MCBS MAIN STUDY - ROUND 46, FALL 2006

COMMUNITY COMPONENT

HH. HOME HEALTH UTILIZATION AND EVENTS

HH1.   (Besides what you have already mentioned,) [Since (REF. DATE)/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], (have you been/has SP been/was SP) helped <u>at home</u> 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 <u>PERSON</u> WHO HELPED, NOT NAME OF PLACE OR ORGANIZATION.]
[ENTER ONLY ONE PROVIDER.]
PROVNAME

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

HH. HOME HEALTH UTILIZATION AND EVENTS

8/1/06 – last revised
MCBS Comm. (Round 46 Main)

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*
	REFUSED	-7	*BOX HH1*
	DON'T KNOW	-8	*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 V.A. FACILITIES (HI36 = 1)	1	(b)
		SP HAS NOT USED V.A. (HI36 ≠ 1)	2	*BOX HH1A*
	b.	VA FLAG ≠ -1 FOR HH4/HH2 PROVIDER	1	*BOX HH1A*
		VA FLAG = -1 FOR HH4/HH2 PROVIDER	2	(HH8)

BOX HH2 OMITTED IN ROUND 1.

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 AND HH8b OMITTED IN ROUND 12.

HH9 AND HH10 OMITTED IN ROUND 1.

HH. HOME HEALTH UTILIZATION AND EVENTS

8/1/06 – last revised
MCBS Comm. (Round 46 Main)

BOX HH1A	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, AND MEDICARE MANAGED CARE FLAG ≠ 1 FOR ALL PLANS)	2 (HH11)
	b.	"MANAGED CARE FLAG" = 1 FOR THIS PROVIDER	1 (HH11)
		"MANAGED CARE FLAG" = 2, -7, -8, -9 FOR THIS PROVIDER...	2 (HH10b)
		"MANAGED CARE FLAG" = -1 FOR THIS PROVIDER	3 (HH10a)

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 (HH10d)
                                 REFUSED .... -7 (HH11)
                                 DON'T KNOW .... -8 (HH11)

HH10c OMITTED IN ROUND 44.

HH10d.   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?

NOGOHMO   PLAN DOES NOT COVER THE SERVICE SP WANTED 1
NOGOHMOS   DIFFICULTY OR DELAY IN GETTING SERVICES 2
                         SP PROVIDER PREFERENCE 3
                         THIS SERVICE WAS COVERED BY OTHER INSURANCE SP HAS 4
                         NOT IN A MANAGED CARE PLAN AT TIME OF EVENT 5
                         NO CHOICE – MEDICAL EMERGENCY OR OUT OF SERVICE AREA. 6
                         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).]
[ENTER ONLY ONE CODE.]

```
TOTAL NUMBER OF TIMES  ........................  1  (a)
NUMBER OF TIMES PER DAY  ....................  2  (b)
NUMBER OF TIMES PER WEEK  .................  3  (c)
NUMBER OF TIMES PER MONTH  ..............  4  (d)
REFUSED  ...................................................  -7  (HH12)
DON'T KNOW  ...............................................  -8  (HH12)
```
HELPUNIT

a. TOTAL NUMBER OF TIMES: _____
b. NUMBER OF TIMES PER DAY: _____
c. NUMBER OF TIMES PER WEEK: _____
d. NUMBER OF TIMES PER MONTH: _____
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.]
[ENTER ONLY ONE CODE.]

```
HOURS ONLY .................................................  1  (a)
MINUTES ONLY  ...........................................  2  (b)
HOURS AND MINUTES ................................  3  (a&b)
REFUSED  ....................................................  -7  (HH13)
DON'T KNOW  ...............................................  -8  (HH13)
```
STAYUNIT

a. NUMBER OF HOURS: _____
b. NUMBER OF MINUTES: _____
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)]? [DON'T INCLUDE ANY OTHER PERSONS COMING FROM THE SAME ORG/ AGENCY LISTED BELOW]

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

HH. HOME HEALTH UTILIZATION AND EVENTS

8/1/06 – last revised
MCBS Comm. (Round 46 Main)

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 <u>PERSON</u> 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
        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

HH. HOME HEALTH UTILIZATION AND EVENTS

8/1/06 – last revised
MCBS Comm. (Round 46 Main)

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 ≠ 1)	2	***BOX HH4A***
	b.	"V.A. FLAG" ≠ -1 FOR HH19/HH24 PROVIDER	1	***BOX HH4A***
		"V.A. FLAG" = -1 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

HH. HOME HEALTH UTILIZATION AND EVENTS

8/1/06 – last revised
MCBS Comm. (Round 46 Main)

<table>
<tr><td rowspan="2">BOX
HH4A</td><td>a.</td><td>SP BELONGS TO A MANAGED CARE PLAN (HI10a, HI25
OR MEDICARE MANAGED CARE FLAG = 1 FOR ANY PLAN) .</td><td>1</td><td>(b)</td></tr>
</table>

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, AND MEDICARE MANAGED CARE FLAG ≠ 1 FOR ALL PLANS).. 2 ***BOX HH5*** b. "MANAGED CARE FLAG" = 1 FOR THIS PROVIDER .... 1 ***BOX HH5*** "MANAGED CARE FLAG" = 2, -7, -8, -9 FOR THIS PROVIDER .... 2 (HH27b) "MANAGED CARE FLAG" = -1 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	(HH27d)
	REFUSED	-7	***BOX HH5***
	DON'T KNOW	-8	***BOX HH5***

HH27c OMITTED IN ROUND 44.

HH27d.   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?

NOGOHMO	PLAN DOES NOT COVER THE SERVICE SP WANTED	1
NOGOHMOS	DIFFICULTY OR DELAY IN GETTING SERVICES	2
	SP PROVIDER PREFERENCE	3
	THIS SERVICE WAS COVERED BY OTHER INSURANCE SP HAS	4
	NOT IN A MANAGED CARE PLAN AT TIME OF EVENT	5
	NO CHOICE – MEDICAL EMERGENCY OR OUT OF SERVICE AREA.	6
	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

BOX HH4A OMITTED IN ROUND 12.

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/I 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 other 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 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.]

TEMP

    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.

HH Addendum

                    Segments: EVNT
                                 HEAL
                                 HERO
                                 PROV
                                 HRND

BOX HH1, BOX HH4:
  ■ "V.A. FLAG" SET FOR THIS PROVIDER: VAPLACE ≠ -1
  ■ "V.A. FLAG" NOT SET FOR THIS PROVIDER: VAPLACE = -1

BOX HH1A, BOX HH4A:
  ■ HI10a = MCAIDHMO
  ■ HI25 = PPRVHMO
  ■ MEDICARE MANAGED CARE FLAG = COVANYTM
  ■ MANAGED CARE FLAG = HMOASSOC
  ■ "MANAGED CARE FLAG" NOT SET FOR THIS PROVIDER: HMOASSOC = -1