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FORM **HHCS-3**
(3-27-98)

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

CURRENT PATIENT QUESTIONNAIRE

1998 NATIONAL HOME AND HOSPICE CARE SURVEY

Section A – ADMINISTRATIVE INFORMATION

1. Field representative name	2. FR code	3. Date of interview							
		Month		Day		Year			

Section B – PATIENT INFORMATION

1. Patient name or other identifier			2. Patient line number
First	M.I.	Last	

Section C – STATUS OF INTERVIEW

01 ☐ Complete
02 ☐ Partial
03 ☐ Patient included in sampling list in error
04 ☐ Incorrect sample line number selected
05 ☐ Refused
06 ☐ Assessment only
07 ☐ Unable to locate record
08 ☐ Less than 6 patients selected
09 ☐ Other noninterview – *Specify* _____
10 ☐ No current patients

NOTES

Read to each new respondent.

In order to obtain national level data about the patients of hospices and home health agencies such as this one, we are collecting information about a sample of current patients. I will be asking questions about the background, health status, treatment, social contacts, and billing information for each sampled patient.

The information you provide will be held in strict confidence and will be used ONLY by persons involved in the survey and only for the purposes of the survey.

In answering these questions, it is especially important to locate the information in the patient's medical record. Do you have the medical file(s) and record(s) for *(Read name(s) of selected current patient(s))***?**

If not, ask the respondent to get it/them prior to beginning the interview. Fill sections A and B on the front of all the current patient forms while the respondent gets the records. If no record is available for a patient, try to obtain as much information as possible from whatever administrative records are available and/or from the respondent's memory.

1. What is . . .'s sex?

01 ☐ Male
02 ☐ Female

2. What is . . .'s date of birth?

Current age

Month		Day		Year				OR	OR
									Years / Months

3a. Is . . . of Hispanic or Latino origin?

01 ☐ Yes
02 ☐ No
03 ☐ Don't know

HAND FLASHCARD 1.

b. Which of these best describes . . .'s race?

Mark (X) one or more boxes.

01 ☐ American Indian or Alaska Native
02 ☐ Asian
03 ☐ Black or African American
04 ☐ Native Hawaiian or other Pacific Islander
05 ☐ White
06 ☐ Other – *Specify* _____
07 ☐ Don't know

4. What is . . .'s current marital status?

Mark (X) only one box.

01 ☐ Married
02 ☐ Widowed
03 ☐ Divorced
04 ☐ Separated
05 ☐ Never married
06 ☐ Single
07 ☐ Don't know

HAND FLASHCARD 2.

5a. Where is . . . currently living?

Mark (X) only one box.

01 ☐ Private residence (house or apartment)
02 ☐ Rented room, boarding house
03 ☐ Retirement home
04 ☐ Board and care, assisted living, or residential care facility
05 ☐ Nursing home, hospital, or other inpatient health facility (including mental health facility) – *SKIP to item 6 Introduction*
06 ☐ Other – *Specify* _____

b. Is . . . living with family members, nonfamily members, both family and nonfamily members, or alone?

01 ☐ With family members
02 ☐ With nonfamily members
03 ☐ With both family members and nonfamily members
04 ☐ Alone
05 ☐ Don't know

Read the introductory paragraph for the Social Security Number only once for each respondent.

As part of this survey, we would like to have . . .'s Social Security Number. Provision of this number is voluntary and providing or not providing the number will have no effect in any way on . . .'s benefits. This number will be useful in conducting future followup studies. It will be used to match against the vital statistics records maintained by the National Center for Health Statistics. This information is collected under the authority of Section 306 of the Public Health Service Act.

6. What is . . .'s Social Security Number?

Social Security Number

☐☐☐ – ☐☐ – ☐☐☐☐

01 ☐ Refused
02 ☐ Don't know

HAND FLASHCARD 3.

7. Who referred . . . to this agency?

Mark (X) all that apply.

PROBE: **Any other sources?**

01 ☐ Self/Family
02 ☐ Nursing home
03 ☐ Hospital
04 ☐ Physician
05 ☐ Health department
06 ☐ Social service agency
07 ☐ Home health agency
08 ☐ Hospice
09 ☐ Religious organization
10 ☐ Health maintenance organization
11 ☐ Friend/Neighbor
12 ☐ Other – *Specify* _____
13 ☐ Don't know

8. What was the date of . . .'s most recent admission with your agency, that is, the date on which . . . was admitted for the current episode of care?

