HOME CARE PROVIDER COMPONENT
FOR REFERENCE YEAR 2009

CONTACT GUIDE FOR HOME CARE ORGANIZATIONS

ORGANIZATION SCREENER

S1. [N/A] (ASK IF NOT OBVIOUS) Have I reached (PROVIDER)?

☐ YES → CONTINUE WITH S2

☐ NO → VERIFY TELEPHONE NUMBER, ADDRESS, AND NAME OF PROVIDER. IF PROVIDER IS DIFFERENT, RECORD PROBLEM AND TERMINATE CALL. CONTACT DIRECTORY ASSISTANCE. IF NO BETTER NUMBER CAN BE FOUND, MARK FOR SUPERVISOR REVIEW.

S2. [revised version of cover page]

IF ORGANIZATION IS A HOSPITAL:

May I please speak to someone in the home care department? [READ "INTRODUCTION" AND SKIP TO H1a]

IF ORGANIZATION IS NOT A HOSPITAL:

May I please speak to a person who handles patient billing for this organization?

☐ SPEAKING TO PERSON WHO HANDLES PATIENT BILLING →
RECORD NAME AND VERIFY TELEPHONE NUMBER

(May I please have your name?) (IF ONLY FIRST NAME GIVEN PROBE FOR FULL NAME)

NAME: _____

The telephone number that I dialed is (FILL TELEPHONE NUMBER). Is that the best number at which to reach you?

TELEPHONE NUMBER: (_____) _____ EXT: _____

YES → CONTINUE WITH "INTRODUCTION"
NO → MAKE CORRECTIONS AS NECESSARY, CONTINUE WITH "INTRODUCTION"

☐ INTERNAL BILLING DEPARTMENT → RECORD NAME AND TELEPHONE NUMBER

NAME: _____

TELEPHONE NUMBER: (_____) _____ EXT: _____

Will you please transfer me to them?

YES → CONTINUE WITH "INTRODUCTION"

NO → TERMINATE CALL, CONTACT INTERNAL BILLING DEPARTMENT, CONTINUE WITH "INTRODUCTION"

☐ BILLING IS PERFORMED BY AN OUTSIDE BILLING SERVICE
→ ASK TO SPEAK TO SOMEONE WHO DEALS WITH THE OUTSIDE BILLING SERVICE → RECORD NAME AND TELEPHONE NUMBER

NAME: _____

TELEPHONE NUMBER: (_____) _____ EXT: _____

Will you please transfer me to them?

YES → CONTINUE WITH "INTRODUCTION"

NO → TERMINATE CALL, CONTACT PERSON WHO DEALS WITH BILLING SERVICE, CONTINUE WITH "INTRODUCTION"

☐ NO BILLING DEPARTMENT; NOT CLEAR WHO TO SPEAK TO
→ RECORD PROBLEM; TERMINATE CALL AND MARK FOR SUPERVISOR REVIEW _____
_____

INTRODUCTION

Hello, my name is (YOUR NAME) and I am calling on behalf of the U.S. Department of Health and Human Services. We are conducting MEPS which is a study about how people in the United States use and pay for health care. [NUMBER FROM PATIENT LIST] client(s) identified (ORGANIZATION) as a source of care during 2009. (The/Each) client signed an authorization form allowing us to contact you for information about the cost of the care they received from (ORGANIZATION) in 2009. I just need to ask you a few brief questions about (the organization/the services you provide).

IF PROVIDER IS A HOSPITAL, SKIP TO H1a.

H1. [H1] First, let me verify that this is a home care organization.

YES, HOME CARE ORGANIZATION OR HOSPITAL ..... 1 (GO TO H3)
NO, SOME OTHER KIND OF ORGANIZATION ..... 2 (GO TO H2)

H1a. [H1a] Does your organization include a home care unit or department?

YES ..... 1 (GO TO H3)
NO 2

H1b. [H1b] Does your organization ever make arrangements for <u>other</u> organizations or individuals to provide some kind of assistance to people in their homes?

