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National Home and Hospice Care Survey, 2007

United States Department of Health and Human Services. Centers for Disease Control and Prevention. National Center for Health Statistics

Patient File Questionnaire

Inter-university Consortium for
Political and Social Research
P.O. Box 1248
Ann Arbor, Michigan 48106
www.icpsr.umich.edu

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2007 National Home and Hospice Care Survey

Patient Health Module (PH)

PH1A ZIP CODE

What {is/was} {sampled patient}'s zip code?

ENTER ZIP CODE. _____

IF HOME ADDRESS NOT AVAILABLE, ENTER 99.

REFUSED
DON'T KNOW

PH1 Patient OASIS Form Completion

Is there an OASIS form completed on this patient?

1 YES
2 NO

REFUSED
DON'T KNOW

PH2A Assessment Month OASIS Form

What is the assessment date of the most recent OASIS form completed for {sampled patient} ?

ENTER MONTH. (1-12) _____

REFUSED
DON'T KNOW

PH2B Assessment Day OASIS Form

What is the assessment date of the most recent OASIS form completed for {sampled patient} ?

ENTER DAY. _____

REFUSED
DON'T KNOW

PH2C Assessment Year OASIS Form

What is the assessment date of the most recent OASIS form completed for {sampled person} ?

ENTER A 4-DIGIT YEAR. _____

REFUSED
DON'T KNOW

PH4A Admission Month

What was the date of {sampled patient}'s most recent admission with this agency ?

That is, the date (he/she) was admitted for the current episode of care.

On what date was the {sampled patient} admitted to this agency for the episode of care that ended on {Discharge date}?

ENTER MONTH (1-12) _____

IF PATIENT RECEIVED ASSESSMENT ONLY, ENTER 99}

REFUSED
DON'T KNOW

PH4B Recent Admission Day

What was the date of {sampled patient}'s most recent admission with this agency ?

That is, the date {he/she) was admitted for the current episode of care).

On what date was the {sampled patient} admitted to this agency for the episode of care that ended on {Discharge date}?

ENTER DAY. (1-31) _____

PH4 Recent Admission Year

What was the date of {sampled patient}'s most recent admission with this agency ?

That is, the date {he/she) was admitted for the current episode of care).

On what date was the {sampled patient} admitted to this agency for the episode of care that ended on {Discharge date} ?

ENTER A 4-DIGIT YEAR. _____

PH4D Readmission

Was this a re-admission for {sampled patient} to this agency for {home health/hospice} Care?

1 YES
2 NO

REFUSED
DON'T KNOW

PH5A Discharge Month

On what date was the {sampled patient} discharged from this agency?

ENTER MONTH (1-12) _____

REFUSED
DON'T KNOW

PH5B Discharge Day

On what date was the {patient} discharged from this agency?]

ENTER DAY (1-31). _____

REFUSED
DON'T KNOW

PH5C Discharge Year

On what date was {patient} discharged from this agency?

ENTER A 4-DIGIT YEAR _____

PH6 Deceased At Discharge

At discharge, was {patient} deceased?

1 YES
2 NO

REFUSED
DON'T KNOW

PH7 Reason For Discharge

Why was {patient} discharged from this agency?

1 CONDITION STABILIZED OR IMPROVED
2 OBTAIN MORE AGGRESSIVE TREATMENT FOR CONDITION
3 MOVED TO GEOGRAPHIC LOCATION NOT SERVICED BY THIS AGENCY
91 OTHER (SPECIFY)

REFUSED
DON'T KNOW

PH7A Specify Discharge Reason

SPECIFY REASON FOR DISCHARGE. (PH7 – 91)

_____

PH8 Destination After Discharge

Where did {sampled patient} go after (he/she) was discharged from this agency?

1 PRIVATE HOME OR APARTMENT
2 RESIDENTIAL CARE PLACE
3 SKILLED NURSING FACILITY
4 HOSPITAL
5 ANOTHER HOSPICE FACILITY
91 OTHER PLACE (SPECIFY)
REFUSED
DON'T KNOW

PH8A Facility Type Description

DESCRIBE FACILITY TYPE. (PH8 – 91)

_____

PH9 Gender

Is/Was {sampled patient} male or female?

1 MALE
2 FEMALE

REFUSED
DON'T KNOW

PH10A Birth Month

What {is/was} {sampled patient}'s date of birth?

ENTER MONTH (1-12). _____

REFUSED
DON'T KNOW

PH10B Day Of Birth

What {is/was} {sampled patient}'s date of birth?

ENTER DAY. (1-31) _____

REFUSED
DON'T KNOW

PH10C Birth Year

What {is/was} {sampled patient}'s date of birth?

ENTER A 4-DIGIT YEAR. _____

REFUSED
DON'T KNOW

PH11 Discharge Age

Approximately how old {is/was} {sampled patient} at the time of discharge}?

Enter Age. _____

REFUSED
DON'T KNOW

PH12 Hispanic or Latino Origin

{Is/Was} (he/she) of Hispanic or Latino origin?

1 YES
2 NO

REFUSED
DON'T KNOW

PH13 Race

SHOW CARD PH13.

Please look at this card and tell me what {sampled patient}'s race {is/was}?

SELECT ALL THAT APPLY.

1 AMERICAN INDIAN OR ALASKA NATIVE
2 ASIAN
3 BLACK OR AFRICAN AMERICAN
4 NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
5 WHITE
91 OTHER RACE (SPECIFIY)

REFUSED
DON'T KNOW

PH13A Specify Race

SPECIFY RACE (PH13 – 91).

_____

PH14 Marital Status

{Is/Was} {sampled patient} married, widowed, divorced, separated, never married, or living with a partner in a marriage-like relationship?

IF NEEDED: (at time of discharge.)

1 MARRIED
2 WIDOWED
3 DIVORCED
4 SEPARATED
5 NEVER MARRIED
6 LIVING WITH A PARTNER

REFUSED
DON'T KNOW

PH14A Veteran Status

{Is/Was} {sampled patient} a veteran of U.S. military service?

PRESS F1 FOR HELP SCREEN.

1 YES

2 NO

REFUSED
DON'T KNOW

PH15 Medicare Enrolled

SHOW CARD PH15

{Is/Was} {sampled patient} enrolled in Medicare?

1 YES
2 NO

REFUSED
DON'T KNOW

PH16 Medicare ID Number

What {is/was} (his/her) Medicare ID Number?

_____

REFUSED
DON'T KNOW

PH17 Verify Medicare Number

I have entered {PH16/MEDICARE NUMBER}. Is this correct?

1 YES
2 NO

PH18 Medicaid Enrolled

Is/Was {sampled patient} enrolled in Medicaid?

1 YES
2 NO
3 MEDICAID PENDING

REFUSED
DON'T KNOW

PH19 Medicaid ID Number

What {is/was} (his/her) {'PREFERRED' NAME FOR MEDICAID} {or 'ALLOWED FOR' NAME FOR MEDICAID} ID number?

IF NO MEDICAID NUMBER, ENTER 99. _____

REFUSED
DON'T KNOW

PH20 Verify Medicaid Number

I have entered {MEDICAID NUMBER}. Is this correct?

1 YES
2 NO

PH21 Alpha Or Numeric SSN

Does {sampled patient}'s Social Security number begin with a letter or a number?

1 LETTER
2 NUMBER

REFUSED
DON'T KNOW

PH21A Social Security Number

What is {sampled patient}'s Social Security number?

