

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****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 DHHS Reports Clearance Officer; Paperwork Reduction Project (0920-0353) Rm. 531-H; H.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 – 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 <input type="checkbox"/> Complete | 07 <input type="checkbox"/> Less than 6 discharges selected |
| 02 <input type="checkbox"/> Partial | 08 <input type="checkbox"/> Other noninterview – <i>Specify</i> <input checked="" type="checkbox"/> |
| 03 <input type="checkbox"/> Resident included in sampling list in error | |
| 04 <input type="checkbox"/> Incorrect sample line number selected | |
| 05 <input type="checkbox"/> Refused | |
| 06 <input type="checkbox"/> Unable to locate record | 09 <input type="checkbox"/> 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
08 Other - Specify _____
09 Don't Know

} SKIP to item 6 Introduction

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.

<p>6. What was . . . 's Social Security Number?</p>	<p>Social Security Number</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> <td style="border: 1px solid black; width: 25px; height: 25px;"></td> </tr> </table> <p>01 <input type="checkbox"/> Refused 02 <input type="checkbox"/> Don't know</p>												
<p>7. What was the date of . . . 's admission for the period of care which ended on (Date of discharge)?</p>	<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <th style="width: 25%;">Month</th> <th style="width: 25%;">Day</th> <th style="width: 50%;">Year</th> </tr> <tr> <td style="width: 25px; height: 25px;"></td> <td style="width: 25px; height: 25px;"></td> <td style="width: 50px; height: 25px;"></td> </tr> </table>	Month	Day	Year									
Month	Day	Year											
<p>8. Why was . . . discharged.</p> <p><i>Mark (X) only one box.</i></p>	<p>01 <input type="checkbox"/> Recovered 02 <input type="checkbox"/> Stabilized 03 <input type="checkbox"/> Deceased 04 <input type="checkbox"/> Admitted to hospital 05 <input type="checkbox"/> Admitted to another nursing home 06 <input type="checkbox"/> Other - <i>Specify</i> <input checked="" type="checkbox"/></p> <p>_____</p>												
<p>9a. According to . . . 's medical record, what were the primary and other diagnoses at the time of admission on (date in item 7)?</p> <p><i>PROBE: Any other diagnoses?</i></p>	<p>Primary: 1 _____</p> <p>Others: 2 _____</p> <p>3 _____</p> <p>4 _____</p> <p>5 _____</p> <p>6 _____</p>												
<p>b. According to . . . 's medical record, what were . . . 's primary and other diagnoses at the time of discharge on (Date of discharge)?</p> <p><i>PROBE: Any other diagnoses?</i></p>	<p>00 <input type="checkbox"/> Same as 9a</p> <p>Primary: 1 _____</p> <p>Others: 2 _____</p> <p>3 _____</p> <p>4 _____</p> <p>5 _____</p> <p>6 _____</p>												
<p>10. What level of care was . . . receiving from your facility? Was it skilled care, intermediate care or residential care?</p>	<p>01 <input type="checkbox"/> Skilled care 02 <input type="checkbox"/> Intermediate care 03 <input type="checkbox"/> Residential care</p>												

INSTRUCTION BOX

For items 11 through 22, 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 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 <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 . . . 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 <input type="checkbox"/> | 02 <input type="checkbox"/> |
| (2) Another person? | 01 <input type="checkbox"/> | 02 <input type="checkbox"/> |

16a. (At the time of discharge/immediately prior to discharge), did . . . receive any assistance in eating?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No – <i>SKIP to item 17a</i>
b. Did . . . 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"/>
17a. During the last 7 days before discharge, from (Date 7 days prior to discharge) to (Date of discharge), was . . . bedfast?	01 <input type="checkbox"/> Yes – <i>SKIP to item 21a</i> 02 <input type="checkbox"/> No
b. Was . . . chairfast?	01 <input type="checkbox"/> Yes – <i>SKIP to item 21a</i> 02 <input type="checkbox"/> 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 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No } <i>SKIP to item 19a</i> 03 <input type="checkbox"/> Don't know
b. Did . . . 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"/>
19a. (At the time of discharge/immediately prior to discharge), did . . . receive any assistance in walking?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No – <i>SKIP to item 20a</i>
b. Did . . . 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"/>
20a. (At the time of discharge/immediately prior to discharge), did . . . go outside the grounds of this facility?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No – <i>SKIP to item 21a</i>
b. When . . . went outside the grounds, did . . . 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"/>
21a. (At the time of discharge/immediately prior to discharge), did . . . have an ostomy, an indwelling catheter or similar device?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No – <i>SKIP to item 21c</i>
b. Did . . . receive personal help from another person in caring for this device?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No
c. Did . . . receive any assistance using the toilet room?	01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No – <i>SKIP to item 22</i> 03 <input type="checkbox"/> Does not use toilet room (ostomy patient, chairfast, etc.) – <i>SKIP to item 22</i>
d. Did . . . 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"/>

