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FORM **HHCS-5**
(3-29-96)

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

DISCHARGED PATIENT QUESTIONNAIRE

1996 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. 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	**3.** Date of Discharge Month/Day/Year
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 discharges selected
09 ☐ Other noninterview – *Specify* ______________________
10 ☐ No discharges

NOTES

NOTES

Read to each new respondent.

In order to obtain national level data about patients who are discharged from hospices and home health agencies such as this one, we are collecting information about a sample of discharges. I will be asking questions about the background, health status, treatment, social contacts, and billing information for each sampled discharge.

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 discharged 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 discharged 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 was . . .'s sex?

- 01 ☐ Male
- 02 ☐ Female

2. What was . . .'s date of birth?

Month		Day		Year			

OR Age (at admission) ______ Years OR ______ Months

HAND FLASHCARD 1.

3a. Which of these best described . . .'s race?

Mark (X) only one box.

- 01 ☐ White
- 02 ☐ Black
- 03 ☐ American Indian, Eskimo, Aleut
- 04 ☐ Asian, Pacific Islander
- 05 ☐ Other – *Specify* ______
- 06 ☐ Don't know

b. Was . . . of Hispanic origin?

- 01 ☐ Yes
- 02 ☐ No
- 03 ☐ Don't know

4. What was . . .'s marital status at the time of discharge?

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. During the episode of care that ended on *(date of discharge)***, where was . . . living?**

Mark (X) only one box.

- 01 ☐ Private residence
- 02 ☐ Rented room, boarding house
- 03 ☐ Retirement home
- 04 ☐ Board and care assisted living or residential care facility
- 05 ☐ Other type of health facility (including mental health facility) – *SKIP to item 6 Introduction*
- 06 ☐ Other – *Specify* ______

b. Was . . . 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 was . . .'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 ☐ Other – *Specify* ______
11 ☐ Don't know

8. What was the date of . . .'s admission for the period of care which ended on *(Date of discharge)***?**

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 . . .'s admission that ended with this (discharge/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 COMPLETE SECTION C ON THE COVER. THEN GO TO the next discharged 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 were . . .'s primary and other diagnoses at the time of discharge – that is, on *(Date of discharge)***?**

PROBE: **Any other diagnoses?**

00 ☐ No diagnosis
01 ☐ Same as 9a

Primary: 1 ______

Others: 2 ______

3 ______

4 ______

5 ______

6 ______

9c. According to . . .'s medical record, did . . . have any diagnostic or surgical procedures that were related to . . .'s admission to this agency?

00 ☐ No procedures
01 ☐ Yes 1 ______________________
2 ______________________

HAND FLASHCARD 4.

d. Why was . . . discharged?

Mark (X) only one box.

If the respondent answers "01 – Goals met", PROBE to determine which of the boxes "02–06" you should mark.

01 ☐ Goals met
02 ☐ Recovered
03 ☐ Stabilized
04 ☐ Family/friends resumed care
05 ☐ Services no longer needed
06 ☐ Other – *Specify* ______________________
07 ☐ Moved out of area
08 ☐ Admitted to hospital
09 ☐ Admitted to nursing home
10 ☐ Benefits exhausted
11 ☐ Charged/transferred home health/hospice agency
12 ☐ Deceased
13 ☐ Other – *Specify* ______________________
14 ☐ Don't know

10. What type of care was . . . receiving at the time of discharge? Was it home health care or hospice care?

01 ☐ Home health care
02 ☐ Hospice care

11a. Did . . . have a primary caregiver (outside of this agency)?

01 ☐ Yes
02 ☐ No. . . . . . } *SKIP to item 12*
03 ☐ Don't know } *INSTRUCTION BOX*

b. Did . . . usually live with (his/her) primary caregiver?

01 ☐ Yes
02 ☐ No
03 ☐ Don't know

HAND FLASHCARD 5.

c. What was the relationship of the primary caregiver to . . .?

Mark (X) only one box.

01 ☐ Spouse
02 ☐ Parent
03 ☐ Child
04 ☐ Daughter-in-law/Son-in-law
05 ☐ Other relative – *Specify* ______________________
06 ☐ Neighbor
07 ☐ Friend
08 ☐ Volunteer group
09 ☐ Other – *Specify* ______________________
10 ☐ Don't know

INSTRUCTION BOX

For items 12 through 19, use the phrase "THE LAST TIME SERVICE WAS PROVIDED PRIOR TO (discharge on *date of discharge*)" *if the patient was discharged alive. Use the phrase* "THE LAST TIME SERVICE WAS PROVIDED PRIOR TO (death)" *if the patient was discharged dead.*

HAND FLASHCARD 6.

12. The following questions refer to the patient's status the last time service was provided prior to (discharge on *date of discharge***/death).**

The last time service was provided prior to (discharge on *date of discharge***/death), which of these aids did . . . regularly use?**

Mark (X) all that apply.