_____

PH22 Social Security Number

What is {sampled patient}'s Social Security number?

_____

PH23 Verify Social Security Number

I have entered {SOCIAL SECURITY NUMBER}. Is this correct?

1 YES
2 NO

PH24 Advanced Directives Request

SHOW CARD PH24.

Which of the following Advance Directives {has {sampled patient} requested/are listed in {sampled patient}'s medical records}.

SELECT ALL THAT APPLY.

PRESS F1 FOR HELP SCREEN.

1 LIVING WILL
2 DO NOT RESUSCITATE (DNR)
3 DO NOT HOSPITALIZE/DO NOT SEND TO EMERGENCY DEPARTMENT
4 FEEDING RESTRICTIONS
5 MEDICATION RESTRICTIONS
6 COMFORT MEASURES ONLY
7 DURABLE POWER OF ATTORNEY
8 HEALTH CARE PROXY/SURROGATE
9 ORGAN DONATION
10 NO ADVANCED DIRECTIVES PROVIDED
91 OTHER (SPECIFY)

REFUSED
DON'T KNOW

PH24A Directive Description

DESCRIBE OTHER ADVANCE DIRECTIVE(S). (PH24 – 91)

_____

PH25 Where Stayed Before HHC

Immediately before {sampled patient} began receiving {home health/hospice} care from this agency, was he/she an inpatient in a hospital, nursing home, or some other kind of health care facility?

For the most recent episode of care.

PRESS F1 FOR HELP SCREEN

1 YES
2 NO

REFUSED
DON'T KNOW

PH25A Place Stayed Before Care

What kind of place was that?

PRESS F1 FOR HELP SCREEN.

1 HOSPITAL/EMERGENCY ROOM
2 NURSING HOME/SKILLED NURSING FACILITY/SUB-ACUTE FACILITY
3 REHABILITATION FACILITY
4 ASSISTED LIVING
91 OTHER (SPECIFY)

REFUSED
DON'T KNOW

PH25B SPECIFIY FACILITY TYPE

What kind of place was that {OTHER SPECIFY}? (PH25A – 91)

_____

PH26 Where Stay After HHC

Does {sampled patient} now live in a private home or apartment , in a residential care place or somewhere else?

Residential care place refers to an assisted living facility, a board and care home, a life care or a continuing care retirement community

1 PRIVATE HOME OR APARTMENT
2 RESIDENTIAL CARE PLACE
91 OTHER (SPECIFY)

REFUSED
DON'T KNOW

PH26A Specify Place

Specify Place. (PH 26 – 91)

_____

PH27 Where Staying Before HHC

Where was {sampled patient} staying when (he/she) first began receiving hospice care?

NOTE: A RESIDENTIAL CARE PLACE INCLUDES AN ASSISTED LIVING FACILITY, A BOARD AND CARE HOME, A LIFE CARE OR A CONTINUING CARE RETIREMENT COMMUNITY.

1 THIS AGENCY'S INPATIENT/ RESIDENTIAL FACILITY
2 PRIVATE HOME OR APARTMENT
3 RESIDENTIAL CARE PLACE
4 SKILLED NURSING FACILITY (NURSING HOME)
5 HOSPITAL
91 OTHER PLACE (SPECIFY)

REFUSED
DON'T KNOW

PH27A Specify Facility Type

SPECIFY FACILITY TYPE

_____

PH28 Where Last Day Hospice Care

Where was {sampled patient} staying on the last day (he/she) received hospice care ?

NOTE: A RESIDENTIAL CARE PLACE INCLUDES AN ASSISTED LIVING FACILITY, A BOARD AND CARE HOME, A LIFE CARE OR A CONTINUING CARE RETIREMENT COMMUNITY.

1 THIS AGENCY'S INPATIENT/ RESIDENTIAL FACILITY
2 PRIVATE HOME OR APARTMENT
3 RESIDENTIAL CARE PLACE
4 SKILLED NURSING FACILITY (NURSING HOME)
5 HOSPITAL
91 OTHER PLACE (SPECIFY)

REFUSED
DON'T KNOW

PH28A Facility Type

SPECIFY FACILITY TYPE. (PH28 – 91)

_____

PH29 Living Companion During HHC

Who does {sampled patient} currently live with? Or Who was (he/she) living with while receiving hospice care?

SELECT ALL THAT APPLY

1 ALONE
2 SPOUSE/SIGNIFICANT OTHER
3 PARENT
4 CHILD (INCLUDING DAUGHTER/SON-IN-LAW)
5 OTHER FAMILY MEMBER
6 NON-FAMILY MEMBER(S)

REFUSED
DON'T KNOW

PH30 Any Outside Primary Care

Does {sampled patient} now/or Did {sampled patient}} have a primary caregiver outside of this agency?

PRESS F1 FOR HELP SCREEN.

1 YES
2 NO

REFUSED
DON'T KNOW

PH32 Caregiver Relationship to Sampled Patient

Who {is/was} {PATIENT}'s primary caregiver?

1 SPOUSE/SIGNIFICANT OTHER
2 PARENT
3 CHILD (INCLUDING DAUGHTER/SON-IN-LAW)
4 OTHER FAMILY MEMBER
5 NOT RELATED

REFUSED
DON'T KNOW

PH34 Primary Diagnosis

According to {sample patient}'s medical records, what was the primary diagnosis or condition at the time (he/she) was admitted to this agency (that is, on or around ADMISSION DATE})? _____

REFUSED
DON'T KNOW

PH34A SPECIFY Primary Diagnosis

Specify Primary Diagnosis

_____

PH35 Current Primary Diagnosis

What is {sampled patients}'s current primary diagnosis or condition/What was the primary diagnosis or condition at discharge}?

_____

REFUSED
DON'T KNOW

PH35A Specify Primary Diagnosis

_____

PH36a_o Diagnoses At Discharge

What {are/were} all the other conditions {sampled patient} {currently has/had at discharge}?

Anything else?

PRESS F1 FOR HELP SCREEN

PH36A1_15 Specify Secondary Diagnoses

_____

PH37 Surgical/Diagnostic Procedures at Admission

Did {sampled patient} have any surgical, diagnostic or therapeutic procedures or treatments that were related to (his/her) admission to this agency (for the current episode of care)?

1 YES
2 NO

REFUSED
DON'T KNOW

PH38 Procedure/Operation Description

What kind of operation or procedure did {sampled patient} have?

Any others?

Enter all procedures _____

PH38A1_5 Other Specify Procedure / Operation

Enter other specified procedures _____

PH39 Pressure Ulcers Prior to Discharge

Does (sampled patient) now/or on the last day (patient) received hospice care, did (he/she) have pressure ulcers?

**A pressure ulcer is any lesion caused by pressure, resulting in damage to underlying tissue.

1 YES
2 NO

REFUSED
DON'T KNOW

PH40 Highest Stage of Pressure Ulcer

SHOW CARD PH40

Please look at this card and tell me the highest stage of any pressure ulcer the patient has now or had .

1 STAGE I
2 STAGE II
3 STAGE III
4 STAGE IV
5 UNSTAGED (NOT ASSESSED)

REFUSED
DON'T KNOW

PH41 Status At Highest Pressure Ulcer Stage

SHOW CARD PH41

What {is/was} the last recorded healing status of this pressure ulcer?

PRESS F1 FOR HELP SCREEN.

