OMB #
Expires:

SP ID #: _____

SP NAME: _____

INTERVIEWER NAME: _____

INTERVIEWER ID: _____

FACILITY ID #: _____

START TIME: _____ am/pm

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

MEDICARE CURRENT BENEFICIARY SURVEY

FACILITY COMPONENT

USE OF HEALTH CARE SERVICES

ROUND 58
2010

ASSURANCE OF CONFIDENTIALITY

Information contained on this form that would permit identification of any individual or establishment is collected with a guarantee that it will be held in strict confidence by the contractor and CMS, will be used only for purposes stated in this study, and will not be disclosed or released to anyone other than authorized staff of CMS without the consent of the individual or the establishment in accordance with the Privacy Act of 1974.

US. USE OF SERVICES MODULE

(CORE ONLY)

BOX USO omitted.

FB37-FB45 omitted.

US1PRE
Display "The questions include...acute care hospital." the first time a respondent is asked the Use of Services questionnaire; else do not display.

CTRL/E OK

US1PRE

This series of questions is about the health care services that {SP} may have received between {REFERENCE START DATE} and {REFERENCE END DATE} while {she/he} resided in {FACILITY/[READ FACILITY/UNITS ABOVE]}. {The questions include any services that {she/he} received outside this facility, as well as care from any providers who saw {her/him} here. The kinds of services I will be asking about include physician care, dental care, mental health services, various kinds of therapies, and care from other kinds of health care providers. I will be asking about the type of provider and the frequency or duration of the services. Please do not include care while {she/he} was an overnight inpatient in an acute care hospital.}

CURRENT TIMELINE

PLACE NAME	START DATE	END DATE	STAY TYPE
{ }	{ }	{ }	{ }
{ }	{ }	{ }	{ }
{ }	{ }	{ }	{ }
ETC.	ETC.	ETC.	ETC.

USE ARROW KEYS. TO EXIT, PRESS ESCAPE.

FACR.US1LONG

US1

Between {REFERENCE START DATE} and {REFERENCE END DATE} while a resident in this {FACILITY/HOME}, did {she/he} see a medical doctor of any kind, outside the {FACILITY/HOME}, excluding mental health therapy provided by a psychiatrist?

YES	1	(US2)
NO	0	(US3)
DK	-8	(US3)
RF	-7	(US3)

USES.OUTMDVST

US2

Between {REFERENCE START DATE} and {REFERENCE END DATE}, how many times did {she/he} see doctors outside this facility?

_____
NUMBER

USES.OUTMDFRQ

PROGRAMMER SPECS:
Hard range: 1-999; soft range: 1-50.

US3

Between {REFERENCE START DATE} and {REFERENCE END DATE}, did {she/he} see a medical doctor of any kind, here, in this {FACILITY/HOME}, excluding mental health therapy provided by a psychiatrist?

YES	1	(US5A)
NO	0	(US6PRE)
DK	-8	(US3a)
RF	-7	(US6PRE)

USES.INMDVST

BOX US1 omitted.

US3A

Please tell me the name and title of someone in {FACILITY/[READ FACILITY/UNITS ABOVE]} who could give me that information.

RECORD RESPONDENT INFORMATION ON PAPER FROG.

Thank you for your time, those are all the questions I have for you. Right now I need to continue with [NAME FROM FROG] to complete these questions.

PRESS ENTER TO CONTINUE.

PERM.USABORT

PROGRAMMER SPECS:
Terminate Use with this respondent and return to navigation screen. Set USE status, on the navigate screen RDY. The next time ENTER is struck on this cell, begin USE at US1PRE.

US4 omitted.

US4A omitted.

US5 omitted.

US5A

Between {REFERENCE START DATE} and {REFERENCE END DATE}, how many times did {she/he} see any doctor here?

( )
NUMBER

USES.ANYMDFRQ

PROGRAMMER SPECS:
Hard range: 1-999; soft range: 1-50.

CTRL/E OK

US6PRE

The following questions are about services used both inside and outside this facility. We are only interested in services {SP} received while residing in {FACILITY/[READ FAC/UNITS LISTED ABOVE]}.

PRESS ENTER TO CONTINUE.

US6

Between {REFERENCE START DATE} and {REFERENCE END DATE}, did {she/he} see a dentist, dental surgeon, dental assistant, or any other professional for dental care?

