MAIN STUDY - ROUND 19

COMMUNITY COMPONENT

HH. HOME HEALTH UTILIZATION AND EVENTS

HH1. (Other than what we just talked about,) [Since (REF. DATE)/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], (have you been/has SP been/was SP) helped **at home** by any (other) health or medical professionals, such as those listed on this card? [Health professionals include nurse (visiting nurse, private duty nurse, etc.), doctor, social worker, therapist, and hospice worker.]

SHOW CARD HH1	**HHPRPROF**	YES	1	(HH2)
		NO	2	(HH18)
		REFUSED	-7	(HH18)
		DON'T KNOW	-8	(HH18)

HH2. What is the name of the health professional who helped (you/SP) at home [since (REF. DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)]?
[ENTER NAME OF PERSON WHO HELPED, NOT NAME OF PLACE OR ORGANIZATION.]
[ENTER ONLY ONE PROVIDER.]
PROVNAME

HH3. What kind of health professional is (PROVIDER)?
PROVSPEC

HH4. Who does (HH2 PROVIDER) work for, that is, for what place or organization?
[PROBE: Or does (HH2 PROVIDER) work for herself/himself?]

WORKSFOR	NAME OF ORGANIZATION GIVEN	1	(HH5)
	WORKS FOR SELF	2	***BOX HH1***
	REFUSED	-7	***BOX HH1***
	DON'T KNOW	-8	***BOX HH1***

HH5. [Who does (HH2 PROVIDER) work for, that is, what place or organization?]
[PROBE: Who would (you/SP) call if (HH2 PROVIDER) did not show up?]
[ENTER OR SELECT ONLY ONE PROVIDER.]
PROVNAME
SUBPROV

HH6. What kind of place or organization is (HH5 PROVIDER)?

HHPLACE	HMO	1	***BOX HH1***
	MEAL PROGRAM (SUCH AS MEALS ON WHEELS)	2	(HH7)
	VISITING NURSE ASSOCIATION	3	***BOX HH1***
	HOME HEALTH AGENCY	4	***BOX HH1***
	HOSPITAL	5	***BOX HH1***
	PRIVATE PHYSICIAN/GROUP PRACTICE	6	***BOX HH1***
	HOSPICE	7	***BOX HH1***
	REHABILITATION OR SPORTS MEDICINE THERAPY	8	***BOX HH1***
	LOCAL GOVERNMENT ORGANIZATION	9	(HH11)
	CHURCH OR COMMUNITY ORGANIZATION	10	(HH11)
	ASSISTED LIVING/RETIREMENT HOME	11	***BOX HH1***
	OTHER (SPECIFY) _____		
HHPLACOS	_____	91	***BOX HH1***

HH7. Between (PREV. ROUND INT. DATE/INT. DATE FROM ST10a, NS7a, CT72a) and (TODAY/DATE OF DEATH/DATE OF INSTITUTIONALIZATION/INT. DATE FROM ST10a, NS7a, CT72a), did (HH5 PROVIDER) provide any services to (you/SP) other than delivering meals?

OTHMEALS	YES	1	***BOX HH1***
	NO	2	***BOX HH3***
	REFUSED	-7	***BOX HH3***
	DON'T KNOW	-8	***BOX HH3***

BOX HH1	a.	SP HAS USED VA FACILITIES (HI36=1)	1	(b)
		SP HAS NOT USED VA FACILITIES (HI36=2 OR MISSING)	2	***BOX HH1A***
	b.	VA FLAG SET FOR HH4/HH2 PROVIDER	1	***BOX HH1A***
		VA FLAG NOT SET FOR HH4/HH2 PROVIDER	2	(HH8)

Box HH2 omitted.

HH8. Is (HH2/HH5 PROVIDER) associated with a Department of Veterans Affairs, or V.A., facility?

VAPLACE	YES	1
	NO	2
	REFUSED	-7
	DON'T KNOW	-8

HH8a, HH8b, HH9, and HH10 omitted.

BOX HH1A	a.	SP BELONGS TO AN HMO (HI25 OR MEDICARE HMO FLAG = 1 FOR ANY PLAN)	1	(b)
		SP DOES NOT BELONG TO AN HMO (HI25 OR MEDICARE HMO FLAG = 2 OR MISSING FOR ALL PLANS)	2	(HH11)
	b.	"HMO FLAG" CODED YES FOR THIS PROVIDER	1	(HH11)
		"HMO FLAG" CODED NO OR MISSING FOR THIS PROVIDER	2	(HH10b)
		"HMO FLAG" NOT SET FOR THIS PROVIDER	3	(HH10a)

HH10a. Is (PROVIDER) associated with (your/SP's) {READ HMO PLAN NAME(S) BELOW] plan?