1 FULLY GRANULATING
2 EARLY/PARTIAL GRANULATION
3 NOT HEALING
91 OTHER (SPECIFY)

REFUSED
DON'T KNOW

PH41A Specify Pressure Ulcer Status (PH41 – 91)

Other Specify status of pressure ulcer

_____

PH42 Pressure Ulcers Prior to Discharge

Is/Was patient comatose or in a vegetative state {at the time (he/she) was admitted to this agency for hospice care}?

1 YES
2 NO

REFUSED
DON'T KNOW

PH42A Need Help Dressing

Does/At admission, did patient need any help from another person with the following activity?

Dressing

PRESS F1 FOR HELP SCREEN

1 YES
2 NO

REFUSED
DON'T KNOW

PH42A1 Agency Help Dressing

Do/Did any agency staff help the patient with dressing?

1 YES
2 NO

REFUSED
DON'T KNOW

PH42B Need Help Bathing

Does/At admission, did patient need any help from another person with the following activity ?

Bathing

1 YES
2 NO

REFUSED
DON'T KNOW

PH42B1 Agency Help Bathing

Do/Did any agency staff help patient with bathing?

1 YES
2 NO

REFUSED
DON'T KNOW

PH42C Need Help Using Toilet

Does/At admission, did patient need any help from another person with the following activity?

Using Toilet

1 YES
2 NO

REFUSED
DON'T KNOW

PH42C1 Agency Help Toilet

Do/Did any agency staff help patient with using the toilet?

1 YES
2 NO

REFUSED
DON'T KNOW

PH42D Help Getting In or Out of Bed or Chairs

At admission, did patient need any help from another person with the following activity?

Getting in or out of bed or chairs

1 YES
2 NO
3 DOESN'T DO

REFUSED
DON'T KNOW

PH42D1 Agency Help Getting In or Out of Bed

Do/Did any agency staff help the patient with getting in or out of bed or chairs?

1 YES
2 NO

REFUSED
DON'T KNOW

PH42E Help in Walking Or Climbing Stairs

Does/At admission, did patient need any help from another person with the following activity?

Walking or Climbing Stairs

1 YES
2 NO
3 DOESN'T DO

REFUSED
DON'T KNOW

PH42E1 Agency Help with Walking Or Climbing Stairs

Do/Did any agency staff help the patient/discharge with walking or climbing stairs?

1 YES
2 NO

REFUSED
DON'T KNOW

PH42F Help Eating Or Feeding

At admission, did patient need any help from another person with the following activity?

Eating or feeding (himself/herself)

PRESS F1 FOR HELP SCREEN.

_____

REFUSED
DON'T KNOW

PH42F1 Agency Help Eating

Do/Did any agency staff help the patient with eating or feeding himself/herself?

1 YES
2 NO

REFUSED
DON'T KNOW

PH44G Preparing or Taking Medication Help

Does patient currently/did patient receive any help from this agency's staff with the following activity?

PRESS F1 FOR HELP SCREEN.

1 YES
2 NO
3 DOESN'T DO

REFUSED
DON'T KNOW

PH47 Mental Status In Hospice Care

SHOW CARD PH47

Please look at this card and tell me which category best describes patient's current level of cognitive functioning or current mental status at the time (he/she) was admitted to this agency for hospice care.

0 NO COGNITIVE IMPAIRMENT

1 REQUIRE{S/D} ONLY OCCASSIONAL REMINDERS (IN NEW SITUATIONS)

2 REQUIRE{S/D} SOME ASSISTANCE/DIRECTION IN CERTAIN SITUATIONS (IS EASILY DISTRACTED)

3 REQUIRES A GREAT DEAL OF ASSISTANCE/DIRECTION IN ROUTINE SITUATIONS

4 SEVERE COGNITIVE IMPAIRMENT (CONSTANTLY DISORIENTED, COMATOSE, DELIRIUM)

REFUSED
DON'T KNOW

PH48 Aids Or Devices Used

SHOW CARD PH48

Which of these aids or special devices on this card does the patient use?

PROBE: Any others?

SELECT ALL THAT APPLY

1 WALKER/CANE/CRUTCH
2 WHEELCHAIR
3 MOTORIZED CART/SCOOTER
4 ORTHOTICS (INCLUDING BRACES)
5 PROSTHETICS (LIMBS)
6 NONE OF THESE

REFUSED
DON'T KNOW

PH49 Activity Assistive Devices

SHOW CARD PH49

Which of these aids or special devices on this card does the patient use?

PROBE: Any others?

SELECT ALL THAT APPLY

1 BEDSIDE COMMODE
2 ELEVATED/RAISED TOILET SEAT
3 HOSPITAL BED
4 SPECIALIZED MATTRESS (EGG CRATE, FOAM, AIR, GEL, ETC.)
5 SPECIALIZED CHAIRS (GERI CHAIR, LIFT CHAIRS)
6 GRAB BARS
7 TRANSFER EQUIPMENT (LIFTS, GAIT BELTS)
8 SHOWER CHAIR/BATH BENCH
9 OVER BED TABLE
10 EATING DEVICES (BUILT UP UTENSILS, PLATE GUARD, NON-SPILL CUP)
11 NONE OF THESE

REFUSED
DON'T KNOW

PH50 Hospice Medical Devices Used

SHOW CARD {PH50a/PH50b}

Which of the medical devices on this card does the patient use/did patient use while in hospice care?

PROBE: Any others?

SELECT ALL THAT APPLY

PRESS F1 FOR HELP SCREEN

1	IV INFUSION PUMP (LARGE VOLUME)
2	PATIENT CONTROLLED ANALGESIA PUMP
3	AMBULATORY INFUSION PUMP (OTHER THAN INSULIN)
4	PERITONEAL/HEMODIALYSIS
5	OXYGEN (OXYGEN CONCENTRATOR, LIQUID, TANK OR OTHER DELIVERY SYSTEM)
6	METERED DOSE INHALER
7	APNEA MONITOR
8	CONTINUOUS POSITIVE PRESSURE AIRWAY (CPAP)
9	BLOOD GLUCOSE MONITOR
10	ENTEROSTOMAL DEVICE (URINE OR STOOL BAG)
11	ENTERAL (NASOGASTRIC OR OTHER) TUBE FEEDING EQUIPMENT
12	PARENTERAL IV (TPN)
13	PRESSURE RELIEVING DEVICES (SPECIAL BED, MATTRESS, OR OVERLAY)
14	NONE OF THESE
	REFUSED
	DON'T KNOW

PH51 Agency Staff Support

Does/Did this agency's staff provide support with instruction, maintenance or monitoring of any of those medical devices for patient?

1	YES
2	NO
	REFUSED
	DON'T KNOW

PH52 Medical Devices

Which ones?

PROBE: Any others?

SELECT ALL THAT APPLY

1 IV INFUSION PUMP (LARGE VOLUME)
2 PATIENT CONTROLLED ANALGESIA PUMP
3 AMBULATORY INFUSION PUMP (OTHER THAN INSULIN)
4 PERITONEAL/HEMODIALYSIS
5 OXYGEN (OXYGEN CONCENTRATOR, LIQUID, TANK OR OTHER DELIVERY SYSTEM)
6 METERED DOSE INHALER
7 APNEA MONITOR
8 CONTINUOUS POSITIVE PRESSURE AIRWAY (CPAP)
9 BLOOD GLUCOSE MONITOR
10 ENTEROSTOMAL DEVICE (URINE OR STOOL BAG)
11 ENTERAL (NASOGASTRIC OR OTHER) TUBE FEEDING EQUIPMENT
12 PARENTERAL IV (TPN)
13 PRESSURE RELIEVING DEVICES (SPECIAL BED, MATTRESS, OR OVERLAY)

REFUSED
DON'T KNOW

PH53 Urinary Catheter Use

During hospice care did patient have a urinary catheter?

