CarePartners of Connecticut

Hospice Agency Questionnaire

Date: ________________________

Name of person completing this questionnaire:____

Agency name:____

Address:____

Phone number: ____

Fax number:____

Principal contact:____

Director/administrator:____

1. Is your agency **Medicare** certified? Yes ☐ No ☐

   What is the date of your last survey?____________

   Please attach copies of your two (2) most recent federal and state survey reports.

2. Please describe your service area and attach a list of all offices.

3. Are you affiliated with a home health care agency? Do you provide a bridge program? If so, describe your program? What percentage of patients transition to hospice?

4. How many patients were on service with your agency last calendar year? ____________

5. What is your average daily census?_____________

6. What is your average length of stay?_____________

7. What is your median length of stay?_____________

8. Please list the most common diagnoses of your patient population:

9. Please describe your intake procedures. If you have more than one office, do you have a central intake process? How soon after receiving a referral are you able to provide services?

10. Do you admit after regular hours? Yes ☐ No ☐

    Please describe your availability.

11. Do you provide the pre-election hospice evaluation and counseling services for Medicare patients? Yes ☐ No ☐

12. Does anyone on your staff do palliative consults? Yes ☐ No ☐

    If so, please provide the name and telephone number of each person.

13. Please list and describe your agency's staffing. Include whether staff is full time, part time, per diem, or contracted. If staff is contracted, list with whom you subcontract and for what service.

14. What percentage of your nurses are hospice certified?____________

15. Do you offer pediatric hospice services? Yes ☐ No ☐

16. Do you have formal or informal affiliations for inpatient hospice services (acute and nonacute settings)? Are acute and nonacute (e.g., SNF) beds available to you for needed admissions? Please list and describe.

17. What other institutions do you have formal or informal affiliations with? List and describe.

18. Do you allow palliative treatments, such as palliative chemotherapy or radiation? Yes ☐ No ☐

19. Do you allow IVs and transfusions? Yes ☐ No ☐

20. Do you admit patients with no identified caregivers? Yes ☐ No ☐

21. Do you provider respite care? Yes ☐ No ☐ Please describe.

22. At present, what are the primary sources for your referrals? Please check and list specific referral sources below.

    ☐ Hospitals ☐ Physicians ☐ Other (Please specify) ________________________________

23. Are your staff members capable of serving other linguistic populations? Yes ☐ No ☐
    Please list languages below.

24. What Quality Assurance/Utilization Review (QA/UR) tools does your agency employ (specific criteria)?

    Please attach a description of your QA/UR management process.

25. What organized vehicles does your agency employ to accomplish QA/UR activities (e.g., peer review committees, organized meetings)? Please describe.

26. Do you employ a case management approach to patient care? Yes ☐ No ☐
If so, please explain your system?

27. Is there a specific employee responsible for managing/coordinating the care of patients who require two or more services and/or complicated cases? Yes ☐ No ☐

28. Which staff member(s) is responsible for communicating with insurers, and what methods of communication are used?

29. Does your agency hold team conferences? Yes ☐ No ☐
Do you include the insurer's case manager in family/team meetings? Yes ☐ No ☐

30. Do you have an Ethics Committee? Yes ☐ No ☐

Please attach a list of all services offered and specify your organization's areas of expertise. Feel free to expand on any of the above questions if necessary.