MCBS MAIN STUDY - ROUND 34, FALL 2002

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** **HHPRPRF** | 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) _____ | 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***.<br>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.<br>c. IF THIS VISIT ADDED THROUGH UTS, GO TO UTSINTRC.<br>d. IF THIS VISIT ADDED THROUGH CTRL/I OR ST, GO TO ***BOX ST12***.<br>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 <u>other</u> 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 <u>other</u> 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 <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**

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) _____ | 91 | ***BOX HH4*** |

HH26. [HH7_26] 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. [HH8_27, FACLVA] Is [(HH19 PROVIDER) associated with/(HH24 PROVIDER)] 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 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. [HMOPLAN] Is (PROVIDER) associated with (your/SP's) [READ MANAGED CARE PLAN NAME(S) BELOW] plan?

**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.<br>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.<br><br>IF HH19 PROVIDER WORKS FOR SOMEONE ELSE (HH23 = 1), GO TO HH29.<br><br>IF THIS VISIT ADDED THROUGH UTS, GO TO UTSINTRC.<br><br>IF THIS VISIT ADDED THROUGH CRTL/I OR ST, GO TO ***BOX ST12***.<br><br>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)?

| | | |
|---|---|---|
| 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.]

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

ATTACHMENT HH1. HOME HEALTH UTILIZATION AND EVENTS

MEDICAL PROVIDER SPECIALTY CODE LIST

| | |
|---|---|
| 1 | DENTIST/DENTAL PROVIDER |
| 2 | MEDICAL DOCTOR |
| 29 | ACUPUNCTURIST |
| 3 | AUDIOLOGIST |
| 4 | CHIROPRACTOR |
| 5 | CLINICAL SOCIAL WORKER |
| 6 | DIETITIAN-NUTRITIONIST |
| 7 | HEARING THERAPIST |
| 8 | HOME HEALTH/HEALTH AIDE |
| 9 | HOMEMAKER |
| 30 | HOMEOPATH |
| 10 | HOSPICE WORKER |
| 11 | I.V. THERAPIST |
| 28 | LICENSED PRACTICAL NURSE (LPN) |
| 31 | MASSAGE THERAPIST |
| 32 | NATUROPATH |
| 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 |
| 91 | OTHER MEDICAL PROVIDER SPECIALTY (SPECIFY) |