

MAIN STUDY - ROUND 16
COMMUNITY COMPONENT
MP. MEDICAL PROVIDER UTILIZATION AND EVENTS

BOX MP1A	IF EXIT INTERVIEW AND PREVIOUS INTERVIEW <u>NOT</u> SKIPPED, GO TO BOX OM1A.
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MP1. (Besides what you have already mentioned), [Since (REF. DATE), (have you/has SP) seen/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION), did (SP) see] any medical doctors?

[INCLUDE ANY VISITS FOR TESTS/X-RAYS.]

[SEE REFERENCE CARD FOR M.D. SPECIALTIES, IF NECESSARY.]

MPPRMDOC

YES	1 (MP2)
NO	2 (MP18)
REFUSED	-7 (MP18)
DON'T KNOW	-8 (MP18)

MP2. Who did (you/SP) see?
[ENTER ONLY ONE PROVIDER.]

PROVNAME

BOX MP1	<p>a. SP HAS USED V.A. FACILITIES (HI36=1)..... 1 (b) SP HAS NOT USED V.A. (HI36=2 OR MISSING) 2 BOX MP2</p> <p>b. "V.A. FLAG" SET FOR THIS PROVIDER 1 BOX MP2 "V.A. FLAG" NOT SET FOR THIS PROVIDER 2 (MP3)</p>
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MP3. Is (DOCTOR) associated with a facility of the Veterans Administration?

VAPLACE

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

BOX MP2	<p>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 OR MEDICARE HMO=2 OR MISSING FOR <u>ALL</u> PLANS) 2 BOX MP2A1</p> <p>b. "HMO FLAG" CODED YES FOR THIS PROVIDER 1 BOX MP2A1 "HMO FLAG" CODED NO OR MISSING FOR THIS PROVIDER 2 (MP5) "HMO FLAG" NOT SET FOR THIS PROVIDER 3 (MP4)</p>
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MP4. Is (DOCTOR) associated with (your/SP's) [READ HMO PLAN NAME(S) BELOW] HMO plan?

HMOASSOC YES 1 **BOX MP2A1**
 NO 2 (MP5)
 REFUSED -7 (MP5)
 DON'T KNOW -8 (MP5)

MP5. (Were you/Was SP) referred to (PROVIDER) by [READ HMO PLAN NAME(S) BELOW]?

HMOREFER YES 1 **BOX MP2A1**
 NO 2 (MP5a)
 REFUSED -7 **BOX MP2A1**
 DON'T KNOW -8 **BOX MP2A1**

MP5a. What is the most important reason (you/SP) did not see a doctor associated with [READ PLAN NAMES BELOW] or a doctor 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
NOHMOMAI THROUGH THE HMO 6
 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
 HMO ADMINISTRATIVE OBSTACLES FOR SP 10
 NOT IN HMO AT TIME OF EVENT..... 11
NOHMOMOS OTHER (SPECIFY) _____ 91
 REFUSED -7
 DON'T KNOW -8

BOX MP2A1	IF THIS VISIT ADDED THROUGH UTS, GO TO BOX MP2A. OTHERWISE, GO TO MP6.
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MP6. When did (you/SP) see (PROVIDER)? Please tell me all the dates [since (REF. DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)].
 [ENTER ALL DATES.]

EVNTTYPE
EVNTPROV
EVBEGMM
EVBEGDD
EVBEGYG

MP9. What condition required the [READ SURGICAL PROCEDURES BELOW]?
 [ENTER ALL CONDITIONS.]
CONDTION

BOX MP3	GO TO BOX MP2D .
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MP10. Was this visit to (PROVIDER) for any specific condition?

SPECCOND YES 1 (MP11)
 NO 2 **BOX MP2D**
 DON'T KNOW -8 **BOX MP2D**

MP11. What was the condition?
 [ENTER ALL CONDITIONS.]
CONDTION

BOX MP2D	IF THIS VISIT ADDED THROUGH MP1, MP18, MP26, MP34, MP42 OR MP50, GO TO MP12. IF THIS VISIT ADDED THROUGH UTS, CTRL/I, ST, OR NS, GO TO BOX MP4 .
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MP12. During this visit to (PROVIDER), were any medicines prescribed for (you/SP)?

