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FORM **HHCS-5**
(3-29-96)

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

1996 NATIONAL HOME AND HOSPICE CARE SURVEY

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 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?

Age (at admission)

Month		Day		Year			

OR _____ Years OR _____ Months

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. During the episode of care that ended on *(date of discharge)***, where was . . . living?**

Mark (X) only one box.

01 ☐ Private residence
02 ☐ Rented room, boarding house
03 ☐ Retirement home
04 ☐ Board and care assisted living or residential care facility
05 ☐ Other type of 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 ☐ Other – *Specify* _____
11 ☐ 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 COMPLETE 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 _____

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.

If the respondent answers "01 – Goals met", PROBE to determine which of the boxes "02–06" you should mark.

01 ☐ Goals met
02 ☐ Recovered
03 ☐ Stabilized
04 ☐ Family/friends resumed care
05 ☐ Services no longer needed
06 ☐ Other – *Specify* _____
07 ☐ Moved out of area
08 ☐ Admitted to hospital
09 ☐ Admitted to nursing home
10 ☐ Benefits exhausted
11 ☐ Charged/transferred home health/hospice agency
12 ☐ Deceased
13 ☐ Other – *Specify* _____
14 ☐ 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

11a. Did . . . have a primary caregiver (outside of this agency)?

01 ☐ Yes
02 ☐ No. . . . . } *SKIP to item 12 INSTRUCTION BOX*
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 ☐ Other relative – *Specify* _____
06 ☐ Neighbor
07 ☐ Friend
08 ☐ Volunteer group
09 ☐ Other – *Specify* _____
10 ☐ Don't know

INSTRUCTION BOX

For items 12 through 19, use the phrase "THE LAST TIME SERVICE WAS PROVIDED PRIOR TO (discharge on *date of discharge*)" *if the patient was discharged alive. Use the phrase* "THE LAST TIME SERVICE WAS PROVIDED PRIOR TO (death)" *if the patient was discharged dead.*

HAND FLASHCARD 6.

12. The following questions refer to the patient's status the last time service was provided prior to (discharge on *date of discharge*/death).

The last time service was provided prior to (discharge on *date of discharge*/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 ☐ Brace (any type)
03 ☐ Cane
04 ☐ Crutches
05 ☐ Dentures (full or partial)
06 ☐ Eyeglasses (including contact lenses)
07 ☐ Hearing aid
08 ☐ Hospital bed
09 ☐ Orthotics
10 ☐ Shower chair
11 ☐ Walker
12 ☐ Wheel chair – Manually operated
13 ☐ Wheel chair – Motorized
14 ☐ Other – *Specify* _____

For items 13a–14b, refer to item 12.

13a. The last time service was provided prior to (discharge on *date of discharge*/death), did . . . have any difficulty in seeing (when wearing glasses)?

01 ☐ Yes
02 ☐ No . . . . . }
03 ☐ Not applicable (e.g., comatose) . . } *SKIP to item 14a*
04 ☐ Don't know . . . . . }

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. The last time service was provided prior to (discharge on *date of discharge*/death), did . . . have any difficulty in hearing (when wearing a hearing aid)?

01 ☐ Yes
02 ☐ No . . . . . }
03 ☐ Not applicable (e.g., comatose) . . } *SKIP to item 15a*
04 ☐ Don't know . . . . . }

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

15. *HAND FLASHCARD 9.*

*Ask questions 15a through 15k in **PART I FIRST**. As you ask each part of the question, PAUSE to allow the respondent time to refer to the flashcard. Mark (X) the "Yes" box for each item the respondent says the patient had in his/her home. Then, **GO TO PART II**, and ask the question for each item marked "Yes" in Part I.*

