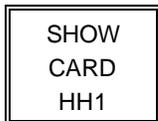


MAIN STUDY - ROUND 4

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.]



HHPROF	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 ONLY ONE PROVIDER.]

PROVNAME

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

PROVSPEC

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

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?]
[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)?

HHPLACE	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)
	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?

OTHMEALS	YES	1	BOX HH1
	NO	2	BOX HH3
	REFUSED	-7	BOX HH3
	DON'T KNOW	-8	BOX HH3

HH8. Is (HH2/HH5 PROVIDER) associated with a facility of the Veterans Administration?

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

HH9, and HH10 omitted.

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

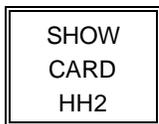
HH12. (Generally speaking, how long (does/did)/How long did) (HH2 OR HH19 PROVIDER/someone from HH5 OR HH24 PROVIDER) stay with (you/SP)?
 [PROBE: We just need to know in general.]

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.]



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 .
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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)]?

- 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?



HHPFRND

- YES, AT LEAST ONE 1 (HH19)
- NO 2 **BOX MP1**
- REFUSED -7 **BOX MP1**
- DON'T KNOW -8 **BOX MP1**

HH19. Who helped (you/SP)? What is the name of the person who helped (you/him/her)?
[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)?
HHFRELAT
HHFRELOS

BOX HH5

HH22. What kind of home health provider is (HH19 PROVIDER)?

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

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

PROVNAME
SUBPROV

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

- HHPLACE** HMO 1 **BOX HH4**
- MEAL PROGRAM (SUCH AS MEALS ON WHEELS) 2 (HH26)
- 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 **BOX HH5**
- CHURCH OR COMMUNITY ORGANIZATION 10 **BOX HH5**
- 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 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 HH5
	b.	"V.A. FLAG" SET FOR HH19/HH24 PROVIDER	1 BOX HH5
		"V.A. FLAG" NOT SET FOR HH19/HH24 PROVIDER	2 (HH27)

HH27. Is (HH19/HH24 PROVIDER) associated with a facility of the Veterans Administration?

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

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/1 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 MP1**
- REFUSED -7 **BOX MP1**
- DON'T KNOW -8 **BOX MP1**

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) ?

- YES 1 (HH19)
- NO 2 **BOX MP1**
- REFUSED -7 **BOX MP1**
- DON'T KNOW -8 **BOX MP1**

HH1. HOME HEALTH UTILIZATION AND EVENTS

MEDICAL PROVIDER SPECIALTY CODE LIST

- 1 DENTIST/DENTAL PROVIDER
- 2 MEDICAL DOCTOR
- 3 AUDIOLOGIST
- 4 CHIROPRACTOR
- 5 CLINICAL SOCIAL WORKER
- 6 DIETITIAN-NUTRITIONIST
- 7 HEARING THERAPIST
- 8 HOME HEALTH/HEALTH AIDE
- 9 HOMEMAKER
- 10 HOSPICE WORKER
- 11 I.V. THERAPIST
- 12 NURSE (RN)
- 13 NURSE PRACTITIONER (LPN)
- 14 NURSE'S AIDE
- 15 OCCUPATIONAL THERAPIST (OT)
- 16 OPTOMETRIST
- 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)