Research, Quality Improvement, and Data Collection

A Survey of Health Care for the Homeless Grantees & Medical Respite Programs

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NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

Internal Document

Background

The Health Care for the Homeless (HCH) Practice-Based Research network (PBRN) was established in 2007. Its mission is to facilitate improvement of health care practice and policy for homeless individuals and families through effective use of research. Federally-funded HCH grantees, and their subcontractors, Medical Respite Care Programs, and Projects for Assistance in Transition from Homelessness (PATH) programs are eligible to join the PBRN. Historically, new PBRN members were asked to complete a survey when they joined to examine research interests, experiences, and capacity. Results of the survey provided network leadership and collaborators information needed to develop research studies and evaluate the appropriateness of proposed studies for the PBRN membership.

Purpose

As of fall 2014, the PBRN membership had grown to approximately 35 members. Much of the data on members was outdated and PBRN leadership wanted to learn more about quality improvement activities and interests of members. Quality Improvement projects can be very informative and also less burdensome, more affordable, and less time intensive than large-scale research studies. In addition, PBRN leadership wanted to make a meaningful effort to recruit more members. The PBRN has been involved in a number of multi-site research studies and at times has had to go beyond the membership to recruit participants for these studies. Expanding PBRN membership would provide a larger pool of clinics from which to recruit participants as new studies arise. A survey sent to all HCH grantees and Medical Respite programs with new and modified questions would help accomplish the goals of gathering updated information on current PBRN members and non-members, and recruiting new members to the network.

Methodology

On October 15, email invitations were sent to Program Directors of 326 organizations – 254 Health Care for the Homeless (HCH) grantees and 72 Medical Respite Care Programs – to complete the HCH Research, Quality Improvement, and Data Collection Survey. (Invitation in Appendix A.) All known HCH grantees and respite programs were included. Program Director contacts were identified through the National HCH Council database and files updated and managed by staff. If those individuals were unable to respond, they were asked to forward the survey to someone else in the organization to complete.

The survey was modified to include questions about quality improvement, patient satisfaction practices, and technical assistance needs and included 32 multiple choice and open-ended questions. The survey was administered using an online platform (SurveyMonkey) for ease of data collection and management. It remained open for 6 weeks with 3 reminders sent during that time. (Survey in Appendix B.)

Week 1 (Oct 15-21) = 20 responses (1st survey invite – Oct 15)
Week 2 (Oct 22-Oct 28) = 2 responses
Week 3 (Oct 29-Nov 4) = 22 responses (1st reminder – Oct 29)
Week 4 (Nov 5-Nov 11) = 3 responses
Week 5 (Nov 12-Nov 18) = 16 responses (2nd reminder – Nov 17)
Week 6 (Nov 19-26) = 29 responses (3rd reminder – Nov 24, survey closed Nov 26)

Results

Out of the 326 organizations invited to participate, 102 responded. However, ten records were removed because they were incomplete. The final number of records used in analysis was 92, which was 28% of those invited. Respondents represented 38 states with the highest number coming from the following

states: California (14%); Texas (8%); Florida (7%); Connecticut, Massachusetts, New York, Washington (5%); Colorado, Ohio (4%); North Carolina, Virginia (3%). Survey invitations were sent to HCH and Medical Respite Program Directors. Respondents were mostly HCH directors, chief officers, and clinic directors [Table 1].

Table 1. Survey participants by position title*		
	Frequency	Percentage
HCH Coordinator/Program Director	35	38%
CEO/COO/Deputy CEO	20	22%
Medical Director/Clinic Director/Clinic Administrator	13	14%
Resource Development Director/Grants/Integration/Planning	7	8%
Clinician/Provider	5	5%
Support Services Manager/Director	5	5%
Other Manager/Director	5	5%
Health IT	1	1%

*The position titles listed in this table are a combination of pre-determined titles provided in the multiple choice question and qualitative responses provided by respondents.

Survey respondents represented medical respite programs and HCH clinics from a variety of health care settings. The top four organizations represented in this sample were HCH clinics from Community Health Centers, stand-alone HCH clinics, medical respite programs, and shelter-based HCH clinics [Figure 1]. Respondents had an average of 7.19 sites, including satellite practice clinics, associated with their organizations with a range of one to 20. Half of the respondent had 5 sites or less.

Figure 1. Types of settings in which survey respondents operate
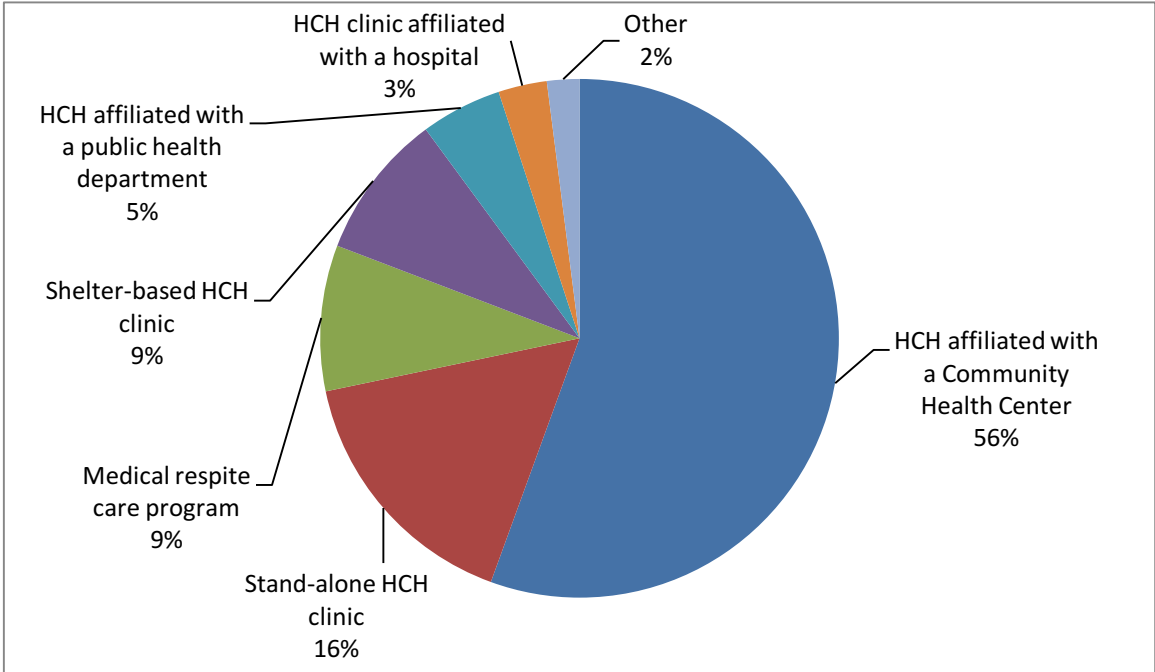
Other
- Shelter based site with HCH FQHC Clinic
- HCH operating as part of a Community Mental Health organization