PART I The following questions refer to the patient's status the last time service was provided prior to (discharge on *date of discharge*/death). The last time service was provided prior to (discharge on *date of discharge*/death), which of the following items did . . . have in (his/her) home?	**PART II** Did . . . receive assistance from your agency staff in caring for or using:
a. Oxygen, respiratory therapy equipment?	
(1) Ventilator/Respirator . . . . . 01 ☐ Yes	. . . . 01 ☐ Yes . . . . . 02 ☐ No . . . . 03 ☐ Don't know
(2) Liquid oxygen delivery system . . . . . 01 ☐ Yes	. . . . 01 ☐ Yes . . . . . 02 ☐ No . . . . 03 ☐ Don't know
(3) Oxygen concentrator . . . . . 01 ☐ Yes	. . . . 01 ☐ Yes . . . . . 02 ☐ No . . . . 03 ☐ Don't know
(4) Gaseous oxygen delivery system . . . . . 01 ☐ Yes	. . . . 01 ☐ Yes . . . . . 02 ☐ No . . . . 03 ☐ Don't know
(5) Nebulizer . . . . . 01 ☐ Yes	. . . . 01 ☐ Yes . . . . . 02 ☐ No . . . . 03 ☐ Don't know
(6) Humidifier . . . . . 01 ☐ Yes	. . . . 01 ☐ Yes . . . . . 02 ☐ No . . . . 03 ☐ Don't know
(7) Suction equipment . . . . . 01 ☐ Yes	. . . . 01 ☐ Yes . . . . . 02 ☐ No . . . . 03 ☐ Don't know
(8) Tracheostomy . . . . . 01 ☐ Yes	. . . . 01 ☐ Yes . . . . . 02 ☐ No . . . . 03 ☐ Don't know
b. Intravenous therapy equipment?	
(1) Peripheral catheter . . . . . 01 ☐ Yes	. . . . 01 ☐ Yes . . . . . 02 ☐ No . . . . 03 ☐ Don't know
(2) Midline catheter . . . . . 01 ☐ Yes	. . . . 01 ☐ Yes . . . . . 02 ☐ No . . . . 03 ☐ Don't know
(3) Central venous catheter (e.g. Hickman, Broviac, Porta-cath., etc.) . . . . . 01 ☐ Yes	. . . . 01 ☐ Yes . . . . . 02 ☐ No . . . . 03 ☐ Don't know
(4) Infusion pumps . . . . . 01 ☐ Yes	. . . . 01 ☐ Yes . . . . . 02 ☐ No . . . . 03 ☐ Don't know
c. Decubitus ulcer prevention/treatment equipment?	
(1) Air mattress/air fluidized bed . . . . . 01 ☐ Yes	. . . . 01 ☐ Yes . . . . . 02 ☐ No . . . . 03 ☐ Don't know
(2) Foam mattress (egg-crate mattress) . . . . . 01 ☐ Yes	. . . . 01 ☐ Yes . . . . . 02 ☐ No . . . . 03 ☐ Don't know
d. Enteral nutrition equipment?	
(1) Nasogastric tube . . . . . 01 ☐ Yes	. . . . 01 ☐ Yes . . . . . 02 ☐ No . . . . 03 ☐ Don't know
(2) Gastrostomy/jejunostomy tube . . . . . 01 ☐ Yes	. . . . 01 ☐ Yes . . . . . 02 ☐ No . . . . 03 ☐ Don't know
(3) Pump . . . . . 01 ☐ Yes	. . . . 01 ☐ Yes . . . . . 02 ☐ No . . . . 03 ☐ Don't know
CONTINUED ON NEXT PAGE	***CONTINUED ON NEXT PAGE***