PRESMDCN YES 1 (MP13)
 NO 2 **BOX MP4**
 REFUSED -7 **BOX MP4**
 DON'T KNOW -8 **BOX MP4**

MP13. Were any of the prescriptions filled?

PRESFILL YES 1 (MP14)
 NO 2 **BOX MP4**
 REFUSED -7 **BOX MP4**
 DON'T KNOW -8 **BOX MP4**

MP14. Please tell me the names of these medicines.
 [ENTER ALL MEDICINES.] [CHECK SPELLING.]
PMEDNAME

BOX MP4	<p>IF THE TOTAL NUMBER OF REMAINING VISITS TO THIS PROVIDER IS:</p> <p>0..... (GO TO BOX MP6(b))</p> <p>1-4 (RETURN TO BOX MP2A/MP7/MP10 FOR NEXT VISIT)</p> <p>5 OR MORE (BOX MP5)</p>
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BOX MP5	<p>IF MP7 CODED 1 FOR THIS VISIT, RETURN TO MP7/MP10 FOR NEXT VISIT. IF MP 7 CODED -1, 2, -7 OR -8 AND MP10 = 1, GO TO MP15. IF MP7 CODED -1, 2, -7 OR -8 AND MP10 = 2, -7 OR -8, GO TO MP7/MP10 FOR NEXT VISIT.</p>
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MP15. You told me that (you/SP) also went to (PROVIDER) on [READ DATES BELOW]. Were any of these visits made for the same condition as the one you've just told me about?

- SAMEREAS**
- YES 1 (MP16)
- NO 2 (MP7/MP10 FOR NEXT VISIT)
- REFUSED -7 (MP7/MP10 FOR NEXT VISIT)
- DON'T KNOW -8 (MP7/MP10 FOR NEXT VISIT)

MP16. Which visits were the same? What were the dates? [ENTER ALL DATES.]

EVNTLINK

BOX MP6	<p>a. FLAG DATE(S) OF IDENTICAL VISITS IN VISIT ROSTER. IF ANY REMAINING DATES, GO TO BOX MP2A /MP7/MP10 FOR NEXT UNFLAGGED VISIT.</p> <p>b. IF THIS VISIT ADDED THROUGH MP1/MP18/MP26/MP34/MP42/MP50, GO TO MP17/MP25/MP33/MP41/MP49/MP56. 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.</p>
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MP17. [Since (REF. DATE)/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], did (you/SP) have any other visits to this doctor or any other medical doctor?

- TEMP**
- YES 1 (MP2)
- NO 2 **BOX MP6A**
- REFUSED -7 **BOX MP6A**
- DON'T KNOW -8 **BOX MP6A**

BOX MP6A	IF THIS IS <u>NOT</u> A ROUND WHERE SUPPLEMENTARY SECTION AC QUESTIONS ARE ASKED, GO TO MP18. IF THIS IS A ROUND WHERE SUPPLEMENTARY SECTION AC QUESTIONS ARE ASKED, BUT NO MP VISITS FOR THIS ROUND, GO TO MP18. IF THIS IS A ROUND WHERE SUPPLEMENTARY SECTION AC QUESTIONS ARE ASKED, BUT SP IS DECEASED OR INSTITUTIONALIZED, GO TO MP18. FOR THE FOLLOWING: MOST RECENT MP VISIT IS AN MP VISIT WHERE MP6A=2 OR MISSING AND PROVIDER ROSTER SPECIALTY (PROVSPEC)=2. GO TO AC20, AC21, AC24-AC28 FOR MOST RECENT MP VISIT.
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AC20. Think about the most recent time (you/SP) saw a medical doctor somewhere other than at home or at a hospital. What is the doctor's specialty?

MDSPCLTY
MDSPCLOS

AC21. What was the reason (you/SP) saw the doctor?
[CODE ALL THAT APPLY. PRESS CTRL/L TO LEAVE SCREEN.]