1 YES
2 NO

REFUSED
DON'T KNOW

PH54 Bladder Control Difficulty

Does / Did patient have difficulty controlling (his/her) bladder?

1 YES
2 NO
3 NOT APPLICABLE

REFUSED
DON'T KNOW

PH55 Ostomy Usage

Does/Did patient have a colostomy or ileostomy for bowel elimination?

1 YES
2 NO

REFUSED
DON'T KNOW

PH56 Bowel Control Problem

Does/Did patient have difficulty controlling (his/her) bowels?

1 YES
2 NO

REFUSED
DON'T KNOW

PH57A Month First Pain Assessed

On what date was patient first assessed for pain (for the episode of care beginning on (admission date)?

ENTER MONTH _____

IF PATIENT NOT ASSESSED FOR PAIN SINCE ADMISSION, ENTER 99.

IF PATIENT ASSESSED FOR PAIN ON SAME DAY AS ADMISSION, ENTER 97.

PH57B Day First Pain Assessed

On what date was patient first assessed for pain (for the episode of care beginning on (admission date).

ENTER DAY _____

PH57B Year First Pain Assessed

On what date was patient first assessed for pain (for the episode of care beginning on (admission date).

ENTER 4-DIGIT YEAR _____

PH58 Pain Assessment Tool Used

SHOW CARD PH58

What type of pain assessment tool was used to assess patient's pain?

IF MORE THAN ONE PAIN ASSESSMENT TOOL REPORTED, ASK:

Which of those pain assessment tools gave the most accurate assessment for patient's pain level?

1	0-10 SCALE
2	0-5 SCALE
3	WORD SCALE (MILD, MODERATE, SEVERE)
4	FACE SCALE (0-5)
5	FACE SCALE (0-10)
6	FLACC
7	OBSERVATION OF PATIENT'S BEHAVIOR
8	PATIENT'S/FAMILY'S DESCRIPTION OF PAIN
91	OTHER ASSESSMENT TOOLS (SPECIFY)
	REFUSED
	DON'T KNOW

PH58A Specify Pain Assessment Tool

Specify pain assessment tool

_____

PH59A Pain Level Recorded 1

What was the level of patient's pain recorded at that assessment (Date of assessment)?

0	PAIN LEVEL 0
1	PAIN LEVEL 1
2	PAIN LEVEL 2
3	PAIN LEVEL 3
4	PAIN LEVEL 4
5	PAIN LEVEL 5
6	PAIN LEVEL 6
7	PAIN LEVEL 7
8	PAIN LEVEL 8
9	PAIN LEVEL 9
10	PAIN LEVEL 10
	REFUSED
	DON'T KNOW

PH59B Pain Level Recorded 2

What was the level of patient's pain recorded at that assessment on date of assessment?

0 PAIN LEVEL 0
1 PAIN LEVEL 1
2 PAIN LEVEL 2
3 PAIN LEVEL 3
4 PAIN LEVEL 4
5 PAIN LEVEL 5

REFUSED
DON'T KNOW

PH59C Pain Level Recorded 3

What was the level of {PATIENT}'s pain recorded at that assessment on date of assessment?

1 PAIN LEVEL MILD
2 PAIN LEVEL MODERATE
3 PAIN LEVEL SEVERE
4 NO PAIN

REFUSED
DON'T KNOW

PH59D What Level Pain Recorded

What was the level of patient's pain recorded at that assessment on date of assessment?

IF PAIN CANNOT BE DESCRIBED, STATED OR REPORTED ENTER 999.

_____

REFUSED
DON'T KNOW

PH60A Month Last Pain Assessed

When was the last time the patient was assessed for pain for the episode of care that ended on (discharge date)?

ENTER MONTH _____

REFUSED
DON'T KNOW

PH60B Day Last Pain Assessed

When was the last time the patient was assessed for pain for the episode of care that ended on (discharge date).

ENTER DAY _____

REFUSED
DON'T KNOW

PH60C Year Last Pain Assessed

When was the last time the patient was assessed for pain for the episode of care that ended on (discharge date).

ENTER A 4-DIGIT YEAR. _____

REFUSED
DON'T KNOW

PH61 Pain Assessment Tool Used 1

SHOW CARD PH61

What type of pain assessment tool was used to assess {PATIENT}'s pain {that time}?

IF MORE THAN ONE PAIN ASSESSMENT TOOL REPORTED, ASK:
Which of those pain assessment tools gave the most accurate assessment for the patient's pain level?

1	0-10 SCALE
2	0-5 SCALE
3	WORD SCALE (MILD, MODERATE, SEVERE)
4	FACE SCALE (0-5)
5	FACE SCALE (0-10)
6	FLACC
7	OBSERVATION OF PATIENT'S BEHAVIOR
8	PATIENT'S/FAMILY'S DESCRIPTION OF PAIN
91	OTHER ASSESSMENT TOOLS (SPECIFY)
	REFUSED
	DON'T KNOW

PH61A Specify Pain Assessment Tool X

Specify pain assessment tool

_____

PH61B Pain Level Recorded 3X

What was the level of the patient's pain recorded at that assessment (date of assessment)?

0	PAIN LEVEL 0
1	PAIN LEVEL 1
2	PAIN LEVEL 2
3	PAIN LEVEL 3
4	PAIN LEVEL 4
5	PAIN LEVEL 5
6	PAIN LEVEL 6
7	PAIN LEVEL 7
8	PAIN LEVEL 8
9	PAIN LEVEL 9
10	PAIN LEVEL 10
	REFUSED
	DON'T KNOW

PH61C Pain Level Recorded 4

What was the level of the patient's pain recorded at that assessment (date of assessment)?

0	PAIN LEVEL 0
1	PAIN LEVEL 1
2	PAIN LEVEL 2
3	PAIN LEVEL 3
4	PAIN LEVEL 4
5	PAIN LEVEL 5
	REFUSED
	DON'T KNOW

PH61D Pain Level Recorded 5

What was the level of the patient's pain recorded at that assessment (on date of assessment).

1	PAIN LEVEL MILD
2	PAIN LEVEL MODERATE
3	PAIN LEVEL SEVERE
4	NO PAIN
	REFUSED
	DON'T KNOW

PH62 Pain Level Assessment Date

What was the level of the patient's pain recorded at that assessment (on date of Assessment).

RECORD DESCRIPTION OF PAIN LEVEL.

IF PAIN LEVEL CANNOT BE DESCRIBED, STATED OR REPORTED, ENTER 999.

_____

REFUSED
DON'T KNOW

PH64 Pain Management Strategy

SHOW CARD PH64

According to the patient's medical record, what strategies on this card are/were used to manage (his/her) pain.