PROBE: **Any other aids?**

00 ☐ No aids used
01 ☐ Bedside commode
02 ☐ Brace (any type)
03 ☐ Cane
04 ☐ Crutches
05 ☐ Dentures (full or partial)
06 ☐ Eyeglasses (including contact lenses)
07 ☐ Hearing aid
08 ☐ Hospital bed
09 ☐ Orthotics
10 ☐ Shower chair
11 ☐ Walker
12 ☐ Wheel chair – Manually operated
13 ☐ Wheel chair – Motorized
14 ☐ Other – *Specify* ______________________

For items 13a–14b, refer to item 12.

13a. The last time service was provided prior to (discharge on *date of discharge***/death), did . . . have any difficulty in seeing (when wearing glasses)?**

01 ☐ Yes
02 ☐ No . . . . } *SKIP to item 14a*
03 ☐ Not applicable (e.g., comatose) . . } *SKIP to item 14a*
04 ☐ Don't know . . . . } *SKIP to item 14a*

HAND FLASHCARD 7.

b. Was . . .'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. The last time service was provided prior to (discharge on *date of discharge***/death), did . . . have any difficulty in hearing (when wearing a hearing aid)?**

01 ☐ Yes
02 ☐ No . . . . } *SKIP to item 15a*
03 ☐ Not applicable (e.g., comatose) . . } *SKIP to item 15a*
04 ☐ Don't know . . . . } *SKIP to item 15a*

HAND FLASHCARD 8.

b. Was . . .'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

15. *HAND FLASHCARD 9.*

Ask questions 15a through 15k in ***PART I FIRST****. As you ask each part of the question, PAUSE to allow the respondent time to refer to the flashcard. Mark (X) the "Yes" box for each item the respondent says the patient had in his/her home. Then,* ***GO TO PART II****, and ask the question for each item marked "Yes" in Part I.*

PART I The following questions refer to the patient's status the last time service was provided prior to (discharge on *date of discharge***/death).**

The last time service was provided prior to (discharge on *date of discharge***/death), which of the following items did . . . have in (his/her) home?**

PART II Did . . . receive assistance from your agency staff in caring for or using:

PART I		PART II		
a. Oxygen, respiratory therapy equipment?				
(1) Ventilator/Respirator	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(2) Liquid oxygen delivery system	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(3) Oxygen concentrator	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(4) Gaseous oxygen delivery system	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(5) Nebulizer	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(6) Humidifier	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(7) Suction equipment	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(8) Tracheostomy	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
b. Intravenous therapy equipment?				
(1) Peripheral catheter	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(2) Midline catheter	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(3) Central venous catheter (e.g. Hickman, Broviac, Porta-cath., etc.)	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(4) Infusion pumps	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
c. Decubitus ulcer prevention/treatment equipment?				
(1) Air mattress/air fluidized bed	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(2) Foam mattress (egg-crate mattress)	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
d. Enteral nutrition equipment?				
(1) Nasogastric tube	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(2) Gastrostomy/jejunostomy tube	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(3) Pump	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know

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15. **PART I – Continued** **The last time service was provided prior to (discharge on *date of discharge*/death), which of the following items did . . . have in (his/her) home?**		15. **PART II – Continued** **Did . . . receive assistance from your agency staff in caring for or using:**		
e. Dialysis equipment?				
(1) Peritoneal Dialysis – Manual (continuous)	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(2) Peritoneal Dialysis – Automated (intermittent/continuous cyclic)	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(3) Peritoneal – unspecified	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(4) Hemodialysis	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
f. Blood glucose monitor?	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
g. Drainage devices?	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(1) Wound/bile duct/ureteral drainage catheter	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(2) Foley catheter	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(3) Intermittent bladder catheterization	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(4) External urinary collection devices (e.g. condom catheter)	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(5) Urostomy	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(6) Ileostomy/Colostomy	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
h. Protective restraints (e.g. vests, belts)?	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
i. Pediatric care?	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(1) Apnea monitor	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
(2) Phototherapy lights/equipment	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
j. Prenatal uterine monitoring?	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know
k. Other? – *Specify* ______________	01 ☐ Yes	01 ☐ Yes	02 ☐ No	03 ☐ Don't know

16. The last time service was provided prior to (discharge on *date of discharge*/death), did . . . have any difficulty in controlling (his/her) bowels?

01 ☐ Yes
02 ☐ No
03 ☐ Not applicable (e.g. infant, had an ostomy)
04 ☐ Don't know

17. The last time service was provided prior to (discharge on *date of discharge*/death), did . . . have any difficulty in controlling (his/her) bladder?