YES ..... 1 (GO TO H3)
NO ..... 2 (GO TO H2)

H2. [H2] Does your organization provide <u>any</u> kind of assistance to people <u>in their homes</u>?

YES 1
NO ..... 2 (TERMINATE CALL AND MARK FOR SUPERVISOR REVIEW)

H2a. [H2a] Are your services provided exclusively to persons who need in-home assistance for health reasons?

EXPLAIN, IF NECESSARY: Health reasons can include either physical or mental health conditions.

YES ..... 1 (GO TO H3)
NO ..... 2 (GO TO H2b)

H2b. [H2b] What kind of services does your organization provide to people in their homes?

CLEANING OR YARD WORK 1
TRANSPORTATION 2
SHOPPING 3
EMOTIONAL SUPPORT PERSON OR ONE-ON-ONE BUDDY ... 4
SUPPORT GROUPS 5
CHILD CARE 6
} (GO TO H4)
OTHER (RECORD:) _____ 7
(TERMINATE CALL AND MARK FOR SUPERVISOR REVIEW)

H3. [BOX 1 / H3] CONTROL SYSTEM WILL FLAG IF PROVIDER IS PART OF CONTACT GROUP:

IF CONTACT GROUP ..... 1 (GO TO H3a)
IF NOT A CONTACT GROUP ..... 2 (GO TO H5)

H3a. [H3a] I need to verify that the following organizations were associated with this organization during 2009. REVIEW EACH PROVIDER WITH THE POINT OF CONTACT (POC) AND VERIFY WHETHER THE PROVIDER IS IN THE CONTACT GROUP.

[CONTINUE WITH H5 FOR PROVIDERS IN THE CONTACT GROUP. PROVIDERS WHO ARE NOT IN THE CONTACT GROUP WILL BE REMOVED FROM THIS GROUP AND TREATED SEPARATELY WITHIN THE SYSTEM.]

H4. [Box 2] **FOR ORGANIZATIONS OR INDIVIDUALS THAT DO NOT EXCLUSIVELY PROVIDE SERVICES FOR HEALTH REASONS (REFERENCE H2a):**

We need information about the services provided to the persons in our study and about the charges and payments for those services. Would you or someone in your office be able to provide this information?

YES, OFFICE CAN PROVIDE INFORMATION ..... 1 (GO TO H5a)
NO, NEED TO CONTACT BILLING SERVICE ..... 2 (GO TO H9)
NO, THIS TYPE OF INFORMATION IS NOT AVAILABLE
(RECORD:) _____ (TERMINATE CALL AND MARK FOR SUPERVISOR REVIEW)

LOGIC FOR OUTSIDE BILLING SERVICE
IF S2 = BILLING IS PERFORMED BY AN OUTSIDE BILLING SERVICE, GO TO H9

H5. [H4] We are collecting information about the in-home services provided to the persons in our study and about the charges and payments for those services. Would you (or someone in your office) be able to provide this information?

IF ASKED READ PATIENT NAMES AND OTHER IDENTIFYING INFORMATION FROM THE PATIENT DATA FORM

YES ..... 1 (GO TO H5a)
NO ..... 2 (GO TO H5b)

H5a. [N/A] I would like to fax the authorization forms to you, along with additional information explaining the study.

[READ IF THE RESPONDENT WOULD LIKE TO PROVIDE THE DATA PRIOR TO RECEIVING AUTHORIZATION FORM(S)]: In order to remain HIPAA compliant, I need to send you the authorization form(s) first. Once you have received the form(s), then we can collect the data.

DEPARTMENT HAS ACCESS TO THE INFORMATION:

FAX AUTHORIZATION FORM(S) ..... 1 (GO TO H6)
MAIL AUTHORIZATION FORM(S) ..... 2 (GO TO H7)

DEPARTMENT DOES NOT HAVE ACCESS TO THE INFORMATION:

THIS TYPE OF INFORMATION IS NOT AVAILABLE
(RECORD:) _____ 3 (TERMINATE
_____ CALL AND MARK FOR
_____ SUPERVISOR REVIEW)

H5b. [H4a] Can you please provide the name, title, department, and telephone number of the person able to provide this information?