MDMCOND	MEDICAL CONDITION NAMED	1
MDTESTS	TESTS	2
MDFOLUP	FOLLOWUP	3
MDCHKUP	CHECKUP	4
MDRFRL	REFERRAL	5
MDSURGY	SURGERY	6
MDPSHOT	OTHER (SPECIFY)	91
MDTSHOT	REFUSED	-7
MDPMED	DON'T KNOW	-8
MDOTHER		
MDOTHOS		

AC22./AC23. OMITTED.

AC24. Did (you/SP) have an appointment for this visit with the medical doctor or did (you/he/she) just walk in?

MDAPPT	APPOINTMENT	1 (AC25)
	WALKED IN	2 (AC27)
	REFUSED	-7 (AC27)
	DON'T KNOW	-8 (AC27)

AC25. Did someone tell (you/SP) when to come back during an earlier visit, or did (you/SP) call for an appointment?

MDDRTEL	TOLD TO COME BACK DURING	
	EARLIER VISIT	1 (AC27)
	CALLED FOR APPOINTMENT	2 (AC26)
	REFUSED	-7 (AC27)
	DON'T KNOW	-8 (AC27)

AC26. How long did (you/SP) have to wait for the appointment with the medical doctor -- about how many days, weeks, or months?

MDAWUNT DID NOT HAVE TO WAIT 0 (AC27)
 DAYS 1 (a)
 WEEKS 2 (b)
 MONTHS 3 (c)
 REFUSED -7 (AC27)
 DON'T KNOW -8 (AC27)

MDAWDAY a. NUMBER OF DAYS _____
MDAWWKS b. NUMBER OF WEEKS _____
MDAWMOS c. NUMBER OF MONTHS _____

AC27. From the time (you/SP) arrived until the time (you/he/she) left, about how long did the visit to the medical doctor take altogether?

MDVLUNT HOURS ONLY 1 (a)
 MINUTES ONLY 2 (b)
 HOURS AND MINUTES 3 (a & b)
 REFUSED -7 (AC28)
 DON'T KNOW -8 (AC28)

MDVLHRS a. NUMBER OF HOURS _____
MDVLMIN b. NUMBER OF MINUTES _____

AC28. How much of that time was spent waiting before (you/SP) saw a doctor or some other medical person?

MDVWUNT DID NOT HAVE TO WAIT 0 (MP18)
 HOURS ONLY 1 (a)
 MINUTES ONLY 2 (b)
 HOURS AND MINUTES 3 (a & b)
 REFUSED -7 (MP18)
 DON'T KNOW -8 (MP18)

MDVWHRS a. NUMBER OF HOURS _____
MDVWMIN b. NUMBER OF MINUTES _____ (GO TO MP18)

MP18. (Besides what you have already mentioned,) [Since (REF. DATE) (have you/has SP) seen/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION), did (SP) see] a health practitioner like any of the ones listed on this card? [Health practitioners include audiologist, optometrist, chiropractor, podiatrist (foot doctor), or any kind of health provider who is not a medical doctor.] [INCLUDE ANY VISITS FOR TESTS/X-RAYS.]

SHOW CARD MP1

MPPRPRAC YES 1 (MP19)
 NO 2 (MP26)
 REFUSED -7 (MP26)
 DON'T KNOW -8 (MP26)

MP19. Who did (you/SP) see?
[ENTER ONLY ONE PROVIDER.]
PROVNAME

MP20. What kind of health practitioner is (PROVIDER)?
PROVSPEC

BOX MP7	a.	SP HAS USED V.A. FACILITIES (HI36=1).....	1 (b)
		SP HAS NOT USED V.A. (HI36=2 OR MISSING).....	2 BOX MP8
	b.	"V.A. FLAG" SET FOR THIS PROVIDER	1 BOX MP8
		"V.A. FLAG" NOT SET FOR THIS PROVIDER	2 (MP21)

MP21. Is (PROVIDER) associated with a facility of the Veterans Administration?

VAPLACE

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

BOX MP8	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 OR MEDICARE HMO FLAG=2 OR MISSING FOR <u>ALL</u> PLANS)	2 (MP24)
	b.	"HMO FLAG" CODED YES FOR THIS PROVIDER	1 (MP24)
		"HMO FLAG" CODED NO OR MISSING FOR THIS PROVIDER	2 (MP23)
		"HMO FLAG" NOT SET FOR THIS PROVIDER	3 (MP22)

MP22. Is (PROVIDER) associated with (your/SP's) [READ HMO PLAN NAME(S) BELOW] HMO plan?