SELECT ALL THAT APPLY

PRESS F1 FOR HELP SCREEN

1 STANDING ORDER FOR PAIN MEDICATION
2 PRN ORDER FOR PAIN MEDICATION
3 NON-PHARMACOLOGICAL METHODS (DISTRACTION, HEAT/COLD MASSAGE/POSITIONING, MUSIC THERAPY)
4 NO STRATEGIES SPECIFIED
91 OTHER (SPECIFY)

REFUSED
DON'T KNOW

PH64A Specify Pain Management Strategy

Specify pain management strategy

_____

PH66 Medical Services Received

SHOW CARD {PH66A/PH66B}

What services did/does the patient received from this agency during the last 60 days in which the patient was receiving care from the agency since admission during his/her hospice care?

Include services received from the agency as a result of contractual arrangements.

SELECT ALL THAT APPLY

PRESS F1 FOR HELP

1 SKILLED NURSING SERVICES
2 PHYSICIAN SERVICES
3 PHARMACY SERVICES
4 PODIATRY SERVICES
5 WOUND CARE
6 DIETARY AND NUTRITIONAL SERVICES
7 TELEMEDICINE
8 NONE OF THESE

REFUSED
DON'T KNOW

PH67 Other Services Received

SHOW CARD PH67

What other services did/does the patient received from this agency during the last 60 days in which the patient was receiving care from the agency since admission during his/her hospice care?

Include services received from the agency as a result of contractual arrangements.

PROBE: Any others on this card?

SELECT ALL THAT APPLY.

PRESS F1 FOR HELP

1	HOMEMAKER SERVICES
2	ASSISTANCE WITH ADLs
3	VOLUNTEER SERVICES
4	CONTINUOUS HOME CARE
5	MEALS ON WHEELS
6	TRANSPORTATION
7	OCCUPATIONAL THERAPY
8	PHYSICAL THERAPY
9	RESPIRATORY THERAPY
10	SPEECH THERAPY/AUDIOLOGY
11	COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM)
12	NONE OF THESE
	REFUSED
	DON'T KNOW

PH68 Counseling and/or Psychosocial Services

SHOW CARD PH68

Which of these services were provided from this agency during the last 60 days of care since admission?

Include services received from {AGENCY} as a result of contractual arrangements.

PROBE: Any others on this card?

SELECT ALL THAT APPLY

PRESS F1 FOR HELP SCREEN

1	PASTORAL SPIRITUAL SERVICES
2	DIETARY COUNSELING
3	ETHICAL ISSUES COUNSELING
4	REFERRAL SERVICES
5	(MEDICAL) SOCIAL SERVICES
6	MENTAL HEALTH SERVICES
7	RESPITE SERVICES
8	INTERPRETER SERVICES
9	NONE OF THESE
	REFUSED
	DON'T KNOW

PH70 Service Type Provided

SHOW CARD PH70
Did this agency offer or provide the patient's family members or friends any of the services listed on this card? Which ones?

Include services received from the agency as a result of contractual arrangements.

SELECT ALL THAT APPLY

PRESS F1 FOR HELP SCREEN

1	BEREAVEMENT
2	CAREGIVER HEALTH/WELLNESS
3	SPIRITUAL
4	DIETARY
5	DEALING WITH DIFFICULT BEHAVIORS
6	MEDICATION MANAGEMENT/ADMINISTRATION
7	EQUIPMENT USE
8	PATIENT ADLS (BATHING, DRESSING, TOILETING, FEEDING, ETC.)
9	SAFETY TRAINING
10	SUSPECTED ABUSE/NEGLECT/EXPLOITATION
11	REFERRAL/RESOURCE INFORMATION
12	RESPITE CARE
13	NO SERVICES OFFERED OR PROVIDED
91	OTHER (SPECIFY)
	REFUSED
	DON'T KNOW

PH70A Specify Service Type

Specify type of service

_____

PH71A Staff Visits Received

How many visits did (he/she) receive from agency's staff for nursing services?

Nursing services include nursing care and nursing services provided by or under the supervision of a RN.

Number of (nursing service) visits _____

REFUSED
DON'T KNOW

PH71B Number of Staff Visits

How many visits did the patient received from this agency's staff during his/her hospice care?

Number of (physician services) visits _____

REFUSED
DON'T KNOW

PH71D Medical Social Services Visits

How many visits were there for medical social services?

PRESS F1 FOR HELP SCREEN.

Number of (medical social services) visits _____

REFUSED
DON'T KNOW

PH71E Volunteer Services Visits

How many visits were there for @volunteer services?

Number of (volunteer services) visits _____

REFUSED
DON'T KNOW

PH71F Skilled Nursing Visits

How many visits did the patient receive for skilled nursing service from the agency's staff in the past 60 days (prior to interview) since admission?

Nursing services include: nursing care and nursing services provided by or under the supervision of a RN.

PRESS F1 FOR HELP SCREEN.

Number of skilled nursing service visits _____

REFUSED
DON'T KNOW

PH71G Physical Therapy Visits

How many visits did the patient receive for physical therapy from the agency's staff in the past 60 days (prior to interview) since admission?

PRESS F1 FOR HELP SCREEN.

Number of physical therapy visits _____

REFUSED
DON'T KNOW

PH71H Occupational Therapy Visits

How many visits did the patient receive for occupational therapy from the agency's staff in the past 60 days (prior to interview) since admission?

PRESS F1 FOR HELP SCREEN.

Number of occupational therapy visits _____

REFUSED
DON'T KNOW

PH71I Speech Therapy Visits

How many visits did the patient receive for occupational therapy from the agency's staff in the past 60 days (prior to interview) since admission?

PRESS F1 FOR HELP SCREEN.

Number of speech therapy visits _____

REFUSED
DON'T KNOW

PH71J Medical Social Services Visits

How many visits did the patient receive for occupational therapy from the agency's staff? in the past 60 days (prior to interview) since admission?

PRESS F1 FOR HELP SCREEN.

Number of medical social service visits _____

REFUSED
DON'T KNOW

PH71K Home Health Aide and Homemaker Visits

How many visits did the patient receive for occupational therapy from the agency's staff? in the past 60 days (prior to interview) since admission?

PRESS F1 FOR HELP SCREEN.

Number of home health aide and homemaker visits _____

REFUSED
DON'T KNOW

PH73 Emergency Care Services

SHOW CARD PH73

Did or has the patient used any of these services for emergent care during the last 60 days (prior to interview) since admission?

SELECT ALL THAT APPLY

PRESS F1 FOR HELP SCREEN.

1 HOSPITAL EMERGENCY ROOM (INCLUDES 23-HOUR HOLDING)
2 DOCTOR'S OFFICE EMERGENCY VISIT/HOUSE CALL
3 OUTPATIENT DEPARTMENT/CLINIC (INCLUDES URGICENTER SITES)
4 NO EMERGENT CARE

REFUSED
DON'T KNOW

PH74 Emergency Care Reason

For what reason did (he/she) obtain emergent care?

SELECT ALL THAT APPLY.

