EPIDEMIOLOGY OF DIABETES INTERVENTIONS AND COMPLICATIONS

Health Care Delivery Questionnaire

INSTRUCTIONS:

- **The information requested pertains to the past 12 months.**
- **Evaluations performed as part of the EDIC evaluation should NOT be included in the answers requested.**
- **Health Insurance Coverage also implies the receipt of any health care benefits.**

A. IDENTIFYING INFORMATION

1. Clinic Number: __ __
2. Patient ID Number: __ __ __ __ __
3. Patient's Initials: __ __ __
4. Date Form Completed: __ __/__ __/__ __ (Month Day Year)
5. EDIC Year: __ __

B. HEALTH CARE INSURANCE COVERAGE

	YES	NO	UNCERTAIN
1. In the past 12 months, was there any time that you did not have health insurance coverage or health care benefits? **If "no", go to item #4a.**	(1)	(2)	(3)
2. If "yes" to item #1, how long were you without coverage?	___ ___ months		
3. Currently, do you have health insurance coverage?	(1)	(2)	(3)

4a. If you have had any health insurance coverage in the past 12 months, what is the name(s) of your plan(s)? If you have had coverage with more than one company, please list them all. _____ _____

4b. If you have had any health insurance coverage in the past 12 months, how would you describe your insurance plan(s)? (CHECK ALL THAT APPLY.)

a. An individual plan - the member pays for the plan premium (1)
b. A group plan through an employer, union, etc. - the employer pays all or part of the plan premium (1)
c. A government plan - the government pays for the plan premium (1)
   1. U.S. Government Health Plan (e.g., Military, CHAMPUS, VA) (1)
   2. Canadian Government Plan (1)
   3. Medicaid (1)
   4. Medicare (1)

4c. If you have had any health insurance coverage in the past 12 months, what type(s) have you had? (CHECK ALL THAT APPLY.)

a. Indemnity or fee-for-service plan (i.e., you choose which doctor you see for care without financial penalty) (1)
b. Health Maintenance Organization (HMO) (i.e., you must have a primary care physician who must refer you to specialty care if needed) (1)
c. Preferred Provider Organization (PPO) (i.e., you have lower co-payments when you see a preferred provider within the network, but can see a provider out-of-network for a higher co-payment) (1)
d. Point of Service (POS) (i.e., you must have a primary care provider; you have the option to self-refer to in-network specialist, or you can see out-of-network specialist with higher co-payment) (1)
e. Other, specify: _____ (1)

5. If you **currently** have health insurance, does it provide coverage (complete coverage or partial coverage after co-payments or deductibles) for any of the following:
(If you do not currently have health insurance, go to Section C.)

		YES	NO	UNCERTAIN
a.	Medical visits for diabetes (medical doctor, doctor of osteopathy)	(1)	(2)	(3)
b.	Medical visits for diabetes (nurse practitioner, physician assistant)	(1)	(2)	(3)
c.	Insulin	(1)	(2)	(3)
d.	Syringes	(1)	(2)	(3)
e.	Blood glucose testing strips	(1)	(2)	(3)
f.	Blood glucose testing meters	(1)	(2)	(3)
g.	Glucose tablets	(1)	(2)	(3)
h.	Glucagon	(1)	(2)	(3)
i.	Insulin infusion pump	(1)	(2)	(3)
j.	Insulin infusion pump supplies	(1)	(2)	(3)
k.	Glycosylated hemoglobin or HbA_1C test	(1)	(2)	(3)
l.	Fructosamine test (blood test like HbA_1C that reflects past 2-3 weeks blood sugar levels)	(1)	(2)	(3)
m.	Blood tests (in general)	(1)	(2)	(3)
n.	Urine tests (in general)	(1)	(2)	(3)
o.	Electrocardiograms (EKG)	(1)	(2)	(3)
p.	Cardiovascular stress tests	(1)	(2)	(3)
q.	Dilated eye exams	(1)	(2)	(3)
r.	Eye photos	(1)	(2)	(3)
s.	Laser treatment for eyes for diabetic retinopathy / macular edema	(1)	(2)	(3)
t.	Dialysis (in-home or outpatient)	(1)	(2)	(3)
u.	Nutrition counseling	(1)	(2)	(3)
v.	Diabetes education services	(1)	(2)	(3)
w.	Services of mental health professionals	(1)	(2)	(3)
x.	Emergency room visits	(1)	(2)	(3)
y.	Walk-in clinics or urgent care center visits	(1)	(2)	(3)
z.	Hospitalization due to diabetes related complications	(1)	(2)	(3)
aa.	Hospitalization for other health issues	(1)	(2)	(3)
bb.	Nursing home care, convalescent care, or rehabilitation care	(1)	(2)	(3)
cc.	Home health care services	(1)	(2)	(3)

