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FORM **HHCS-1** (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

AGENCY QUESTIONNAIRE

1998 NATIONAL HOME AND HOSPICE CARE SURVEY

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. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of to 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 A – AGENCY INFORMATION

1a. Agency telephone number	**b.** Alternate telephone number	**c.** Alternate telephone number

2a. Administrator name	**b.** Respondent name

Section B – RECORD OF CONTACTS

Day (a)	Date (b)	Time (c)	Notes (d)
		a.m. p.m.	
		a.m. p.m.	
		a.m. p.m.	
		a.m. p.m.	
		a.m. p.m.	
		a.m. p.m.	
		a.m. p.m.	
		a.m. p.m.	
		a.m. p.m.	

Section C – RECORD OF INTERVIEW

1. STATUS OF INTERVIEW – *Mark (X) appropriate box.*

- 01 ☐ Complete interview
- 02 ☐ Partial interview
- 03 ☐ Refusal
- 04 ☐ Unable to locate
- 05 ☐ Not a Hospice/Home Health Agency
- 06 ☐ Temporarily closed
- 07 ☐ Not yet in operation
- 08 ☐ No longer operating
- 09 ☐ Merged with (Control No.) _____
- 10 ☐ Duplicate (Control No. of duplicate) _____
- 11 ☐ Other noninterview – *Specify* _____

2. Date of interview			**3.** Field Representative name	FR Code
Month	Day	Year		

Notes	Agency FAX number

Section D – ARRANGING THE ADMINISTRATOR APPOINTMENT

1. INTRODUCTION

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 Edward J. Sondik, the 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.*

2. 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 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.

3. 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.* ➶

4. ADDRESS VERIFICATION

Is *(Address of agency on label)* **the correct address?**

☐ Yes – *Go to Item 5 – SET APPOINTMENT*
☐ No – *Enter correct agency address below.* ➶

Number Street	P.O. Box, Route, etc.
City or town	
State	ZIP Code

5. SET APPOINTMENT

I would like to arrange a morning appointment at your convenience to conduct the survey. What would be a convenient date and time to visit your agency?

Day	Date	Time	a.m. p.m.
Day	Date	Time	a.m. p.m.

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 E – QUESTIONS ABOUT THE AGENCY

Before I begin the interview, I'd like to take a moment to explain the purpose of the survey. I believe you (received/did not receive) the letter from the National Center for Health Statistics.

If administrator did not receive the letter, hand him/her a copy. Allow him/her to briefly read it through.

As it says in the letter, the purpose of the National Home and Hospice Care Survey is to collect information about hospices and home health agencies such as yours. The information you provide is strictly confidential and will be used only by persons involved in the survey and only for the purposes of the survey.

HAND FLASHCARD 1

1a. What is the type of ownership of this agency as shown on this card?

Mark (X) only ONE box.

01 ☐ PROPRIETARY – Includes individually or privately owned, partnership, corporation
02 ☐ NONPROFIT – Includes church-related, nonprofit corporation, other nonprofit ownership
03 ☐ STATE OR LOCAL GOVERNMENT – Includes State, county, city, city-county, hospital district or authority
04 ☐ FEDERAL GOVERNMENT – Includes USPHS, Armed Forces, Veterans Administration OR other Federal Government – *Specify if other than listed here* ➶
05 ☐ Other – *Specify* ➶

b. Does this agency operate under the general authority of a hospital?

01 ☐ Yes
02 ☐ No

Section E – QUESTIONS ABOUT THE AGENCY – Continued

1c. 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

3a. Is this agency certified under Medicare as a Home Health Agency?

01 ☐ Yes
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 Medicaid 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. Are the medical records of this agency computerized?

01 ☐ Yes – *Skip to item 6*
02 ☐ No

b. Does this agency plan to computerize its medical records within the next year?

01 ☐ Yes
02 ☐ No

HAND FLASHCARD 2

6. Does this agency provide any of the following services?

Mark (X) all that apply.

Probe: **Any other services?**

00 ☐ None
01 ☐ Bereavement care
02 ☐ Continuous home care
03 ☐ Counseling
04 ☐ Dental treatment services
05 ☐ Dietary and nutritional services
06 ☐ Durable medical equipment and supplies
07 ☐ Enterostomal therapy
08 ☐ High tech care (e.g., IV therapy)
09 ☐ Homemaker/Household services
10 ☐ Meals on Wheels
11 ☐ Medications
12 ☐ Occupational therapy
13 ☐ Oral hygiene/Prevention services
14 ☐ Pastoral care
15 ☐ Personal care
16 ☐ Physical therapy
17 ☐ Physician services
18 ☐ Referral services
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 services – *Specify* _____

7a. Does this agency currently have any active patients?

01 ☐ Yes – *GO to item 7b*
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?

_____ Number of 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
00000 ☐ None
99999 ☐ Don't know

b. What is the number of hospice care patients currently being served by this agency?

_____ Number of hospice patients
00000 ☐ None
99999 ☐ Don't know

Section E – QUESTIONS ABOUT THE AGENCY – Continued

READ **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 these lists, I will draw a sample of up to 6 current patients and up to 6 discharges.

9a. From whom shall I obtain the list of current patients?

Name

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.

01 ☐ Yes – *GO to item 10a*

02 ☐ No – *Determine which staff member would have this knowledge and enter the name and title below.* ☞

I will not be contacting or interviewing the patients in any way. I will depend on your staff to consult the medical records.

b. Would *(person named in item 9a)* **know which staff member I should interview for those patients selected for the sample?**

Name

Title

10a. From whom shall I obtain the list of discharges?

☐ Same as 9a

Name

Title

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. Retrieve the questionnaire and continue reading.

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 member I should interview for those discharges that fall into the sample?**

Name

Title

11. Thank you for your time. I will be checking with you before I leave to say good-bye.

At this time, could you introduce me to *(Names of person(s) listed in items 9a, 9b, 10a, and 10b).*

Notes