

FORM **NNHS-5**
(4-27-99)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****1999 NATIONAL NURSING HOME SURVEY****NOTICE** - Public reporting burden of 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 CDC/ATSDR Reports Clearance Officer; Paperwork Reduction Project (0920-0353) 1600 Clifton Road, MSD-24, Atlanta, GA 30333. 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 - SAMPLE INFORMATION

1. Discharged resident line number

2. 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/Comments section

- 01 Check this box if comments are written in this section
 or any other place on this questionnaire.

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.

<p>1. What was the resident's sex?</p>	<p>01 <input type="checkbox"/> Male 02 <input type="checkbox"/> Female</p>						
<p>2. What was (his/her) date of birth?</p>	<table border="1" style="display: inline-table; margin-right: 20px;"> <tr> <th style="width: 25px;">Month</th> <th style="width: 25px;">Day</th> <th style="width: 40px;">Year</th> </tr> <tr> <td style="width: 25px; height: 20px;"></td> <td style="width: 25px; height: 20px;"></td> <td style="width: 40px; height: 20px;"></td> </tr> </table> <p style="text-align: right;">Age at admission</p> <p style="text-align: right;">OR _____ Years</p>	Month	Day	Year			
Month	Day	Year					
<p>3a. Was (he/she) of Hispanic or Latino origin?</p>	<p>01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Don't know</p>						
<p><i>HAND FLASHCARD 1.</i></p> <p>b. Which of these best described (his/her) race?</p> <p><i>Mark (X) one or more boxes.</i></p>	<p>01 <input type="checkbox"/> American Indian or Alaska Native 02 <input type="checkbox"/> Asian 03 <input type="checkbox"/> Black or African American 04 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 05 <input type="checkbox"/> White 06 <input type="checkbox"/> Other – <i>Specify</i> _____ 07 <input type="checkbox"/> Don't know</p>						
<p>4. What was (his/her) marital status at the time of discharge?</p> <p><i>Mark (X) only one box.</i></p>	<p>01 <input type="checkbox"/> Married 02 <input type="checkbox"/> Widowed 03 <input type="checkbox"/> Divorced 04 <input type="checkbox"/> Separated 05 <input type="checkbox"/> Never married 06 <input type="checkbox"/> Single 07 <input type="checkbox"/> Don't know</p>						
<p><i>HAND FLASHCARD 2.</i></p> <p>5a. Where was (he/she) staying immediately before entering this facility?</p> <p><i>Mark (X) only one box.</i></p>	<p>01 <input type="checkbox"/> Private residence (house or apartment) 02 <input type="checkbox"/> Rented room, boarding house 03 <input type="checkbox"/> Retirement home 04 <input type="checkbox"/> Board and care, assisted living or residential care facility 05 <input type="checkbox"/> Nursing home 06 <input type="checkbox"/> Hospital 07 <input type="checkbox"/> Rehabilitation facility 08 <input type="checkbox"/> Other inpatient health facility (including mental health facility) 09 <input type="checkbox"/> Other – <i>Specify</i> _____ 10 <input type="checkbox"/> Don't know</p> <p style="text-align: right;">} <i>SKIP to item 6</i></p>						
<p>b. At that time, was (he/she) living with family members, nonfamily members, both family and nonfamily members, or alone?</p>	<p>01 <input type="checkbox"/> With family members 02 <input type="checkbox"/> With nonfamily members 03 <input type="checkbox"/> With both family members and nonfamily members 04 <input type="checkbox"/> Alone 05 <input type="checkbox"/> Don't know</p>						

6. What was the date of (his/her) admission for the period of care which ended on (Date of discharge)?

Month		Day		Year		

7. Why was (he/she) 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

8a. According to (his/her) medical record, what were the primary and other diagnoses at the time of admission on (date in item 6)?

PROBE: Any other diagnoses?

Primary: 1 _____

Others: 2 _____

3 _____

4 _____

5 _____

6 _____

b. According to (his/her) medical record, what were (his/her) primary and other diagnoses at the time of discharge on (Date of discharge)?

PROBE: Any other diagnoses?

00 Same as 8a

Primary: 1 _____

Others: 2 _____

3 _____

4 _____

5 _____

6 _____

9. What level of care was (he/she) receiving from your facility? Was it skilled care, intermediate care or residential care?

- 01 Skilled care
- 02 Intermediate care
- 03 Residential care

Notes/Comments

INSTRUCTION BOX

For items 10 through 21, use the phrase **"AT THE TIME OF DISCHARGE"** if the resident was discharged alive. Use the phrase **"IMMEDIATELY PRIOR TO DISCHARGE"** if the resident was discharged dead.

HAND FLASHCARD 3.

10. 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 (he/she) 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 Bedside commode
- 12 Other aids or devices – *Specify* _____
- 13 Don't know

For items 11a-12b, refer to item 10.

11a. (At the time of discharge/immediately prior to discharge), did (he/she) 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 12a*

HAND FLASHCARD 4.

b. Was (his/her) 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

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

HAND FLASHCARD 5.

b. Was (his/her) 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

13a. (At the time of discharge/immediately prior to discharge), did (he/she) receive any assistance in bathing or showering?

