

MCBS MAIN STUDY - ROUND 37, FALL 2003

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

HCPROF

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.]

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

PROVSPEC
PROVSPOS

- HH4. Who does (HH2 PROVIDER) work for, that is, for what place or organization?
[HH4_23] [PROBE: Or does (HH2 PROVIDER) work for himself/herself?]

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?]
[HH5_24] [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)?

[HH6_25]

HHPLACE MANAGED CARE PLAN (SUCH AS 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/
 [HH7_26] 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 PROVIDER) associated with/(HH5 PROVIDER)] a Department of Veterans Affairs, or V.A., facility?
 [HH8_27,
 FACLVA]

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

HH8a, HH8b, HH9, and HH10 omitted.

BOX HH1A	<p>a. SP BELONGS TO A MANAGED CARE PLAN (HI10a, HI25 OR MEDICARE MANAGED CARE FLAG = 1 FOR ANY PLAN) 1 (b)</p> <p>SP DOES NOT BELONG TO A MANAGED CARE PLAN (HI10a, HI25 OR MEDICARE MANAGED CARE FLAG = 2 OR MISSING FOR <u>ALL</u> PLANS) 2 (HH11)</p> <p>b. "MANAGED CARE FLAG" CODED YES FOR THIS PROVIDER 1 (HH11)</p> <p>"MANAGED CARE FLAG" CODED NO OR MISSING FOR THIS PROVIDER 2 (HH10b)</p> <p>"MANAGED CARE FLAG" NOT SET FOR THIS PROVIDER 3 (HH10a)</p>
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HH10a. Is (PROVIDER) associated with (your/SP's) [READ MANAGED CARE PLAN NAME(S) BELOW] plan?
[HMOPLAN]

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 MANAGED CARE PLAN NAME(S) BELOW]?
[HMOREFD]

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 [HMONO] MANAGED CARE PLAN NAME(S) BELOW] or a home health provider that [READ MANAGED CARE PLAN NAME(S) BELOW] would refer (you/SP) to?

	PLAN DOES NOT COVER THE SERVICE SP WANTED	1
	SP COULD NOT GET SERVICES QUICKLY ENOUGH THROUGH THE PLAN.....	2
	OFFICE NOT CONVENIENTLY LOCATED FOR THE SP	3
	PLAN PROVIDERS NOT COMPETENT/QUALIFIED TO HANDLE 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 PLAN	6
NOHMOMAI	SP WANTED TO USE A PROVIDER THEY HAD PRIOR TO THEIR ENROLLMENT IN THE PLAN	7
	PLAN REFUSED TO PROVIDE THE CARE THE SP THOUGHT WAS NECESSARY	8
	THIS SERVICE WAS COVERED BY OTHER INSURANCE SP HAS	9
NOHMOMOS	PLAN ADMINISTRATIVE OBSTACLES FOR SP	10
	NOT IN A MANAGED CARE PLAN 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)? [INCLUDE TIME SPENT SHOPPING OR RUNNING ERRANDS.] [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?

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)]? [DON'T INCLUDE ANY OTHER PERSONS COMING FROM THE SAME ORG/ AGENCY LISTED BELOW]

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 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.]

- 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
PROVSPOS

HH23. Who does (HH19 PROVIDER) work for, that is, for what place or organization?
[HH4_23] [PROBE: Or does (HH19 PROVIDER) work for himself/herself?]

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?]
[HH5_24] [PROBE: Who would (you/SP) call if (HH19 PROVIDER) did not show up?]
[ENTER OR SELECT ONLY ONE PROVIDER.]

PROVNAME
SUBPROV

HH25. What kind of place or organization is (HH24 PROVIDER)?
[HH6_25]

HHPLACE	MANAGED CARE PLAN (SUCH AS 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
[HH7_26] 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 PROVIDER) associated with/(HH24 PROVIDER)] a Department of Veterans Affairs, or V.A., facility?
 [HH8_27,
 FACLVA]

VAPLACE

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

BOX HH4A	a.	SP BELONGS TO A MANAGED CARE PLAN (HI10a, HI25 OR MEDICARE MANAGED CARE FLAG = 1 FOR ANY PLAN) . 1 (b)
		SP DOES NOT BELONG TO A MANAGED CARE PLAN (HI10a, HI25 OR MEDICARE MANAGED CARE FLAG = 2 OR MISSING FOR <u>ALL</u> PLANS) 2 BOX HH5
	b.	"MANAGED CARE FLAG" CODED YES FOR THIS PROVIDER 1 BOX HH5
		"MANAGED CARE FLAG" CODED NO OR MISSING FOR THIS PROVIDER 2 (HH27b)
		"MANAGED CARE FLAG" NOT SET FOR THIS PROVIDER 3 (HH27a)

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

HMOASSOC

YES	1 BOX HH5
NO	2 (HH27b)
REFUSED	-7 (HH27b)
DON'T KNOW	-8 (HH27b)

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

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 [HMONO] MANAGED CARE PLAN NAME(S) BELOW] or a home health provider that [READ MANAGED CARE PLAN NAME(S) BELOW] would refer (you/SP) to?

	PLAN DOES NOT COVER THE SERVICE SP WANTED	1
	SP COULD NOT GET SERVICES QUICKLY ENOUGH THROUGH THE PLAN.....	2
	OFFICE NOT CONVENIENTLY LOCATED FOR THE SP	3
	PLAN PROVIDERS NOT COMPETENT/QUALIFIED TO HANDLE 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 PLAN	6
NOHMOMAI	SP WANTED TO USE A PROVIDER THEY HAD PRIOR TO THEIR ENROLLMENT IN THE PLAN	7
	PLAN REFUSED TO PROVIDE THE CARE THE SP THOUGHT WAS NECESSARY	8
	THIS SERVICE WAS COVERED BY OTHER INSURANCE SP HAS	9
NOHMOMOS	PLAN ADMINISTRATIVE OBSTACLES FOR SP	10
	NOT IN A MANAGED CARE PLAN 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 .
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BOX HH6	<p>IF HH19 PROVIDER IS A FRIEND OR RELATIVE (HH20 = 1 OR 2) OR WORKS FOR SELF (HH23 = 2), GO TO HH28.</p> <p>IF HH19 PROVIDER WORKS FOR SOMEONE ELSE (HH23 = 1), GO TO HH29.</p> <p>IF THIS VISIT ADDED THROUGH UTS, GO TO UTSINTRC.</p> <p>IF THIS VISIT ADDED THROUGH CRTL/I OR ST, GO TO BOX ST12.</p> <p>IF THIS VISIT ADDED THROUGH NS, GO TO BOX NS11.</p>
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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 other persons who (do/did) not live with (you/him/her)?

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 other persons who (do/did) not live with (you/him/her)? [DON'T INCLUDE ANY OTHER PERSONS COMING FROM THE SAME ORG/AGENCY LISTED BELOW.]

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

Attachment HH1 (MEDICAL PROVIDER SPECIALTY CODE LIST) moved to General Programming Specifications as Attachment 6.