OMB No. 0920-0298: Approval Expires 03/31/200

FORM **HHCS-5**
(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

DISCHARGED 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	3. Date of Discharge		
First	M.I.	Last		Month	Day	Year

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

3a. Was . . . of Hispanic or Latino origin?

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

HAND FLASHCARD 1.

b. Which of these best described . . .'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 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 (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. 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 ☐ Health maintenance organization
11 ☐ Friend/Neighbor
12 ☐ Other – *Specify* ______
13 ☐ 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 MARK STATUS CODE "06" IN 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 ______

Question	Response
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.*	**Goals met** 01 ☐ Recovered 02 ☐ Stabilized 03 ☐ Family/friends resumed care 04 ☐ Other – *Specify* ____ **Transferred to inpatient care** 05 ☐ Hospital 06 ☐ Nursing home 07 ☐ Other – *Specify* ____ 08 ☐ Transferred to another form of outpatient care – *Specify* ____ 09 ☐ Moved out of area 10 ☐ Deceased 11 ☐ Other – *Specify* 12 ☐ 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 a ☐ In the home or usual place of residence b ☐ Inpatient
11a. Did . . . have a primary caregiver outside of this agency?	01 ☐ Yes 02 ☐ No. . . . . . } *SKIP to INSTRUCTION BOX above Item 12* 03 ☐ Don't know }
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 ☐ Sister or brother 06 ☐ Other relative – *Specify* ____ 07 ☐ Neighbor 08 ☐ Friend 09 ☐ Volunteer group 10 ☐ Paid help/staff of facility where patient resides 11 ☐ Other – *Specify* ____ 12 ☐ Don't know

NOTES

INSTRUCTION BOX	*For items 12 through 20, use the phrase* "AT THE TIME OF DISCHARGE ON *(date of discharge)*" *if the patient was discharged alive. Use the phrase* "IMMEDIATELY PRIOR TO DEATH" *if the patient was discharged dead.*

HAND FLASHCARD 6.

12. The following questions refer to the patient's status (At the time of discharge on *(date of discharge)***/Immediately prior to death).**

(At the time of discharge on *(date of discharge)***/ Immediatley prior to 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 ☐ Blood glucose monitor
- 03 ☐ Brace (any type)
- 04 ☐ Cane
- 05 ☐ Crutches
- 06 ☐ Dentures (full or partial)
- 07 ☐ Elevated/raised toilet seat
- 08 ☐ Eyeglasses (including contact lenses)
- 09 ☐ Grab bars
- 10 ☐ Hearing aid
- 11 ☐ Hospital bed
- 12 ☐ IV therapy equipment
- 13 ☐ Mattress, special (eggcreate, foam, air, gel, etc.)
- 14 ☐ Orthotics
- 15 ☐ Oxygen (including oxygen concentrator)
- 16 ☐ Shower chair/Bath bench
- 17 ☐ Walker
- 18 ☐ Wheel chair (Manually operated)
- 19 ☐ Wheel chair (Motorized)
- 20 ☐ Other – *Specify* ____________

For items 13a–14b, refer to item 12.

13a. (At the time of discharge on *(date of discharge)***/ Immediately prior to 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. (At the time of discharge on *(date of discharge)***/ Immediately prior to 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

15a. (At the time of discharge on *(date of discharge)***/ Immediately prior to death), did . . . have an indwelling urinary catheter?**

- 01 ☐ Yes
- 02 ☐ No . . . . } *SKIP to item 16*
- 03 ☐ Don't know . . . . } *SKIP to item 16*

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

- 01 ☐ Yes. . . . . } *SKIP to item 17a*
- 02 ☐ No . . . . } *SKIP to item 17a*
- 03 ☐ Don't know . . . . } *SKIP to item 17a*

16. (At the time of discharge on *(date of discharge)***/ Immediately prior to death), did . . . have any difficulty in controlling (his/her) bladder?**

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

17a. (At the time of discharge on *(date of discharge)*/ **immediately prior to death), did . . . have a colostomy or ileostomy?**

01 ☐ Yes
02 ☐ No . . . . *SKIP to item 18*
03 ☐ Don't know . . . . *SKIP to item 18*

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

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

18. (At the time of discharge on *(date of discharge)*/ **immediately prior to death), did . . . have any difficulty in controlling (his/her) bowels?**

01 ☐ Yes
02 ☐ No
03 ☐ Infant
04 ☐ Don't know

HAND FLASHCARD 9.

19. At the time of discharge on *(date of discharge)*/ **immediately prior to 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 is 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 10.

20. (At the time of discharge on *(date of discharge)*/ **immediately prior to death), did . . . receive personal help from your 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 is 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 ☐

NOTES

HAND FLASHCARD 11.

21a. During the 30 days prior to (discharge/death), 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 ☐ Dental treatment services
- 04 ☐ Dietary/nutritional services
- 05 ☐ Durable medical equipment and supplies
- 06 ☐ Enterostomal therapy
- 07 ☐ Homemaker-household services
- 08 ☐ IV therapy
- 09 ☐ Meals on wheels
- 10 ☐ Medications
- 11 ☐ Occupational therapy
- 12 ☐ Oral hygiene/prevention services
- 13 ☐ Personal care
- 14 ☐ Physical therapy
- 15 ☐ Physician services
- 16 ☐ Psychological services
- 17 ☐ Referral services
- 18 ☐ Respiratory therapy
- 19 ☐ Respite care (inpatient)
- 20 ☐ Skilled nursing services
- 21 ☐ Social services
- 22 ☐ Speech therapy/Audiology
- 23 ☐ Spiritual care
- 24 ☐ Transportation
- 25 ☐ Vocational therapy
- 26 ☐ Volunteers
- 27 ☐ Other high tech care (e.g., enteral nutrition, dialysis)
- 28 ☐ Other services – *Specify* ↙

____

HAND FLASHCARD 12.

21b. During the 30 days prior to (discharge/death), which of these service providers FROM YOUR AGENCY visited...?

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 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 ☐ Medicare		
a. Fee-for-service Medicare . .	01a ☐	01a ☐
b. Medicare HMO	01b ☐	01b ☐
02 ☐ Medicaid		
a. Fee-for-service or traditional Medicaid	02a ☐	02a ☐
b. Privately insured through Medicaid	02b ☐	02b ☐
03 ☐ Other government medical assistance	03 ☐	03 ☐
04 ☐ Private insurance		
a. HMO or IPA	04a ☐	04a ☐
b. Indemnity plan or PPO	04b ☐	04b ☐
c. Other – *Specify* ↙	04c ☐	04c ☐
05 ☐ Own income, family support, Social Security benefits, retirement funds, or welfare . .	05 ☐	05 ☐
06 ☐ Supplemental Security Income (SSI).	06 ☐	06 ☐
07 ☐ Religious organizations, foundations, agencies	07 ☐	07 ☐
08 ☐ Veterans Administration	08 ☐	08 ☐
09 ☐ CHAMPVA/CHAMPUS	09 ☐	09 ☐
10 ☐ Other military medicine	10 ☐	10 ☐
11 ☐ No charge made for care	*SKIP to item 26*	
12 ☐ Payment source not yet determined	*SKIP to item 26*	
13 ☐ Other – *Specify* ↙	13 ☐	13 ☐

NOTES