# Attachment M

# National Facility Screening/Appointment Setting Interview

## Introduction to Screening Questionnaire

ASK GATEKEEPER TO SPEAK WITH DIRECTOR/ ADMINISTRATOR OF FACILITY

Hello, my name is _____ with RTI International, a nonprofit research organization. I'm calling about the National Survey of Residential Care Facilities, a survey sponsored by the National Center for Health Statistics in the U.S. Department of Health and Human Services. You should have received a letter introducing the survey in the past few days.

I-1. Did you receive the letter?

| | |
|---|---|
| O YES | BEGIN WITH "I'd like to briefly explain the study" in **Statement A** |
| O NO<br>O DON'T KNOW/DON'T REMEMBER | BEGIN WITH "Although you have not received the letter" in **Statement A** |

STATEMENT A
(*Although you have not received the letter)* I'd like to briefly explain the study.

This study collects information about the characteristics of residential care facilities and the people who live in them. Results will be used to understand how facilities like this one meet the needs of elders and adults with disabilities. This study, called the National Survey of Residential Care Facilities, is a federally-sponsored statistical survey to collect information on these services.

The survey is being conducted nationwide and will involve 2,250 facilities. Your facility was chosen by a random selection process to represent residential care facilities like yours. All information you provide will be held in strict confidence and only will be used for statistical purposes. All published information will be presented in such a way that no individual facility, staff, or residents can be identified. Your participation is voluntary and there are no penalties for not participating in the survey; however, data from your facility are necessary to accurately portray residential care facilities.

I would like to verify some information we have about (NAME OF FACILITY) and then set up an appointment for an in-person interview at your facility. The questions I have right now should take just a few minutes.

## Facility Screening Questionnaire

NOTE TO REVIEWERS: THIS DEFINITION OF THE TARGET POPULATION UNDERLIES THE SCREENING QUESTIONS. IT IS PRESENTED HERE TO ASSIST IN REVIEW AND IS NOT INTENDED TO BE READ TO RESPONDENTS. IT WILL BE DELETED IN THE FINAL VERSION.

"RESIDENTIAL CARE FACILITIES ARE PLACES THAT ARE LICENSED, REGISTERED, CERTIFIED, OR OTHERWISE REGULATED. BY THE STATE AND THAT PROVIDE ROOM AND BOARD WITH AT LEAST TWO MEALS A DAY, AROUND-THE-CLOCK ON-SITE SUPERVISION, AND HELP WITH PERSONAL CARE SUCH AS BATHING AND DRESSING OR HEALTH RELATED SERVICES SUCH AS MEDICATION MANAGEMENT. THESE FACILITIES SERVE AN ADULT POPULATION. FACILITIES LICENSED TO EXCLUSIVELY SERVE PEOPLE WITH MENTAL ILLNESS, MENTAL RETARDATION/DEVELOPMENTAL DISABILITIES, OR CHILDREN ARE EXCLUDED."

S1. {CAPI: IF FACILITY HAS A SINGLE LICENSURE CATEGORY ON THE SAMPLE FRAME} Our records show that this facility is currently _____ (CAPI FILL: licensed, registered, or certified) in _____ (CAPI FILL: State) as a (CAPI FILL FROM SAMPLE FRAME LISCENSURE CAT FIELD}.

**O** YES --- GO TO S2
**O** NO --- GO TO S1a

S1_multiple. {CAPI: IF MULTIPLE LICENSURE FACILITY} Our records show that this facility has multiple (CAPI FILL: licenses, registrations, certifications) in _____ (CAPI FILL: State) as a {CAPI: FILL FROM SAMPLE FRAME LISCENSURE CAT FIELD 1} and {CAPI: FILL FROM SAMPLE FRAME LISCENSURE CAT FIELD 2} and {CAPI – IF NEEDED: FILL FROM SAMPLE FRAME LISCENSURE CAT FIELD3}. Is that correct?

**O** YES --- GO TO S2
**O** NO --- GO TO S1a

S1a. IF NO TO S1 OR S1_multiple: Is this facility licensed as… {CAPI: UPLOAD LISCENSURE CATEGORY OF RES CARE FACILITIES BY STATE FROM DATABASE}

**O** YES
**O** NO

{CAPI – IF YES TO AT LEAST ONE CATEGORY FROM THE DATABASE THEN CONTINUE} {CAPI: IF NONE OF THE CATEGORIES APPLY, THEN FACILITY IS INELIGIBLE – GOTO Elig_2.}

CAPI: IF MULTIPLE LISCENSURE FACILITY: Please respond to the following questions for the residential care portions of the facility only.

S2. Does this residential care facility have 4 or more licensed, registered, or certified beds?

**O** YES
**O** NO

S2a. Does this facility serve children aged 17 and under?

O YES
O NO

S3. Does this facility serve a predominantly elderly population? A predominantly elderly population means more than half of the total residents are age 65 or older.

O YES
O NO

S3a. Does this residential care facility exclusively serve adults with dementia or Alzheimer's disease?

