National Palliative Care Registry™

What's New for the Home Survey

Based on feedback from participating palliative care programs, the CAPC home-based palliative care workgroup and the field, we have made some changes to the home-based palliative care survey. This version of the survey will be available starting **January 1, 2019** for annual data entry. Below is an outline of those changes.

1. **Focused Scope:** The new Home Survey has strengthened focus on actionable structure and process measures that are feasible for programs to collect.
2. **Length and Question Changes:** The new Home Survey is shorter than our previous version. Questions were removed for a series of reasons, including low participation rates, too burdensome for programs to collect, requires chart review/custom reporting from the EMR, non-reliable answers from participants, and/or outside of the process and structure scope.
3. **One of Many Data Resources:** While patient reported outcomes and clinical data are extremely important for programs to collect to show program value and impact, the Registry is not the correct venue to collect it. Data collection for quality improvement purposes are better met by other systems, such as participating in a palliative care quality improvement collaborative. To help palliative care programs with measurement, CAPC will be releasing a Measurement Toolkit for CAPC Members, including information on which data points are important to collect for different purposes and audiences.

We thank you for your continued participation in the National Palliative Care Registry. Please contact the National Palliative Care Registry™ if you have any questions or concerns about the outlined changes via email at registryhelpdesk@capc.org or call us at 212-201-2689.

Home Survey Outline

Table of Contents

Module 1. Program Description....3

Module 2. Patient Visits....6

Module 3. Patient Demographics....9

Module 4. Referral Sources, Diagnosis, and Code Status....11

Module 5. Services and Goals of Care....13

Module 6. Electronic Health Record....14

Module 7. Discharge Status and Length of Service....15

Module 8. Staffing....16

Module 9. Pediatric Palliative Care: Coming soon!....19

Module 1. Program Description

1. What type(s) of communities does your palliative care program serve? (Check all that apply)
   - ☐ Urban
   - ☐ Suburban
   - ☐ Rural

   Please select the answer that best represents the communities your palliative care program serves.

2. Which counties does your home palliative care program serve?

   ________________, ________________, ________________, ________________,

   ________________, ________________, ________________, ________________,

   ________________, ________________, ________________, ________________,

   ________________, ________________, ________________, ________________

   From the drop-down menu of counties by state, select which counties are served by your palliative care program. If you serve multiple states, you have the ability to add counties for more than one state.

3. What type of entity administers your home palliative care program?
   a. Health System
   b. Hospital
   c. Hospice
   d. Home Health Agency
   e. Long-term Care Facility/Organization
   f. Medical Group
   g. Other: _______________

   Select which of the answer options best represents the administrative home for your palliative care program. If your program is administered by an organization that is unlisted, please select other and specify the organization (example: if your palliative care program is administered by an independent organization).

4. Do you have a formal partnership with any of the following entities? (Check all that apply)
   - ☐ Hospital
   - ☐ Hospice
   - ☐ Home Health Agency
   - ☐ Long-term Care Facility/Organization
   - ☐ Physician Group

☐ Specialty Center (e.g., Cancer Center)
☐ Other: _______________

Please select all entities with which your palliative care program has a formal partnership. A formal partnership means that your palliative care program has established a formal partnership agreement. A formal partnership ensures that patients can be referred to specialist care when required for consultation and/or management and that patients can move smoothly between palliative care and other services based on their level of need.

5. Does your palliative care program work with or have partnerships with any of these community service providers? (Check all that apply)
   ☐ Friendly Visitor Volunteer Program
   ☐ Respite Care
   ☐ Meals-on-Wheels
   ☐ Visiting Doctors
   ☐ Community Chaplains
   ☐ Legal Services
   ☐ Social Services
   ☐ Local Agencies on Aging
   ☐ Disease-specific Associations (e.g., Alzheimer's Association)
   ☐ Other: _______________

Please select all community organizations with which your palliative care program has a relationship. If there is an organization not listed here or in the previous question with which you partner, please indicate that in "other."