NAME: _____
TITLE:_____
DEPARTMENT: _____
TELEPHONE NUMBER: (_____) _____ EXT: _____

□ DON'T KNOW

Thank you very much for your help. [END CONTACT AND FOLLOW-UP WITH THE CONTACT NAMED IN H5b OR IF "DON'T KNOW" MARK FOR SUPERVISOR REVIEW.]

H6. [H5] I need to be sure I have the correct information for the fax cover page.
Should I address this fax to you?

YES → What is the fax number I can use to send you the authorization form(s)?

FAX NUMBER: (_____)_____

Can I also have your title and department?

TITLE: _____
DEPARTMENT: _____

GO TO H8

NO → Please tell me to whom I should fax this information.

NAME: _____
TITLE:_____
DEPARTMENT: _____
FAX NUMBER: (_____)_____

TELEPHONE NUMBER: (_____)_____ EXT: _____

GO TO H8

H7. [H6] I need to make sure that I have the correct mailing information.
Should I address the package to you?

YES → What is the mailing address that I can use to send you the authorization form(s)?

TITLE:_____
DEPARTMENT: _____
ADDRESS: _____
_____
CITY: _____ STATE: _____ ZIP: _____

NO→ Can I have that person's information to mail the authorization form(s)?

NAME: _____
TITLE:_____
DEPARTMENT: _____
ADDRESS: _____
_____
CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBER: (_____)_____ EXT: _____

H8. [H7] Once you have received the authorization form(s), we will call back to collect the data. For each date of service in 2009 we are requesting information about charges, payments, [FILL WITH "diagnoses" UNLESS ROUTED THROUGH H4, THEN NO FILL], and services provided.

What would be the best day and time to call back to collect this information by phone?

DAY:_____ DATE:_____ R's TIME:_____ AM/PM

IF PROVIDER DOESN'T WANT TO PROVIDE DATA OVER THE PHONE, OFFER FAX OR MAIL

You can send us the medical records by either fax or mail.

PROVIDER WILL RESPOND:

BY PHONE..... 1
BY FAX..... 2

BY MAIL 3

IF POINT OF CONTACT (POC) WILL RESPOND BY PHONE READ:
Thank you very much. We will allow time for you to receive and review the authorization form(s), and then we will call you back to collect the data.

IF POC WILL RESPOND BY FAX OR MAIL READ:
We hope you can send the records to our office within two weeks. We will include an instruction sheet when we (fax/mail) the authorization form(s). If you have any questions about what to send us, please call our toll-free number on the instruction sheet. We may call again if other patients identify this practice as a source of medical services. Thank you very much for your help.

H9. [H8] We should be able to get all of the information we need from the billing service. We can also fax you a copy of the authorization form(s) for your files.

Can you please provide the name of the billing service, the name of a contact person, their telephone number, and title?

NAME OF BILLING SERVICE:_____

CONTACT NAME:_____

TELEPHONE NUMBER: (_____)_____ EXT:____

TITLE: _____

H10. [H9] We would like to fax you a copy of the authorization form(s) for your files.

FAX AUTHORIZATION FORM(S) ..... 1 (GO TO H10a)
MAIL AUTHORIZATION FORM(S) ..... 2 (GO TO H10b)

H10a. [H9] I need to be sure I have the correct information for the fax cover page.
Should I address this fax to you?

YES → What is the fax number I can use to send you the authorization form(s)?

FAX NUMBER: (_____)_____

Can I also have your title and department?

TITLE: _____
DEPARTMENT: _____

NO → Please tell me to whom I should fax this information.

NAME: _____
TITLE:_____
DEPARTMENT: _____
FAX NUMBER: (_____)_____

TELEPHONE NUMBER: (_____)_____ EXT: _____

Thank you very much for your help. We may call again if other patients identify this practice as a source of medical services. END CONTACT AND CALL BILLING SERVICE NAMED IN H9.

H10b. [H9] I need to make sure that I have the correct mailing information.
Should I address the package to you?

YES → What is the mailing address that I can use to send you the authorization form(s)?

