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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

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.

1. What was the resident's sex?

01 ☐ Male
02 ☐ Female

2. What was (his/her) date of birth?

Month		Day		Year			

OR Age at admission _____ Years

3a. Was (he/she) of Hispanic or Latino origin?

01 ☐ Yes
02 ☐ No
03 ☐ Don't know

HAND FLASHCARD 1.

b. Which of these best described (his/her) 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 (his/her) 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 (he/she) staying immediately before entering this facility?

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
06 ☐ Hospital
07 ☐ Rehabilitation facility
08 ☐ Other inpatient health facility (including mental health facility)

SKIP to item 6

09 ☐ Other – *Specify* _____
10 ☐ Don't know

b. At that time, was (he/she) 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

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 phase **"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 . . . . . } *SKIP to item 12a*
03 ☐ Not applicable (e.g., comatose) . } *SKIP to item 12a*
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 . . . . . } *SKIP to item 13a*
03 ☐ Not applicable (e.g., comatose) . } *SKIP to item 13a*
04 ☐ Don't know . . . . . } *SKIP to item 13a*

HAND FLASHCARD 5.

b. Was (his/her) hearing (when wearing a hearing ing 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 ☐	02 ☐
(2) Another person?	01 ☐	02 ☐

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 ☐	02 ☐
(2) Another person?	01 ☐	02 ☐

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

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:

	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 ☐

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		Month	Day	Year
			TO			

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.*

	Month	Day	Year
Date of Birth – Question 2 on page 2			
Date of Admission – Question 6 on page 3			
Date of Discharge – Item B2 on cover			
Date of Interview – Item A3 on cover			

Notes/Comments