6. Is your organization a member of an Accountable Care Organization (ACO)?
   a. Yes
   b. No
   c. I don't know

An Accountable Care Organizations (ACO) is a group of providers organized to take responsibility for the overall quality of care and the total cost of all the health care services needed by a group of patients over a period of time. An Accountable Care Organization is not a payment model; it is an organizational structure designed to accept accountability for care delivery quality and costs. ACOs can be a Medicare ACO (Medicare Shared Savings Program, Advance Payment ACO Model, or Pioneer ACO Model) or a commercial ACO.

7. Is your home palliative care program primarily a pediatric program?
    a. Yes
    b. No

Please select "yes" if your program identifies as a pediatric palliative care program and primarily accepts referrals for children and infants. Many pediatric programs may also see young adults over the age of 18 or other patient populations, but still consider themselves a pediatric palliative care program. We may release special reports and findings on pediatric palliative care using this question's responses to categorize programs.

8. From what age groups will you accept new referrals?
    - ☐ Pediatric (less than 18 years)
        - ☐ Prenatal (before birth)
        - ☐ Neonate (birth to 28 days)
        - ☐ Infant (29 days to 11 months)
        - ☐ Children (12 months to 12 years)
        - ☐ Adolescent (13 to 17 years)
    - ☐ Young Adult (18 to 25 years)
    - ☐ Adult (26 years and older)

Please select all ages served by your palliative care program during the reporting period. If selecting "Pediatric", there is an option to provide further details on that population, although this is not required. Young adult is a separate category to represent the unique needs of this population.

9. Has your home palliative care program been in operation for 12 full months?
    a. Yes
    b. No

Data from palliative care programs that are less than one-year-old can be still submitted. Please report your data accurately for that time period. For example, if your program was operational for only 3 months, then report the data for the actual 3-month period. Do not provide estimates for the entire year based on your 3-month performance.

9a. If not 12 months, how many months of data are your reporting? ________________

If your program has been in operation for less than 10 months, your program data will not be included in any reports or findings that we produce.

Module 2. Patient Visits

1. What is the average daily census (ADC) for your home palliative care program? ________________

   Average daily census is the average number of people served in a single day during the reporting period; the figure is calculated by dividing the number of patient days by the number of days in the reporting period.

2. How many palliative care patients did you have on your service during the reporting period? ________________

   Please provide the total number of patients that were on your home palliative care service during the reporting period. These can be patients that were enrolled in previous years as well as new enrollees during the reporting period.

3. How many patients were new to your home-based palliative care program or enrolled in the palliative care program during the reporting period? ________________

   Please provide the total number of patients that were new to the program during the reporting period. This number should not include patients that were enrolled in previous years and still on the palliative care service. However, this number should include patients that went off the service and were re-enrolled during the reporting period. This number should be less than or equal to the previous question's answer.

4. What was the total number of follow-up in-person visits completed by your home-based palliative care program during the reporting period? ________________

   Provide the number of follow-up in-person visits that your palliative care program provided during the reporting period. In-person visits can be provided by physicians, nurses, social workers, chaplains, administrative staff, volunteers, and other members of the palliative care team.

5. What was the total number of follow-up phone calls (excluding telemedicine) completed by your home palliative care team during the reporting period? ________________

   Provide the number of follow-up phone calls that your palliative care program provided during the reporting period. Follow-up calls can be provided by physicians, nurses, social workers, chaplains, administrative staff, volunteers, and other members of the palliative care team.

6. Does your palliative care team provide telemedicine services?
   a. Yes, audio and video (e.g., Skype)
   b. No, audio only (phone only)
   c. No

   Telemedicine or telehealth can be defined broadly as the use of telecommunications technology to provide medical informational services to parties that are remote from each other. For this question, we define

telemedicine as video conferencing. Telemedicine can increase utilization and access to palliative care specialists.

6a. If yes, approximately what percentage of your patients use telemedicine services?