HMOASSOC

YES	1	(HH11)
NO	2	(HH10b)
REFUSED	-7	(HH10b)
DON'T KNOW	-8	(HH10b)

HH10b. (Were you/Was SP) referred to (PROVIDER) by [READ HMO PLAN NAME(S) BELOW]?

HMOREFER

YES	1	(HH11)
NO	2	(HH10c)
REFUSED	-7	(HH11)
DON'T KNOW	-8	(HH11)

HH10c. What is the most important reason (you/SP) did not use a home health provider associated with [READ PLAN NAMES BELOW] or a home health provider that [READ PLAN NAMES BELOW] would refer (you/SP) to?

	HMO DOES NOT COVER THE SERVICE SP WANTED	1
	SP COULD NOT GET SERVICES QUICKLY ENOUGH AT THE HMO	2
	HMO NOT CONVENIENTLY LOCATED FOR THE SP	3
	HMO PROVIDERS NOT COMPETENT/QUALIFIED TO HANDLE SP'S CONDITION/NEEDS	4
	SP DIDN'T WANT TO GO THROUGH PRIMARY CARE PHYSICIAN TO GET REFERRAL	5
	SP WANTED TO GO TO A PROVIDER NOT AVAILABLE THROUGH THE HMO	6
NOHMOMAI	SP WANTED TO USE A PROVIDER THEY HAD PRIOR TO THEIR ENROLLMENT IN THE HMO	7
	HMO REFUSED TO PROVIDE THE CARE THE SP THOUGHT WAS NECESSARY	8
	THIS SERVICE WAS COVERED BY OTHER INSURANCE SP HAS	9
NOHMOMOS	HMO ADMINISTRATIVE OBSTACLES FOR SP	10
	NOT IN HMO AT TIME OF EVENT	11
	SP HAD A MEDICAL EMERGENCY AND WENT OR WAS TAKEN TO THE CLOSEST PROVIDER	12
	SP WAS OUTSIDE OF THE SERVICE AREA WHEN URGENT CARE WAS NEEDED	13
	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

HH11. Between (PREV. ROUND INT. DATE/INT. DATE FROM ST10a, NS7a, CT72a) and (TODAY/DATE OF DEATH/DATE OF INSTITUTIONALIZATION/INT. DATE FROM ST10a, NS7a, CT72a), how many times (has/did) (HH2 OR HH19 PROVIDER/someone from HH5 OR HH24 PROVIDER) come to the home to help (you/SP)? [Remember to include all home health providers from (HH5 OR HH24 PROVIDER).]

TOTAL NUMBER OF TIMES	1		TOTAL NUMBER OF TIMES: _____
NUMBER OF TIMES PER DAY	2		NUMBER OF TIMES PER DAY: _____
NUMBER OF TIMES PER WEEK	3		NUMBER OF TIMES PER WEEK: _____
NUMBER OF TIMES PER MONTH	4		NUMBER OF TIMES PER MONTH: _____
REFUSED	-7	(HH12)	
DON'T KNOW	-8	(HH12)	
HELPUNIT			**HELPNUM**

HH12. (Generally speaking, how long (does/did)/How long did) (HH2 OR HH19 PROVIDER/someone from HH5 OR HH24 PROVIDER) stay with (you/SP)?
[PROBE: We just need to know in general.]

HOURS ONLY.....	1		NUMBER OF HOURS: _____
MINUTES ONLY	2		NUMBER OF MINUTES: _____
HOURS AND MINUTES.....	3		
REFUSED	-7	(HH13)	
DON'T KNOW	-8	(HH13)	
STAYUNIT			**STAYHOUR** **STAYMIN**

HH13. (Generally speaking, (does/did)/Did) (HH2 OR HH19 PROVIDER/someone from HH5 OR HH24 PROVIDER) help (you/SP) by giving any medical or nursing treatment, such as the things shown on this card? ["MEDICAL OR NURSING TREATMENT" MEANS SUCH THINGS AS APPLYING STERILE BANDAGES OR DRESSINGS, GIVING MEDICATIONS, TAKING BLOOD PRESSURE, GIVING SHOTS OR INJECTIONS.]
[PROBE: We just need to know in general.]

