MAIN STUDY - ROUND 16

COMMUNITY COMPONENT

DU. DENTAL UTILIZATION AND EVENTS

BOX DU1A	IF EXIT INTERVIEW AND PREVIOUS INTERVIEW NOT SKIPPED, GO TO ***BOX ER1A***. OTHERWISE, GO TO DU1INTRO.

DUINTRO. The next questions are about any medical care (you/SP) may have had between (REF. DATE) and (today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION). (Now would be a good time to get out the calendar that we left at the last interview.)

First we'll talk about dental care.

[PRESS ENTER TO CONTINUE.]

DU1. Please look at this card. [Since (REF. DATE)/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], did (you/SP) go to a dentist or any other person for dental care? [Dental providers include dentists, dental surgeons, endodontists, periodontists, and dental hygienists.]

SHOW CARD DU

DUPROBE

YES	1	(DU2)
NO	2	***BOX ER1A***
REFUSED	-7	***BOX ER1A***
DON'T KNOW	-8	***BOX ER1A***

DU2. Who did (you/SP) see? [ENTER ONLY ONE DENTAL PROVIDER.]
PROVNAME
PROVSPEC

BOX DU1

a.	SP HAS USED V.A. FACILITIES (HI36 = 1)	1	(b)
	SP HAS NOT USED V.A. (HI36 = 2 OR MISSING)	2	***BOX DU2***
b.	"V.A. FLAG" SET FOR THIS PROVIDER	1	***BOX DU2***
	"V.A. FLAG" NOT SET FOR THIS PROVIDER	2	(DU3)

DU3. Is (PROVIDER) associated with a facility of the Veterans Administration?

VAPLACE

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

BOX DU2	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 = 2 OR MISSING FOR ALL PLANS) ..... 2 ***BOX DU2A*** b. "HMO FLAG" CODED YES FOR THIS PROVIDER ..... 1 ***BOX DU2A*** "HMO FLAG" CODED NO OR MISSING FOR THIS PROVIDER ..... 2 (DU5) "HMO FLAG" NOT SET FOR THIS PROVIDER 3 (DU4)

DU4. Is (PROVIDER) associated with (your/SP's) [READ HMO PLAN NAME(S) BELOW] HMO plan?

HMOASSOC

YES	1	(DU6)
NO	2	(DU5)
REFUSED	-7	(DU5)
DON'T KNOW	-8	(DU5)

DU5. (Were you/Was SP) referred to (PROVIDER) by [READ HMO PLAN NAME(S) BELOW]?

HMOREFER

YES	1	***BOX DU2A***
NO	2	(DU5a)
REFUSED	-7	***BOX DU2A***
DON'T KNOW	-8	***BOX DU2A***

DU5a. What is the most important reason (you/SP) did not see a dental provider associated with [READ PLAN NAMES BELOW] or a dental 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
	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

BOX DU2A	IF THIS VISIT ADDED THROUGH UTS, GO TO DU7. OTHERWISE, GO TO DU6.

DU6. When did (you/SP) see (PROVIDER NAMED IN DU2)? Please tell me all the dates [since (REF. DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)]. [ENTER ALL DATES.]
EVBEGMM
EVBEGDD
EVBEGYY

DU7. For (your/SP's) visit on (FIRST/NEXT VISIT DATE), what did (you/SP) have done?
[CODE ALL THAT APPLY.]
[PRESS CTRL/L TO LEAVE SCREEN.]

DVXRAYS	X-RAYS TAKEN	1	
DVCLEAN	CLEANING TEETH	2	
DVEXAM	EXAMINATION	3	
DVFILLNG	FILLINGS	4	
DVEXTRAC	EXTRACTIONS	5	
DVRTCNAL	ROOT CANALS	6	
DVCROWN	CROWNS	7	
DVBRIDGE	BRIDGES, DENTURES, PLATES, ETC. -- EITHER NEW ONES OR REPAIR WORK	8	
DVORTHO	ORTHODONTIA -- BITE ADJUSTMENT, BRACES, RETAINERS, ETC.	9	
DVPERIOD	PERIODONTIA	10	
DVBONDNG	BONDING	11	
DVOTHER	OTHER (SPECIFY)	91	
EVNTQUES	REFUSED	-7	***BOX DU3A***
EVOSTEXT	DON'T KNOW	-8	

BOX DU3	IF DU7 CODED 1, REGARDLESS OF OTHER CODES SELECTED, GO TO ***BOX DU3A***. IF 1 NOT CODED AT DU7, GO TO DU8.

DU8. Were X-rays taken on this visit?

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

BOX DU3A	IF THIS VISIT ADDED THROUGH DU1, GO TO DU9. IF THIS VISIT ADDED THROUGH UTS, CRTL/I, ST, OR NS, GO TO ***BOX DU4***.

DU9. Were any medicines prescribed for (you/SP) when (you/he/she) went to (DENTAL PROVIDER) on (EVENT DATE)?

PRESMDCN

YES	1	(DU10)
NO	2	***BOX DU4***
REFUSED	-7	***BOX DU4***
DON'T KNOW	-8	***BOX DU4***

DU10. Were any of the prescriptions filled?

PRESFILL

YES	1	(DU11)
NO	2	***BOX DU4***
REFUSED	-7	***BOX DU4***
DON'T KNOW	-8	***BOX DU4***

DU11. Please tell me the names of these medicines.
[ENTER ALL MEDICINES.] [CHECK SPELLING.]
PMEDNAME
PMROTYPE

	IF THE TOTAL NUMBER OF REMAINING VISITS TO THIS DENTAL PROVIDER IS:	
BOX DU4	0	(GO TO ***BOX DU5(b)***)
	1-4	(RETURN TO DU7 FOR NEXT VISIT)
	5 OR MORE REMAINING	(GO TO DU12)

DU12. You told me that (you/SP) also visited (NAME OF DENTAL PROVIDER FROM DU2) on [READ DATES BELOW]. Were any of these visits made for the same reason as the one you've just told me about?

SAMEREAS

YES	1	(DU13)
NO	2	(DU7 FOR NEXT VISIT)
REFUSED	-7	(DU7 FOR NEXT VISIT)
DON'T KNOW	-8	(DU7 FOR NEXT VISIT)

DU13. Which visits were for the same reason? What were the dates?
EVNTLINK

BOX DU5	a.	FLAG DATE(S) OF IDENTICAL VISITS IN VISIT ROSTER. IF ANY REMAINING DATES, GO TO DU7 FOR NEXT UNFLAGGED VISIT.
	b.	IF THIS VISIT ADDED THROUGH DU1, GO TO DU14. IF THIS VISIT ADDED THROUGH UTS, GO TO UTSINTRC. IF THIS VISIT ADDED THROUGH CTRL/I OR ST, GO TO ***BOX ST12***. IF THIS VISIT ADDED THROUGH NS, GO TO ***BOX NS11***.

DU14. [Since (REF. DATE)/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], did (you/SP) have any other dental care visits to this or any other provider?

TEMP

YES	1	(DU2)
NO	2	***BOX ER1A***
REFUSED	-7	***BOX ER1A***
DON'T KNOW	-8	***BOX ER1A***