



**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 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.

**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 individual or private, 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  
 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 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
d. Is (Name of agency) a member of a group of agencies operating under one corporate authority or corporate ownership?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
2. Does this agency operate under the authority of a Health Maintenance Organization (HMO)?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
3a. Is this agency certified under Medicare as a Home Health Agency?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Certification pending
b. Is this agency certified under Medicare as a Hospice?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Certification pending
4a. Is this agency certified under Medicaid as a Home Health Agency?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Certification pending
b. Is this agency certified under Medicaid as a Hospice?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Certification pending
5a. Does this agency provide bereavement care to families of the patients that you serve?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
b. Does this agency provide pastoral care?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
HAND FLASHCARD 2 6. Does this agency provide any of the following services? Mark (X) all that apply. Probe: Any other services?	00 <input type="checkbox"/> None 01 <input type="checkbox"/> Continuous home care 02 <input type="checkbox"/> Counseling 03 <input type="checkbox"/> Dental treatment services 04 <input type="checkbox"/> Dietary and nutritional services 05 <input type="checkbox"/> Durable medical equipment and supplies 06 <input type="checkbox"/> Enterostomal therapy 07 <input type="checkbox"/> High tech care (e.g., IV therapy) 08 <input type="checkbox"/> Homemaker/Companion services 09 <input type="checkbox"/> Meals on Wheels 10 <input type="checkbox"/> Medications 11 <input type="checkbox"/> Occupational therapy/Vocational therapy 12 <input type="checkbox"/> Oral hygiene/Prevention services 13 <input type="checkbox"/> Personal care 14 <input type="checkbox"/> Physical therapy 15 <input type="checkbox"/> Physician services 16 <input type="checkbox"/> Referral services 17 <input type="checkbox"/> Respite care (inpatient) 18 <input type="checkbox"/> Skilled nursing services 19 <input type="checkbox"/> Social Services 20 <input type="checkbox"/> Speech therapy/Audiology 21 <input type="checkbox"/> Spiritual care 22 <input type="checkbox"/> Transportation 23 <input type="checkbox"/> Volunteers 24 <input type="checkbox"/> Other services - Specify <u>      </u>
7a. Does this agency currently have any active patients?	01 <input type="checkbox"/> Yes - GO to item 7b 02 <input type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> None 99999 <input type="checkbox"/> Don't know
b. What is the number of hospice care patients currently being served by this agency?	_____ Number of hospice patients 0000 <input type="checkbox"/> None 99999 <input type="checkbox"/> Don't know