Almost all survey participants reported serving single adults as a principal population. Half of respondents reported that elderly individuals, families, veterans, and LGBTQ individuals were principal populations served by their agencies [Table 2]. The mean number of single adults served by respondents is over 4,000 and the highest number served was 55,000. Note that this data includes responses from Medical Respite programs that serve much fewer patients than HCH grantees, resulting in very large ranges. Mean number of families served is greater than 5,000 and almost 400 for unaccompanied youth [Table 3].

Table 2. Principal Populations Served (check all that apply)		
	Frequency	Percent
Single adults	91	99%
Elderly	60	65%
Families	57	62%
Veterans	49	53%
LGBTQ	46	50%
Children	44	48%
Pregnant women	38	41%
Unaccompanied youth (13-18 years old)	28	30%
Rural residents	26	28%
Other	10	11%
Farmworkers	(3)	
Anyone regardless of status or age	(2)	
HIV	(2)	
American Indian/Alaska Native	(1)	
Chronically homeless	(1)	
Co-occurring behavioral health	(1)	
Immigrants without documentation	(1)	

Table 3. Estimate of your annual unduplicated patient volume					
	Minimum	Maximum	Mean	Std deviation	n
Single adults	24	55,000	4,163	7,418	72
Persons in families	0	98,000	5,310	15,526	54
Unaccompanied youth (13-18 years old)	47	10,000	372	1,468	47

Survey respondents provide a multitude of services at their organizations [Table 4]. The top five services offered are: primary health care (89%), case management and social services (87%), mental health counseling (78%), health education (78%), and dental services (73%).

Table 4. Services offered by organization	Frequency	Percent
Primary health care	82	89%
Case management/social services	80	87%
Mental health counseling	72	78%
Health education	72	78%
Dental	67	73%
Financial counseling/eligibility assistance	59	64%
Street outreach	55	60%
Other outreach	55	60%
Transportation	52	57%
Pharmacy	50	54%
Interpretation	49	53%
Substance abuse	49	53%
Pediatric	48	52%
Psychiatry	42	46%
Basic needs	39	42%
Prenatal	37	40%
Geriatric	34	37%
Medical respite	33	36%
Mobile clinic	31	34%
Vision	29	32%
Podiatry	27	29%
Housing assistance	25	27%
Supportive housing	24	26%
Specialty care	23	25%
Perinatal	23	25%
Employment assistance	21	23%
Emergency shelter	11	12%
Complementary/alternative medicine	7	8%
Domestic violence shelter	1	1%
Other	8	9%
Food pantry	(1)	
HIV/AIDS clinic (in the future)	(1)	
Nutrition	(1)	
Shower and laundry	(1)	
Syringe exchange harm reduction	(1)	
Suboxone/MAT	(1)	
Specialty clinics by referral	(1)	

Over half of respondents to the survey employ physicians, nurses, case managers, medical assistants, advance practice nurses, social workers, dentists, outreach workers, dental hygienists, and mental health counselors [Table 5]. Less than 25% or respondents employ ophthalmologists/optometrists, podiatrists, or psychologists.

Table 5. Providers at organization (check all that apply)		
	Frequency	Percentage
Physician	78	85%
Nurse	77	84%
Case manager	76	83%
Medical assistant	73	79%
Advance practice nurse	70	76%
Social worker	69	75%
Dentist	65	71%
Outreach worker	61	66%
Dental hygienist	56	61%
Mental health counselor (MA level)	49	53%
Physician assistant	44	48%
Substance abuse counselor	43	47%
Pharmacist	41	45%
Psychiatrist	38	41%
Community health worker	35	38%
Ophthalmologist/optometrist	21	23%
Podiatrist	21	23%
Psychologist	15	16%
Other	5	5%
Benefits enrollment specialist, chiropractor	(1)	
Housing specialist, employment specialist	(1)	
Harm reduction specialist, EOW	(1)	
Respite care workers	(1)	
Shelter staff	(1)	

Eighty-nine percent of the participants reported having an Electronic Medical Record (EMR), 9% do not have one, and 2% are in the process of converting from paper to EMR. Fifty-one percent of those with an EMR would be willing to pull patient data for research or quality improvement activities in collaboration with the National HCH Council and other HCH grantees; 38% were unsure and only 1% stated they would not.

Sixty percent of the participants reported their organization had participated in research. The next section will include results from a part of the survey that was only administered to participants who responded that their organization had participated in research (n=55).

Of those sites who have participated in research, 80% do not have dedicated research staff or a research department. Eighteen percent do have dedicated research staff or a research department [Figure 2]. Of those organizations, one has 8 FTE, two have 2 FTE and 2 have 1 FTE or less. At this point, 6 survey respondents did answer any more questions regarding research experience, so the new n=49. Sixty-two percent of these organizations reported they did not have an established research review process [Figure 3].