TITLE:_____
DEPARTMENT: _____
ADDRESS: _____
_____
CITY: _____ STATE: _____ ZIP: _____

NO→ Can I have that person's information to mail the authorization form(s)?

NAME: _____
TITLE:_____
DEPARTMENT: _____
ADDRESS: _____
_____
CITY: _____ STATE: _____ ZIP: _____
TELEPHONE NUMBER: (_____)_____ EXT: _____

Thank you very much for your help. We may call again if other patients identify this practice as a source of medical services. END CONTACT AND CALL BILLING SERVICE NAMED IN H9.
[CONTINUE WITH H11]

BILLING SERVICE

H11. [N/A] (ASK IF NOT OBVIOUS) Have I reached (BILLING SERVICE)?

☐ YES → CONTINUE WITH H12

☐ NO → VERIFY TELEPHONE NUMBER, ADDRESS, AND NAME OF BILLING SERVICE. IF BILLING SERVICE IS DIFFERENT, RECORD PROBLEM AND TERMINATE CALL. CONTACT DIRECTORY ASSISTANCE. IF NO BETTER NUMBER CAN BE FOUND, GO TO "RECONTACT ORGANIZATION"

_____

_____

H12. [N/A] May I please speak to the person who handles patient billing for (PROVIDER(S))?

☐ SPEAKING TO PERSON WHO HANDLES PATIENT BILLING →
RECORD NAME AND VERIFY TELEPHONE NUMBER

(May I please have your name?) (IF ONLY FIRST NAME GIVEN PROBE FOR FULL NAME)

NAME: _____

The telephone number that I dialed is (FILL TELEPHONE NUMBER). Is that the best number at which to reach you?

TELEPHONE NUMBER: (_____)_____ EXT: _____

YES → CONTINUE WITH H13
NO → MAKE CORRECTIONS AS NECESSARY, THEN CONTINUE WITH H13

☐ POC PROVIDED

May I please have the (name and) telephone number of the person who handles patient billing for (PROVIDER(S)) → RECORD NAME AND TELEPHONE NUMBER

NAME: _____

TELEPHONE NUMBER: (_____)_____ EXT: _____

Will you please transfer me to them?

YES → CONTINUE WITH H13

NO → TERMINATE CALL, CONTACT PERSON WHO DEALS WITH BILLING FOR PROVIDER(S), AND CONTINUE WITH H13

☐ BILLING SERVICE DID NOT MAINTAIN RECORDS FOR (PROVIDER(S)) IN 2009
→ TERMINATE CALL; GO TO "RECONTACT ORGANIZATION"

H13. [H10] Hello, my name is (YOUR NAME) and I am calling on behalf of the U.S. Department of Health and Human Services. We are conducting MEPS which is a study about how people in the United States use and pay for health care. We were referred to you by (HOME CARE ORGANIZATION) for information about [NUMBER FROM PATIENT LIST] of (his/her/their) patients. (The/Each) client signed an authorization form allowing us to contact you for information about the cost of the care they received from (HOME CARE ORGANIZATION) in 2009. I would like to fax the authorization forms to you, along with additional information explaining the study.

IF ASKED READ PATIENT NAMES AND OTHER IDENTIFYING INFORMATION FROM THE PATIENT DATA FORM

[READ IF THE RESPONDENT WOULD LIKE TO PROVIDE THE DATA PRIOR TO RECEIVING AUTHORIZATION FORM(S)]: In order to remain HIPAA compliant, I need to send you the authorization form(s) first. Once you have received the form(s), then we can collect the data.

FAX AUTHORIZATION FORM(S)	1	(GO TO H14)
MAIL AUTHORIZATION FORM(S)	2	(GO TO H15)
OFFICE DOES NOT MAINTAIN THE INFORMATION.....	3	(TERMINATE AND MARK FOR SUPERVISOR REVIEW)

H14. [H11] I need to be sure I have the correct information for the fax cover page.
Should I address this fax to you?

YES → What is the fax number I can use to send you the authorization form(s)?

FAX NUMBER: (_____)_____

Can I also have your title and department?