01 ☐ Yes
02 ☐ No
03 ☐ Not applicable (e.g. infant, had an indwelling catheter, had an ostomy)
04 ☐ Don't know

NOTES

HAND FLASHCARD 10. **18. The last time service was provided prior to (discharge on** *date of discharge***/death), did . . . receive personal help from this agency in any of the following activities as defined on this card - -** *Mark (X) one box for each activity.*	Yes	No	Don't know	Not applicable (e.g., patient was bedfast)
a. Bathing or showering?	01 ☐	02 ☐	03 ☐	04 ☐
b. Dressing?	01 ☐	02 ☐	03 ☐	04 ☐
c. Eating?	01 ☐	02 ☐	03 ☐	04 ☐
d. Transferring in or out of beds or chairs?	01 ☐	02 ☐	03 ☐	04 ☐
e. Walking?	01 ☐	02 ☐	03 ☐	04 ☐
f. Using the toilet room?	01 ☐	02 ☐	03 ☐	04 ☐

HAND FLASHCARD 11. **19. The last time service was provided prior to (discharge on** *date of discharge***/death), did . . . receive personal help from your agency in any of the following activities –** *Mark (X) one box for each activity.*	Yes	No	Don't know	Not applicable (e.g., patient was bedfast)
a. Doing light housework?	01 ☐	02 ☐	03 ☐	04 ☐
b. Managing money?	01 ☐	02 ☐	03 ☐	04 ☐
c. Shopping for groceries or clothes?	01 ☐	02 ☐	03 ☐	04 ☐
d. Using the telephone (dialing or receiving calls)?	01 ☐	02 ☐	03 ☐	04 ☐
e. Preparing meals?	01 ☐	02 ☐	03 ☐	04 ☐
f. Taking medications?	01 ☐	02 ☐	03 ☐	04 ☐

HAND FLASHCARD 12.

20a. During the 30 days prior to discharge, which of these services were provided to . . . BY YOUR AGENCY?

Mark (X) all that apply.

PROBE: **Any other services?**

- 00 ☐ None
- 01 ☐ Continuous home care
- 02 ☐ Counseling
- 03 ☐ Homemaker-household services
- 04 ☐ Medications
- 05 ☐ Mental health services
- 06 ☐ Nursing services
- 07 ☐ Nutritionist services
- 08 ☐ Occupational therapy
- 09 ☐ Physical therapy
- 10 ☐ Physician services
- 11 ☐ Social services
- 12 ☐ Speech therapy/Audiology
- 13 ☐ Transportation
- 14 ☐ Volunteers
- 15 ☐ Other services – *Specify*

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HAND FLASHCARD 13.

20b. During the 30 days prior to discharge, which of these service providers FROM YOUR AGENCY visited . . .?

Mark (X) all that apply.

PROBE: **Any other providers?**

- 00 ☐ None
- 01 ☐ Chaplain
- 02 ☐ Dieticians/Nutritionists
- 03 ☐ Home health aides
- 04 ☐ Homemakers/Personal caretakers
- 05 ☐ Licensed practical or vocational nurses
- 06 ☐ Nursing aides and attendants
- 07 ☐ Occupational therapists
- 08 ☐ Physical therapists
- 09 ☐ Physicians
- 10 ☐ Registered nurses
- 11 ☐ Respiratory therapists
- 12 ☐ Social workers
- 13 ☐ Speech pathologists/audiologists
- 14 ☐ Volunteers
- 15 ☐ Other providers – *Specify* ↙ ______________________

HAND FLASHCARD 14.

21. What was the PRIMARY expected source of payment for . . . 's entire episode of care?

Mark (X) only one source.

For the source of payment ask:
Was the *(source of payment)* **for home health care or hospice care?**

	Home Health Care	Hospice Care
01 ☐ Private insurance	01 ☐	01 ☐
02 ☐ Own income, family support, Social Security benefits, retirement funds, or welfare	02 ☐	02 ☐
03 ☐ Supplemental Security Income (SSI)	03 ☐	03 ☐
04 ☐ Medicare	04 ☐	04 ☐
05 ☐ Medicaid	05 ☐	05 ☐
06 ☐ Other government medical assistance	06 ☐	06 ☐
07 ☐ Religious organizations, foundations, agencies	07 ☐	07 ☐
08 ☐ VA contract, pensions, or other VA compensation	08 ☐	08 ☐
09 ☐ No charge made for care	09 ☐	09 ☐
10 ☐ Payment source not yet determined	10 ☐	10 ☐
11 ☐ Other – *Specify* ↙ ______________________	11 ☐	11 ☐
12 ☐ Don't know		

NOTES

HAND FLASHCARD 14.

22. What were ALL the secondary sources of payment for . . . 's entire episode of care?

Mark (X) all that apply.

PROBE: **Any other sources of payment?**

For the source of payment ask:
Was the *(source of payment)* **for home health care or hospice care?**

	Home Health Care	Hospice Care
01 ☐ Private insurance	01 ☐	01 ☐
02 ☐ Own income, family support, Social Security benefits, retirement funds, or welfare	02 ☐	02 ☐
03 ☐ Supplemental Security Income (SSI)	03 ☐	03 ☐
04 ☐ Medicare	04 ☐	04 ☐
05 ☐ Medicaid	05 ☐	05 ☐
06 ☐ Other government medical assistance	06 ☐	06 ☐
07 ☐ Religious organizations, foundations, agencies	07 ☐	07 ☐
08 ☐ VA contract, pensions, or other VA compensation	08 ☐	08 ☐
09 ☐ No charge made for care	09 ☐	09 ☐
10 ☐ Payment source not yet determined	10 ☐	10 ☐
11 ☐ Other – *Specify* ↙ ______	11 ☐	11 ☐
12 ☐ Don't know		

23. When was the last time service was provided?

Month		Day		Year	

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

NOTES

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