- 01 Yes
- 02 No – *SKIP to item 14a*
- 03 Don't know

b. Did (he/she) bathe or shower with the help of:

- | | | |
|------------------------------|-----------------------------|-----------------------------|
| | Yes | No |
| (1) Special equipment? | 01 <input type="checkbox"/> | 02 <input type="checkbox"/> |
| (2) Another person? | 01 <input type="checkbox"/> | 02 <input type="checkbox"/> |

14a. (At the time of discharge/immediately prior to discharge), did (he/she) receive any assistance in dressing?

- 01 Yes
- 02 No – *SKIP to item 15a*

b. Did (he/she) dress with the help of:

- | | | |
|------------------------------|-----------------------------|-----------------------------|
| | Yes | No |
| (1) Special equipment? | 01 <input type="checkbox"/> | 02 <input type="checkbox"/> |
| (2) Another person? | 01 <input type="checkbox"/> | 02 <input type="checkbox"/> |

15a. (At the time of discharge/immediately prior to discharge), did (he/she) receive any assistance in eating?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No – <i>SKIP to item 16a</i>
b. Did (he/she) eat with the help of: (1) Special equipment? (2) Another person?	Yes No 01 <input type="checkbox"/> 02 <input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/>
16a. During the last 7 days before discharge, from (Date 7 days prior to discharge) to (Date of discharge), was (he/she) bedfast?	01 <input type="checkbox"/> Yes – <i>SKIP to item 20a</i> 02 <input type="checkbox"/> No
b. Was (he/she) chairfast?	01 <input type="checkbox"/> Yes – <i>SKIP to item 20a</i> 02 <input type="checkbox"/> No
17a. (At the time of discharge/immediately prior to discharge), did (he/she) receive any assistance in transferring in and out of bed or a chair?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No } <i>SKIP to item 18a</i> 03 <input type="checkbox"/> Don't know
b. Did (he/she) require the help of: (1) Special equipment? (2) Another person?	Yes No 01 <input type="checkbox"/> 02 <input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/>
18a. (At the time of discharge/immediately prior to discharge), did (he/she) receive any assistance in walking?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No – <i>SKIP to item 19a</i>
b. Did (he/she) walk with the help of: (1) Special equipment? (2) Another person?	Yes No 01 <input type="checkbox"/> 02 <input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/>
19a. (At the time of discharge/immediately prior to discharge), did (he/she) go outside the grounds of this facility?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No – <i>SKIP to item 20a</i>
b. When (he/she) went outside the grounds, did (he/she) require the help of: (1) Special equipment? (2) Another person?	Yes No 01 <input type="checkbox"/> 02 <input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/>
20a. (At the time of discharge/immediately prior to discharge), did (he/she) have an ostomy, an indwelling catheter or similar device?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No – <i>SKIP to item 20c</i>
b. Did (he/she) receive personal help from another person in caring for this device?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
c. Did (he/she) receive any assistance using the toilet room?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No – <i>SKIP to item 21</i> 03 <input type="checkbox"/> Does not use toilet room (ostomy patient, chairfast, etc.) – <i>SKIP to item 21</i>
d. Did (he/she) require the help of: (1) Special equipment? (2) Another person?	Yes No 01 <input type="checkbox"/> 02 <input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/>

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

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

22. Did (he/she) 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.

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

a. Care of personal possessions?	01 <input type="checkbox"/>	Yes	No	02 <input type="checkbox"/>
b. Managing money?	01 <input type="checkbox"/>			02 <input type="checkbox"/>
c. Securing personal items such as newspapers, toilet articles, snack food?	01 <input type="checkbox"/>			02 <input type="checkbox"/>
d. Using the telephone (dialing or receiving calls)?	01 <input type="checkbox"/>			02 <input type="checkbox"/>

HAND FLASHCARD 7.

24. During the billing period that included (Date of discharge) which of these services were received by (him/her) 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

HAND FLASHCARD 8.

25. What was the PRIMARY source of payment for (his/her) care for the month of (Month and year of discharge)?

Refer to item B2 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.

26. What were all the secondary sources of payment for (his/her) care for the month of (Month and year of discharge)?

Mark (X) all that apply.

PROBE: Any other sources?

- 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

27. What were the total charges billed for (his/her) care, including all charges for services, drugs and special medical supplies?

Mark (X) only one box.

Put dates in the boxes shown ONLY if the charge is NOT for a month, day, or week.

\$ _____ per

00 Mark (X) if drugs and medical supplies are included in this total.

- 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

FR Date Check - Prior to leaving the facility, you must verify the dates you entered in other sections of this questionnaire. Copy the dates below to the space provided. Check that the dates go from the oldest to the newest and are logical. Correct errors by referring to the resident records and/or facility staff.

Date of Birth - Question 2 on page 2

Month	Day	Year

Date of Admission - Question 6 on page 3

Month	Day	Year

Date of Discharge - Item B2 on cover

Month	Day	Year

Date of Interview - Item A3 on cover

Month	Day	Year

Notes/Comments