TITLE: _____
DEPARTMENT: _____

GO TO H16

NO → Please tell me to whom I should fax this information.

NAME: _____
TITLE:_____
DEPARTMENT: _____
FAX NUMBER: (_____)_____

TELEPHONE NUMBER: (_____)_____ EXT: _____

GO TO H16

H15. [H12] I need to make sure that I have the correct mailing information.
Should I address the package to you?

YES → What is the mailing address that I can use to send you the authorization form(s)?

TITLE:_____
DEPARTMENT: _____
ADDRESS: _____
_____
CITY: _____ STATE: _____ ZIP: _____

NO→ Can I have that person's information to mail the authorization form(s)?

NAME: _____
TITLE:_____
DEPARTMENT: _____
ADDRESS: _____
_____
CITY: _____ STATE: _____ ZIP: _____
TELEPHONE NUMBER: (_____)_____ EXT: _____

H16. [H13] Once you have received the authorization form(s), we will call back to collect the data. For each date of service in 2009 we are requesting information about charges, payments, [FILL WITH "diagnoses" UNLESS ROUTED THROUGH H4, THEN NO FILL], and services provided.

What would be the best day and time to call back to collect this information by phone?

DAY:_____ DATE:_____ R's TIME:_____ AM/PM

IF BILLING SERVICE DOESN'T WANT TO PROVIDE DATA OVER THE PHONE, OFFER FAX OR MAIL

You can send us the medical records by either fax or mail.

PROVIDER WILL RESPOND:

BY PHONE 1
BY FAX 2
BY MAIL 3

IF POC WILL RESPOND BY PHONE READ:
Thank you very much. We will allow time for you to receive and review the authorization form(s), and then we will call you back to collect the data.

IF POC WILL RESPOND BY FAX OR MAIL READ:
We hope you can send the records to our office within two weeks. We will include an instruction sheet when we (fax/mail) the authorization form(s). If you have any questions about what to send us, please call our toll-free number on the instruction sheet. We may call again if other patients identify a practice associated with this billing service as a source of medical services. Thank you very much for your help.

CALL BACK TO CONFIRM AUTHORIZATION FORM(S) RECEIPT

H17. [HF1] May I please speak to (RESPONDENT)?

Hello, my name is (YOUR NAME) and I am calling on behalf of the U.S. Department of Health and Human Services. We previously spoke about the MEPS study. Did you receive the authorization form(s) we (faxed/sent)?

YES ..... (GO TO H18 IF MODE = PHONE; GO TO H20 IF MODE = FAX OR MAIL)
NO ..... (GO TO H21)

IF MODE = PHONE, ASK H18

H18. [HF6] If it is convenient for you, we can just go ahead and complete the data forms together over the phone right now. I'd be happy to hold on while you get the information you need from your records.

WILL COMPLETE BY PHONE NOW ..... 1 (GO TO EVENT FORM)
WILL COMPLETE BY PHONE IN THE FUTURE..... 2 (GO TO H19)

H19. [HF8] What would be the best day and time to call you back?

DAY:_____ DATE:_____ R's TIME:_____AM/PM

Thank you very much for your help.

IF MODE = FAX or MAIL, ASK H20

H20. [HF9] Our records indicate that you will (fax/mail) the records to us. We hope you can do so within two weeks. Thank you very much for your help.

H21. [HF2] I'm sorry. Let me (re-fax/re-send) the authorization form(s) to you.

FAX AUTHORIZATION FORM(S) ..... 1 (GO TO H22)
MAIL AUTHORIZATION FORM(S)..... 2 (GO TO H23)

IF ASKED READ PATIENT NAMES AND OTHER IDENTIFYING INFORMATION FROM THE PATIENT DATA FORM

[READ IF THE RESPONDENT WOULD LIKE TO PROVIDE THE DATA PRIOR TO RECEIVING AUTHORIZATION FORM(S)]: In order to remain HIPAA compliant, I need to send you the authorization form(s) first. Once you have received the form(s), then we can collect the data.