Month	Day	Year
☐☐	☐☐	☐☐☐☐

00 ☐ Only an assessment was done for this patient (patient was not provided services by this agency)

9a. According to . . .'s medical record, what were the primary and other diagnoses at the time of that (admission/assessment)?

PROBE: **Any other diagnoses?**

00 ☐ No diagnosis

Primary: 1 _____

Others: 2 _____

3 _____

4 _____

5 _____

6 _____

*Refer to Q8. If **ONLY** an assessment was done for this patient, END THE INTERVIEW AND MARK STATUS CODE "06" IN SECTION C ON THE COVER. THEN GO TO the next current patient questionnaire.*

If the patient was admitted to the agency and provided services by the agency, CONTINUE this interview.

b. According to . . .'s medical records, what are . . .'s CURRENT primary and other diagnoses?

PROBE: **Any other diagnoses?**

00 ☐ No diagnosis
01 ☐ Same as 9a

Primary: 1 _____

Others: 2 _____

3 _____

4 _____

5 _____

6 _____

9c. According to . . .'s medical record, did . . . have any diagnostic or surgical procedures that were related to . . .'s admission to this agency?

00 ☐ No procedures

01 ☐ Yes 1 _____

2 _____

10. What type of care is . . . currently receiving from your agency? Is it home health care or hospice care?

01 ☐ Home health care
02 ☐ Hospice care
a ☐ In the home or usual place of residence
b ☐ Inpatient

11a. Does . . . have a primary caregiver outside of this agency?

01 ☐ Yes
02 ☐ No. . . . . } *SKIP to item 12*
03 ☐ Don't know }

b. Does . . . usually live with (his/her) primary caregiver?

01 ☐ Yes
02 ☐ No
03 ☐ Don't know

HAND FLASHCARD 5.

c. What is the relationship of the primary caregiver to . . .?

Mark (X) only one box.

01 ☐ Spouse
02 ☐ Parent
03 ☐ Child
04 ☐ Daughter-in-law/Son-in-law
05 ☐ Sister or brother
06 ☐ Other relative – *Specify* _____
07 ☐ Neighbor
08 ☐ Friend
09 ☐ Volunteer group
10 ☐ Paid help/staff of facility where patient resides
11 ☐ Other – *Specify* _____
12 ☐ Don't know

HAND FLASHCARD 6.

12. Which of these aids does . . . currently use?

Mark (X) all that apply.

PROBE: **Any other aids?**

00 ☐ No aids used
01 ☐ Bedside commode
02 ☐ Blood glucose monitor
03 ☐ Brace (any type)
04 ☐ Cane
05 ☐ Crutches
06 ☐ Dentures (full or partial)
07 ☐ Elevated/raised toilet seat
08 ☐ Eyeglasses (including contact lenses)
09 ☐ Grab bars
10 ☐ Hearing aid
11 ☐ Hospital bed
12 ☐ IV therapy equipment
13 ☐ Mattress, special (eggcrate, foam, air, gel, etc.)
14 ☐ Orthotics
15 ☐ Oxygen (including oxygen concentrator)
16 ☐ Shower chair/Bath bench
17 ☐ Walker
18 ☐ Wheel chair – Manually operated
19 ☐ Wheel chair – Motorized
20 ☐ Other – *Specify* _____

For items 13a–14b, refer to item 12.

13a. Does . . . have any difficulty in seeing (when wearing glasses)?

01 ☐ Yes
02 ☐ No . . . . . } *SKIP to item 14a*
03 ☐ Not applicable (e.g., comatose) . . } *SKIP to item 14a*
04 ☐ Don't know . . . . . } *SKIP to item 14a*

HAND FLASHCARD 7.

b. Is . . .'s sight (when wearing glasses) partially, severely, or completely impaired as defined on this card?

01 ☐ Partially impaired
02 ☐ Severely impaired
03 ☐ Completely lost, blind
04 ☐ Don't know

14a. Does . . . have any difficulty in hearing (when wearing a hearing aid)?

