FORM HHCS-1 (3-29-96)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
U.S. PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL CENTER FOR HEALTH STATISTICS

AGENCY QUESTIONNAIRE

1996 NATIONAL HOME AND **HOSPICE CARE SURVEY**

OMB No. 0920-0298: Approval Expires 03/31/
NOTICE – Public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to DHHS Reports Clearance Officer; Paperwork Reduction Project (0920-0298) Room 531-H; Hubert H. Humphrey Bldg.; 200 Independence Ave., SW; Washington, DC 20201. Information contained on this form which would permit identification of any individual or establishment has been collected with a guarantee that it will be held in strict confidence, will be used for purposes stated for this study, and will not be disclosed or released to others without the consent of the individual or establishment in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

	Section	on A - AGENCY INFO	RMATION	Notes
1a.	Agency tele	phone number		
b.	Alternate tel	lephone number		
c.	Alternate tel	lephone number		
2a. Administrator name				
b.	Respondent	name		
Section B - RECORD OF CONTACTS				
	Day I	Date Time (b) (c)	Notes (d)	
		a.m. p.m.		
		a.m. p.m.		
	•	a.m. p.m.		
		a.m. p.m.		
Trá-		a.m. p.m.		
		on C - RECORD OF I	TEPROPRIATIVE SELECTION	
1.	01 Compl 02 Partial 03 Refusa 04 Unable 05 Not a H 06 Tempo 07 Not ye	il e to locate Hospice/Home Health prarily closed t in operation ger operating		
2.	10 Duplica	d with (Control No.) _ ate (Control No. of du noninterview - Specifi rview	plicate)	
	Month	I Day	l Year	
3.	Field Repres	sentative name	FR Code	

INTRODUCTION	3. NAME VERIFICATION
Good morning (afternoon). My name is I'm from the Bureau of the Census. We are currently conducting the National Home and Hospice Care Survey for the National Center for Health Statistics which is part of the Centers for Disease Control and Prevention. We are studying home health agencies, hospices and their patients. You should have received a letter from Mr. John Anderson, the Acting Director of the National Center for Health Statistics, which describes this project. Have you received this letter? Yes – Skip to Item 3, NAME VERIFICATION. No – Continue with Item 2, SURVEY EXPLANATION. SURVEY EXPLANATION If administrator wants a copy of the letter, explain that you will bring a copy when you visit the agency. I'm sorry that you did not receive the letter. Let me briefly outline its contents. The National Home and Hospice Care Survey is authorized under Section 306 of the Public Health Service Act to collect information about home and hospice care agencies, their services, and patients. The survey is endorsed by the National Association for Home Care and the National Hospice Organization. The statistics compiled from the data are used to support research for effective treatment of long-term health problems and to study utilization of hospice and home care agencies and the efficient use of the Nation's health care resources. All information which would permit identification of the individual patient or agency will be held in strict confidence, will be used ONLY by persons involved	NAME VERIFICATION I would like to verify some information from my records. Is (Name of agency on label) the correct name of your agency? Yes - Go to Item 4, ADDRESS VERIFICATION No - Enter correct agency name below.; Yes - Go to Item 5 - SET APPOINTMENT No - Enter correct agency address below.; Number
in the survey and only for the purposes of the survey, and will not be disclosed or released to others for any purpose. The survey includes a small sample of hospices and home health agencies. Although your participation is voluntary and there are no penalties for refusing to answer any questions, it is essential that we obtain data from all sample agencies. READ IF NECESSARY: We are asking participants for a list of current patients and a list of discharges during a designated one-month period. We will draw a sample of 6 current patients and a sample of 6 discharges from the lists and complete a questionnaire for each of the 12 sampled patients. Continue with Item 3, NAME VERIFICATION.	6. Could you give me directions to your agency from some easy to identify starting point? (Record directions in number 7 below.) Thank you very much for your time. I will see you at (Time) on (Date). Good-bye. 7. DIRECTIONS TO AGENCY (If needed)
Section F - OUESTION	IS ABOUT THE AGENCY
Before I begin the interview, I'd like to take a mome	ent to explain the purpose of the survey. I believe you
(received/did not receive) the letter from the Nation If administrator did not receive the letter, hand him/her a As it says in the letter, the purpose of the National about hospices and home health agencies such as y and will be used only by persons involved in the sur	copy. Allow him/her to briefly read it through. Home and Hospice Care Survey is to collect information rours. The information you provide is strictly confidential
HAND FLASHCARD 1 a. What is the type of ownership of this agency as shown on this card? Mark (X) only ONE box.	o1 ☐ PROPRIETARY – Includes individual or private, partnership, corporation o2 ☐ NONPROFIT – Includes church-related, nonprofit corporation, other nonprofit ownership o3 ☐ STATE OR LOCAL GOVERNMENT – Includes State, county, city, city-county, hospital district or authority o4 ☐ FEDERAL GOVERNMENT – Includes USPHS, Armed Forces, Veterans Administration o5 ☐ Other – Specify
b. Does this agency operate under the general	! 01 ☐ Yes