C. HEALTH CARE PROVIDERS AND SOURCES OF CARE

1. Where do you usually go to receive **DIABETES** health care services? (CHECK ONLY ONE (1) LOCATION.)

   a. Doctor's private office (1)
   b. Outpatient general medical clinic (2)
   c. Outpatient diabetes clinic (3)
   d. Company clinic (4)
   e. Walk-in clinic or urgent care center (5)
   f. Hospital emergency room (6)
   g. The EDIC annual evaluation is your only source of diabetes health care (7)
   h. Other, specify: _____ (8)
   i. There is no single location where you usually go for health care. (9)

2. Who currently provides your **DIABETES** health care at this location? **(**CHECK ONLY ONE (1) PROVIDER.)

   a. Generalist (general practitioner, family practitioner, internist, or nurse, nurse practitioner, physician assistant working with a generalist) (1)
   b. Specialist (diabetologist, endocrinologist, or nurse, nurse practitioner, physician assistant working with a diabetologist or endocrinologist) (2)
   c. Other, specify: _____ (3)
   d. None. You have no current health care provider. (4)

	YES	NO	NOT APPLICABLE
3. Was the diabetes provider checked in item #2 a member of the DCCT staff or a current member of the EDIC staff?	(1)	(2)	(3)

4. Where do you usually go to receive **GENERAL** health care services? (CHECK ONLY ONE (1) LOCATION.)

   a. Doctor's private office (1)
   b. Outpatient general medical clinic (2)
   c. Outpatient diabetes clinic (3)
   d. Company clinic (4)
   e. Walk-in clinic or urgent care center (5)
   f. Hospital emergency room (6)
   g. The EDIC annual evaluation is your only source of general health care. (7)
   h. There is no single location where you usually go for health care. (8)

5. Who currently provides your **GENERAL** health care at this location? **(**CHECK ONLY ONE (1) PROVIDER.)

   a. Generalist (general practitioner, family practitioner, internist, or nurse, nurse practitioner, physician assistant working with a generalist) (1)
   b. Specialist (diabetologist, endocrinologist, or nurse, nurse practitioner, physician assistant working with a diabetologist or endocrinologist) (2)
   c. Other, specify: _____ (3)
   d. None. You have no current health care provider. (4)

	YES	NO	NOT APPLICABLE
6. Is your general health care provider the same person who provides your diabetes health care?	(1)	(2)	(3)

	YES	NO	# OF VISITS
7. In the past 12 months, have you visited your EDIC clinic for health care services unrelated to the EDIC study?	(1)	(2)	__ __
8. In the past 12 months, have your EDIC annual evaluations been the **only** health care services you have received?	(1)	(2)	

9. Please indicate if you have had any visits in the past 12 months to any of the providers listed below. For each "yes" response record the number of visits in the past 12 months. **(Do not include EDIC evaluations in response to this question. Include outpatient visits only.)**