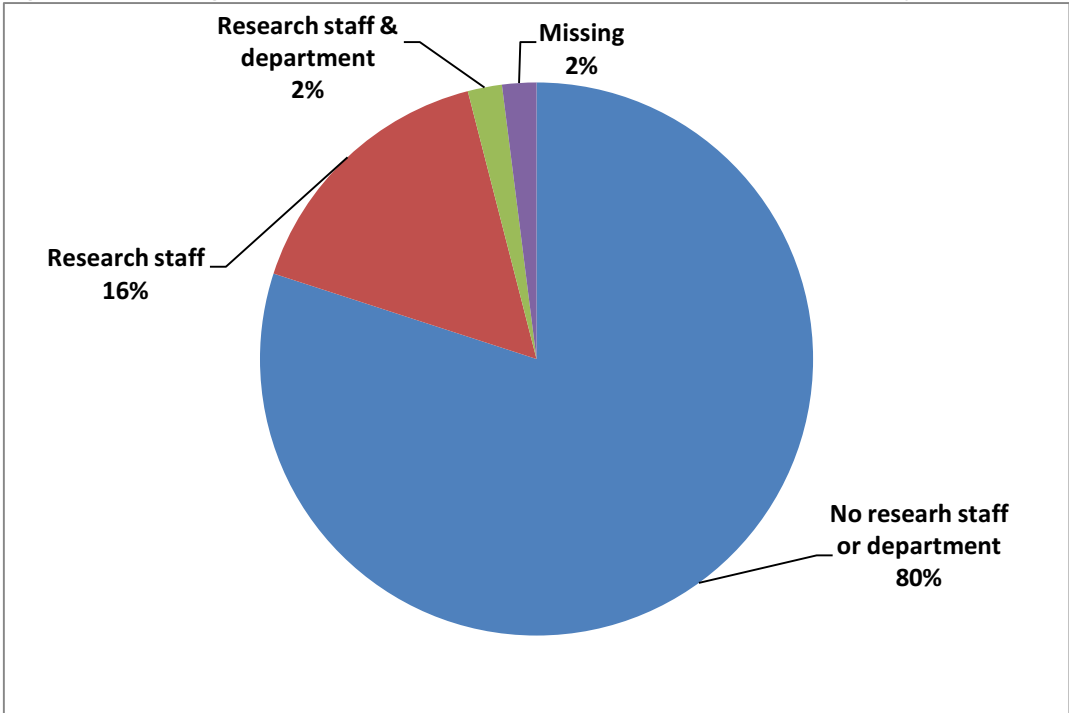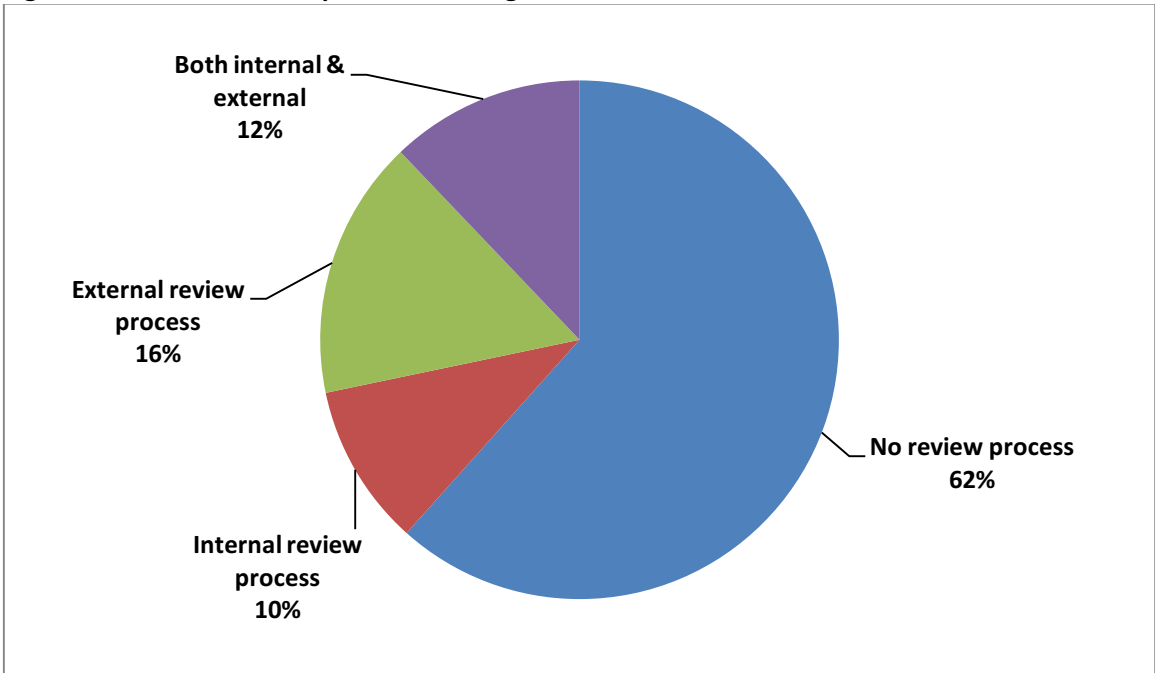**Figure 2. Does organization have dedicated research staff or a research department?**

**Figure 3. Research review processes at organization**

Organizations who have conducted research have collaborated with many types of partners, including: academic institutions (65%), community organizations (45%), government agencies (39%), other health centers (35%), and hospitals (22%). Other partners described were philanthropic organizations, the

National HCH Council, and evaluation agencies. Organizations have received a mix of external and internal support for research activities and materials though 43% reported that their staff must fit research activities into their full-time duties [Table 6].