01 ☐ Yes
02 ☐ No . . . . . } *SKIP to item 15a*
03 ☐ Not applicable (e.g., comatose) . . } *SKIP to item 15a*
04 ☐ Don't know . . . . . } *SKIP to item 15a*

HAND FLASHCARD 8.

b. Is . . .'s hearing (when wearing a hearing aid) partially, severely, or completely impaired, as defined on this card?

01 ☐ Partially impaired
02 ☐ Severely impaired
03 ☐ Completely lost, deaf
04 ☐ Don't know

15a. Does . . . have an indwelling urinary catheter?

01 ☐ Yes
02 ☐ No . . . . . } *SKIP to item 16*
03 ☐ Don't know . . . . . } *SKIP to item 16*

b. Does . . . receive assistance from your agency staff in caring for this device?

01 ☐ Yes. . . . . } *SKIP to item 17a*
02 ☐ No . . . . . } *SKIP to item 17a*
03 ☐ Don't know . . . . . } *SKIP to item 17a*

16. Does . . . currently have any difficulty in controlling (his/her) bladder?

01 ☐ Yes
02 ☐ No
03 ☐ Infant
04 ☐ Don't know

17a. Does . . . have a colostomy or ileostomy?

01 ☐ Yes
02 ☐ No . . . . . } *SKIP to item 18*
03 ☐ Don't know . . . . . } *SKIP to item 18*

b. Does . . . receive assistance from your agency staff in caring for this device?

01 ☐ Yes. . . . . } *SKIP to item 19*
02 ☐ No . . . . . } *SKIP to item 19*
03 ☐ Don't know . . . . . } *SKIP to item 19*

18. Does . . . currently have any difficulty in controlling (his/her) bowels?

01 ☐ Yes
02 ☐ No
03 ☐ Infant
04 ☐ Don't know

NOTES

HAND FLASHCARD 9.

19. Does . . . currently receive personal help from this agency in any of the following activities as defined on this card - - *Mark (X) one box for each activity.*	Yes	No	Don't know	Not applicable (e.g., patient is bedfast)
a. Bathing or showering?	01 ☐	02 ☐	03 ☐	04 ☐
b. Dressing?	01 ☐	02 ☐	03 ☐	04 ☐
c. Eating?	01 ☐	02 ☐	03 ☐	04 ☐
d. Transferring in or out of beds or chairs?	01 ☐	02 ☐	03 ☐	04 ☐
e. Walking?	01 ☐	02 ☐	03 ☐	04 ☐
f. Using the toilet room?	01 ☐	02 ☐	03 ☐	04 ☐

HAND FLASHCARD 10.

20. Does . . . receive personal help from your agency in any of the following activities as defined on this card – *Mark (X) one box for each activity.*	Yes	No	Don't know	Not applicable (e.g., patient is bedfast)
a. Doing light housework?	01 ☐	02 ☐	03 ☐	04 ☐
b. Managing money?	01 ☐	02 ☐	03 ☐	04 ☐
c. Shopping for groceries or clothes?	01 ☐	02 ☐	03 ☐	04 ☐
d. Using the telephone (dialing or receiving calls)?	01 ☐	02 ☐	03 ☐	04 ☐
e. Preparing meals?	01 ☐	02 ☐	03 ☐	04 ☐
f. Taking medications?	01 ☐	02 ☐	03 ☐	04 ☐

HAND FLASHCARD 11.

21a. Which of these services does . . . currently receive FROM YOUR AGENCY?

Mark (X) all that apply.

PROBE: **Any other services?**

00 ☐ None
01 ☐ Continuous home care
02 ☐ Counseling
03 ☐ Dental treatment services
04 ☐ Dietary/nutritional services
05 ☐ Durable medical equipment and supplies
06 ☐ Enterostomal therapy
07 ☐ Homemaker-household services
08 ☐ IV therapy
09 ☐ Meals on wheels
10 ☐ Medications
11 ☐ Occupational therapy
12 ☐ Oral hygiene/prevention services
13 ☐ Personal care
14 ☐ Physical therapy
15 ☐ Physician services
16 ☐ Psychological services
17 ☐ Referral services
18 ☐ Respiratory therapy
19 ☐ Respite care (inpatient)
20 ☐ Skilled nursing services
21 ☐ Social services
22 ☐ Speech therapy/Audiology
23 ☐ Spiritual care
24 ☐ Transportation
25 ☐ Vocational therapy
26 ☐ Volunteers
27 ☐ Other high tech care (e.g., enteral nutrition, dialysis)
28 ☐ Other services – *Specify* ↙

_____

HAND FLASHCARD 12.

