Unable to discuss with primary caregiver prior to discharge)

70. **(C670) Primary Caregiver's Discharge Planning Involvement:** To what extent was the primary caregiver involved in planning for the patient's discharge?

- ❑ 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 (no primary caregiver or primary caregiver is cognitively incapable of involvement)

Physician Information

71. **(C770) Decision to Terminate Home Health Services:** Prior to discharging the patient, did the physician suggest that home health services be terminated?

- ❑ 0 - No
- ❑ 1 - Yes

Agency Information

72. **(C950) Feedback from Other Agency Personnel About Discharging:** Did you receive feedback from other agency personnel (e.g., case manager, supervisor, other discipline) about discharging this patient?

- ❑ 0 - No
- ❑ 1 - Yes

Thank you for completing this questionnaire