HH. HOME HEALTH UTILIZATION AND EVENTS

(CORE ONLY)

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
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.]
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

OMB # 0938-0568
Exp. 4/30/04

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/ DATE OF INSTITUTIONALIZATION/INT. DATE FROM ST10a, NS7a, CT72a), did (HH5 PROVIDER) provide any services to (you/SP) other than delivering meals?
[HH7_26]

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	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 ALL PLANS)	2 (HH11)
	b.	"MANAGED CARE FLAG" CODED YES FOR THIS PROVIDER	1 (HH11)
		"MANAGED CARE FLAG" CODED NO OR MISSING FOR THIS PROVIDER	2 (HH10b)
		"MANAGED CARE FLAG" NOT SET 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	(HH10c)
REFUSED	-7	(HH11)
DON'T KNOW	-8	(HH11)

HH10c. [HMONO] What is the most important reason (you/SP) did not use a home health provider associated with [READ 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		_____	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)]? [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)

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.]
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

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 ALL 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. [HMONO] What is the most important reason (you/SP) did not use a home health provider associated with [READ 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***.

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 <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)? [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***