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FORM **NNHS-5**
(3-12-97)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL CENTER FOR HEALTH STATISTICS

DISCHARGED RESIDENT QUESTIONNAIRE

1997 NATIONAL NURSING HOME SURVEY

Section A – ADMINISTRATIVE INFORMATION

1. Field representative name

2. FR code

3. Date of interview

Month		Day		Year	

Section B – RESIDENT INFORMATION

1. Resident name or other identifier

First	M.I.	Last

2. Resident line number

3. Date of discharge

Month		Day		Year	

Section C – STATUS OF INTERVIEW

01 ☐ Complete
02 ☐ Partial
03 ☐ Resident included in sampling list in error
04 ☐ Incorrect sample line number selected
05 ☐ Refused
06 ☐ Unable to locate record
07 ☐ Less than 6 discharges selected
08 ☐ Other noninterview – *Specify* ↙

_____

09 ☐ No discharges

Notes

Read to each new respondent.

In order to obtain national level data about the residents of nursing homes such as this one, we are collecting information about a sample of discharges. I will be asking questions about the background, health status, and charges for each sampled resident.

The identifying 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.

Do you have the medical file(s) and record(s) for *(Read name(s) of selected current resident(s))***? If you have a Health Care Finance Administration Minimum Data Set for Nursing Home Resident Assessment form in the records, you may use it while we complete this questionnaire.**

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 resident forms while the respondent gets the records. If no record is available for a resident, 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?

~~Current age~~
Age at admission

Month	Day	Year

OR _____ Years

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. Where was . . . staying immediately before entering this facility?

Mark (X) only one box.

01 ☐ Private residence
02 ☐ Rented room, boarding house
03 ☐ Retirement home
04 ☐ Board and care or residential care facility
05 ☐ Nursing home
06 ☐ Hospital
07 ☐ Mental health facility

SKIP to item 6 Introduction

08 ☐ Other – *Specify* _____
09 ☐ Don't Know

b. At that time, 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. This number 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

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

Month		Day		Year	

8. Why was . . . discharged.

Mark (X) only one box.

01 ☐ Recovered
02 ☐ Stabilized
03 ☐ Deceased
04 ☐ Admitted to hospital
05 ☐ Admitted to another nursing home
06 ☐ Other – *Specify*

_____

9a. According to . . .'s medical record, what were the primary and other diagnoses at the time of admission on *(date in item 7)***?**

PROBE: **Any other diagnoses?**

Primary: 1 _____

Others: 2 _____

3 _____

4 _____

5 _____

6 _____

b. According to . . .'s medical record, what were . . .'s primary and other diagnoses at the time of discharge on *(Date of discharge)***?**

PROBE: **Any other diagnoses?**

00 ☐ Same as 9a

Primary: 1 _____

Others: 2 _____

3 _____

4 _____

5 _____

6 _____

10. What level of care was . . . receiving from your facility? Was it skilled care, intermediate care or residential care?

01 ☐ Skilled care
02 ☐ Intermediate care
03 ☐ Residential care

INSTRUCTION BOX

*For items 11 through 22, use the phase **"AT THE TIME OF DISCHARGE"** if the resident was discharged alive. Use the phase **"IMMEDIATELY PRIOR TO DISCHARGE"** if the resident was discharged dead.*

HAND FLASHCARD 3D.

11. The following questions refer to the resident's status at the (time of discharge/immediately prior to discharge) on *(Date of discharge)*.

(At the time of discharge/immediately prior to discharge), which of these aids did . . . regularly use?

Mark (X) all that apply.

PROBE: **Any other aids?**

- 00 ☐ No aids used
- 01 ☐ Eye glasses (including contact lenses)
- 02 ☐ Hearing aid
- 03 ☐ Dentures
- 04 ☐ Transfer equipment
- 05 ☐ Wheelchair
- 06 ☐ Cane
- 07 ☐ Walker
- 08 ☐ Crutches
- 09 ☐ Brace (any type)
- 10 ☐ Oxygen
- 11 ☐ Commode
- 12 ☐ Other aids or devices – *Specify* _____
- 13 ☐ Don't know

For items 12a-13b, refer to item 11.

12a. (At the time of discharge/immediately prior to discharge), did . . . 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 13a*

HAND FLASHCARD 4.

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

13a. (At the time of discharge/immediately prior to discharge), did . . . 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 14a*

HAND FLASHCARD 5.

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

14a. (At the time of discharge/immediately prior to discharge), did . . . receive any assistance in bathing or showering?

- 01 ☐ Yes
- 02 ☐ No – *SKIP to item 15a*

b. Did . . . bathe or shower with the help of:

	Yes	No
(1) Special equipment?	01 ☐	02 ☐
(2) Another person?	01 ☐	02 ☐

15a. (At the time of discharge/immediately prior to discharge), did . . . receive any assistance in dressing?

- 01 ☐ Yes
- 02 ☐ No – *SKIP to item 16a*

b. Did . . . dress with the help of:

	Yes	No
(1) Special equipment?	01 ☐	02 ☐
(2) Another person?	01 ☐	02 ☐

16a. (At the time of discharge/immediately prior to discharge), did . . . receive any assistance in eating?

01 ☐ Yes
02 ☐ No – *SKIP to item 17a*

b. Did . . . eat with the help of:

	Yes	No
(1) Special equipment?	01 ☐	02 ☐
(2) Another person?	01 ☐	02 ☐

17a. During the last 7 days before discharge, from *(Date 7 days prior to discharge)* **to** *(Date of discharge)*, **was . . . bedfast?**

01 ☐ Yes – *SKIP to item 21a*
02 ☐ No

b. Was . . . chairfast?