YES	1	(US7)
NO	0	(US8)
DK	-8	(US8)
RF	-7	(US8)

USES.DENTVST

US7
If US6 = "YES", display US7 as an overlay of US6.

US7

Between {REFERENCE START DATE} and {REFERENCE END DATE}, how many times did {she/he} see a dentist, dental surgeon, dental assistant, or any other professional for dental care?

_____ (US8)
NUMBER

USES.DENTFRQ

PROGRAMMER SPECS:
Hard range: 1-400; soft range: 1-50.

US8

Between {REFERENCE START DATE} and {REFERENCE END DATE}, did {she/he} see a psychiatrist or any other mental health care professional either inside or outside this facility?

YES	1	(US9)
NO	0	(US12)
DK	-8	(US12)
RF	-7	(US12)

USES.MENTLVST

US9

What type of mental health specialist did {she/he} see?

PROBE: Any others?.

LICENSED CLINICAL SOCIAL WORKER	(US10)
PSYCHIATRIC NURSE	(US10)
PSYCHIATRIC SOCIAL WORKER	(US10)
PSYCHIATRIST	(US10)
PSYCHOLOGIST	(US10)
OTHER (SPECIFY:_____)	(US10)

USE ARROW KEYS. TO SELECT OR DESELECT, PRESS ENTER. TO EXIT, PRESS ESC.

USES.PSYCHIAT .LICSOCW
.PSYCHOLO .PSOTHER
.PSYCNURS .PSYCHOS
.PSYCSOCW

US10
Display US10 as an overlay of US9.

US10

Between {REFERENCE START DATE} and {REFERENCE END DATE}, how many sessions or visits did {she/he} have?

_____ (US11)

USES.PSCIASES .LCSOWSES
.PSCOLSES .PSOTRSES
.PSCNUSES
.PSSOWSES

PROGRAMMER SPECS:
Hard range: 1-400; soft range: 1-50.

US11
Display US11 as an overlay of US10.

US11

Were these individual sessions, group sessions, or some of both?

INDIVIDUAL	1	
GROUP	2	
BOTH	3	

USES.PSCIATYP .PSSOWTYP
.PSCOLTYP .LCSOWTYP
.PSCNUTYP .PSOTRTYP

US12

Between {REFERENCE START DATE} and {REFERENCE END DATE}, did {she/he} see a therapist such as a physical therapist, speech therapist, I.V. therapist, occupational therapist, or respiratory therapist?

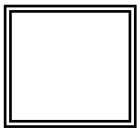
YES	1	(US13)
NO	0	(US22A)
DK	-8	(US22A)
RF	-7	(US22A)

USES.PHYSTHPY

US13
If US12 = "YES", display US13 as an overlay of US12.

US13

Please look at this card and tell me about how often each week therapy was provided.



MORE THAN 5 TIMES A WEEK	1	(US14)
LESS THAN ONCE A WEEK	2	(US14)
3 TO 5 TIMES A WEEK	3	(US14)
MORE THAN 5 TIMES A WEEK	4	(US14)
ONE-TIME EVALUATION	5	(US22A)
DK	-8	(US14)

PRESS F1 FOR INFORMATION ON "ONE-TIME EVALUATION".

USES.PHTPYWKL

US14

Now look at this card. Between {REFERENCE START DATE} and {REFERENCE END DATE}, over how long a period was therapy provided?

SHOW CARD US2

LESS THAN 1 WEEK	1
1 TO 3 WEEKS	2
4 TO 8 WEEKS	3
MORE THAN 8 WEEKS BUT NOT THE WHOLE TIME	4
ABOUT THE WHOLE TIME	5
DK	-8
RF	-7

USES.PHTPYFRQ

US15-US22 omitted.

US22A

Between {REFERENCE START DATE} and {REFERENCE END DATE} was {SP} seen by a podiatrist (either inside or outside this facility)?

YES	1	
NO	0	

USES.PODRTHPY

US23

Between {REFERENCE START DATE} and {REFERENCE END DATE}, did {she/he} receive educational or habilitational services (either inside or outside this facility)?

PROBE: "Habilitational services" include training in daily living skills, self care, and so on, in a structured program.

YES	1	(US24)
NO	0	(US29)
DK	-8	(US29)
RF	-7	(US29)

USES.EDHBSERV

US24

Were those services educational, habilitational, or both?