O YES
O NO

S4. Does this facility exclusively serve adults with mental retardation or developmental disability, such as autism, or Down syndrome?

O YES
O NO

S5. Does this facility exclusively serve adults with severe mental illness such as schizophrenia or psychosis? Please do not include Alzheimer's disease or other dementias.
O YES
O NO

S6. Does this facility provide or arrange for care staff to be on duty 24 hours a day, 7 days a week?
O YES
O NO

S7. Does this facility offer help with activities of daily living, such as help with bathing, either directly or arranged through an outside vendor?
O YES
O NO

S8. Does this facility offer assistance with the administration of medications or provide central storage of medications?
**O** YES
**O** NO

S9. Does this facility offer at least 2 meals a day to residents?
**O** YES
**O** NO

{CAPI – IF (S1 or S1_multiple= YES) AND S2, S6, AND S9 ALL = YES AND S4 AND S5 BOTH = NO AND (S7 OR S8 = YES) THEN S10 else Elig_2}

S10. (CAPI: IF S3a=YES GOTO S11) Does this residential care facility have a distinct unit, wing, or floor that is designated as a Dementia/Alzheimer's Special Care Unit?
O YES
O NO

S11. Does this facility provide the following other types of services at the same location? By at the same location I mean at this campus or address, not necessarily in the same building.
SELECT ALL THAT APPLY
□ Independent living or independent apartments
□ Nursing home
□ Rehabilitation subacute or postacute care unit in a nursing home
□ Hospital
□ Other SPECIFY_____

S12. CAPI: IF NURSING HOME SELECTED ASK:
Does this facility have a designated Alzheimer's / dementia special care unit that is part of the nursing home?
O YES
O NO

CAPI: IF INDEPENDENT LIVING/INDEPENDENT APARTMENTS AND NURSING HOME ARE SELECTED IN S11, THEN S13 ELSE S14

S13. Is this a continuing care retirement community, that is, a community that offers multiple levels of care such as independent living, residential care, and skilled nursing care and gives residents the opportunity to remain in the same community as their needs change?
**O** YES
**O** NO

S14. Is this facility owned by a chain, group, or multi-facility system?

IF NEEDED: A chain means more than one facility under common ownership or management. This may include facilities within-state or across multiple states.
**O** YES
**O** NO

S15. What is the type of ownership of this facility?
**O** Private, for profit
**O** Private, nonprofit
**O** State, county, or local government
**O** Other – SPECIFY: _____

GO TO STATEMENT B.

ELIG_2: Thank you very much for answering these questions. Unfortunately, this facility does not qualify for our study which is focused on facilities that provide a broader array of residential care services.

STATEMENT B

Based on your responses, your facility is eligible to participate in our study. This will involve a site visit to your facility to collect additional information about your facility and residents. The interview about your facility will take about 40 minutes to complete.

Before the on-site visit, I will be sending a form with some questions about the facility, like number of beds and counts of staff, to complete prior to my arrival. We find that this makes responding to the facility questionnaire easier.

The facility interview, including the questions I will send in advance should be completed by someone who is familiar with the operations of the facility, usually the administrator or director of the facility.

S16. In (NAME OF FACILITY) is that you or someone else?

O ADMINISTRATOR
O SOMEONE ELSE → Please give me the name of that person.

_____
NAME OF RESPONDENT FOR FACILITY QUESTIONNAIRE

While on-site, we will need for you or one of your staff to assist us in selecting a few residents at random. We would like a staff member that knows these residents best, usually a staff caregiver, to complete a short questionnaire about the resident. No residents will be directly interviewed. These interviews may take up to 20 minutes each. In order to protect the confidentiality of your residents, I will need to work with you or someone on your staff to assist with selecting this sample and locating staff who are familiar the sampled resident.

S17. Would this be you or someone on your staff?

O ADMINISTRATOR
O SOMEONE ELSE ON THE STAFF → Please give me the name of that person.

_____
NAME OF STAFF ASSISTING WITH RESIDENT SAMPLE SELECTION

S18. Let me verify that I have the correct name and address for your facility.

A. Is the correct name of your facility [filled from the sample frame] ? O YES O NO → *Enter correct name*

B. Is your facility located at [filled from the sample frame] ? O YES O NO → *Enter correct address*

C. Is this also your mailing address? O YES O NO → *Enter correct address*

IF RESPONDENT IS THE ADMINISTRATOR, SCHEDULE AN APPOINTMENT.

IF APPOINTMENT NEEDS TO BE MADE WITH ANOTHER STAFF MEMBER, RECORD CONTACT INFORMATION.

DETAILS ABOUT NEXT STEPS AND LINKS TO THE CASE MANAGEMENT SYSTEM WILL BE PROGRAMMED AT THIS POINT. APPROVALS FROM CORPORATE OFFICES OR REQUESTS FOR ADDITIONAL INFORMATION AND ANY RESULTS OTHER THAN AN APPOINTMENT BEING SET WILL BE CAPTURED IN THE CASE MANAGEMENT SYSTEM.