____

Provide the approximate percentage of your palliative care patients that utilize the telemedicine services your program offers. This number should be less than 100%.

7. Considering all initial (first) palliative care in-home visits, who completes these visits? Provide percentage by provider type.
   a. Physician (MD/DO) ________
   b. Advance Practice Registered Nurse (APRN) ________
   c. Physician Assistant (PA) ________
   d. Registered Nurse (RN) ________
   e. Licensed Practicing Nurse (LPN) ________
   f. Certified Nursing Assistant (CNA) ________
   g. Social Worker ________
   h. Case Manager ________
   i. Community Health Worker ________
   j. Chaplain/Spiritual Care Provider ________
   k. Volunteer ________
   l. Other: ________________ ________

   For the first time that the palliative care program visits a patient in their home, who provides these visits? These numbers do not need to add to 100% as more than 1 person may be completing all initial visits with patients. For example, if the physician and APRN both provide all first in-home visits with patients, your response should show 100% for physicians and 100% for APRNs. If provided by a title not listed, please specify the title and percentage in the "other."

8. Considering all follow-up in-home visits, who completes these visits? Provide percent of follow-up visits by provider type.
   a. Physician (MD/DO) ________
   b. Advance Practice Registered Nurse (APRN) ________
   c. Physician Assistant (PA) ________
   d. Registered Nurse (RN) ________
   e. Licensed Practicing Nurse (LPN) ________
   f. Certified Nursing Assistant (CNA) ________

g. Social Worker ________
h. Case Manager ________
i. Community Health Worker ________
j. Chaplain/Spiritual Care Provider ________
k. Volunteer ________
l. Other: ________________ ________

For all follow-up in-home visits with patients, who provides these visits? These numbers do not need to add to 100%. If a social worker is present during all follow-up visits, you should put 100% for social worker and put the appropriate percentage for the other titles. If provided by a title not listed, please specify the title and percentage in the "other."

9. Considering all follow-up phone calls (excluding telemedicine), who completes these calls? Provide percent of follow-up phone calls by provider type.
   a. Physician (MD/DO) ________
   b. Advance Practice Registered Nurse (APRN) ________
   c. Physician Assistant (PA) ________
   d. Registered Nurse (RN) ________
   e. Licensed Practicing Nurse (LPN) ________
   f. Certified Nursing Assistant (CNA) ________
   g. Social Worker ________
   h. Case Manager ________
   i. Community Health Worker ________
   j. Chaplain/Spiritual Care Provider ________
   k. Volunteer ________
   l. Other: ________________ ________

   For all follow-up phone calls with patients, who provides these calls? These numbers do not need to add to 100%. If provided by a title not listed, please specify the title and percentage in the "other."

10. Considering all patient telemedicine contacts, who completes these? Provide percent of telemedicine contacts by provider type.
   a. Physician (MD/DO) ________
   b. Advance Practice Registered Nurse (APRN) ________
   c. Physician Assistant (PA) ________
   d. Registered Nurse (RN) ________
   e. Licensed Practicing Nurse (LPN) ________

f. Certified Nursing Assistant (CNA) ________
g. Social Worker ________
h. Case Manager ________
i. Community Health Worker ________
j. Chaplain/Spiritual Care Provider ________
k. Volunteer ________
l. Other: ________________ ________

If you indicated that your program provided telemedicine services (audio and video) for home palliative care patients, who is providing these video conferences? These numbers do not need to add to 100%. If a case manager is present on all telemedicine contacts and a chaplain joins half of those, you would put 100% for case manager and 50% for chaplains. If provided by a title not listed, please specify the title and percentage in the "other."

11. What is the average amount of time (in minutes) spent traveling to/from in-home visits (round-trip)? ________________

Approximately what is the average time spent traveling, round-trip, for in-home visits. Please provide the average in minutes.

12. What is the average distance traveled, round-trip, for in-home visits (in miles)?

____

Approximately what is the average distance for a round-trip in-home visit for your palliative care program. Please provide the average in miles.