Table 6. How does organization support research (check all that apply)		
	Frequency	**Percentage**
External – academic	18	37%
External – foundation	16	33%
External – federal	15	31%
External – local or community agency	9	18%
External – supporting staff effort	8	16%
External – supporting research materials, supplies, equipment	2	4%
Internal – supporting staff effort	13	27%
Internal – operations budget	10	20%
Internal – supporting research materials, supplies, equipment	8	16%
Staff must fit research activities into their other full-time duties	21	43%

Forty-one percent of the organizations had received zero external funding in the last 10 years compared to 18% whose research projects had been 100% externally funded [Figure 4].

Figure 4. Percent of research projects externally funded in past 10 years
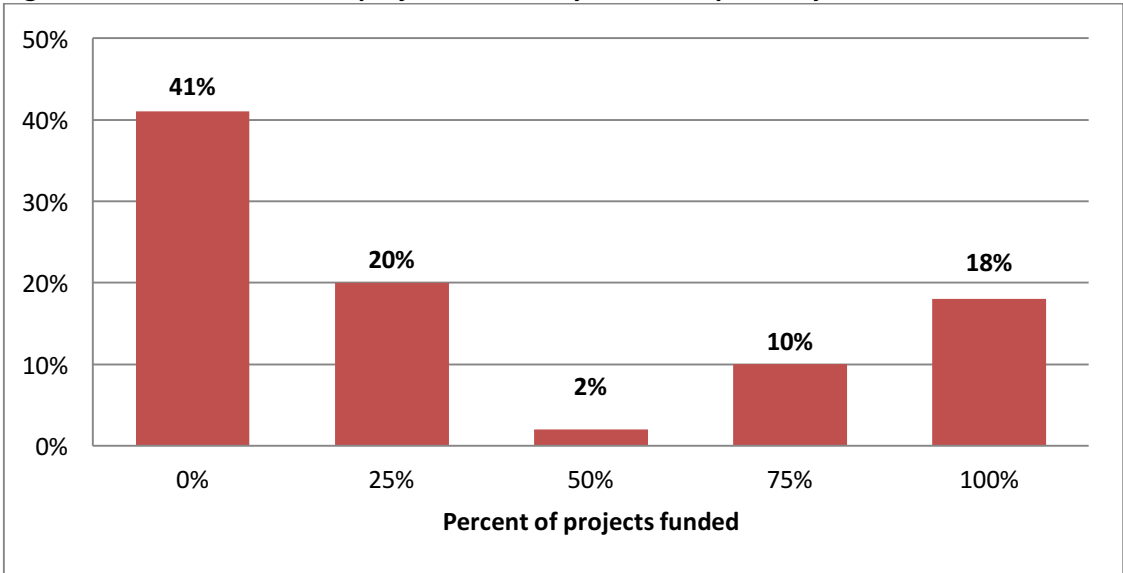
Survey participants were asked to list up to five of the most important research projects conducted at their agencies in the past 10 years. Thirty-six participants provided qualitative answers and they are

provided below in themes developed during analysis. Chronic disease management, behavioral health (including mental health and substance use), and housing were the most commonly reported areas of study.

- Chronic disease management (14)
    - Obesity
    - Chronic Disease Management
    - HEAT - hypertension
    - Diabetes patient education
    - Diabetes data integrity
    - Diabetes Improvement and Behavioral Health
    - Diabetes collaborative
    - Cardiovascular collaborative
    - Asthma collaborative
    - Clinical Directors Network (CDN) - Diabetes
    - Identifying High Risk Cardiovascular Disease Patients using Electronic Health Record Data
    - Managing diabetes in African American women aged 25 to 49
    - Diabetes
    - Hypertension
- Behavioral health – mental health and substance use (13)
    - Integrated Health Care for African Americans with Serious Mental Illness Who Are Homeless in Chicago's Edgewater-Uptown Neighborhood
    - Integration of behavioral health into primary care
    - Clinical Directors Network (CDN) - PTSD
    - Integrated Healthcare (behavioral and physical)
    - Smoking cessation
    - Tobacco cessation in homeless individuals
    - NIAAA (UMMS/NHCHC) - (starting up) - Women and Alcohol study
    - OD prevention/Narcan distribution study
    - Tierra Del Sol (research demonstration of trauma-informed, relapse tolerant residential recovery for women and children, SAMHSA-funded)
    - NIDA study for relapse prevention.
    - Re-Entry Collaborative (Suboxone/med-assisted therapy + case management + housing for people struggling with opiate addiction, recently incarcerated and housing unstable)
    - Alcohol/Drug Incentive Program
    - ETOH use in homeless women and programs in primary care
- Housing (7)
    - SAMHSA cooperative agreements - evaluation of permanent supportive housing (Housing First)
    - Albuquerque Heading Home (cost study, Housing First systems initiative for medically vulnerable whose homelessness is most chronic)
    - Evaluation of 100,000 Homes Campaign
    - Housing and Health Care through the AIDS foundation of Chicago
    - Homeless count
    - Mission Housing first (spencer house) PBHCI
    - Implementing Opening Doors at the Community Level (Dissertation for Dr. Kate Fox Nagel, Chief Administrative Officer)

