

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**

NOTICE - Public reporting burden for this collection of information is estimated to average 10 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 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 - 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	Years	OR	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 _____

For items 13a-14b, refer to item 12.

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

- 01 Yes
 - 02 No
 - 03 Not applicable (e.g., comatose) . .
 - 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
 - 03 Not applicable (e.g., comatose) . .
 - 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
 - 03 Don't know
- } SKIP to item 16

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

- 01 Yes
 - 02 No
 - 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
 - 03 Don't know
- } SKIP to item 18

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

- 01 Yes
 - 02 No
 - 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 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 <input type="checkbox"/> Medicare | | |
| a. Fee-for-service Medicare . . . | 01a <input type="checkbox"/> | 01a <input type="checkbox"/> |
| b. Medicare HMO | 01b <input type="checkbox"/> | 01b <input type="checkbox"/> |
| 02 <input type="checkbox"/> Medicaid | | |
| a. Fee-for-service or traditional Medicaid | 02a <input type="checkbox"/> | 02a <input type="checkbox"/> |
| b. Privately insured through Medicaid | 02b <input type="checkbox"/> | 02b <input type="checkbox"/> |
| 03 <input type="checkbox"/> Other government medical assistance | 03 <input type="checkbox"/> | 03 <input type="checkbox"/> |
| 04 <input type="checkbox"/> Private insurance | | |
| a. HMO or IPA | 04a <input type="checkbox"/> | 04a <input type="checkbox"/> |
| b. Indemnity plan or PPO | 04b <input type="checkbox"/> | 04b <input type="checkbox"/> |
| c. Other - Specify <input checked="" type="checkbox"/> | 04c <input type="checkbox"/> | 04c <input type="checkbox"/> |
| <hr/> | | |
| 05 <input type="checkbox"/> Own income, family support, Social Security benefits, retirement funds, or welfare . . | 05 <input type="checkbox"/> | 05 <input type="checkbox"/> |
| 06 <input type="checkbox"/> Supplemental Security Income (SSI) | 06 <input type="checkbox"/> | 06 <input type="checkbox"/> |
| 07 <input type="checkbox"/> Religious organizations, foundations, agencies | 07 <input type="checkbox"/> | 07 <input type="checkbox"/> |
| 08 <input type="checkbox"/> Veterans Administration | 08 <input type="checkbox"/> | 08 <input type="checkbox"/> |
| 09 <input type="checkbox"/> CHAMPVA/CHAMPUS | 09 <input type="checkbox"/> | 09 <input type="checkbox"/> |
| 10 <input type="checkbox"/> Other military medicine | 10 <input type="checkbox"/> | 10 <input type="checkbox"/> |
| 11 <input type="checkbox"/> No charge made for care | | |
| 12 <input type="checkbox"/> Payment source not yet determined | | |
| 13 <input type="checkbox"/> Other - Specify <input checked="" type="checkbox"/> | 13 <input type="checkbox"/> | 13 <input type="checkbox"/> |

} SKIP to item 26

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 <input type="checkbox"/> No secondary sources | 00 <input type="checkbox"/> | 00 <input type="checkbox"/> |
| 01 <input type="checkbox"/> Medicare | | |
| a. Fee-for-service Medicare | 01a <input type="checkbox"/> | 01a <input type="checkbox"/> |
| b. Medicare HMO | 01b <input type="checkbox"/> | 01b <input type="checkbox"/> |
| 02 <input type="checkbox"/> Medicaid | | |
| a. Fee-for-service or traditional Medicaid | 02a <input type="checkbox"/> | 02a <input type="checkbox"/> |
| b. Privately insured through Medicaid | 02b <input type="checkbox"/> | 02b <input type="checkbox"/> |
| 03 <input type="checkbox"/> Other government medical assistance | 03 <input type="checkbox"/> | 03 <input type="checkbox"/> |
| 04 <input type="checkbox"/> Private insurance | | |
| a. HMO or IPA | 04a <input type="checkbox"/> | 04a <input type="checkbox"/> |
| b. Indemnity plan or PPO | 04b <input type="checkbox"/> | 04b <input type="checkbox"/> |
| c. Other - Specify <input checked="" type="checkbox"/> | 04c <input type="checkbox"/> | 04c <input type="checkbox"/> |

-
- | | | |
|--|-----------------------------|-----------------------------|
| 05 <input type="checkbox"/> Own income, family support, Social Security benefits, retirement funds, or welfare | 05 <input type="checkbox"/> | 05 <input type="checkbox"/> |
| 06 <input type="checkbox"/> Supplemental Security Income (SSI) | 06 <input type="checkbox"/> | 06 <input type="checkbox"/> |
| 07 <input type="checkbox"/> Religious organizations, foundations, agencies | 07 <input type="checkbox"/> | 07 <input type="checkbox"/> |
| 08 <input type="checkbox"/> Veterans Administration | 08 <input type="checkbox"/> | 08 <input type="checkbox"/> |
| 09 <input type="checkbox"/> CHAMPVA/CHAMPUS | 09 <input type="checkbox"/> | 09 <input type="checkbox"/> |
| 10 <input type="checkbox"/> Other military medicine | 10 <input type="checkbox"/> | 10 <input type="checkbox"/> |
| 11 <input type="checkbox"/> No charge made for care | | |
| 12 <input type="checkbox"/> Payment source not yet determined | | |
| 13 <input type="checkbox"/> Other - Specify <input checked="" type="checkbox"/> | 13 <input type="checkbox"/> | 13 <input type="checkbox"/> |
- } SKIP to item 26

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	to	Month	Day	Year

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.**

19. (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

27. (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 <input type="checkbox"/> | 00 <input type="checkbox"/> 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 <input type="checkbox"/> | 01 <input type="checkbox"/> 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 <input type="checkbox"/> | 02 <input type="checkbox"/> Able to walk only with supervision or assistance of another person at all times |
| 03 <input type="checkbox"/> | 03 <input type="checkbox"/> Chairfast, unable to ambulate but is able to wheel self independently |
| 04 <input type="checkbox"/> | 04 <input type="checkbox"/> Chairfast, unable to ambulate and is <u>unable</u> to wheel self |
| 05 <input type="checkbox"/> | 05 <input type="checkbox"/> Bedfast, unable to ambulate or be up in a chair |
| 06 <input type="checkbox"/> | UK Unknown |

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

- | Prior | Current |
|-----------------------------|--|
| 00 <input type="checkbox"/> | 00 <input type="checkbox"/> Able to independently drive a regular car or adapted car, OR uses a regular or handicap-accessible public bus |
| 01 <input type="checkbox"/> | 01 <input type="checkbox"/> 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 <input type="checkbox"/> | 02 <input type="checkbox"/> Unable to ride in a car, taxi, bus, or van and requires transportation by ambulance |
| 03 <input type="checkbox"/> | 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 <input type="checkbox"/> | 00 <input type="checkbox"/> | 0-(a) Able to plan for shopping needs and independently perform shopping tasks including carrying packages: <u>OR</u> |
| | | (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 <input type="checkbox"/> | 01 <input type="checkbox"/> | 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: <u>OR</u> |
| | | (b) Unable to go shopping, but can go with someone to assist |
| 02 <input type="checkbox"/> | 02 <input type="checkbox"/> | 2-Unable to go shopping, but is able to identify items needed, place orders, and arrange home delivery |
| 03 <input type="checkbox"/> | 03 <input type="checkbox"/> | 3-Needs someone to do all shopping and errands |
| 04 <input type="checkbox"/> | UK | Unknown |

NOTES

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