13. Does your palliative care team utilize public transportation for in-home visits?
   a) Yes
   b) No

Examples of public transportation include city buses, trolleybuses, trams, light rail and passenger trains, rapid transit (metro/subway/underground, etc.) and ferries.

Module 3. Patient Demographics

1. Indicate the number of female and male palliative care patients seen by your program during the reporting period.
   a. Female ________
   b. Male ________

Please indicate the number of female and male patients that were on your home palliative care service during the reporting period.

2. Indicate the number of palliative care patients, by age group, seen by your program during the reporting period.
    a. 0 to 1 year ________
    b. 2 to 17 years ________
    c. 18 to 44 years ________
    d. 45 to 64 years ________
    e. 65 to 85 years ________
    f. 86 years or more ________

    Provide a breakdown of your home palliative care patients by age.

3. Please provide the race/ethnic distribution of palliative care patients seen by your program during the reporting period.
    a. Black/African-American, non-Hispanic ________
    b. White/Caucasian, non-Hispanic ________
    c. Asian, non-Hispanic ________
    d. American Indian/Alaska Native, non-Hispanic ________
    e. Hawaiian Native/Pacific Islander, non-Hispanic ________
    f. Hispanic/Latino ________
    g. Other/unknown: ________________ ________

    Provide a breakdown of your home palliative care patients by race/ethnicity. For patients where the race or ethnicity is not known, please include those in "Other/unknown."

4. Please provide the number of home palliative care patients seen by your program, during the reporting period, by living situation at the time of referral.

    Living Situation **Number of patients**
    a. Living Alone ________
    b. Living with Healthy Spouse/Other Adult ________
    c. Living with Spouse or Other Adult with Limiting Medical/Physical Conditions ________
    d. Living with Parent or Legal Guardian ________
    e. Living with Adult Child(ren) ________
    f. Living with Another Family Member ________
    g. Living in a Nursing Home ________
    h. Living in an Assisted Living Community/Facility ________
    i. Other: ________________ ________

a. I cannot answer this question

Provide the number of palliative care patients by their living situation at the time of referral. Please select the category that best fits – if a category is missing from the list, please add it in under "other." If you do not collect this data or are not able to answer this question for any reason, select "I cannot answer this question."

5. Does your palliative care program require patients to be homebound?
   a. Yes
   b. No

The patient is considered "homebound" if the patient cannot leave home without considerable and taxing effort. Palliative care patients do not need to be "bed bound" to be considered homebound.

5a. If no, approximately what percentage of your palliative care patients are considered homebound (unable to leave their homes)? _______

The patient is considered "homebound" if the patient cannot leave home without considerable and taxing effort. Palliative care patients do not need to be "bed bound" to be considered homebound.

6. What is the distribution of your palliative care patients by primary insurance coverage?
   a. Medicare (including Medicare Advantage) ________
   b. Medicaid ________
   c. Private Insurance ________
   d. Tricare or Other Military Insurance ________
   e. No Insurance ________
   f. Other: ________________ ________
   a. I cannot answer this question

Please provide the number of your patients in the following primary insurance coverage groups. The Medicare category should also include Medicare Advantage. For patients without insurance, please use the "no insurance option" and for insurance types that do not fit any of the options, include those in "other." If you cannot provide this data, please select "I cannot answer this question."

Module 4. Referral Sources, Diagnosis, and Code Status

1. Where do your referrals come from? Provide the number of home palliative care patients by referral source during the reporting period.

Referral Source **Number of patients**

   a. Office-based or Outpatient Primary Care Practice ________
   b. Specialist Practice ________

c. Health Plan ________
d. Hospital and/or Emergency Department ________
e. Hospice ________
f. Nursing Home/Long-term Care ________
g. Group Home ________
h. Home Health Agency ________
i. Community Service Agency/Organization ________
j. Patient or Family ________
k. Other: ________________ ________
b. I cannot answer this question

We are interested in learning from where home palliative care patients are referred. Please provide the percent breakdown of your palliative care patients during the reporting period by referral source. If there is a referral category that does not fit any of the options, please add it in "other." If you cannot provide this data, please select "I cannot answer this question."