- Enabling services (5)
  - SAMHSA cooperative agreement - evaluation of supportive services to chronically homeless persons
  - CMS/NHCHC - CHW and Diversion of High Risk Patients from ER
  - Enabling Services Study with AAPCHO and the NHCHC
  - Enabling Services project
  - Community Health Workers and HCH: A Partnership to Promote Primary Care
- Health care delivery models (5)
  - Patient Centered Medical Home
  - Respite Care, Dr. Bruce Doblin
  - California Hospital-Based Palliative Care Survey - surveyed about 300 California hospitals about their palliative care programs and how they are structured. Also captured barriers to establishing such programs, how new programs can be implemented, and how to increase the quality of existing programs.
  - Our [HCH] program as a public health model
  - Outreach methods
- Quality improvement (5)
  - GPRA [Government Performance and Results Act]
  - MU [Meaningful Use]
  - UDS [Uniform Data System]
  - Patient Satisfaction initiatives
  - Patient experience study
- Health care utilization (4)
  - Changes in Health Insurance coverage among Health Center Patients: Impact on Health Care Utilization
  - Self Pay Study: Trends in Hospital Utilization by Uninsured Southern Californians - The report utilizes data from the 2000 through 2007 Office of Statewide Health Planning and Development (OSHPD) Patient Discharge and Emergency Department databases as well as 2008 and 2009 hospital surveys to conduct the analyses.
  - ER Diversion program- study of patients and conditions that could have been seen at the health center
  - Health-seeking behaviors surveying in Cleveland's Central Promise Neighborhood
- Infectious diseases (4)
  - Project Focus- HIV opt out testing Gilead Pharma
  - Hep C
  - Clinical Directors Network (CDN) – HIV
  - Los Angeles County Pandemic Flu Hospital Planning Model - Developed and analyzed a model that simulates inpatient and emergency department (ED) care at more than 100 Los Angeles County hospitals.
- Health literacy (3)
  - Johnson & Johnson - Health Literacy
  - Health Literacy projects for men at risk for prostate cancer.
  - Patient literacy
- Cancer (2)
  - Colorectal
  - Cervical cancer screening in homeless women
- Women's health issues (2)

- o   Fred Hutchinson Research center on breast health
- o   Homeless Council research on services for women
- o   Women's health
- Dental (2)
  - o   Kansas University Dental Service
  - o   Restoring Smiles (dentures program)
- Sexual health (2)
  - o   Condom use
  - o   Morehouse College- An overview of Sexual Health Programs
- Trauma (2)
  - o   Study of violence experienced by people experiencing homelessness led by the Council
  - o   Adverse childhood events in homeless patients seen
- Children (2)
  - o   Thrive by Five Washington - Early Learning Initiative
  - o   Early Learning Initiative - Gates Foundation (Ready by Five) study
- Mortality studies (2)
  - o   Mortality in subpopulations
  - o   Causes of mortality and age of mortality
- Needs assessment (2)
  - o   Needs Assessment via community-driven data analysis (meta-analysis of first responder, public utilities assistance, other non-traditional and larger scale data sets indicating prevalence)
  - o   Needs Assessment
- Other
  - o   CDC - National Ambulatory Medical Care Survey (NAMCS)
  - o   Addressing Caregiver Issues with The HSC Foundation - conducted a series of focus groups with caregivers of special needs populations and conducted a qualitative analysis on data collected.
  - o   Healthy Families
  - o   Atlas program
  - o   Medicaid claims utilization and disease burden study
  - o   Physician Workforce Shortage Issues in California's Rural Hospitals - a survey of federally and state designated rural hospitals to understand workforce concerns.

Survey participants were asked to report the factors that contributed to a positive or challenging research experience. Participants whose organizations had not participated in research were asked to consider the same factors as ones that might prevent or encourage them to participate in research. The top three most commonly reported factors that would contribute to a positive research experience or be a facilitator to participating in research were: improvement in health outcomes, improvement in health care delivery, and knowledge gained [Figure 5]. Respondents from organizations that had experience with research and those whose organizations did not ranked these positive factors similarly. Interestingly, those without research experience were more likely to report those factors as contributing to a positive experience.

Figure 5. Factors that contribute to a positive research experience, or would be a facilitator to participating in research
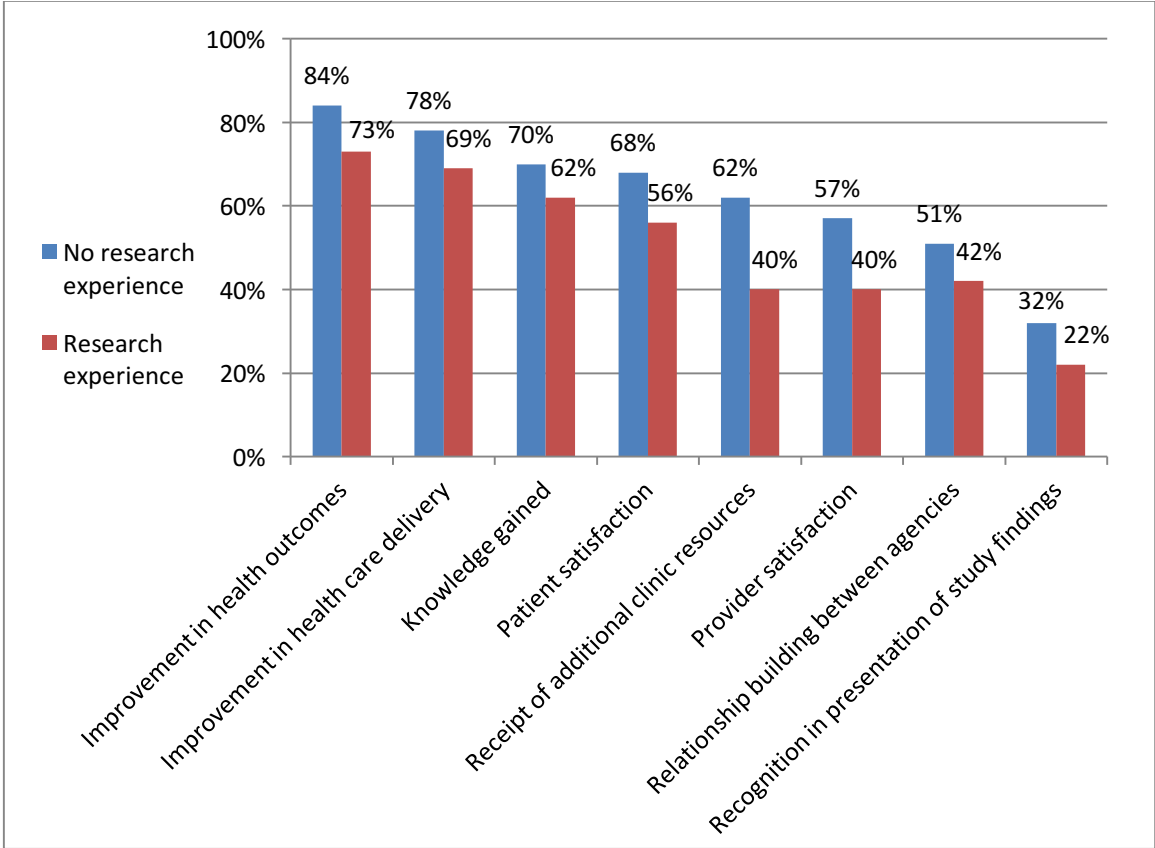
The top factor contributing to a challenging research experience, or preventing an organization from participating in research, was limited resources [Figure 6]. Little or no benefit to clinic or patients was a far second. Factors that respondents provided in addition to the multiple choice options included: time consuming nature of research, the fact that other agencies will not return data, lack of research opportunities, and competing priorities.