15. PART I – Continued The last time service was provided prior to (discharge on *date of discharge*/death), which of the following items did . . . have in (his/her) home?	15. PART II – Continued Did . . . receive assistance from your agency staff in caring for or using:
e. Dialysis equipment?	
(1) Peritoneal Dialysis – Manual (continuous) . . 01 ☐ Yes	. . . . . 01 ☐ Yes . . . . 02 ☐ No . . . . 03 ☐ Don't know
(2) Peritoneal Dialysis – Automated (intermittent/continuous cyclic) . . . . . 01 ☐ Yes	. . . . . 01 ☐ Yes . . . . 02 ☐ No . . . . 03 ☐ Don't know
(3) Peritoneal – unspecified . . . . . 01 ☐ Yes	. . . . . 01 ☐ Yes . . . . 02 ☐ No . . . . 03 ☐ Don't know
(4) Hemodialysis . . . . . 01 ☐ Yes	. . . . . 01 ☐ Yes . . . . 02 ☐ No . . . . 03 ☐ Don't know
f. Blood glucose monitor? . . . . . 01 ☐ Yes	. . . . . 01 ☐ Yes . . . . 02 ☐ No . . . . 03 ☐ Don't know
g. Drainage devices? . . . . . 01 ☐ Yes	. . . . . 01 ☐ Yes . . . . 02 ☐ No . . . . 03 ☐ Don't know
(1) Wound/bile duct/ureteral drainage catheter . . 01 ☐ Yes	. . . . . 01 ☐ Yes . . . . 02 ☐ No . . . . 03 ☐ Don't know
(2) Foley catheter . . . . . 01 ☐ Yes	. . . . . 01 ☐ Yes . . . . 02 ☐ No . . . . 03 ☐ Don't know
(3) Intermittent bladder catheterization . . . . . 01 ☐ Yes	. . . . . 01 ☐ Yes . . . . 02 ☐ No . . . . 03 ☐ Don't know
(4) External urinary collection devices (e.g. condom catheter) . . . . . 01 ☐ Yes	. . . . . 01 ☐ Yes . . . . 02 ☐ No . . . . 03 ☐ Don't know
(5) Urostomy . . . . . 01 ☐ Yes	. . . . . 01 ☐ Yes . . . . 02 ☐ No . . . . 03 ☐ Don't know
(6) Ileostomy/Colostomy . . . . . 01 ☐ Yes	. . . . . 01 ☐ Yes . . . . 02 ☐ No . . . . 03 ☐ Don't know
h. Protective restraints (e.g. vests, belts)? . . . . . 01 ☐ Yes	. . . . . 01 ☐ Yes . . . . 02 ☐ No . . . . 03 ☐ Don't know
i. Pediatric care? . . . . . 01 ☐ Yes	. . . . . 01 ☐ Yes . . . . 02 ☐ No . . . . 03 ☐ Don't know
(1) Apnea monitor . . . . . 01 ☐ Yes	. . . . . 01 ☐ Yes . . . . 02 ☐ No . . . . 03 ☐ Don't know
(2) Phototherapy lights/equipment . . . . . 01 ☐ Yes	. . . . . 01 ☐ Yes . . . . 02 ☐ No . . . . 03 ☐ Don't know
j. Prenatal uterine monitoring? . . . . . 01 ☐ Yes	. . . . . 01 ☐ Yes . . . . 02 ☐ No . . . . 03 ☐ Don't know
k. Other? – *Specify* _____ . . . . 01 ☐ Yes	. . . . . 01 ☐ Yes . . . . 02 ☐ No . . . . 03 ☐ Don't know

16. The last time service was provided prior to (discharge on *date of discharge*/death), did . . . have any difficulty in controlling (his/her) bowels?	01 ☐ Yes 02 ☐ No 03 ☐ Not applicable (e.g. infant, had an ostomy) 04 ☐ Don't know
17. The last time service was provided prior to (discharge on *date of discharge*/death), did . . . have any difficulty in controlling (his/her) bladder?	01 ☐ Yes 02 ☐ No 03 ☐ Not applicable (e.g. infant, had an indwelling catheter, had an ostomy) 04 ☐ Don't know

NOTES

HAND FLASHCARD 10.

18. The last time service was provided prior to (discharge on *date of discharge*/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 was 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 11.