PRESS F1 FOR HELP SCREEN

1 MEDICATION PROBLEM/COMPLICATION (IMPROPER MEDICATION ADMINISTRATION, MEDICATION SIDE EFFECTS, TOXICITY, ANAPHYLAXIS)
2 NAUSEA, DEHYDRATION, MALNUTRITION, CONSTIPATION, IMPACTION
3 INJURY DUE TO A FALL
4 OTHER TYPE OF INJURY
5 RESPIRATORY PROBLEMS (E.G., SHORTNESS OF BREATH, RESPIRATORY INFECTION, TRACHEOBRONCHIAL OBSTRUCTION)
6 WOUND INFECTION, DETERIORATING WOUND STATUS, NEW LESION/ULCER
7 CARDIAC PROBLEMS (E.G., FLUID OVERLOAD, EXACERBATION OF CHF, CHEST PAIN)
8 HYPOGLYCEMIA/HYPERGLYCEMIA, DIABETES OUT OF CONTROL
9 GI BLEEDING/OBSTRUCTION
10 URINARY TRACT INFECTION (UTI)
11 UNCONTROLLED PAIN
91 OTHER (SPECIFY)

REFUSED
DON'T KNOW

PH74A Specify Reason for Emergent Care

SPECIFY REASON FOR EMERGENT CARE

_____

PH75 Overnight Hospital Stay

Since being admitted to this agency has the patient had a hospital admission that required an overnight stay where (he/she) she was not formally discharged from the agency?

1 YES
2 NO

REFUSED
DON'T KNOW

PH76a_y PRN Medications

What are the names of all the medications and drugs the patient currently takes or was taking seven days prior to and on the day of his/her discharge/death while in hospice?

Please include any standing, routine, or PRN medications.

Enter all drugs _____

PH76A1_25 Specify Medication

Specify medication

_____

PH77 Symptoms Prior to Discharge

SHOW CARD PH77

When this agency last provided care to the patient did (he/she) have any of these symptoms? Before (his/her) death.

SELECT ALL THAT APPLY.

1 DIFFICULTY BREATHING (DYSPNEA)
2 END STAGE RESTLESSNESS
3 DEPRESSION
4 PAIN
5 CONSTIPATION
6 ANOREXIA
7 NONE OF THESE

REFUSED
DON'T KNOW

PH78 Care Or Treatments Received

SHOW CARD PH78

Which formal care or treatments did the patient receive while in hospice care?

SELECT ALL THAT APPLY

PRESS F1 FOR HELP SCREEN.

1 IV THERAPY
2 TRANSFUSION
3 TUBE FEEDING (NASOGASTRIC/OTHER ENTERAL FEEDINGS)
4 HYPODERMCLYSIS
5 TOTAL PARENTERAL NUTRITION (TPN)
6 RESPIRATORY THERAPY
7 RADIATION THERAPY
8 CHEMOTHERAPY
9 PALLIATIVE SEDATION
10 NONE OF THESE

REFUSED
DON'T KNOW

PH79 Level of Hospice Care

SHOW CARD PH79

Which level of hospice care on this card was the patient receiving at the time of his/her discharge?

1 ROUTINE HOME CARE FOR PATIENTS RECEIVING HOSPICEE SERVICES IN THEIR HOMES
2 CONTINUOUS HOME CARE PROVIDED 8 TO 24 HOURS PER DAY PRIMARILY BY SKILLED HOSPICE PERSONNEL
3 GENERAL INPATIENT CARE PROVIDED BY SKILLED HOSPICE STAFF
4 INPATIENT RESPITE CARE TO RELIEVE THE PRIMARY CAREGIVER

REFUSED
DON'T KNOW

PH80 Life Expectancy

According to the patient's medical record, does (his/her) current prognoses indicate a life expectancy of greater than 6 months, or 6 months or less?

Is (he/she) only receiving palliative, end of life, or terminal care instead of active or curative treatment

0 YES, LIFE EXPECTANCY GREATER THAN 6 MONTHS
1 YES, LIFE EXPECTANCY 6 MONTHS OR LESS
2 NO, LIFE EXPECTANCY NOT INDICATED BUT RECEIVING PALLIATIVE/END OF LIFE CARE ONLY
3 NO, LIFE EXPECTANCY NOT INDICATED AND NOTRECEIVING PALLIATIVE/END OF LIFE CARE
INAPPLICABLE / NOT ASCERTAINED

REFUSED
DON'T KNOW

PH81 Symptoms Last Visit

SHOW CARD PH81

During this agency's last visit to provide care to the patient, did (he/she) have any of these symptoms?

SELECT ALL THAT APPLY

PRESS F1 FOR HELP SCREEN

1 DIFFICULTY BREATHING (DYSPNEA)
2 END STAGE RESTLESSNESS
3 DEPRESSION
4 PAIN
5 CONSTIPATION
6 ANOREXIA
7 NONE OF THESE

PH82 Care Or Treatment At Last Visit

SHOW CARD PH82

During this agency's last visit, which formal care or treatments was {PATIENT} receiving?

Include formal care/treatments the patient obtained from ANY provider, not just what the agency provided.

SELECT ALL THAT APPLY.

1 IV THERAPY
2 TRANSFUSION
3 TUBE FEEDING (NASOGASTRIC/OTHER ENTERAL FEEDINGS)
4 HYPODERMCLYSIS
5 TOTAL PARENTERAL NUTRITION (TPN)
6 RESPIRATORY THERAPY
7 RADIATION THERAPY
8 CHEMOTHERAPY
9 PALLIATIVE SEDATION
10 NONE OF THESE

REFUSED
DON'T KNOW

Payment Source Module (PA)

PA1 Primary Source of Payment

What {is/was} the primary source of payment for (sampled patient's) home health/hospice care?

IF PAYMENT NOT RECEIVED YET: What is the expected primary source of payment?

1	MEDICARE
2	MEDICAID
3	TRICARE (FORMERLY CHAMPUS)
4	DEPARTMENT OF VETERANS AFFAIRS
5	CHAMPVA
6	WORKER'S COMPENSATION
7	OTHER GOVERNMENT
8	PRIVATE INSURANCE
9	LONG-TERM CARE INSURANCE
10	SELF-PAY (PATIENT/FAMILY)
11	NO CHARGE FOR CARE
12	PAYMENT SOURCE NOT DETERMINED
91	OTHER (SPECIFY)
	REFUSED
	DON'T KNOW

PA1A Medicare Fee Type

Is the Medicare fee for service (traditional Medicare), managed care, or some other type of Medicare?

1	FEE FOR SERVICE/TRADITIONAL MEDICARE
2	MANAGED CARE
91	OTHER MEDICARE
	REFUSED
	DON'T KNOW

PA1B Specify Medicare Type (PA1A – 91)

SPECIFY TYPE OF MEDICARE

_____

PA1C Medicaid Fee Type

Is the Medicaid fee for service (traditional Medicaid), managed care, or some other type of Medicaid?

1 FEE FOR SERVICE/TRADITIONAL MEDICAID
2 MANAGED CARE
91 OTHER MEDICAID

REFUSED
DON'T KNOW

PA1D Specify Medicaid Type (PA1C – 91)

SPECIFY TYPE OF MEDICAID

_____

PA1E Specify Govt Source Payment

SPECIFY OTHER TYPE OF GOVERNMENT SOURCE FOR PAYMENT.

_____

PA1F Private Insurance Fee Type

Is the private insurance fee for service, managed care, or some other type of private insurance?

1 FEE FOR SERVICE
2 MANAGED CARE
91 OTHER PRIVATE INSURANCE

REFUSED
DON'T KNOW

PA1G Specify Private Insurance (PA1F – 91)

SPECIFY TYPE PRIVATE INSURANCE

_____

PA1H Specify Other Source Payment

SPECIFY OTHER SOURCE OF PAYMENT.

_____

PA2 Why Other Source Payment

Is this because sampled patient (does/did not) have health insurance, or the agency's services (he/she) received are not covered by insurance or some other reason?