21b. Which of these service providers FROM YOUR AGENCY visited . . . during the last 30 days?

Mark (X) all that apply.

PROBE: **Any other providers?**

00 ☐ None
01 ☐ Chaplain
02 ☐ Dietitians/Nutritionists
03 ☐ Home health aides
04 ☐ Homemakers/Personal caretakers
05 ☐ Licensed practical or vocational nurses
06 ☐ Mental health specialists
07 ☐ Nursing aides and attendants
08 ☐ Occupational therapists
09 ☐ Physical therapists
10 ☐ Physicians
11 ☐ Registered nurses
12 ☐ Respiratory therapists
13 ☐ Social workers
14 ☐ Speech pathologists/audiologists
15 ☐ Volunteers
16 ☐ Other providers – *Specify* ↙

_____

HAND FLASHCARD 13.

22. What is the PRIMARY expected source of payment for . . . 's care?

Mark (X) only one source.

For the source of payment ask:
Is the *(source of payment)* **for home health care or hospice care?**

	Home Health Care	Hospice Care
01 ☐ Medicare		
a. Fee-for-service Medicare . .	01a ☐	01a ☐
b. Medicare HMO	01b ☐	01b ☐
02 ☐ Medicaid		
a. Fee-for-service or traditional Medicaid	02a ☐	02a ☐
b. Privately insured through Medicaid	02b ☐	02b ☐
03 ☐ Other government medical assistance	03 ☐	03 ☐
04 ☐ Private insurance		
a. HMO or IPA	04a ☐	04a ☐
b. Indemnity plan or PPO. . . .	04b ☐	04b ☐
c. Other – *Specify* ↙	04c ☐	04c ☐

_____

05 ☐ Own income, family support, Social Security benefits, retirement funds, or welfare. .	05 ☐	05 ☐
06 ☐ Supplemental Security Income (SSI).	06 ☐	06 ☐
07 ☐ Religious organizations, foundations, agencies	07 ☐	07 ☐
08 ☐ Veterans Administration	08 ☐	08 ☐
09 ☐ CHAMPVA/CHAMPUS	09 ☐	09 ☐
10 ☐ Other military medicine	10 ☐	10 ☐
11 ☐ No charge made for care	*SKIP to item 26*	
12 ☐ Payment source not yet determined		
13 ☐ Other – *Specify* ↙	13 ☐	13 ☐

_____

HAND FLASHCARD 13.

23. What are ALL the secondary sources of payment for . . . 's care?

Mark (X) all that apply.

PROBE: **Any other sources of payment?**

For the source of payment ask:
Is the *(source of payment)* **for home health care or hospice care?**

	Home Health Care	Hospice Care
00 ☐ No secondary sources	00 ☐	00 ☐
01 ☐ Medicare		
a. Fee-for-service Medicare . . .	01a ☐	01a ☐
b. Medicare HMO	01b ☐	01b ☐
02 ☐ Medicaid		
a. Fee-for-service or traditional Medicaid	02a ☐	02a ☐
b. Privately insured through Medicaid	02b ☐	02b ☐
03 ☐ Other government medical assistance	03 ☐	03 ☐
04 ☐ Private insurance		
a. HMO or IPA	04a ☐	04a ☐
b. Indemnity plan or PPO	04b ☐	04b ☐
c. Other – *Specify* ↙	04c ☐	04c ☐
05 ☐ Own income, family support, Social Security benefits, retirement funds, or welfare. . .	05 ☐	05 ☐
06 ☐ Supplemental Security Income (SSI)	06 ☐	06 ☐
07 ☐ Religious organizations, foundations, agencies	07 ☐	07 ☐
08 ☐ Veterans Administration	08 ☐	08 ☐
09 ☐ CHAMPVA/CHAMPUS	09 ☐	09 ☐
10 ☐ Other military medicine	10 ☐	10 ☐
11 ☐ No charge made for care	*SKIP to item 26*	
12 ☐ Payment source not yet determined		
13 ☐ Other – *Specify* ↙	13 ☐	13 ☐

24a. (Last month/since admission) what (are/were) the total charges for . . . 's care, including all charges for services, drugs, special medical supplies, etc., before discounts or adjustments?