Figure 6. Factors that contribute to a challenging research experience, or have prevented organization for joining a research project
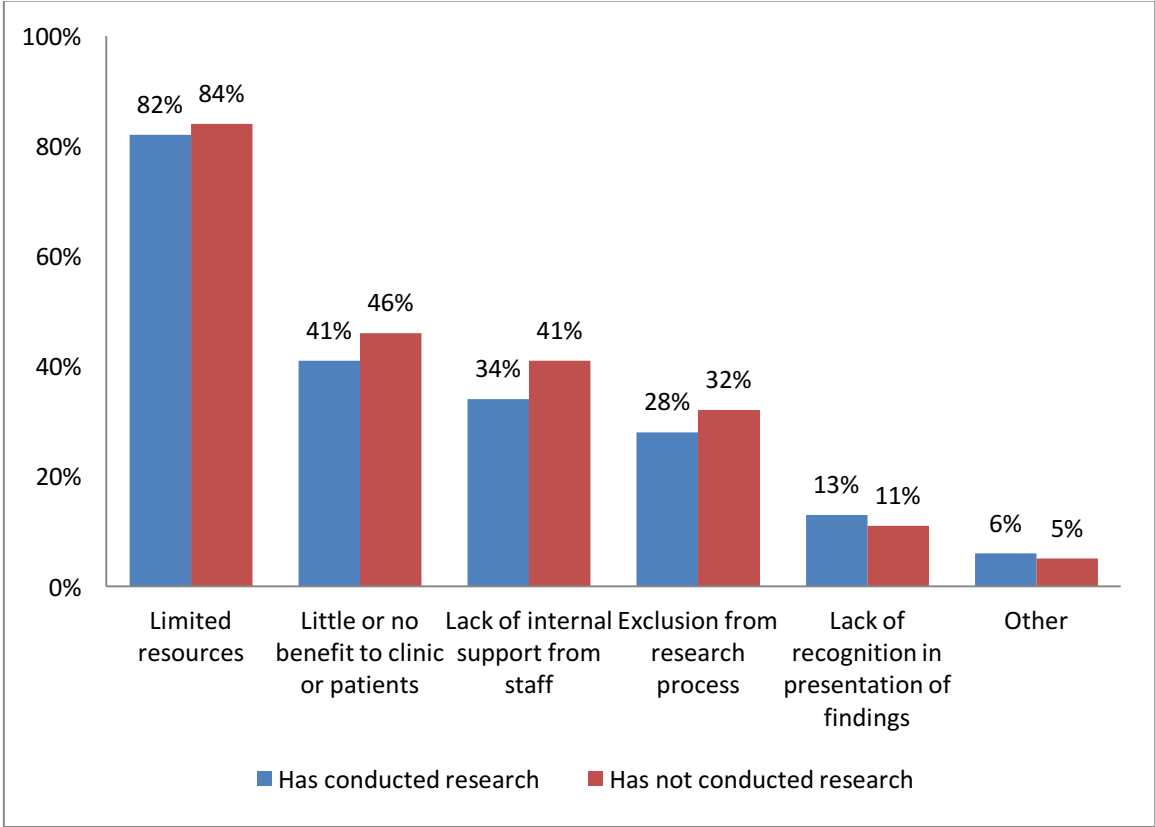
The top 5 topics that respondents would like to learn more about through research are: chronic disease management, mental health, multiple chronic conditions, substance abuse, and housing [Figure 7]. Other response provided that were not included in the multiple choice options were: Preventative health best practices; pain management (alternative therapies), and measuring and addressing ethnic and linguistic disparities. Forty-five percent of respondents would be willing to participate in an unfunded research project.

Survey participants were asked if they were members of the HCH Practice-Based Research network (PRBN). Ten respondents reported they were members of the PBRN and 38 were unsure. Thirty-seven stated they were not PBRN members and, out of those, 21 opted to join.