	Health Care Provider	YES	NO	# OF VISITS
a.	Generalist visit (general practitioner, family practitioner, internist, or nurse, nurse practitioner, physician assistant working with a generalist)	(1)	(2)	__ __
b.	Specialist visit (diabetologist, endocrinologist, or nurse, nurse practitioner, physician assistant working with a diabetologist or endocrinologist)	(1)	(2)	__ __
c.	Nurse educator or certified diabetes educator for diabetes education only	(1)	(2)	__ __
d.	Dietitian	(1)	(2)	__ __
e.	Psychiatrist (M.D.)	(1)	(2)	__ __
f.	Psychologist	(1)	(2)	__ __
g.	Social worker	(1)	(2)	__ __
h.	Ophthalmologist (eye specialist, M.D.)	(1)	(2)	__ __
i.	Optometrist (eye specialist, not an M.D.)	(1)	(2)	__ __
j.	Cardiologist (heart specialist)	(1)	(2)	__ __
k.	Podiatrist (foot specialist)	(1)	(2)	__ __
l.	Nephrologist (kidney specialist)	(1)	(2)	__ __
m.	Gastroenterologist (digestive disease specialist: stomach, liver, gall bladder, bowel)	(1)	(2)	__ __
n.	Neurologist (nerve specialist)	(1)	(2)	__ __
o.	Oncologist (cancer specialist)	(1)	(2)	__ __
p.	Surgeon	(1)	(2)	__ __
q.	Gynecologist or obstetrician	(1)	(2)	__ __
r.	Urologist (specialist for bladder problems, impotence)	(1)	(2)	__ __
s.	Dermatologist (skin specialist)	(1)	(2)	__ __
t.	Orthopedist (bone specialist)	(1)	(2)	__ __
u.	Physical therapist	(1)	(2)	__ __
v.	Chiropractor	(1)	(2)	__ __
w.	Dentist	(1)	(2)	__ __
x.	Oral surgeon	(1)	(2)	__ __
y.	Other health care provider(s), **specify**:	(1)	(2)	__ __
	_____	(1)	(2)	__ __
	_____	(1)	(2)	__ __

D. HOSPITALIZATIONS AND OTHER HEALTH CARE SERVICES USED

	YES	NO
1. During the past 12 months, were you admitted overnight to a hospital? This does not include emergency room visits or same day procedures. **If "no", go to D.2**		(1) (2)
a. If "yes" to item #1, how many **times** in the past 12 months were you admitted overnight to a hospital for any reason?	___ ___	
b. If "yes" to item #1, how many total **nights** in the past 12 months did you stay in the hospital?	___ ___	

c. Please list the date(s) and name(s) of **all** the hospitals in which you have stayed overnight or longer during the past 12 months. (Make a separate entry for each time you were admitted. Attach a separate sheet if needed.)

Date of Admission (mo / day / yr)	Number of Nights	Hospital Name	City, State
__ __/__ __/__ __	_____	_____	_____
__ __/__ __/__ __	_____	_____	_____
__ __/__ __/__ __	_____	_____	_____
__ __/__ __/__ __	_____	_____	_____
__ __/__ __/__ __	_____	_____	_____
__ __/__ __/__ __	_____	_____	_____

	YES	NO
2. During the past 12 months, were you seen in a hospital emergency room for any reason? (Do not include urgent care center or walk-in clinic visits.) **If "no" go to D.3.**		(1) (2)
a. If "yes" to item #2, how many **times** in the past 12 months were you seen in a hospital Emergency Room?	___ ___	
b. How many of these times were related to your diabetes?	___ ___	

	YES	NO
3. During the past 12 months, were you a patient in a nursing home or convalescent facility? **If "no" go to D.4.**	(1)	(2)
a. If "yes" to Item #3, how many total nights in the past 12 months did you spend in a nursing home or convalescent facility?	___ ___	

b. Please list the date(s) and name(s) of the nursing home(s) or convalescent facility(s) in which you have stayed during the past 12 months. (Make a separate entry for each time you were admitted. Attach a separate sheet if needed.)

Date of Admission (mo / day / yr)	Number of Nights	Institution	City, State
__ __/__ __/__ __	_____	_____	_____
__ __/__ __/__ __	_____	_____	_____
__ __/__ __/__ __	_____	_____	_____

4. During the past 12 months, have you had any of the following laboratory tests, procedures, etc.?
   - DO NOT include any tests or procedures that may have been done while you were hospitalized.
   - DO NOT include evaluations performed as part of your EDIC visit.
   - CHECK ALL THAT APPLY.