HMOASSOC

YES	1 (MP24)
NO	2 (MP23)
REFUSED	-7 (MP23)
DON'T KNOW	-8 (MP23)

MP23. (Were you/Was SP) referred to (PROVIDER) by [READ HMO PLAN NAME(S) BELOW]?

HMOREFER

YES	1 (MP24)
NO	2 (MP23a)
REFUSED	-7 (MP24)
DON'T KNOW	-8 (MP24)

MP23a. What is the most important reason (you/SP) did not see a health practitioner associated with [READ PLAN NAMES BELOW] or a health practitioner 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
NOHMOMAI PHYSICIAN TO GET REFERRAL 5
- SP WANTED TO GO TO A PROVIDER NOT AVAILABLE
THROUGH THE HMO 6
- 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
- HMO ADMINISTRATIVE OBSTACLES FOR SP 10
- NOHMOMOS** NOT IN HMO AT TIME OF EVENT..... 11
- OTHER (SPECIFY) _____ 91
- REFUSED -7
- DON'T KNOW -8

MP24. When did (you/SP) see (PROVIDER)? 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
EVBEGY Y

BOX MP9	<p>FOR EACH VISIT DATE REPORTED AT MP24: IF PROVIDER'S SPECIALTY = 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 19, 22, 23, 24, 25, 26, 27, OR 28, THEN ASK MP10-MP16. OTHERWISE ASK MP7 - MP16 .</p> <p>FLAG DATE(S) OF IDENTICAL VISITS IN VISIT ROSTER.</p> <p>IF ANY REMAINING DATES, GO TO MP7/MP10 FOR NEXT UNFLAGGED VISIT. OTHERWISE, GO TO MP25.</p>
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MP25. [Since (REF. DATE)/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], did (you/SP) have any other visits to this practitioner or any other health practitioner?

- TEMP** YES 1 (MP19)
- NO 2 (MP26)
- REFUSED -7 (MP26)
- DON'T KNOW -8 (MP26)

MP26. (Besides what you have already mentioned,) [Since (REF. DATE) (have you/has SP) seen/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION), did (SP) see] a mental health professional like any of the ones listed on this card? [Mental health professional includes psychiatrist, psychologist, and clinical social worker.]

SHOW CARD MP2	MPPRMENT	YES	1 (MP27)
		NO	2 (MP34)
		REFUSED	-7 (MP34)
		DON'T KNOW	-8 (MP34)

MP27. Who did (you/SP) see?
[ENTER ONLY ONE PROVIDER.]
PROVNAME

MP28. What kind of mental health professional is (PROVIDER)?
PROVSPEC

BOX MP10	a.	SP HAS USED V.A. FACILITIES (HI36=1)	1 (b)
		SP HAS NOT USED V.A. (HI36=2 OR MISSING)	2 BOX MP11
	b.	"V.A. FLAG" SET FOR THIS PROVIDER	1 BOX MP11
		"V.A. FLAG" NOT SET FOR THIS PROVIDER	2 (MP29)

MP29. Is (PROVIDER) associated with a facility of the Veterans Administration?

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

BOX MP11	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 OR MEDICARE HMO FLAG =2 OR MISSING FOR <u>ALL</u> PLANS)	2 (MP32)
	b.	"HMO FLAG" CODED YES FOR THIS PROVIDER	1 (MP32)
		"HMO FLAG" CODED NO OR MISSING FOR THIS PROVIDER	2 (MP31)
	"HMO FLAG" NOT SET FOR THIS PROVIDER	3 (MP30)	

MP30. Is (PROVIDER) associated with (your/SP's) [READ HMO PLAN NAME(S) BELOW] HMO plan?

HMOASSOC	YES	1 (MP32)
	NO	2 (MP31)
	REFUSED	-7 (MP31)
	DON'T KNOW	-8 (MP31)

MP31. (Were you/Was SP) referred to (PROVIDER) by [READ HMO PLAN NAME(S) BELOW]?

