

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 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.	

Section C - RECORD OF INTERVIEW

1. STATUS OF INTERVIEW - Mark (X) appropriate box.

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

2. Date of interview	3. Field Representative name	FR Code						
<table border="1"> <tr> <th>Month</th> <th>Day</th> <th>Year</th> </tr> <tr> <td></td> <td></td> <td></td> </tr> </table>	Month	Day	Year					
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. z

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. z

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 z
- 05 Other - Specify z

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. Are the medical records of this agency computerized?	01 <input type="checkbox"/> Yes - Skip to item 6 02 <input type="checkbox"/> No
b. Does this agency plan to computerize its medical records within the next year?	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"/> Bereavement care 02 <input type="checkbox"/> Continuous home care 03 <input type="checkbox"/> Counseling 04 <input type="checkbox"/> Dental treatment services 05 <input type="checkbox"/> Dietary and nutritional services 06 <input type="checkbox"/> Durable medical equipment and supplies 07 <input type="checkbox"/> Enterostomal therapy 08 <input type="checkbox"/> High tech care (e.g., IV therapy) 09 <input type="checkbox"/> Homemaker/Household services 10 <input type="checkbox"/> Meals on Wheels 11 <input type="checkbox"/> Medications 12 <input type="checkbox"/> Occupational therapy 13 <input type="checkbox"/> Oral hygiene/Prevention services 14 <input type="checkbox"/> Pastoral care 15 <input type="checkbox"/> Personal care 16 <input type="checkbox"/> Physical therapy 17 <input type="checkbox"/> Physician services 18 <input type="checkbox"/> Referral services 19 <input type="checkbox"/> Respite care (inpatient) 20 <input type="checkbox"/> Skilled nursing services 21 <input type="checkbox"/> Social Services 22 <input type="checkbox"/> Speech therapy/Audiology 23 <input type="checkbox"/> Spiritual care 24 <input type="checkbox"/> Transportation 25 <input type="checkbox"/> Vocational therapy 26 <input type="checkbox"/> Volunteers 27 <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 00000 <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 00000 <input type="checkbox"/> None 99999 <input type="checkbox"/> Don't know