2. Indicate the number of home palliative care patients seen in the following primary underlying diagnosis groupings (secondary categories are optional)

Primary Diagnosis	Number of patients
a. Complex Chronic Conditions/Failure to Thrive	________
b. Dementia	________
c. Cardiac	________
i. CHF	________
ii. Cardiac Arrest	________
iii. MI	________
iv. Other Cardiac	________
d. Cancer	
i. Hematological	________
ii. Non-Hematological	________
e. Pulmonary	________
i. COPD	________
ii. Pneumonia	________
iii. Other Pulmonary	________
f. Neurologic/Stroke/Neurodegenerative	________
g. Renal	________
h. Vascular	________

i. Congenital/Chromosomal ________
j. Infectious/Immunological ________
k. Gastrointestinal ________
l. Hepatic ________
m. Hematology ________
n. Endocrine/Metabolic ________
o. Trauma ________
p. Other: ________________ ________

☐ I cannot answer this question

Provide the total number of home palliative care patients in the disease/diagnostic groups. These should represent the underlying or primary diagnosis category. Secondary categories are not required, but if available, should add up to the total number in the primary category. If you do not track this information or are not able to access it, please check off "I cannot answer this question."

Module 5. Services and Goals of Care

1. Does your palliative care program offer any of the following services for patients in the home? (check all that apply)
   - ☐ Assistance with Patient Activities of Daily Living (ADLs)
   - ☐ Case Management/Patient Navigator
   - ☐ Care Transitions
   - ☐ Our home palliative care program does not provide any of these services

   Please identify which, if any, of the above services you provide to your home palliative care patients. Care Transitions can include the coordination of care for a patient when transferring off of the home palliative care service.

2. Select the top three reasons given by referring providers for the initial palliative care consult:
   - ☐ Pain
   - ☐ Non-pain symptoms
   - ☐ Establishing goals of care
   - ☐ Advance care planning
   - ☐ Withdrawal of treatment
   - ☐ Education or counsel support
   - ☐ Coordination of care
   - ☐ End of life or hospice referral
   - ☐ Other, specify ______________

   Please select the top 3 reasons given by referring clinicians for patient's reason for a palliative care consult.

3. Which of the following does your palliative care program document? (check all that apply)
   - ☐ Goals of Care
   - ☐ Surrogate Decision Maker (or no Surrogate)
   - ☐ Discussion of emotional, psychological, and social needs
   - ☐ Discussion of spiritual/religious concerns
   - ☐ Advance Directive
   - ☐ DNR
   - ☐ POLST/MOLST
   - ☐ Other: _______________

   Please select which items are documented in the patient's record during their time on the home palliative care service. Documentation could include the presence of these discussions or documents, or documentation that they do not have these documents (ex. DNR, POLST form).

4. Do you have policies or procedures in place for the following? (check all that apply)
   - ☐ Regularly scheduled in-person patient/family meetings
   - ☐ Palliative Care Team Wellness
   - ☐ Staff Education and Training

   Examples of a regularly scheduled meeting can include a set time and/or number of days between which the care team meets with a patient and their family to discuss the current plan of care. Common examples of team wellness activities are team retreats, regularly scheduled patient debriefing exercises, relaxation-exercise training, and individual referral for staff counseling. Educational activities are offered to palliative care team members or other health professionals to help improve the quality of care provided to patients and their families.

Module 6. Electronic Health Record

1. Does your home palliative care program us an Electronic Health Record (EHR) for management of the patient's health care?
   a. Yes
   b. No

   An Electronic Health Record (EHR) is an electronic version of a patient's medical history, that is maintained by the provider over time, and may include all of the key administrative clinical data relevant to that persons care under a particular provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports.