	Section E - QUESTIONS ABOUT	T THE AGENCY - Continued
c.	Does this agency operate under the general authority of a nursing home?	01 ☐ Yes 02 ☐ No
d.	Is (Name of agency) a member of a group of agencies operating under one corporate authority or corporate ownership?	01 ☐ Yes 02 ☐ No
2.	Does this agency operate under the authority of a Health Maintenance Organization (HMO)?	01 ☐ Yes 02 ☐ No
За.	Is this agency certified under Medicare as a Home Health Agency?	01 ☐ Yes 1 02 ☐ No 03 ☐ Certification pending
b.	Is this agency certified under Medicare as a Hospice?	01 ☐ Yes 02 ☐ No 03 ☐ Certification pending
4a.	Is this agency certified under Medicald as a Home Health Agency?	01 ☐ Yes 02 ☐ No 03 ☐ Certification pending
b.	Is this agency certified under Medicaid as a Hospice?	01 ☐ Yes 02 ☐ No 03 ☐ Certification pending
5a.	Does this agency provide bereavement care to families of the patients that you serve?	01 ☐ Yes 02 ☐ No
b.	Does this agency provide pastoral care?	01 ☐ Yes 02 ☐ No
	HAND FLASHCARD 2	l oo □ None
6.	Does this agency provide any of the following services?	01 ☐ Continuous home care 02 ☐ Counseling
	Mark (X) all that apply.	03 Dental treatment services 04 Dietary and nutritional services
	Probe: Any other services?	05 ☐ Durable medical equipment and supplies
		1 06 Enterostomal therapy
	*	07 ☐ High tech care (e.g., IV therapy) 08 ☐ Homemaker/Companion services
		os ☐ Meals on Wheels
		10 ☐ Medications 11 ☐ Occupational therapy/Vocational therapy
		1 12 Oral hygiene/Prevention services
		13 ☐ Personal care
		14 Physical therapy
		I 15 ☐ Physician services
		17 Respite care (inpatient)
		18 Skilled nursing services
		19 Social Services
		20 Speech therapy/Audiology
		1 21 Spiritual care 22 Transportation
		23 Volunteers
		24 ☐ Other services – Specify ⊋
7a.	Does this agency currently have any active	01 ☐ Yes – GO to item 7b
	patients?	02 □ No - THANK THE RESPONDENT, END THE INTERVIEW, AND MARK CODE 11 IN SECTION C ON THE COVER PAGE.
b	. What is the number of your current active patients?	
		99999 ☐ Don't know
8a	. What is the number of home health care patients currently being served by this agency?	Number of home health patients
		0000 ☐ None 99999 ☐ Don't know
b	. What is the number of hospice care patients currently being served by this agency?	Number of hospice patients
in the		0000 ☐ None 1 99999 ☐ Don't know
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Section E – QUESTIONS ABOUT THE AGENCY – Continued To complete this survey, I will need a list of all current home health and hospice patients, and a list of all home health and hospice discharges for the month of (Insert discharge sample month and year).

From whom shall I obtain the list of current patients?	Name
<u> </u>	Title
	Title
I will need these patients' medical records and the cooperation of a staff member best acquainted with these patients in order to obtain the information on this questionnaire.	
Hand the administrator a copy of the current patient questionnaire. Allow him/her to examine it briefly. Retrieve the questionnaire and continue reading.	on ☐ Yes – GO to item 10a on ☐ No – Determine which staff member would have this knowledge and enter the name and title below. knowledge
I will not be contacting or interviewing the patients in any way. I will depend on your staff to consult the medical records.	Name
b. Would (person named in item 9a) know which staff member I should interview for those patients selected for the sample?	Title
a. From whom shall I obtain the list of discharges?	Same as 9a
	Name
La companya da la co	Title
[12]	
I will need the help of a staff person familiar with the discharge records to aid me in completing the information requested in this questionnaire. Hand the administrator a copy of the discharged patient questionnaire. Allow him/her to examine it briefly.	01 ☐ Yes – GO to item 11 below 02 ☐ No – Determine which staff member would have this knowledge and enter the name and title below. ⊋
B. Would (person named in item 10a) know which staff	Name
member I should interview for those discharges that fall into the sample?	T'.1.
	Title
1. Thank you for your time. I will be checking with you be Ât this time, could you introduce me to (Names of personates	fore I leave to say good-bye.
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