- HMOREFER**
- YES 1 (MP32)
 - NO 2 (MP31a)
 - REFUSED -7 (MP32)
 - DON'T KNOW -8 (MP32)

MP31a. What is the most important reason (you/SP) did not see a mental health professional associated with [READ PLAN NAMES BELOW] or a mental health professional 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
- HMO ADMINISTRATIVE OBSTACLES FOR SP 10
- NOHMOMOS** NOT IN HMO AT TIME OF EVENT..... 11
- OTHER (SPECIFY) _____ 91
- REFUSED -7
- DON'T KNOW -8

MP32. When did (you/SP) see (PROVIDER)? 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
EVBEGY

BOX MP12	<p>FOR EACH VISIT DATE REPORTED AT MP32: IF PROVIDER'S SPECIALTY = 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 19, 22, 23, 24, 25, 26, 27, OR 28, THEN ASK MP10-MP16. OTHERWISE, ASK MP7 - MP16. FLAG DATE(S) OF IDENTICAL VISITS IN VISIT ROSTER. IF ANY REMAINING DATES, GO TO MP7/MP10 FOR NEXT UNFLAGGED VISIT. OTHERWISE, GO TO MP33.</p>
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MP33. [Since (REF. DATE)/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], did (you/SP) have any other visits to this professional or any other mental health professional?

TEMP YES 1 (MP27)
 NO 2 (MP34)
 REFUSED -7 (MP34)
 DON'T KNOW -8 (MP34)

MP34. (Besides what you have already mentioned,) [Since (REF. DATE) (have you/has SP) seen/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION), did (SP) see] a therapist like any of the ones listed on this card? [Therapist includes physical therapist, speech therapist, intravenous (IV) therapist, occupational therapist, and respiratory therapist.]

SHOW CARD MP3

MPPRTHER YES 1 (MP35)
 NO 2 (MP42)
 REFUSED -7 (MP42)
 DON'T KNOW -8 (MP42)

MP35. Who did (you/SP) see?
 [ENTER ONLY ONE PROVIDER.]

PROVNAME

MP36. What kind of therapist is (PROVIDER)?

PROVSPEC

BOX MP13	a.	SP HAS USED V.A. FACILITIES (HI36=1)	1 (b)
		SP HAS NOT USED V.A. (HI36=2 OR MISSING)	2 BOX MP14
	b.	"V.A. FLAG" SET FOR THIS PROVIDER	1 BOX MP14
		"V.A. FLAG" NOT SET FOR THIS PROVIDER	2 (MP37)

MP37. Is (PROVIDER) associated with a facility of the Veterans Administration?

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

BOX MP14	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 OR MEDICARE HMO FLAG=2 OR MISSING FOR <u>ALL</u> PLANS)	2 (MP40)
	b.	"HMO FLAG" CODED YES FOR THIS PROVIDER	1 (MP40)
		"HMO FLAG" CODED NO OR MISSING FOR THIS PROVIDER	2 (MP39)
		"HMO FLAG" NOT SET FOR THIS PROVIDER	3 (MP38)

MP38. Is (PROVIDER) associated with (your/SP's) [READ HMO PLAN NAME(S) BELOW] HMO plan?

HMOASSOC	YES	1 (MP40)
	NO	2 (MP39)
	REFUSED	-7 (MP39)
	DON'T KNOW	-8 (MP39)

MP39. (Were you/Was SP) referred to (PROVIDER) by [READ HMO PLAN NAME(S) BELOW]?

HMOREFER	YES	1 (MP40)
	NO	2 (MP39a)
	REFUSED	-7 (MP40)
	DON'T KNOW	-8 (MP40)

MP39a. What is the most important reason (you/SP) did not see a therapist associated with [READ PLAN NAMES BELOW] or a therapist that [READ PLAN NAMES BELOW] would refer (you/SP) to?