1a. If yes, what Electronic Health Record (EHR) do you use? ________________

If your home palliative care program has an electronic health record, please list the name of the electronic health record here.

1b. If yes, do you use mobile technology, like a tablet or laptop computer, to record patient information, at the point of care, into the Electronic Health Record (EHR)?

a. Yes – we use mobile technology, connected to our EHR
b. Yes – we use mobile technology, but it is not connected to our EHR
c. No – we do not use mobile technology

Please select which answer best represents your palliative care program and the use of tablets, laptops, or smartphones to record patient information into the electronic health record.

2. Do you use any mobile applications (apps) in your practice?
   a. Yes
   b. No

A mobile application, most commonly referred to as an app, is a type of application software designed to run on a mobile device, such as a smartphone or tablet computer. Home programs may use mobile applications for recording patient information, sending documents, ordering labs, or communicating with patients or their team.

2a. If yes, please list the mobile applications that your program uses:

________________, ________________, ________________, ________________

Provide the name of the apps that your palliative care program uses in its practice. These apps should be relevant to the services that your palliative care program provides.

Module 7. Discharge Status and Length of Service

1. Of all active patients for this reporting period, provide the number of patients, broken down by patient disposition.

Disposition	**Number of patients**
a. Deceased	________
b. Transferred to Hospice Services	________
c. Remained on Home Palliative Care Service	________
d. Disenrolled from Home Palliative Care Service	________
e. Other: ________________	________

Provide the number of patients that fell into the listed dispositions during the reporting period. If a category is not listed, please add it in the “other” option.

2. Approximately what is the average length of service (in days) for patients on your palliative care home program? _______________

   Provide the average length of stay on the palliative care service from admission date to discharge (or death) date for all patients on your service during the reporting year. This number should be reported in the number of days to 0.0 decimals.

Module 8. Staffing

1. Which of these disciplines constitute your palliative care team? What is the head count (HC) and full-time equivalent (FTE) for each discipline?

Professional Discipline	**Head count**	**FTE**
☐ Physician (MD/DO)	_____	_____
☐ Advanced Practice Registered Nurse	_____	_____
☐ Physician's Assistant (PA)	_____	_____
☐ Registered Nurse (RN)	_____	_____
☐ Medical Resident/Fellow	_____	_____
☐ Licensed Practical Nurse (LPN)	_____	_____
☐ Certified Nursing Assistant (CNA)	_____	_____
☐ Social Worker	_____	_____
☐ Chaplain/Spiritual Care	_____	_____
☐ Patient Navigator	_____	_____
☐ Case Manager	_____	_____
☐ Physical/Occupational Therapist	_____	_____
☐ Speech Therapist	_____	_____
☐ Music/Art Therapist	_____	_____
☐ Child Life Specialist	_____	_____
☐ Dietician/Nutritionist	_____	_____
☐ Pharmacist	_____	_____
☐ Administrator (Non-Physician)	_____	_____
☐ Hospice Liaison	_____	_____
☐ Medical Director (Non-Clinical Time)	_____	_____
☐ Administrative Support	_____	_____
☐ Other: _______________	_____	_____

   For each professional discipline listed, provide the total number of individuals in that role (headcount) and the number of full-time equivalents (FTEs) those individuals represent. Staff numbers should represent staffing dedicated to the palliative care program at this specific site of care and match the time period for

which patient volume is being reported. The head count and FTE indicated can be funded positions (included in your palliative care budget), in-kind (not funded in the palliative care budget but funded from elsewhere in your organization's budget), or volunteer (not supported by your budget or your organization). Examples: A full-time staff member represents 1.0 FTE, whereas a halftime team member would be 0.5 FTE. A palliative care team of 6 physicians where each physician works 25%, would be a head count of 6 and 1.5 FTEs. For programs that serve multiple locations: If a palliative care physician spends half her time in the inpatient setting and the other half of her time in the home setting, the table above for physician would be 1 Headcount and 0.5 FTE for time spent on the home-based palliative care service.