<p>22. (At the time of discharge/immediately prior to discharge), did . . . have any difficulty in controlling (his/her) bowels?</p>	<p>01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Not applicable (e.g., infant, had a colostomy)</p>															
<p>23. Did . . . have any difficulty in controlling (his/her) bladder?</p>	<p>01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Not applicable (e.g., infant, has an indwelling catheter, had an ostomy)</p>															
<p><i>HAND FLASHCARD 6.</i></p>																
<p>24. (At the time of discharge/immediately prior to discharge), did . . . receive personal help or supervision in any of the following activities:</p> <p>a. Care of personal possessions?</p> <p>b. Managing money?</p> <p>c. Securing personal items such as newspapers, toilet articles, snack food?</p> <p>d. Using the telephone (dialing or receiving calls)?</p>	<table border="0"> <tr> <td></td> <td>Yes</td> <td>No</td> </tr> <tr> <td>a.</td> <td>01 <input type="checkbox"/></td> <td>02 <input type="checkbox"/></td> </tr> <tr> <td>b.</td> <td>01 <input type="checkbox"/></td> <td>02 <input type="checkbox"/></td> </tr> <tr> <td>c.</td> <td>01 <input type="checkbox"/></td> <td>02 <input type="checkbox"/></td> </tr> <tr> <td>d.</td> <td>01 <input type="checkbox"/></td> <td>02 <input type="checkbox"/></td> </tr> </table>		Yes	No	a.	01 <input type="checkbox"/>	02 <input type="checkbox"/>	b.	01 <input type="checkbox"/>	02 <input type="checkbox"/>	c.	01 <input type="checkbox"/>	02 <input type="checkbox"/>	d.	01 <input type="checkbox"/>	02 <input type="checkbox"/>
	Yes	No														
a.	01 <input type="checkbox"/>	02 <input type="checkbox"/>														
b.	01 <input type="checkbox"/>	02 <input type="checkbox"/>														
c.	01 <input type="checkbox"/>	02 <input type="checkbox"/>														
d.	01 <input type="checkbox"/>	02 <input type="checkbox"/>														
<p>25. During the 12 months prior to discharge on (Date of discharge) did . . . have a flu shot at this facility or any other location?</p>	<p>01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Don't know</p>															
<p>26. Prior to discharge, did . . . EVER have a pneumococcal vaccine, that is, pneumonia vaccination?</p>	<p>01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Don't know</p>															
<p><i>HAND FLASHCARD 7.</i></p>																
<p>27. During the billing period that included (Date of discharge) which of these services were received by . . . either inside or outside this facility?</p> <p><i>Mark (X) all that apply.</i></p> <p>PROBE: Any other services?</p>	<p>00 <input type="checkbox"/> None 01 <input type="checkbox"/> Dental care 02 <input type="checkbox"/> Equipment or devices 03 <input type="checkbox"/> Hospice services 04 <input type="checkbox"/> Medical services 05 <input type="checkbox"/> Mental health services 06 <input type="checkbox"/> Nursing services 07 <input type="checkbox"/> Nutritional services 08 <input type="checkbox"/> Occupational therapy 09 <input type="checkbox"/> Personal care 10 <input type="checkbox"/> Physical therapy 11 <input type="checkbox"/> Prescribed medicines or nonprescribed medicines 12 <input type="checkbox"/> Sheltered employment 13 <input type="checkbox"/> Social services 14 <input type="checkbox"/> Special education 15 <input type="checkbox"/> Speech or hearing therapy 16 <input type="checkbox"/> Transportation 17 <input type="checkbox"/> Vocational rehabilitation 18 <input type="checkbox"/> Other – <i>Specify</i> ↗</p>															
<p>Notes</p>																

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?

\$ _____ . 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