

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

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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 First M.I. Last | 2. Patient line number | 3. Date of Discharge | | |
| | | 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 names) 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?

Age (at admission)

| Month | Day | Year | OR | 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 _____

| | |
|---|--|
| <p>9c. According to . . . 's medical record, did . . . have any diagnostic or surgical procedures that were related to . . . 's admission to this agency?</p> | <p>00 <input type="checkbox"/> No procedures 01 <input type="checkbox"/> Yes 1 _____ 2 _____</p> |
|---|--|

| | |
|--|---|
| <p><i>HAND FLASHCARD 4.</i> d. Why was . . . discharged? Mark (X) only one box.</p> | <p>Goals met 01 <input type="checkbox"/> Recovered 02 <input type="checkbox"/> Stabilized 03 <input type="checkbox"/> Family/friends resumed care 04 <input type="checkbox"/> Other - Specify _____</p> <p>Transferred to inpatient care 05 <input type="checkbox"/> Hospital 06 <input type="checkbox"/> Nursing home 07 <input type="checkbox"/> Other - Specify _____</p> <p>08 <input type="checkbox"/> Transferred to another form of outpatient care - Specify _____</p> <p>09 <input type="checkbox"/> Moved out of area 10 <input type="checkbox"/> Deceased 11 <input type="checkbox"/> Other - Specify _____ 12 <input type="checkbox"/> Don't know</p> |
|--|---|

| | |
|---|---|
| <p>10. What type of care was . . . receiving at the time of discharge? Was it home health care or hospice care?</p> | <p>01 <input type="checkbox"/> Home health care 02 <input type="checkbox"/> Hospice care a <input type="checkbox"/> In the home or usual place of residence b <input type="checkbox"/> Inpatient</p> |
|---|---|

| | |
|--|--|
| <p>11a. Did . . . have a primary caregiver outside of this agency?</p> | <p>01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No } <i>SKIP to INSTRUCTION BOX above Item 12.</i> 03 <input type="checkbox"/> Don't know</p> |
|--|--|

| | |
|--|--|
| <p>b. Did . . . usually live with (his/her) primary caregiver?</p> | <p>01 <input type="checkbox"/> Yes 02 <input type="checkbox"/> No 03 <input type="checkbox"/> Don't know</p> |
|--|--|

| | |
|--|--|
| <p><i>HAND FLASHCARD 5.</i> c. What was the relationship of the primary caregiver to . . . ? Mark (X) only one box.</p> | <p>01 <input type="checkbox"/> Spouse 02 <input type="checkbox"/> Parent 03 <input type="checkbox"/> Child 04 <input type="checkbox"/> Daughter-in-law/Son-in-law 05 <input type="checkbox"/> Sister or brother 06 <input type="checkbox"/> Other relative - Specify _____ 07 <input type="checkbox"/> Neighbor 08 <input type="checkbox"/> Friend 09 <input type="checkbox"/> Volunteer group 10 <input type="checkbox"/> Paid help/staff of facility where patient resides 11 <input type="checkbox"/> Other - Specify _____ 12 <input type="checkbox"/> Don't know</p> |
|--|--|

| |
|--------------|
| <p>NOTES</p> |
|--------------|

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)/immediately 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
 - 03 Not applicable (e.g., comatose)
 - 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
 - 03 Not applicable (e.g., comatose)
 - 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
 - 03 Don't know
- } SKIP to item 16

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

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

} SKIP to item 18

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

01 Yes
 02 No
 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 <input type="checkbox"/> | 02 <input type="checkbox"/> | 03 <input type="checkbox"/> | 04 <input type="checkbox"/> |
| b. Dressing? | 01 <input type="checkbox"/> | 02 <input type="checkbox"/> | 03 <input type="checkbox"/> | 04 <input type="checkbox"/> |
| c. Eating? | 01 <input type="checkbox"/> | 02 <input type="checkbox"/> | 03 <input type="checkbox"/> | 04 <input type="checkbox"/> |
| d. Transferring in or out of beds or chairs? | 01 <input type="checkbox"/> | 02 <input type="checkbox"/> | 03 <input type="checkbox"/> | 04 <input type="checkbox"/> |
| e. Walking? | 01 <input type="checkbox"/> | 02 <input type="checkbox"/> | 03 <input type="checkbox"/> | 04 <input type="checkbox"/> |
| f. Using the toilet room? | 01 <input type="checkbox"/> | 02 <input type="checkbox"/> | 03 <input type="checkbox"/> | 04 <input type="checkbox"/> |

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 <input type="checkbox"/> | 02 <input type="checkbox"/> | 03 <input type="checkbox"/> | 04 <input type="checkbox"/> |
| b. Managing money? | 01 <input type="checkbox"/> | 02 <input type="checkbox"/> | 03 <input type="checkbox"/> | 04 <input type="checkbox"/> |
| c. Shopping for groceries or clothes? | 01 <input type="checkbox"/> | 02 <input type="checkbox"/> | 03 <input type="checkbox"/> | 04 <input type="checkbox"/> |
| d. Using the telephone (dialing or receiving calls)? | 01 <input type="checkbox"/> | 02 <input type="checkbox"/> | 03 <input type="checkbox"/> | 04 <input type="checkbox"/> |
| e. Preparing meals? | 01 <input type="checkbox"/> | 02 <input type="checkbox"/> | 03 <input type="checkbox"/> | 04 <input type="checkbox"/> |
| f. Taking medications? | 01 <input type="checkbox"/> | 02 <input type="checkbox"/> | 03 <input type="checkbox"/> | 04 <input type="checkbox"/> |

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

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

NOTES