Figure 7. Topics respondents would like to learn more about through research
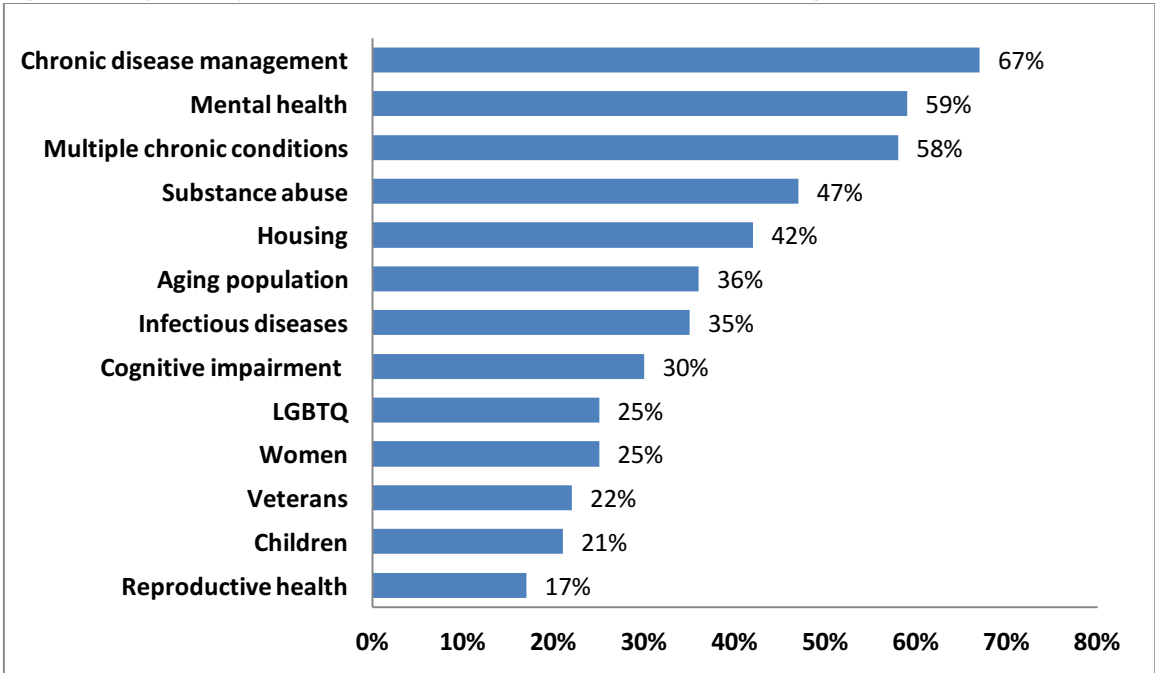
Quality Improvement

The most commonly reported quality improvement priorities were in regards to UDS data and clinical indicators [Figure 8]. Benchmarks, patient safety, and information management were all reported by approximately half of respondents.

Figure 8. Current Quality Improvement priorities of organization
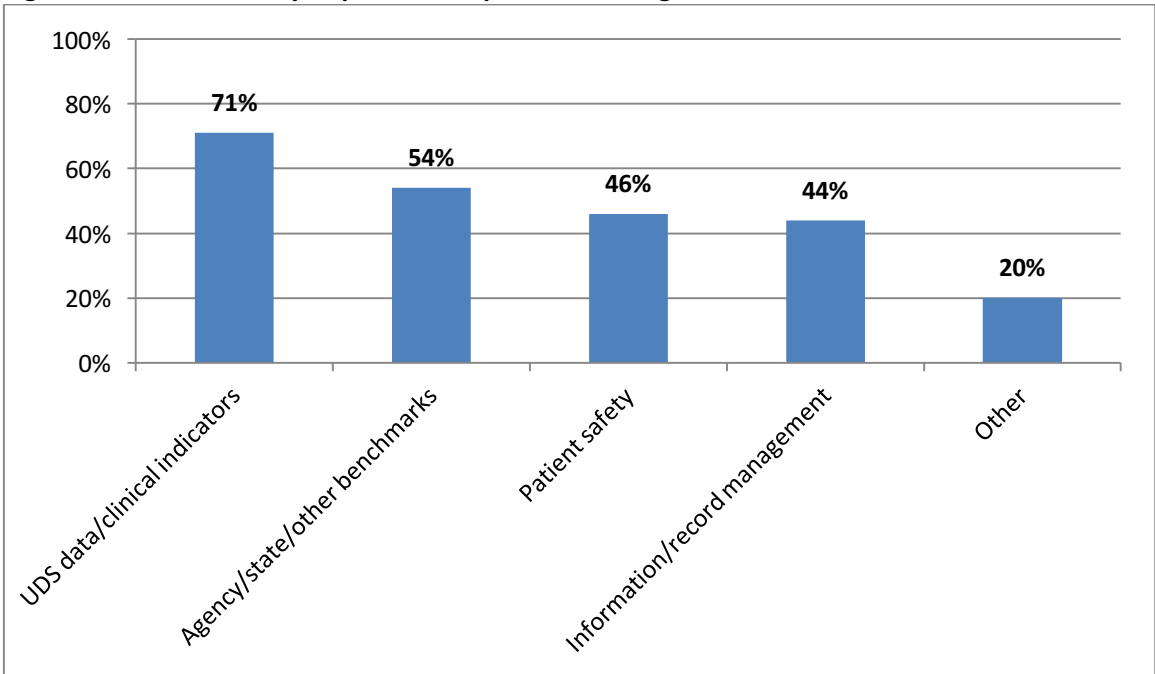
Qualitative responses were organized into themes and provided here.

- Patient outcomes (7)
    - Patient outcomes
    - Patient improvement without readmission to hospital within 30 days
    - Improving patient care - IPC through IHS
    - Improving consumer satisfaction
    - Cross program measures/outcomes
    - Disaggregating outcomes by client demographics
    - Patient satisfaction and more advanced, nuanced metrics
- Operations (7)
    - Organizational management and operations.
    - Performance Improvement Collaborative with PCA
    - Practice Transformation with ACOs
    - Performance improvement
    - Expanding tools, resources and participation in QI
    - Productivity
    - Primary Care and Behavioral Health Care integration
- PCMH (5)
    - PCMH
    - PCMH
    - Patient Centered Medical Home
    - NCQA PCMH
    - Renewal of NCQA Patient Centered Medical Home recognition, Maine PCMH Pilot reporting.
- Meaningful use (5)
    - Meaningful Use
    - Meaningful Use reporting, Meaningful Use Phase one and two criteria
    - EHR System: we are looking into changing our current system as it lacks the reporting capabilities necessary to our organization's needs.
    - Data-driven process and service provision
    - Using data to help improve direct patient care for individual patients is our priority - not broad research that is general in nature.

Thirty-eight percent of respondents reported they would be willing to participate in unfunded Quality Improvement activities with the HCH PBRN; three respondents reported that participation would depend on time, cost, effort required by staff, and extent of project. Fourteen respondents provided ideas for quality improvement projects and they are listed here categorized into themes developed during analysis.