	Test, Procedures, etc.	YES	NO	# Times
a.	Glycosylated hemoglobin or HbA_1C	(1)	(2)	__ __
b.	Fructosamine	(1)	(2)	__ __
c.	Blood glucose (by lab or clinic)	(1)	(2)	__ __
d.	Fasting lipid test (cholesterol)	(1)	(2)	__ __
e.	Other blood tests	(1)	(2)	__ __
f.	Electrocardiogram (EKG)	(1)	(2)	__ __
g.	Stress test	(1)	(2)	__ __
h.	Dilated eye exam	(1)	(2)	__ __
i.	Eye photographs	(1)	(2)	__ __
j.	Fluorescein angiogram (eye photos taken after injection of dye)	(1)	(2)	__ __
k.	Laser treatment for eyes for diabetic retinopathy / macular edema	(1)	(2)	__ __
l.	Timed urine collection	(1)	(2)	__ __
m.	Other urine tests	(1)	(2)	__ __
n.	Kidney dialysis	(1)	(2)	__ __
o.	Gastric emptying studies	(1)	(2)	__ __
p.	Pap smear test	(1)	(2)	__ __
q.	Flu shot	(1)	(2)	__ __

5. During the past 12 months, have you had **any other** laboratory tests or evaluations? (1) (2)

   If "yes", specify: _____

   _____

6. During the past 12 months, have you received **any other** medical treatments? (1) (2)

   If "yes", specify: _____

   _____

7. How many days of work, school, and/or usual activities have you missed in the past 12 months **related to any illness**? (Please include any days spent in the hospital.) ___ ___ ___

7a. How many of these days missed were related to your diabetes? ___ ___ ___

E. PARTICIPATION IN OTHER RESEARCH PROJECTS

		YES	NO
1.	During the past 12 months, have you been asked to participate in any other health related research projects? **If "no", go to Section F.**	(1)	(2)
2.	If "yes" to item #1, did you actually participate in the project? **If "no", go to Section F.**	(1)	(2)

3. If "yes" to item #2, did the research project involve: (CHECK ALL THAT APPLY.)

		YES
a.	Specific drugs	(1)
b.	Test procedures	(1)
c.	Insulin regimen changes	(1)
d.	Diet changes	(1)
e.	Exercise modifications and/or recommendations	(1)
f.	Questionnaires	(1)
g.	Interviews	(1)
h.	Other, specify: _____	(1)

F. ACCESS TO HEALTH CARE SERVICES

		YES	NO
1.	In the past 12 months, did you have **any health problem(s) or condition(s)** that you would have liked to have seen a doctor or other health care provider about, but you did not? **If "no" go to item #3.**	(1)	(2)

2. If "yes" to item #1, please indicate below the reason(s) that explain why you did not see a doctor or other health care provider for this problem or condition. (CHECK ALL THAT APPLY.)

a.	Did not think that the condition was serious	(1)
b.	Health care services for the problem or condition were not covered by health insurance	(1)
c.	Thought the medical care would cost too much	(1)
d.	Did not have money to cover the cost	(1)
e.	Did not have time to see a health care provider	(1)
f.	Could not get an appointment; office hours were inconvenient	(1)
g.	Did not have a way to get to the office or clinic	(1)
h.	Distance to clinic or doctor's office was too great	(1)
i.	Did not have anyone to care for the children	(1)
j.	Felt the health care provider could not help the condition	(1)
k.	Did not feel the health care provider cared about my health	(1)
l.	Was afraid of finding out what was wrong	(1)
m.	Felt the problem could be remedied at home	(1)
n.	Had a lapse in insurance	(1)
o.	Other, specify: _____	(1)

	YES	NO
3. In the past 12 months, do you feel that you **delayed** seeing a doctor or other health care provider longer than you should have? **If "no", STOP.**	(1)	(2)

4. If "yes" to item #3, please indicate below the reason(s) that explain why you delayed seeing a doctor or other health care provider for this problem or condition. (CHECK ALL THAT APPLY.)

a. Did not think that the condition was serious	(1)
b. Health care services for the problem or condition were not covered by health insurance	(1)
c. Thought the medical care would cost too much	(1)
d. Did not have money to cover the cost	(1)
e. Did not have time to see a health care provider	(1)
f. Could not get an appointment; office hours were inconvenient	(1)
g. Did not have a way to get to the office or clinic	(1)
h. Distance to clinic or doctor's office was too great	(1)
i. Did not have anyone to care for the children	(1)
j. Felt the health care provider could not help the condition	(1)
k. Did not feel the health care provider cared about my health	(1)
l. Was afraid of finding out what was wrong	(1)
m. Felt the problem could be remedied at home	(1)
n. Had a lapse in insurance	(1)
o. Other, specify: _____	(1)

Thank you for completing the questionnaire. The data will be used to evaluate the type of health care you and other EDIC participants are receiving.