EDUCATIONAL	1	(US25)
HABILITATIONAL	2	(US25)
BOTH	3	(US25)
DK	-8	(US25)
RF	-7	(US29)

USES.EDUORHAB

US25
If US24 = 1, 2, 3, or -8 (DK), display US25 as an overlay of US24.
If 1 or 3, display "educational;" else if 2, display "habilitational," else if "DK", display neither.

US25

Please look at this card and tell me, between {REFERENCE START DATE} and {REFERENCE END DATE}, over how long a period were these {educational} {habilitational}services provided?

SHOW CARD US4

LESS THAN 1 WEEK	1
1 TO 3 WEEKS	2
4 TO 8 WEEKS	3
MORE THAN 8 WEEKS BUT NOT THE WHOLE TIME	4
ABOUT THE WHOLE TIME	5
DK	-8
RF	-7

USES.EDHABFRQ

US26 omitted.

BOX US2	If US24 = 3, go to US27; else go to US29.

US27
Display US27 as an overlay of US25.

US27

Between {REFERENCE START DATE} and {REFERENCE END DATE}, over how long a period were these habilitational services provided?

SHOW CARD US4

LESS THAN 1 WEEK	1	
1 TO 3 WEEKS	2	
4 TO 8 WEEKS	3	
MORE THAN 8 WEEKS BUT NOT THE WHOLE TIME	4	
ABOUT THE WHOLE TIME	5	
DK	-8	
RF	-7	

USES.HABFRQ

US28 omitted.

US29

USE SHOW CARD US5 FOR PROMPTING AS NEEDED.

Between {REFERENCE START DATE} and {REFERENCE END DATE}, did {she/he} receive care from <u>any other</u> licensed or certified health care provider (either inside <u>or</u> outside this facility)?

YES	1	(US30)
NO	0	(US31PRE)
DK	-8	(US31PRE)
RF	-7	(US31PRE)

PRESS F1 FOR “ANY OTHER PROVIDER” CLARIFICATION.

USES.OTHCPROV

US30
If US29 = "YES", display US30 as an overlay of US29.

US30

What kind of provider was that?

SELECT ALL THAT APPLY.

AUDIOLOGIST
DIETICIAN
LABORATORY TECHNICIAN
NURSE PRACTITIONER
OPHTHALMOLOGIST
OPTOMETRIST
PHYSICIANS ASSISTANT
RECREATIONAL THERAPIST
REGISTERED NURSE
SOCIAL WORKER
X-RAY TECHNICIAN
OTHER (SPECIFY: _____)

USES.TYPAUDIO .TYPRECRE
.TYPDIET .TYPRN
.TYPLABTC .TYPSOCWO
.TYPNURSP .TYPXRTEC
.TYPOPHTH .TYPOTHER
.TYPOPTOM .TYPPRVOS
.TYPPHAST

*** CTRL/E OK***

US31PRE

The next few questions are about any visits {SP} may have made to a hospital emergency room, that is, from {REFERENCE START DATE} through {REFERENCE END DATE}.
Please do not include visits to the emergency room that were immediately followed by inpatient hospital stays.

PRESS ENTER TO CONTINUE.

US32

While {she/he} was in a nursing home, did {she/he} make any visits to a hospital emergency room between {REFERENCE START DATE} and {REFERENCE END DATE}?

YES	1	(US33)
NO	0	(US37)
DK	-8	(US37)
RF	-7	(US37)

USES.ERVISITS

US33

{REF. START DATE} - {REF. END DATE}

On what date did the {first/next} ER visit occur?

MONTH ( ) DAY ( ) YEAR ( )

EMRG.ERVSTMM .ERVSTDD .ERVSTYY

PROGRAMMER SPECS:
Date entered must be between Reference Start Date and Reference End Date, else display the message: DATE MUST BE BETWEEN {REF. START DATE} and {REF. END DATE}. PLEASE RE-ENTER.

BOX US3 omitted.

US34 omitted.

US35 omitted.

US36

{REF. START DATE} - {REF. END DATE}

ER VISIT: {DATE FROM US33}

Other than what you have just told me, did {SP} have any other emergency room visits?

YES	1	(US33)
NO	0	(US37)
DK	-8	(US37)
RF	-7	(US37)

EMRG.EROTHVST

US37

1. If any health care providers have been identified (US1, US3, US6, US8, US12, US22A, US23, or US29 = "YES"), display "health care providers."