NOHMOMAI	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
	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
	HMO ADMINISTRATIVE OBSTACLES FOR SP	10
NOHMOMOS	NOT IN HMO AT TIME OF EVENT	11
	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

MP40. When did (you/SP) see (PROVIDER)? 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
EVBEGY Y

BOX MP15	FOR EACH VISIT DATE REPORTED AT MP40: IF PROVIDER'S SPECIALTY = 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 19, 22, 23, 24, 25, 26, 27, OR 28, THEN ASK MP10-MP16. OTHERWISE, ASK MP7 - MP16. FLAG DATE(S) OF IDENTICAL VISITS IN VISIT ROSTER. IF ANY REMAINING DATES, GO TO MP7/MP10 FOR NEXT UNFLAGGED VISIT. OTHERWISE, GO TO MP41.
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MP41. [Since (REF. DATE)/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], did (you/SP) have any other visits to this therapist or any other therapist?

TEMP YES 1 (MP35)
 NO 2 (MP42)
 REFUSED -7 (MP42)
 DON'T KNOW -8 (MP42)

MP42. (Besides what you have already mentioned,) [Since (REF. DATE) (have you/has SP) seen/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION), did (SP) see] any other medical persons like the ones listed on this card? [Other medical persons include nurse, paramedic, and physician's assistant.]
 [INCLUDE ANY VISITS FOR TESTS/X-RAYS.]

SHOW CARD MP4	MPPRPERS YES 1 (MP43) NO 2 (MP50) REFUSED -7 (MP50) DON'T KNOW -8 (MP50)
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MP43. Who did (you/SP) see?
 [ENTER ONLY ONE PROVIDER.]
PROVNAME

MP44. What kind of medical person is (PROVIDER)?
PROVSPEC

BOX MP16	a.	SP HAS USED V.A. FACILITIES (HI36=1)	1 (b)
		SP HAS NOT USED V.A. (HI36=2 OR MISSING)	2 BOX MP17
	b.	"V.A. FLAG" SET FOR THIS PROVIDER	1 BOX MP17
		"V.A. FLAG" NOT SET FOR THIS PROVIDER	2 (MP45)

MP45. Is (PROVIDER) associated with a facility of the Veterans Administration?

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

BOX MP17	a.	SP BELONGS TO AN HMO (HI25 OR MEDICARE HMO	1 (b)
		FLAG=1 FOR ANY PLAN	
		SP DOES NOT BELONG TO AN HMO (HI25 OR MEDICARE	
		HMO FLAG=2 OR MISSING FOR <u>ALL</u> PLANS)	2 (MP48)
	b.	"HMO FLAG" CODED YES FOR THIS PROVIDER	1 (MP48)
		"HMO FLAG" CODED NO OR MISSING	
	FOR THIS PROVIDER	2 (MP47)	
	"HMO FLAG" NOT SET FOR THIS PROVIDER	3 (MP46)	

MP46. Is (PROVIDER) associated with (your/SP's) [READ HMO PLAN NAME(S) BELOW] HMO plan?

HMOASSOC	YES	1 (MP48)
	NO	2 (MP47)
	REFUSED	-7 (MP47)
	DON'T KNOW	-8 (MP47)

MP47. (Were you/Was SP) referred to (PROVIDER) by [READ HMO PLAN NAME(S) BELOW]?

HMOREFER	YES	1 (MP48)
	NO	2 (MP47a)
	REFUSED	-7 (MP48)
	DON'T KNOW	-8 (MP48)

MP47a. What is the most important reason (you/SP) did not see a medical person associated with [READ PLAN NAMES BELOW] or a medical person 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
- HMO ADMINISTRATIVE OBSTACLES FOR SP 10
- NOHMOMOS** NOT IN HMO AT TIME OF EVENT..... 11
- OTHER (SPECIFY) _____ 91
- REFUSED -7
- DON'T KNOW -8

MP48. When did (you/SP) see (PROVIDER)? Please tell me all the dates since (REF. DATE)?
[ENTER ALL DATES.]