$ _____
Total amount

00 ☐ No charge made for care – *SKIP to item 26*
01 ☐ Don't know – *SKIP to item 25*

b. What dates are covered by the amount charged?

Month	Day	Year		Month	Day	Year
			to			

25. Which best describes the way this agency (will be/was) reimbursed for the total charges?

01 ☐ Based on services provided
02 ☐ Capitation (services provided under a capitation agreement or by salaried staff in an HMO)
03 ☐ Don't know

26. When was the last time service was provided?

Month	Day	Year

27a. Does this agency use the Outcome and Assessment Information Set-B (OASIS-B) form proposed by HCFA under Medicare?

01 ☐ Yes
02 ☐ No. . . . . } *End interview. Go to next questionnaire.*
03 ☐ Don't know

b. Is there a completed Outcome and Assessment Information Set-B (OASIS-B) form in the patient's medical record?

01 ☐ Yes
02 ☐ No. . . . . } *End interview. Go to next questionnaire.*
03 ☐ Don't know

Make certain the respondent has the OASIS-B form in front of him/her and answers the following questions using this form. The numbers next to each question correspond to the question numbers on the OASIS-B form. ***Answer these questions exactly the same way there were answered on the OASIS-B form.***

29. (M0310) Structural Barriers in the patient's environment limiting independent mobility.

Mark (X) all that apply.

00 ☐ None
01 ☐ Stairs inside home which must be used by the patient (e.g., to get to toileting, sleeping, eating areas)
02 ☐ Stairs inside home which are used optionally (e.g., to get to laundry facilities)
03 ☐ Stairs leading from inside the house to outside
04 ☐ Narrow or obstructed doorways

37. (M0700) Ambulation/Locomotion: Ability to SAFELY walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

Prior	Current
00 ☐	00 ☐ Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device)
01 ☐	01 ☐ Requires use of a device (e.g., cane, walker) to walk alone or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces
02 ☐	02 ☐ Able to walk only with supervision or assistance of another person at all times
03 ☐	03 ☐ Chairfast, unable to ambulate but is able to wheel self independently
04 ☐	04 ☐ Chairfast, unable to ambulate and is unable to wheel self
05 ☐	05 ☐ Bedfast, unable to ambulate or be up in a chair
06 ☐	UK Unknown

40. (M0730) Transportation: Physical and mental ability to safely use a car, taxi or public transportation (bus, train, subway).

Prior	Current
00 ☐	00 ☐ Able to independently drive a regular car or adapted car, OR uses a regular or handicap-accessible public bus
01 ☐	01 ☐ Able to ride in a car only when driven by another person, OR able to use a bus or handicap van only when assisted or accompanied by another person
02 ☐	02 ☐ Unable to ride in a car, taxi, bus, or van and requires transportation by ambulance
03 ☐	UK Unknown

63. (M0760) Shopping: Ability to plan for, select, and purchase items in a store and to carry them home or arrange delivery.

Prior	Current	
00 ☐	00 ☐	0-(a) Able to plan for shopping needs and independently perform shopping tasks including carrying packages: OR
		(b) Physically, cognitively, and mentally able to take care of shopping, but has not done shopping in the past (i.e., prior to this home care admission)
01 ☐	01 ☐	1-Able to go shopping, but needs some assistance:
		(a) By self is able to do only light shopping and carry small packages, but needs someone to do occasional major shopping: OR
		(b) Unable to go shopping, but can go with someone to assist
02 ☐	02 ☐	2-Unable to go shopping, but is able to identify items needed, place orders, and arrange home delivery
03 ☐	03 ☐	3-Needs someone to do all shopping and errands
04 ☐	UK	Unknown

NOTES

FILL SECTION C ON THE COVER OF THIS FORM AND CONTINUE WITH THE NEXT CURRENT PATIENT QUESTIONNAIRE.

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