19. The last time service was provided prior to (discharge on *date of discharge*/death), did . . . receive personal help from your agency in any of the following activities – *Mark (X) one box for each activity.*	Yes	No	Don't know	Not applicable (e.g., patient was 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 ☐

HAND FLASHCARD 12.

20a. During the 30 days prior to discharge, 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 ☐ Homemaker-household services
04 ☐ Medications
05 ☐ Mental health services
06 ☐ Nursing services
07 ☐ Nutritionist services
08 ☐ Occupational therapy
09 ☐ Physical therapy
10 ☐ Physician services
11 ☐ Social services
12 ☐ Speech therapy/Audiology
13 ☐ Transportation
14 ☐ Volunteers
15 ☐ Other services – *Specify* ↙

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HAND FLASHCARD 13.

20b. During the 30 days prior to discharge, which of these service providers FROM YOUR AGENCY visited . . .?

Mark (X) all that apply.

PROBE: **Any other providers?**

- 00 ☐ None
- 01 ☐ Chaplain
- 02 ☐ Dieticians/Nutritionists
- 03 ☐ Home health aides
- 04 ☐ Homemakers/Personal caretakers
- 05 ☐ Licensed practical or vocational nurses
- 06 ☐ Nursing aides and attendants
- 07 ☐ Occupational therapists
- 08 ☐ Physical therapists
- 09 ☐ Physicians
- 10 ☐ Registered nurses
- 11 ☐ Respiratory therapists
- 12 ☐ Social workers
- 13 ☐ Speech pathologists/audiologists
- 14 ☐ Volunteers
- 15 ☐ Other providers – *Specify* ↙

_____

HAND FLASHCARD 14.

21. 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 ☐ Private insurance	01 ☐	01 ☐
02 ☐ Own income, family support, Social Security benefits, retirement funds, or welfare	02 ☐	02 ☐
03 ☐ Supplemental Security Income (SSI)	03 ☐	03 ☐
04 ☐ Medicare	04 ☐	04 ☐
05 ☐ Medicaid	05 ☐	05 ☐
06 ☐ Other government medical assistance	06 ☐	06 ☐
07 ☐ Religious organizations, foundations, agencies	07 ☐	07 ☐
08 ☐ VA contract, pensions, or other VA compensation	08 ☐	08 ☐
09 ☐ No charge made for care	09 ☐	09 ☐
10 ☐ Payment source not yet determined	10 ☐	10 ☐
11 ☐ Other – *Specify* ↙	11 ☐	11 ☐

_____

12 ☐ Don't know

NOTES

HAND FLASHCARD 14.

22. What were ALL the secondary sources of payment for . . . 's entire episode of care?

Mark (X) all that apply.

PROBE: **Any other sources of payment?**

For the source of payment ask:
Was the *(source of payment)* **for home health care or hospice care?**

	Home Health Care	Hospice Care
01 ☐ Private insurance	01 ☐	01 ☐
02 ☐ Own income, family support, Social Security benefits, retirement funds, or welfare	02 ☐	02 ☐
03 ☐ Supplemental Security Income (SSI)	03 ☐	03 ☐
04 ☐ Medicare	04 ☐	04 ☐
05 ☐ Medicaid	05 ☐	05 ☐
06 ☐ Other government medical assistance	06 ☐	06 ☐
07 ☐ Religious organizations, foundations, agencies	07 ☐	07 ☐
08 ☐ VA contract, pensions, or other VA compensation	08 ☐	08 ☐
09 ☐ No charge made for care	09 ☐	09 ☐
10 ☐ Payment source not yet determined	10 ☐	10 ☐
11 ☐ Other – *Specify* ↙	11 ☐	11 ☐
12 ☐ Don't know		

23. When was the last time service was provided?

Month		Day		Year	

FILL SECTION C ON THE COVER OF THIS FORM AND CONTINUE WITH THE NEXT DISCHARGED PATIENT QUESTIONNAIRE.

NOTES

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