2. If US32 = "YES", "DK", or "RF", display "emergency room."

3. If Statement 1 and Statement 2 are both true, display "and."

4. If there is a "YES" in either Statement 1 or 2, display "Besides...told me about."; else do not display.

US37

{Besides the {health care providers} {and} {emergency room} visits you have already told me about,} {D/d}id {she/he} ever go to the hospital and return on the same day?

YES	1	(US38)
NO	0	(US40)
DK	-8	(US40)
RF	-7	(US40)

USES.RETSMDAY

US38
If US37 = "YES", display US38 as an overlay of US37.

US38

How many times did this happen between {REFERENCE START DATE} and {REFERENCE END DATE}?

( )
NUMBER

USES.RETSMFRQ

PROGRAMMER SPECS:
Hard range: 1-999; Soft range: 1-50.

BOX US4 omitted.

US39 omitted.

US40

Now I'd like to ask you about any kind of supplies, equipment, or other types of medical services {SP} received other than the ones I've already mentioned. Please look at this first card and tell me what supplies or services {SP} received between {REFERENCE DATE} and {END DATE}.

SHOW CARD US6

SELECT ALL THAT APPLY

DIABETIC EQUIPMENT OR SUPPLIES
EYE
GLASSES OR CONTACT LENSES
HEARING AID OR OTHER COMMUNICATION DEVICE
ORTHOPEDIC ITEMS
EQUIPMENT OR SUPPLIES FOR KIDNEY DIALYSIS
OSTOMY SUPPLIES
CLOTH DIAPERS
DISPOSABLE DIAPERS
AMBULANCE SERVICE
PROSTHESIS
OXYGEN
DON'T KNOW
NONE OF THE ABOVE

USES.DIABETEQ	**.KDIALYEQ**	**.PROSTHEQ**
.EYEEQ	**.OSTOMYEQ**	**.OXYGENEQ**
.HEARNGEQ	**.CLOTDIAP**	
.ORTHOPEQ	**.DIAPEREQ**	
	.AMBULNEQ	

US41 omitted.

BOX US3	If DK selected in US40, go to US43. Else, continue.

US42

Please look at this second card and tell me what medical devices or equipment {he/she} received between {REFERENCE DATE} and {END DATE}.

SHOW CARD US7

SELECT ALL THAT APPLY

BEDSIDE COMMODE
BED PADS (CLOTH OR DISPOSABLE)
CATHETER AND CATHETER SUPPLIES
FEEDING SUPPLIES (INCLUDE PUMPS, SYRINGES, TUBES)
G TUBE AND SUPPLIES
GERI CHAIR
HOSPITAL BED
IV SUPPLIES
NEBULIZER
SPECIAL MATTRESS, CUSHIONS OR MATTRESS PADS (INCLUDING EGG CRATE, AIR)
SUCTION MACHINE AND SUPPLIES
TED HOSE AND SUPPLIES
WHEELCHAIR/WALKER
SOME OTHER TYPE OF DEVICE OR EQUIPMENT
NONE OF THE ABOVE

USES.COMMODE	**.FEEDEQPM**	**.IVSUPPL**	**.TEDHOSE**
.BEDPADS	**.GTUBESUP**	**.NEBULIZR**	**.WHEEWALK**
.CATHETEQ	**.GERCHAIR**	**.MATTRESS**	**.OTHREQPM**
	.HOSPBED	**.SUCTEQPM**	**.OTHREQOS**

US43

Please tell me if {SP} received any of the following medical services? Did {he/she} receive. . .

YES = 1, NO = 0

Turning and positioning..... ( )
Tubefeeding..... ( )
Restraints..... ( )
Injections..... ( )

USES.MSTURN	**.MSTUBE**	**.MSRESTR**	**.MSINJECT**

US44 omitted

US45

Now I'd like to ask about any other medically necessary items or provider services (SP) received that we haven't talked about already.

Please look at this last card and tell me what other items or services {he/she} received between {REFERENCE DATE} and {END DATE}?

SHOW CARD US8

SELECT ALL THAT APPLY

CATHETERIZATION AND IRRIGATION
APPLYING/CHANGING DRESSINGS INCLUDING BAND-AIDS
FEEDING (WITH SPOON, SYRINGE, PUMP, OR OTHER DEVICE)
SKIN TREATMENTS FOR PREVENTION,
TREATMENT OF SKIN ULCERS
APPLYING/MONITORING HOT PACKS
IV USE AND CARE
G TUBE USE AND CARE
PACEMAKER CHECK
SUCTIONING
INCONTINENCE
SOME OTHER KIND OF ITEM OR SERVICE
NONE OF THE ABOVE

USES.CATHIRRI	**.SKINSERV**	**.GTUBEUSE**	**.INCNCARE**
.CHNGBAND	**.HOTPACKS**	**.PACEMCHK**	**.OTHRSERV**
.FEEDSERV	**.IVUSE**	**.SUCTSERV**	**.OTHRSEOS**

US46

DID YOU ABSTRACT?