01 ☐ Yes – *SKIP to item 21a*
02 ☐ No

18a. (At the time of discharge/immediately prior to discharge), did . . . receive any assistance in transferring in and out of bed or a chair?

01 ☐ Yes
02 ☐ No . . . . . } *SKIP to item 19a*
03 ☐ Don't know }

b. Did . . . require the help of:

	Yes	No
(1) Special equipment?	01 ☐	02 ☐
(2) Another person?	01 ☐	02 ☐

19a. (At the time of discharge/immediately prior to discharge), did . . . receive any assistance in walking?

01 ☐ Yes
02 ☐ No – *SKIP to item 20a*

b. Did . . . walk with the help of:

	Yes	No
(1) Special equipment?	01 ☐	02 ☐
(2) Another person?	01 ☐	02 ☐

20a. (At the time of discharge/immediately prior to discharge), did . . . go outside the grounds of this facility?

01 ☐ Yes
02 ☐ No – *SKIP to item 21a*

b. When . . . went outside the grounds, did . . . require the help of:

	Yes	No
(1) Special equipment?	01 ☐	02 ☐
(2) Another person?	01 ☐	02 ☐

21a. (At the time of discharge/immediately prior to discharge), did . . . have an ostomy, an indwelling catheter or similar device?

01 ☐ Yes
02 ☐ No – *SKIP to item 21c*

b. Did . . . receive personal help from another person in caring for this device?

01 ☐ Yes
02 ☐ No

c. Did . . . receive any assistance using the toilet room?

01 ☐ Yes
02 ☐ No – *SKIP to item 22*
03 ☐ Does not use toilet room (ostomy patient, chairfast, etc.) – *SKIP to item 22*

d. Did . . . require the help of:

	Yes	No
(1) Special equipment?	01 ☐	02 ☐
(2) Another person?	01 ☐	02 ☐

22. (At the time of discharge/immediately prior to discharge), did . . . have any difficulty in controlling (his/her) bowels?

01 ☐ Yes
02 ☐ No
03 ☐ Not applicable (e.g., infant, had a colostomy)

23. Did . . . have any difficulty in controlling (his/her) bladder?

01 ☐ Yes
02 ☐ No
03 ☐ Not applicable (e.g., infant, has an indwelling catheter, had an ostomy)

HAND FLASHCARD 6.

24. (At the time of discharge/immediately prior to discharge), did . . . receive personal help or supervision in any of the following activities:

	Yes	No
a. Care of personal possessions?	01 ☐	02 ☐
b. Managing money?	01 ☐	02 ☐
c. Securing personal items such as newspapers, toilet articles, snack food?	01 ☐	02 ☐
d. Using the telephone (dialing or receiving calls)?	01 ☐	02 ☐

25. During the 12 months prior to discharge on *(Date of discharge)* **did . . . have a flu shot at this facility or any other location?**

01 ☐ Yes
02 ☐ No
03 ☐ Don't know

26. Prior to discharge, did . . . EVER have a pneumococcal vaccine, that is, pneumonia vaccination?

01 ☐ Yes
02 ☐ No
03 ☐ Don't know

HAND FLASHCARD 7.

27. During the billing period that included *(Date of discharge)* **which of these services were received by . . . either inside or outside this facility?**

Mark (X) all that apply.

PROBE: **Any other services?**

00 ☐ None
01 ☐ Dental care
02 ☐ Equipment or devices
03 ☐ Hospice services
04 ☐ Medical services
05 ☐ Mental health services
06 ☐ Nursing services
07 ☐ Nutritional services
08 ☐ Occupational therapy
09 ☐ Personal care
10 ☐ Physical therapy
11 ☐ Prescribed medicines or nonprescribed medicines
12 ☐ Sheltered employment
13 ☐ Social services
14 ☐ Special education
15 ☐ Speech or hearing therapy
16 ☐ Transportation
17 ☐ Vocational rehabilitation
18 ☐ Other – *Specify* ↙

_____

Notes

HAND FLASHCARD 8.

28. What was the PRIMARY source of payment for . . .'s care for the month of *(Month and year of discharge)***?**

Refer to item B3 on the cover.

Mark (X) only one source.

01 ☐ Private insurance
02 ☐ Own income, family support, Social Security benefits, retirement funds
03 ☐ Supplemental Security Income (SSI)
04 ☐ Medicare
05 ☐ Medicaid
06 ☐ Other government assistance or welfare
07 ☐ Religious organizations, foundations, agencies
08 ☐ VA contract, pensions, or other VA compensation
09 ☐ Payment source not yet determined
10 ☐ Other – *Specify*

_____

11 ☐ Don't know

HAND FLASHCARD 8.

29. What were all the secondary sources of payment for . . .'s care for the month of *(Month and year of discharge)***?**

Mark (X) all that apply.

00 ☐ None
01 ☐ Private insurance
02 ☐ Own income, family support, Social Security benefits, retirement funds
03 ☐ Supplemental Security Income (SSI)
04 ☐ Medicare
05 ☐ Medicaid
06 ☐ Other government assistance or welfare
07 ☐ Religious organizations, foundations, agencies
08 ☐ VA contract, pensions, or other VA compensation
09 ☐ Payment source not yet determined
10 ☐ Other – *Specify*

_____

11 ☐ Don't know

30. For the month of *(Last calendar month before discharge)***, what were the total charges billed for . . .'s care, including all charges for services, drugs and special medical supplies?**

$ _____ . 00 per

01 ☐ Month
02 ☐ Day
03 ☐ Week
04 ☐ Other period – *Specify*

Month	Day	Year	TO	Month	Day	Year

05 ☐ Not billed yet
00 ☐ No charge was made

FILL SECTION C ON THE COVER OF THIS FORM

Notes

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