SHOW CARD HH2

NEEDNURS

YES, AT LEAST ONE	1
NO	2
REFUSED	-7
DON'T KNOW	-8

HH14. (Generally speaking, (does/did)/Did) (HH2 OR HH19 PROVIDER/someone from HH5 OR HH24 PROVIDER) help with (your/SP's) daily needs by doing things, such as the ones shown on this card? [HELP WITH DAILY NEEDS MEANS HELP IN USING THE TELEPHONE, DOING HOUSEWORK, PREPARING MEALS.]
[PROBE: We just need to know in general.]

SHOW CARD HH3

NEEDMEAL

YES, AT LEAST ONE	1
NO	2
REFUSED	-7
DON'T KNOW	-8

HH15. (Generally speaking, (does/did)/Did) (HH2 OR HH19 PROVIDER/someone from HH5 OR HH24 PROVIDER) help with (your/SP's) personal care by doing things such as those shown on this card? [HELP WITH PERSONAL CARE MEANS HELP WITH BATHING, SHOWERING, DRESSING, EATING, WALKING, USING THE TOILET.] [PROBE: We just need to know in general.]

SHOW CARD HH4

NEEDCARE

YES, AT LEAST ONE	1
NO	2
REFUSED	-7
DON'T KNOW	-8

BOX HH3

a. IF COMING FROM HHS1 OR HHS2, GO TO ***BOX HHS5***.
b. IF THIS VISIT ADDED THROUGH HH1 AND: PROVIDER WORKED FOR SELF (HH4 = 2), GO TO HH16; PROVIDER WORKS FOR SOMEONE ELSE (HH4 = 1), GO TO HH17.
c. IF THIS VISIT ADDED THROUGH UTS, GO TO UTSINTRC.
d. IF THIS VISIT ADDED THROUGH CTRL/I OR ST, GO TO ***BOX ST12***.
e. IF THIS VISIT ADDED THROUGH NS, GO TO ***BOX NS11***.

HH16. [Since (REF. DATE)/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], (have you been/has SP been/was SP) helped at home by any other health professionals?

TEMP

YES	1	(HH2)
NO	2	(HH18)
REFUSED	-7	(HH18)
DON'T KNOW	-8	(HH18)

HH17. Other than the persons who (have) visited (you/SP) from (HH5 PROVIDER) [or from the other(s) we've talked about], (have you been/has SP been/was SP) helped at home by any other health professionals [since (REF. DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)]?

TEMP

YES	1	(HH2)
NO	2	(HH18)
REFUSED	-7	(HH18)
DON'T KNOW	-8	(HH18)

HH18. [Besides what you have already mentioned,] [Since (REF. DATE)/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], because of health problems (have you received/has SP received/did SP receive) any personal care or help at home with daily needs from (any other) persons who (do/did) not live with (you/him/her), including home health aides, homemakers, friends, neighbors, or relatives?

SHOW CARD HH5

HHPRFRND

YES, AT LEAST ONE	1	(HH19)
NO	2	***BOX MP1A***
REFUSED	-7	***BOX MP1A***
DON'T KNOW	-8	***BOX MP1A***

HH19. Who helped (you/SP)? What is the name of the person who helped (you/him/her)?
[ENTER NAME OF PERSON WHO HELPED, NOT NAME OF PLACE OR ORGANIZATION.]
[ENTER ONLY ONE PERSON. DO NOT ENTER A PERSON WHO LIVES WITH SP.]
PROVNAME

HH20. Is (HH19 PROVIDER) a friend or neighbor, a relative, or some other type of home health provider?

HHFTYPE

FRIEND OR NEIGHBOR	1	***BOX HH5***
RELATIVE	2	(HH21)
OTHER TYPE OF HOME HEALTH PROVIDER	3	(HH22)
REFUSED	-7	(HH23)
DON'T KNOW	-8	(HH23)

HH21. How is (HH19 PROVIDER) related to (you/SP)? ***BOX HH5***
HHFRELAT
HHFRELOS

HH22. What kind of home health provider is (HH19 PROVIDER)?
PROVSPEC

HH23. Who does (HH19 PROVIDER) work for, that is, for what place or organization?
[PROBE: Or does (HH19 PROVIDER) work for herself/himself?]