2. Do any members of your team have certification in hospice and palliative care?
    b. Yes
    c. No

Staff certified in palliative care or palliative medicine can include physicians, advanced practice registered nurses, registered nurses, chaplains, or social workers. Include the following:

- Physicians board-certified in Hospice and Palliative Medicine by the American Board of Medical Specialties (ABMS).
- Advanced Practice Nurses and Registered Nurses board-certified by the Hospice and Palliative Credentialing Center (HPCC).
- Chaplains certified in hospice and palliative care by the Association of Professional Chaplains/Board of Chaplaincy Certification or the National Association of Professional Chaplains.
- Social Workers who are certified in Hospice and Palliative Social Work (CHP-SW) from the National Association of Social Workers (NASW). Social Workers may hold either a CHP-SW or be Advanced Certified in Hospice and Palliative Social Workers (ACHP-SW).

2a. If yes, indicate the number (headcount) of staff members with palliative care certification
    d. Physicians ________
    e. Advanced Practice Registered Nurse ________
    f. Registered Nurse ________
    g. Chaplain/Spiritual Care ________
    h. Social Worker _________

Staff certified in palliative care or palliative medicine can include physicians, advanced practice registered nurses, registered nurses, chaplains, or social workers. Include the following:

- Physicians board-certified in Hospice and Palliative Medicine by the American Board of Medical Specialties (ABMS).
- Advanced Practice Nurses and Registered Nurses board-certified by the Hospice and Palliative Credentialing Center (HPCC).
- Chaplains certified in hospice and palliative care by the Association of Professional Chaplains/Board of Chaplaincy Certification or the National Association of Professional Chaplains.

- Social Workers who are certified in Hospice and Palliative Social Work (CHP-SW) from the National Association of Social Workers (NASW). Social Workers may hold either a CHP-SW or be Advanced Certified in Hospice and Palliative Social Workers (ACHP-SW).

3. Does your palliative care program provide 24/7 availability for patients?
   a. Yes
   b. No

   24/7 availability means that your palliative care patients and their families have access to you 24 hours a day, 7 days a week. 24/7 coverage can include in-person, telephone, and/or telehealth access.

3a. If no, what times do you have coverage? (Check all that apply)

- ❏ Weekday, days
- ❏ Weekday, evenings
- ❏ Weekday, nights
- ❏ Weekend, days
- ❏ Weekend, evenings
- ❏ Weekend, nights

If you do not provide 24/7 coverage for your patients and families, please indicate which times you do have coverage. Coverage can include in-person, telephone, and/or telehealth access.

4. Approximately what percent of your total program budget comes from the following sources (should add to 100%):
   a. Financial support from hospital or other parent organization (including salary stipends, not including philanthropy) ______________
   b. Fee for service clinician billing (including Medicare Part B) ______________
   c. Bonus payments for quality measures ______________
   d. Subsidy from partner organizations ______________
   e. Financial contracts/service agreements with other providers or vendors (where you do not bill the payer directly) ______________
   f. Philanthropic and foundation support ______________
   g. Not funded ______________
   h. Other, specify______________ ______________

☐ I cannot answer this question

Provide an approximate breakdown of your total program budget. The sum should equal 100%. If your funding comes from a category that is not listed, please add it under “Other.” If you cannot answer this question, please select “I cannot answer this question.”

5. Which of the following quality metrics do you track? (Check all that apply)
   - ☐ Hospital admissions per 1,000 patients
   - ☐ Emergency Department visits per 1,000 patients
   - ☐ Non-hospital Deaths
   - ☐ Hospice length of stay (Mean and Median)
   - ☐ Program length of stay (Mean and Median)
   - ☐ Patient Satisfaction
   - ☐ Family Satisfaction
   - ☐ Other: _______________

If you do not provide 24/7 coverage for your patients and families, please indicate which times you do have coverage. Coverage can include in-person, telephone, and/or telehealth access.

Module 9. Pediatric Palliative Care Coming soon!