1 PATIENT DID NOT HAVE HEALTH INSURANCE
2 SERVICES NOT COVERED BY INSURANCE
91 OTHER (SPECIFY)

PA2A Specify Self Pay Reason (PA2 – 91)

SPECIFY REASON FOR SELF-PAY

_____

PA3 Other Payment Sources

Besides {PA1 OR PA1F RESPONSE}, what {are/were} all other sources of payment for (sampled patient's home health care) /(sampled patient's hospice care)?

SELECT ALL THAT APPLY.

1 {MEDICARE}
2 {MEDICAID}
3 {TRICARE (FORMERLY CHAMPUS)}
4 {DEPARTMENT OF VETERANS AFFAIRS}
5 {CHAMPVA}
6 {WORKERS COMPENSATION}
7 {OTHER GOVERNMENT}
8 {PRIVATE INSURANCE}
9 {LONG-TERM CARE INSURANCE}
10 {SELF-PAY (PATIENT/FAMILY)
11 NO OTHER PAYMENT SOURCES
91 OTHER (SPECIFY)

REFUSED
DON'T KNOW

PA3A Medicare Fee Type X

Is the Medicare fee for service (traditional Medicare), managed care, or some other type of Medicare?

1 FEE FOR SERVICE/TRADITIONAL MEDICARE
2 MANAGED CARE
91 OTHER MEDICARE

REFUSED
DON'T KNOW

PA3B Specify Type Medicare

SPECIFY TYPE OF MEDICARE

_____

PA3C Medicaid Type Fee

Is the Medicaid fee for service (traditional Medicaid), managed care, or some other type of Medicaid?

1 FEE FOR SERVICE/TRADITIONAL MEDICAID
2 MANAGED CARE
91 OTHER MEDICAID

REFUSED
DON'T KNOW

PA3D Specify Type Medicaid

SPECIFY TYPE OF MEDICAID

_____

PA3E Specify Other Govt Source Pay

SPECIFY OTHER TYPE OF GOVERNMENT SOURCE FOR PAYMENT.

_____

PA3F Private Insurance Fee Type X

Is the private insurance fee for service, managed care, or some other type of private insurance?

1 FEE FOR SERVICE
2 MANAGED CARE
91 OTHER PRIVATE INSURANCE

REFUSED
DON'T KNOW

PA3G Private Insurance

SPECIFY TYPE PRIVATE INSURANCE

_____

PA3H Other Source Payment Specify

SPECIFY OTHER SOURCE OF PAYMENT.

_____

PA4 Other Source Payment Reason

{Is/Was} the other source of payment "patient or family" because sampled patient does not have health insurance, because the {agency's services/hospice services} received {are/were} not covered by insurance, or for some other reason?

1 PATIENT DID NOT HAVE HEALTH INSURANCE
2 SERVICES NOT COVERED BY INSURANCE
91 OTHER (SPECIFY)

REFUSED
DON'T KNOW

PA4A Self Pay Reason (PA4 – 91)

SPECIFY REASON FOR SELF-PAY

_____

PA6 Total Amount Billed

What was the total amount of the charges billed for sampled patient's {care received for the last complete billing period (or since admission if (he/she) has not been here for a complete billing period)/hospice care at theAGENCY?

IF NEEDED: This covers the time period from (his/her) admission on {ADMISSION DATE} to (his/her) discharge on {DISCHARGE DATE}.}

ENTER TOTAL AMOUNT OF CHARGES IN WHOLE DOLLARS.

IF NO CHARGES BILLED TO DATE, ENTER 0.

_____

REFUSED
DON'T KNOW

PA7A Beginning Month Billed

What was the beginning date of the time period covered by this amount?

ENTER MONTH. (1-12) _____

REFUSED
DON'T KNOW

PA7B Beginning Day Billed

What was the beginning date of the time period covered by this amount?

ENTER DAY. (1-31) _____

REFUSED
DON'T KNOW

PA7C Beginning Year Billed

What was the beginning date of the time period covered by this amount?

ENTER YEAR. _____

PA8A Ending Date Billed Month

What was the ending date of the time period covered by this amount?

ENTER MONTH. (1-12) _____

REFUSED
DON'T KNOW

PA8B Ending Day Billed

What was the ending date of the time period covered by this amount?

ENTER DAY. (1-31) _____

REFUSED
DON'T KNOW

PA8C Ending Year Billed

What was the ending date of the time period covered by this amount?

ENTER YEAR. _____

REFUSED
DON'T KNOW

PA11 Total Amount Billed For Year

What was the total amount of the charges billed for sampled patient's hospice care at AGENCY for the 12 month period before (he/she) was discharged?

That would include the time period from (DATE ONE YEAR BEFORE DISCHARGE) to (his/her) discharge on (DISCHARGE DATE).

ENTER WHOLE DOLLAR AMOUNT. (0 to 999999) _____

REFUSED
DON'T KNOW

PA14 Total Amount Paid

Of the total charges, how much did {PA1} pay?
Include any amount {PA1} has already paid and additional payments you expect from {PA1}.

ENTER WHOLE DOLLAR AMOUNT. (0 to 999999) _____

REFUSED
DON'T KNOW

PA14A Total Amount Paid Medicare FFS or TRICAR

Based on sampled patient's current 60-day plan of care, what is the total Medicare/TRICARE PPS payment, that is the RAP plus the final payment, you Expect to receive for this 60-day episode ?

ENTER WHOLE DOLLAR AMOUNT. (0 to 999999) _____

2007 National Home and Hospice Care Survey Patient Questionnaire

Help Screens

PHPRE

Form Approved OMB No. 0920-0298 Exp. Date 07/31/2009

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Assurance of Confidentiality – All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used only by persons engaged in and for the purpose of the survey and will not be disclosed or released to other persons or used for any other purpose without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m).

PH14A - Served as a member of the Army, Navy, Air Force, Marine Corps, Coast Guard, or as a commissioned officer of the Public Health Service, Environmental Science Services Administration or National Oceanic and Atmospheric Administration, or its predecessor, the Coast and Geodetic Survey.

PH24 – A living will is a written document that allows a person to state in advance his/her wishes regarding the use or removal of life-sustaining or death-delaying procedures in the event of illness or injury.

Do not resuscitate is a written order from a doctor that resuscitation should not be attempted if a person suffers cardiac or respiratory arrest. Such an order may be instituted on the basis of an advance directive from a person or from someone entitled to make decisions on his/her behalf, such as a health care proxy.

Comfort measures only refer to pain medications, nursing care and treatments for the purpose of providing comfort and relieving pain only, not for curative purposes.

A durable power of attorney is a written legal document by which an individual designates another person to act on his or her behalf. The power is durable in the sense that the authority endures in the event the individual becomes disabled or incapacitated.

A health care proxy is a legal document in which an individual designates another person to make health care decisions if he or she is rendered incapable of making his/her wishes known. The health care proxy has, in essence, the same rights to request or refuse treatment that the individual would have if capable of making and communicating decisions.

Organ donation is the removal of specific tissues of the human body from a person who has recently died, or from a living donor, for the purpose of transplanting them into other persons.

PH25 - Refers to the place or location {SP} was staying in when he/she was referred to home health or hospice care.

Help Screens

PH25A - A skilled nursing facility provides short-term skilled nursing care on an inpatient basis, following hospitalization. These facilities provide the most intensive care available outside of a hospital.