ALL 1
MAJORITY..... 2
HALF 3
SOME 4
NONE ..... 5 (USEND)

HIRO.DIDABUS

US47

WHY DID YOU ABSTRACT?

NO KNOWLEDGEABLE RESPONDENT AVAILABLE	1
NO TIME/STAFF BURDEN TOO GREAT	2
REFUSAL--UNWILLING TO COOPERATE	3
OTHER, (SPECIFY:_____)	91

HIRO.WHYABUS
HIRO.WHYABUOS

PROGRAMMER SPECS:
Disallow DK and RF entries.

USEND

YOU HAVE COMPLETED THE USE SECTION FOR THIS SP.
PRESS ENTER TO RETURN TO NAVIGATION SCREEN.

CARD
US1

HOW OFTEN EACH WEEK...

Less than once a week

Once or twice a week

3 to 5 times a week

More than 5 times a week

One-time evaluation

CARD
US2

HOW LONG A PERIOD...

Less than 1 week

1 to 3 weeks

4 to 8 weeks

More than 8 weeks, but not the whole time

About the whole time

CARD
US4

HOW LONG A PERIOD...

Less than 1 week

1 to 3 weeks

4 to 8 weeks

More than 8 weeks, but not the whole time

About the whole time

CARD
US5

OTHER CERTIFIED OR LICENSED HEALTH CARE PROVIDERS

AUDIOLOGIST

DIETICIAN

LABORATORY TECHNICIAN

NURSE PRACTITIONER

OPHTHALMOLOGIST

OPTOMETRIST

PHYSICIANS ASSISTANT

RECREATIONAL THERAPIST

REGISTERED NURSE

SOCIAL WORKER

X-RAY TECHNICIAN

SOME OTHER HEALTH CARE PROVIDER

CARD
US6

SUPPLIES AND MEDICAL SERVICES

DIABETIC EQUIPMENT OR SUPPLIES

EYE GLASSES OR CONTACT LENSES

HEARING AID OR OTHER COMMUNICATION DEVICE

ORTHOPEDIC ITEMS

EQUIPMENT OR SUPPLIES FOR KIDNEY DIALYSIS

OSTOMY SUPPLIES

DISPOSABLE DIAPERS

AMBULANCE SERVICE

PROSTHESIS

OXYGEN

CARD
US7

OTHER MEDICAL DEVICE OR EQUIPMENT

BEDSIDE COMMODE

BED PADS (CLOTH OR DISPOSABLE)

CATHETER AND CATHETER SUPPLIES

CLOTH DIAPERS

FEEDING SUPPLIES (INCLUDE PUMPS, SYRINGES, TUBES)

G TUBE AND SUPPLIES

GERI CHAIR

HOSPITAL BED

IV SUPPLIES

NEBULIZER

SPECIAL MATTRESS, CUSHIONS OR MATTRESS PADS (INCLUDE EGG CRATE, AIR)

SUCTION MACHINE AND SUPPLIES

TED HOSE AND SUPPLIES

WHEELCHAIR/WALKER

SOME OTHER TYPE OF DEVICE OR EQUIPMENT

CARD
US8

OTHER NECESSARY MEDICAL ITEMS OR SERVICES

CATHETERIZATION AND IRRIGATION

APPLYING/CHANGING DRESSINGS INCLUDING BANDAIDS

FEEDING (WITH SPOON, SYRINGE, PUMP, OR OTHER DEVICE)

SKIN TREATMENTS FOR PREVENTION, TREATMENT OF SKIN ULCERS

APPLYING, MONITORING HOT PACKS

IV USE AND CARE

G TUBE USE AND CARE

PACEMAKER CHECK

SUCTIONING

INCONTINENCE

SOME OTHER KIND OF ITEM OR SERVICE

USE OF HEALTH CARE SERVICES HELP SCREENS

US13

One-time evaluations for physical and/or occupational therapy may take place across several sessions or days.

US29

Do not include health care providers on the regular (paid for by the basic rate) resident-care staff of the facility.