H22. [HF3] IF FAXED PREVIOUSLY: Before I send the authorization form(s) again, I would like to verify the information to include on the fax cover page.
CONFIRM PRELOAD INFORMATION

FAX NUMBER: (_____)_____
NAME: _____
TITLE:_____
DEPARTMENT: _____

We will call again to ensure that you received the authorization form(s). Thank you for your help.

IF MAILED PREVIOUSLY: I need to be sure I have the correct information for the fax cover page.
Should I address this fax to you?

YES → What is the fax number I can use to send you the authorization form(s)?

FAX NUMBER: (_____)_____

Can I also have your title and department?

TITLE: _____
DEPARTMENT: _____

NO → Please tell me to whom I should fax this information.

NAME: _____
TITLE:_____
DEPARTMENT: _____
FAX NUMBER: (_____)_____
TELEPHONE NUMBER: (_____)_____ EXT: _____

We will call again to ensure that you received the authorization form(s). Thank you for your help.

H23. [HF4] IF MAILED PREVIOUSLY: Before I send the authorization form(s) again, I would like to verify the **i**nformation on the mailing label.
CONFIRM PRELOAD INFORMATION

NAME: _____
TITLE:_____
DEPARTMENT: _____
ADDRESS: _____
_____
CITY: _____ STATE: _____ ZIP: _____
TELEPHONE NUMBER: (_____)_____ EXT: _____

We will call again to ensure that you received the authorization form(s). Thank you for your help.

IF FAXED PREVIOUSLY: I need to make sure that I have the correct mailing information.
Should I address the package to you?

YES → What is the mailing address that I can use to send you the authorization form(s)?

TITLE:_____
DEPARTMENT: _____
ADDRESS: _____
_____

CITY: _____ STATE: _____ ZIP: _____

NO→ Can I have that person's information to mail the authorization form(s)?

NAME: _____

TITLE:_____

DEPARTMENT: _____

ADDRESS: _____

_____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBER: (_____)_____ EXT: _____

We will call again to ensure that you received the authorization form(s). Thank you for your help.

RECONTACT ORGANIZATION

CALL BACK INITIAL CONTACT FOR VERIFICATION / UPDATE OF INFORMATION INITIALLY PROVIDED.

INCORRECT CONTACT INFORMATION

Hello, may I speak to (POC)? This is (YOUR NAME) calling on behalf of the U.S. Department of Health and Human Services. We previously spoke about the MEPS study. Thank you for providing the contact information for (NAME FROM H5b/H9). Unfortunately we were unable to locate (NAME FROM H5b/H9) with the information you provided. Could you please verify the contact information we currently have for (NAME FROM H5b/H9)?

NAME:_____
TITLE: _____
DEPARTMENT/BILLING SERVICE: _____
TELEPHONE:(_____)_____ EXT:_____

SAME INFORMATION CONFIRMED – That is currently the information we have on file. Do you know of any other way we can get in touch with (NAME FROM H5b/H9)?

YES → COLLECT OTHER CONTACT INFORMATION

NAME:_____
TITLE: _____
DEPARTMENT/BILLING SERVICE: _____
TELEPHONE:(_____)_____ EXT:_____

NO → END CONTACT AND MARK FOR SUPERVISOR REVIEW

Thank you very much for your help.

DID NOT MAINTAIN RECORDS

Hello may I speak to (POC)? This is (YOUR NAME) calling on behalf of the U.S. Department of Health and Human Services. We previously spoke about the MEPS study. Thank you for providing the contact information for (NAME FROM H5b/H9). We were able to locate (NAME FROM H5b/H9) with the information you provided. However, they reported that they did not maintain the records for (PROVIDER(S)) in 2009. Could you please check to see if anyone else provided records for (PROVIDER(S)) in 2009?

OTHER CONTACT PROVIDED →

What is the name, title, department, and telephone number for this person?

NAME: _____
TITLE: _____
DEPARTMENT: _____
TELEPHONE: (_____)_____ EXT:_____

Thank you very much for your help.

NO OTHER CONTACT PROVIDED → END CONTACT AND MARK FOR SUPERVISOR REVIEW