WORKSFOR

NAME OF ORGANIZATION GIVEN	1	(HH24)
WORKS FOR SELF	2	***BOX HH4***
REFUSED	-7	***BOX HH4***
DON'T KNOW	-8	***BOX HH4***

HH24. [Who does (HH19 PROVIDER) work for, that is, what place or organization?]
[PROBE: Who would (you/SP) call if (HH19 PROVIDER) did not show up?]
[ENTER ONLY ONE PROVIDER.]
PROVNAME
SUBPROV

HH25. What kind of place or organization is (HH24 PROVIDER)?

HHPLACE	HMO	1	***BOX HH4***
	MEAL PROGRAM (SUCH AS MEALS ON WHEELS)	2	(HH26)
	VISITING NURSE ASSOCIATION	3	***BOX HH4***
	HOME HEALTH AGENCY	4	***BOX HH4***
	HOSPITAL	5	***BOX HH4***
	PRIVATE PHYSICIAN/GROUP PRACTICE	6	***BOX HH4***
	HOSPICE	7	***BOX HH4***
	REHABILITATION OR SPORTS MEDICINE THERAPY	8	***BOX HH4***
	LOCAL GOVERNMENT ORGANIZATION	9	***BOX HH5***
	CHURCH OR COMMUNITY ORGANIZATION	10	***BOX HH5***
	ASSISTED LIVING/RETIREMENT HOME	11	***BOX HH4***
	REFUSED	-7	***BOX HH4***
	DON'T KNOW	-8	***BOX HH4***
	OTHER (SPECIFY) _____		
HHPLACOS	_____	91	***BOX HH4***

HH26. Between (PREV. ROUND INT. DATE/INT. DATE FROM ST10a, NS7a, CT72a) and (TODAY/DATE OF DEATH/DATE OF INSTITUTIONALIZATION/DATE FROM ST10a, NS7a, CT72a), did (HH24 PROVIDER) provide any services to (you/SP) other than delivering meals?

OTHMEALS	YES	1	***BOX HH4***
	NO	2	(HH29)
	REFUSED	-7	(HH29)
	DON'T KNOW	-8	(HH29)

BOX HH4	a.	SP HAS USED V.A. FACILITIES (HI36=1)	1	(b)
		SP HAS NOT USED V.A. (HI36=2 OR MISSING)	2	***BOX HH4A***
	b.	"V.A. FLAG" SET FOR HH19/HH24 PROVIDER	1	***BOX HH4A***
		"V.A. FLAG" NOT SET FOR HH19/HH24 PROVIDER	2	(HH27)

HH27. Is (HH19/HH24 PROVIDER) associated with a Department of Veterans Affairs, or V.A., facility?

VAPLACE	YES	1	
	NO	2	
	REFUSED	-7	
	DON'T KNOW	-8	

BOX HH4A	a.	SP BELONGS TO AN HMO (HI25 OR MEDICARE HMO FLAG = 1 FOR ANY PLAN)	1	(b)
		SP DOES NOT BELONG TO AN HMO (HI25 OR MEDICARE HMO FLAG = 2 OR MISSING FOR <u>ALL</u> PLANS)	2	***BOX HH5***
	b.	"HMO FLAG" CODED YES FOR THIS PROVIDER	1	***BOX HH5***
		"HMO FLAG" CODED NO OR MISSING FOR THIS PROVIDER	2	(HH27b)
		"HMO FLAG" NOT SET FOR THIS PROVIDER	3	(HH27a)

HH27a. Is (PROVIDER) associated with (your/SP's) [READ HMO PLAN NAME(S) BELOW] plan?

HMOASSOC

YES	1	(HH28)
NO	2	(HH27b)
REFUSED	-7	(HH27b)
DON'T KNOW	-8	(HH27b)

HH27b. (Were you/Was SP) referred to (PROVIDER) by [READ HMO PLAN NAME(S) BELOW]?

HMOREFER

YES	1	***BOX HH5***
NO	2	(HH27c)
REFUSED	-7	***BOX HH5***
DON'T KNOW	-8	***BOX HH5***

HH27c. What is the most important reason (you/SP) did not use a home health provider associated with [READ PLAN NAMES BELOW] or a home health provider that [READ PLAN NAMES BELOW] would refer (you/SP) to?