Heath care access and delivery models
- Behavioral health and primary care integration (2)
- Supportive housing and health care integration
- PCMH implementation
- Patient satisfaction
- Access to care after patients leave shelter
- Complex care management

- Applying quality measure to trauma-informed care in HCH setting

Operations/Governance
- Organizational management
- Operations
- Board of Directors
- Finance
- Funding for medical assistance
- Developing meaningful data systems
- Information and record management

Health outcomes
- Improving patient outcomes (2)
- Impact of FQHCs on reducing hospital ED use and hospital readmissions (2)
- Impact of medical respite on hospital ED use, cost reduction, and readmission (2)
- Improving community outcomes
- Identifying and addressing health disparities in rural homeless
- Access and monitor treatment of Hep C
- Improving colorectal cancer screening rates
- Improving pap rates
- Improving contraceptive management
- Developing an agency benchmark

Twenty-one percent of respondents would like training or technical assistance regarding the Uniform Data System. A few respondents shared what kind of training they needed: new or changes in reporting requirements (2); general training for new staff; reporting requirements for Community Health Centers specifically; how to capture data for patients who are referred out for services; and how to capture more data within Practice Analytics system.

Survey participants were asked to supply one UDS measure they could add to reporting if possible. Here is a list of their responses; measures that are already included in UDS reporting are not listed. One person said they would not add more measures.

Demographics
- Social determinants of health (e.g. educational level, household status, etc.) – housing outcomes specifically mentioned 4 times
- Sexual orientation/gender identity
- More specific military/public service history, i.e. ever served in military? If yes, eligible for VA benefits?

Clinical outcomes
- Medication compliance and barriers
- Patient retention
- COPD
- Patients with multiple chronic conditions or with co-occurring medical and mental health or substance use disorders

Quality improvement
- Provider productivity – e.g. patients seen per shift/hour with allowance for patient type (first time visit, homeless or mentally ill, multiple chronic conditions all take longer)

Patient Satisfaction
Eighty-nine percent of respondents currently assess for patient satisfaction and 65% of them were willing to share practices, including instruments used, with the National HCH Council to assist other organizations. Nine percent do not assess for patient satisfaction and 1% were unsure. Thirty-six percent of respondents were interested in receiving assistance is the assessment of patient satisfaction. Below is a list of the types of assistance these respondents would like to receive from the National HCH Council categorized into instrument development and survey methodology.

Survey instrument development
- Sample tools other agencies use (4)
- Tailoring surveys for different patient populations, i.e. homeless (3)
  - Easier, shorter
- Not sure if capturing enough data
- Review tool and recommend improvements
- Determine metric to understand not only patient satisfaction but improved health outcomes

Survey methodology and format
- Best practices in methods of surveying (2)
  - PSS processes for patients with very low literacy rates and those that receive multiple services at one visit
- Developing anonymous electronic survey patients fill out and submit after receiving services

Final comments
Survey participants were provided space to report any final comments on training and technical needs regarding research, quality improvement, and data collection.

- Data collection and management (3)
  - Data collection tools (beyond paper)
  - Data management needs in all areas, in particular related to major changes in the design of our programs. Multiple current manager vacancies must be filled before we can benefit from outside training or technical assistance.
  - Software programs used by other CHC's other than IHS RPMS program
- Research (3)
  - General
  - Startup assistance to model what is being done elsewhere in research, data collection and quality improvement. No research experience.
  - Conducting partnered research with local hospitals (e.g., impact of medical respite on ED use and hospital readmissions)
- Quality improvement (4)
  - General
  - QI software, including safety, incident reporting, mgt, etc. (TA for IT on this)
  - Obtaining homeless specific benchmarks for quality indicators and costs
  - Defining measurable outcomes

Dear Colleague,

We need your input!

You are invited to participate in a survey of Health Care for the Homeless (HCH) grantees and Medical Respite Care Programs regarding Research, Quality Improvement, and Data Collection. The purpose of this survey is to:
(1) understand research and quality improvement interests and capacities of your organization;
(2) capture up-to-date information from our current HCH Practice-Based Research Network (PBRN) members as well as recruit new organizations to become PBRN members; and
(3) identify training and technical assistance needs related to collecting data for quality improvement.

Responses to the survey will help inform research and technical assistance activities of the National Health Care for Homeless Council so that they meet the needs of our constituencies. The survey is online and can be completed by clicking on the following link - http://www.surveymonkey.com/s.aspx . It takes about 15 minutes to complete the survey though you can re-enter the survey at any time to update your response.

Your invitation includes a unique survey link for your organization; therefore, this survey is not anonymous. However, individual level data will not be shared outside of our organization. If we use results from the survey to prepare a research grant application, for example, the data will be presented in aggregate form.

We are providing you with a copy of the survey to print and review so you can consult with other staff before completing the survey online if needed. (Link to printable survey - http://www.nhchc.org/wp-content/uploads/2014/10/2014researchsurvey_final.pdf) The survey asks questions related to services and staffing, research experiences, patient satisfaction assessment, and Uniform Data System training needs. If another staff person is better equipped to complete this survey, please email Molly Meinbresse (mmeinbresse@nhchc.org) and provide new contact information. Since the survey link is uniquely tied to this survey and your email address, please do not forward this message.

The survey will close November 26 at midnight. If you have any questions or problems accessing the survey please contact Molly Meinbresse (mmeinbresse@nhchc.org).

Join us! The mission of the HCH PBRN is to facilitate improvement of health care practice and policy for individuals and families experiencing homelessness through effective use of research. Health Care for the Homeless grantees and medical respite care programs are welcome to join at no cost. No research experience is needed. Read more about the HCH PBRN and its activities here - http://www.nhchc.org/resources/research/practice-based-research-network/.

Thank you for your participation in our work!

The National Health Care for the Homeless Council

Survey Instrument (starting next page)