A rehabilitation facility - is a facility that provides an organized program of medical and clinical treatment designed to maximize residual physical, perceptual, and cognitive abilities following disablement.

Assisted living - is a supportive housing facility designed for those who need extra help in their day-to-day lives but who do not require the 24-hour skilled nursing care found in traditional nursing homes.

PH30 – A Primary Caregiver is a person who helps the majority of time in caring for someone who is ill, disabled, or aged. Some caregivers are friends or relatives who volunteer their help. Some people provide caregiving services for a cost.

PH36 a-o – Co-morbid conditions are other diseases or illnesses the patient has.

PH41 – Healing status of pressure ulcers:

- Fully granulating:
  - wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium
  - no dead space
  - no avascular tissue (eschar and/or slough)
  - no signs or symptoms of infection
  - wound edges are open
- Early/partial granulation:
  - ≥ 25% of the wound bed is covered with granulation tissue
  - there is minimal avascular tissue (eschar and/or slough) (i.e., <25% of the wound bed is covered with avascular tissue)
  - may have dead space
  - no signs or symptoms of infection
  - wound edges are open
- Not healing
  - Wound with ≥ 25% avascular tissue (eschar and/or slough) or
  - Signs/symptoms of infection or
  - Clean but non-granulating wound bed or
  - Closed/hyperkeratotic wound edges or
  - Persistent failure to improve despite appropriate comprehensive wound management

Help Screens

PH42 A – A person does not need assistance if they are able to get clothes and shoes out of closets and drawers, put them on and remove them (with or without dressing aids) without assistance.

PH42 F – This refers only to the process of eating, chewing, and swallowing the food to be eaten, not preparing the food. If the patient had a feeding tube, code "yes."

PH44 G – A person does not need assistance if they are able to prepare and take all prescribed oral medications with the proper dosages and at the correct times.

PH50 – Do not include medical devices that were used only during a visit to a doctor's office or other medical care setting.

PH64 – Standing order for pain medication refers to a pain medication that is administered at regular intervals, 24/7. Examples include timed doses around the clock and a synchromed pump. PRN order for pain medication refers to taking pain medication periodically, only when the patient feels that he/she needs it.

PH66 - Telemedicine is the use of electronic communication and information technologies to provide or support clinical care at a distance.

Services received from the hospice agency, even if performed through a contractor on behalf of the agency, are considered the same as the hospice agency providing the services itself.

PH67 – Homemaker services include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care.

Continuous home care is where the hospice provides a minimum of eight hours during a 24-hour day, which begins and ends at midnight. This care need not be continuous, i.e., four hours could be provided in the morning and another four hours in the evening, but care must reflect the needs of an individual in crisis (the period is which an individual requires continuous care for as much as 24 hours to achieve palliation or management of acute medical symptoms). The care must be predominantly nursing care provided by either a registered nurse (RN) or licensed practical nurse (LPN). In other words, at least half of the hours of care are provided by the RN or LPN. Homemaker or home health aide services may be provided to supplement the nursing care.

Services received from the hospice agency, even if performed through a contractor on behalf of the agency, are considered the same as the hospice agency providing the services itself.

PH67 –Complementary and Alternative Medicine (CAM) is a diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine. CAM includes acupuncture, aromatherapy, art therapy, guided imagery/relaxation, hypnosis, massage, music therapy, pet therapy, reflexology, reiki, supportive group therapy, therapeutic touch, and TENS (transcutaneous electrical nerve stimulation).

PH68 – Referral Services provide information about services available from public and private providers.

Interpreter Services - refer to bilingual staff and/or health education materials that enable agency staff to provide health care to patients whose native language is not English.

PH70 – Referral/Resource Services provide information about services available from public and private providers. They may also order or arrange services but they do not provide the services directly.

Safety training - refers to when the hospice agency comes into a patient's home to evaluate real or potential threats to the health and safety of the patient and to make recommendations (e.g., remove throw rugs that can trip a patient who uses a walker) to reduce or eliminate those threats.

PH71 a-k – A visit is an episode of personal contact with the patient by staff of the HHA, or others under arrangements with the HHA, for the purpose of providing a covered home health service. One visit may be counted each time an HHA employee, or someone providing home health services under arrangements with the HHA, enters the patient's home and provides a covered service to a patient who meets the criteria. If the HHA furnishes services in an outpatient facility under arrangements with the facility, one visit may be counted for each type of services provided.

PH71 a-k If two individuals are needed to provide a service, two visits may be counted. If two individuals are present, but only one is needed to provide the care, only one visit may be counted.

Example: (a) if an occupational therapist and an occupational therapist assistant visit the patient together to provide therapy and the therapist is there to supervise the assistant, one visit is counted; (b) if a nurse visits the patient in the morning to dress a wound and later must return to replace a catheter, two visits are counted; and (c) if the therapist visits the patient for treatment in the morning and the patient is later visited by the assistant for additional treatment, two are counted.

PH71 f – Skilled Nursing Visits refer to nursing care provided by or under the supervision of a registered nurse (RN).

PH73 – Emergent Care refers to any urgent, unplanned medical care.

PH74 – Cardiac problems refers to problems related to the heart.

Hypoglycemia refers to a deficiency of sugar in the blood caused by too much insulin or too little glucose.

Hyperglycemia refers to a higher than normal blood glucose level.

GI bleeding is gastrointestinal bleeding from a source within the gastrointestinal tract such as an ulcer.

PH78 - IV Therapy: Includes hydration, pain pump.

Respiratory Therapy: Includes oxygen (intermittent or continuous), ventilator (continually or at night), and continuous positive airway pressure received in one's home. Therefore, a respiratory therapist does not need to be there in order for the respondent to indicate that the patient received respiratory therapy.

Palliative Sedation: Palliative sedation is the use of sedative medications to relieve extreme suffering by making the patient unaware and unconscious (as in a deep sleep) while the disease takes its course, eventually leading to death. The sedative medication is gradually increased until the patient is comfortable and able to relax. Palliative sedation is not intended to cause death or shorten life.

PH81 – Anorexia is diminished appetite or an aversion to food (distinct from anorexia nervosa).

Patient Sampling HELP SCREEN

Selecting the Current Patient Sample

1. Get the list. It must contain all the patients currently receiving care from the agency as of midnight of the night before the interview.

2. Clean the list

   - Check for duplicates on the list.
   - Correct the list if necessary.

3. Number the list. Number all eligible names on the list sequentially.

   - Check the numbers by groups of 50 or 100.

4. Select the sample. Follow the instructions on CAPI:

   - Enter the number of current patients (last number on your list) at item PS5.

   - Find the line numbers displayed in the 'Circle Number' column in the roster at PS8, and circle the corresponding line numbers on the list of current patients.

Discharge Sampling HELP SCREEN

Selecting the Hospice Discharges Sample

1. Get the list. It must contain all the hospice discharges for 3 months from the beginning month through the ending month 2007 as specified at PS2.

2. Clean the list

   - Correct the list if necessary.

3. Number the list. Number all eligible names on the list sequentially.

   - Check the numbers by groups of 50 or 100.

4. Select the sample. Follow the instructions on CAPI:

   - Enter the number of discharges (last number on your list) at item PS6.

   - Find the line numbers displayed in the 'Circle Number' column in the roster at PS12, and circle the corresponding line numbers on the list of discharges.

   - Enter the name corresponding to the line number into the roster, and the discharge date (month and day), if provided.