EVBEGMM
EVBEGDD
EVBEGY Y

BOX MP18	<p>FOR EACH VISIT DATE REPORTED AT MP48: IF PROVIDER'S SPECIALTY = 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 19, 22, 23, 24, 25, 26, 27, OR 28, THEN ASK MP10-MP16. OTHERWISE, ASK MP7 - MP16. FLAG DATE(S) OF IDENTICAL VISITS IN VISIT ROSTER. IF ANY REMAINING DATES, GO TO MP7/MP10 FOR NEXT UNFLAGGED VISIT. OTHERWISE, GO TO MP49.</p>
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MP49. [Since (REF. DATE)/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], did (you/SP) have any other visits to this person or any other medical person?

- TEMP** YES 1 (MP43)
- NO 2 (MP50)
- REFUSED -7 (MP50)
- DON'T KNOW -8 (MP50)

MP50. (Besides what you have already mentioned,) [Since (REF. DATE) (have you/has SP) visited/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION), did (SP) visit] any other types of medical places like the ones listed on this card? [Other types of medical places include health clinic, neighborhood health center, rural health clinic, infirmary, mental health clinic, urgent care center, or any other place.]

SHOW CARD MP5	MPPRPLAC	YES	1 (MP51)
		NO	2 BOX OM1A
		REFUSED	-7 BOX OM1A
		DON'T KNOW	-8 BOX OM1A

MP51. What is the name of the other medical place that (you/SP) visited during this time?
[ENTER ONLY ONE PROVIDER.]

PROVNAME

BOX MP19	a.	SP HAS USED V.A. FACILITIES (HI36=1)	1 (b)
		SP HAS NOT USED V.A. (HI36=2 OR MISSING)	2 BOX MP20
	b.	"V.A. FLAG" SET FOR THIS PROVIDER	1 BOX MP20
		"V.A. FLAG" NOT SET FOR THIS PROVIDER	2 (MP52)

MP52. Is (PLACE) associated with a facility of the Veterans Administration?

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

BOX MP20	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 OR MEDICARE HMO FLAG=2 OR MISSING FOR <u>ALL</u> PLANS)	2 (MP55)
	b.	"HMO FLAG" CODED YES FOR THIS PROVIDER	1 (MP55)
		"HMO FLAG" CODED NO OR MISSING FOR THIS PROVIDER	2 (MP54)
	"HMO FLAG" NOT SET FOR THIS PROVIDER	3 (MP53)	

MP53. Is (PLACE) associated with (your/SP's) [READ HMO PLAN NAME(S) BELOW] HMO plan?

HMOASSOC	YES	1 (MP55)
	NO	2 (MP54)
	REFUSED	-7 (MP54)
	DON'T KNOW	-8 (MP54)

MP54. (Were you/Was SP) referred to (PROVIDER) by [READ HMO PLAN NAME(S) BELOW]?

- HMOREFER**
- YES 1 (MP55)
 - NO 2 (MP54a)
 - REFUSED -7 (MP55)
 - DON'T KNOW -8 (MP55)

MP54a. What is the most important reason (you/SP) did not go to a medical place associated with [READ PLAN NAMES BELOW] or a medical place 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
- 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
- HMO ADMINISTRATIVE OBSTACLES FOR SP 10
- NOHMOMAI** NOT IN HMO AT TIME OF EVENT..... 11
- NOHMOMOS** OTHER (SPECIFY) _____ 91
- REFUSED -7
- DON'T KNOW -8

MP55. When did (you/SP) visit (PLACE)? 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
EVBEGY

BOX MP21	ASK MP7 - MP16 FOR EACH VISIT DATE REPORTED AT MP55. FLAG DATE(S) OF IDENTICAL VISITS IN VISIT ROSTER. IF ANY REMAINING DATES, GO TO MP7/MP10 FOR NEXT UNFLAGGED VISIT. OTHERWISE, GO TO MP56.
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MP56. [Since (REF. DATE)/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], did (you/SP) have any other visits to this place or any other type of medical place?

- TEMP**
- YES 1 (MP51)
 - NO 2 **BOX OM1A**
 - REFUSED -7 **BOX OM1A**
 - DON'T KNOW -8 **BOX OM1A**

MP1. MEDICAL PROVIDER 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
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
28. LICENSED PRACTICAL NURSE (LPN)
- 91 OTHER MEDICAL PROVIDER SPECIALTY (NON-MD) (SPECIFY)