	HMO DOES NOT COVER THE SERVICE SP WANTED	1
	SP COULD NOT GET SERVICES QUICKLY ENOUGH AT THE HMO	2
	HMO NOT CONVENIENTLY LOCATED FOR THE SP	3
	HMO PROVIDERS NOT COMPETENT/QUALIFIED TO HANDLE SP'S CONDITION/NEEDS	4
	SP DIDN'T WANT TO GO THROUGH PRIMARY CARE PHYSICIAN TO GET REFERRAL	5
	SP WANTED TO GO TO A PROVIDER NOT AVAILABLE THROUGH THE HMO	6
NOHMOMAI	SP WANTED TO USE A PROVIDER THEY HAD PRIOR TO THEIR ENROLLMENT IN THE HMO	7
	HMO REFUSED TO PROVIDE THE CARE THE SP THOUGHT WAS NECESSARY	8
	THIS SERVICE WAS COVERED BY OTHER INSURANCE SP HAS	9
NOHMOMOS	HMO ADMINISTRATIVE OBSTACLES FOR SP	10
	NOT IN HMO AT TIME OF EVENT	11
	SP HAD A MEDICAL EMERGENCY AND WENT OR WAS TAKEN TO THE CLOSEST PROVIDER	12
	SP WAS OUTSIDE OF THE SERVICE AREA WHEN URGENT CARE WAS NEEDED	13
	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

Box HH4A omitted.

BOX HH5	ASK HH11 - HH15 FOR (HH19/HH24) PROVIDER. THEN GO TO ***BOX HH6***.

BOX HH6	IF HH19 PROVIDER IS A FRIEND OR RELATIVE (HH20 = 1 OR 2) OR WORKS FOR SELF (HH23 = 2), GO TO HH28. IF HH19 PROVIDER WORKS FOR SOMEONE ELSE (HH23 = 1), GO TO HH29. IF THIS VISIT ADDED THROUGH UTS, GO TO UTSINTRC. IF THIS VISIT ADDED THROUGH CRTL/1 OR ST, GO TO ***BOX ST12***. IF THIS VISIT ADDED THROUGH NS, GO TO ***BOX NS11***.

HH28. [Since (REF. DATE)/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], (have you received/has SP received/did SP receive) personal care or help (at home) with daily needs from any <u>other</u> persons who (do/did) not live with (you/him/her)?

TEMP

YES	1	(HH19)
NO	2	***BOX MP1A***
REFUSED	-7	***BOX MP1A***
DON'T KNOW	-8	***BOX MP1A***

HH29. Other than the persons who have visited (you/SP) from (HH24 PROVIDER) [since (REF. DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], (have you received/has SP received/did SP receive) personal care or help (at home) with daily needs from any <u>other</u> persons who (do/did) not live with (you/him/her) ?

TEMP

YES	1	(HH19)
NO	2	***BOX MP1A***
REFUSED	-7	***BOX MP1A***
DON'T KNOW	-8	***BOX MP1A***

HH1. HOME HEALTH UTILIZATION AND EVENTS

MEDICAL PROVIDER SPECIALTY CODE LIST

1	DENTIST/DENTAL PROVIDER
2	MEDICAL DOCTOR
3	AUDIOLOGIST
4	CHIROPRACTOR
5	CLINICAL SOCIAL WORKER
6	DIETITIAN-NUTRITIONIST
7	HEARING THERAPIST
8	HOME HEALTH/HEALTH AIDE
9	HOMEMAKER
10	HOSPICE WORKER
11	I.V. THERAPIST
12	NURSE (RN)
13	NURSE PRACTITIONER
14	NURSE'S AIDE
15	OCCUPATIONAL THERAPIST (OT)
16	OPTOMETRIST (OD)
17	OSTEOPATH (DO)
18	PARAMEDIC
19	PHYSICAL THERAPIST (PT)
20	PHYSICIAN'S ASSISTANT
21	PODIATRIST (FOOT DOCTOR)
22	PSYCHOLOGIST
23	RESPIRATORY THERAPIST
24	SOCIAL/CASE WORKER
25	SPEECH THERAPIST
26	THERAPIST (MENTAL HEALTH)
27	X-RAY TECHNICIAN
28	LICENSED PRACTICAL NURSE (LPN)
91	OTHER MEDICAL PROVIDER SPECIALTY (SPECIFY)