Supporting Statement A for Paperwork Reduction Act Submission for

National Survey of Residential Care Facilities

Revised OMB Application

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SUPPORTING STATEMENT

National Center for Health Statistics

National Survey of Residential Care Facilities

This is a request for approval of a revision of a currently approved collection for two years. The National Survey of Residential Care Facilities (NSRCF) (OMB No. 0920-0780, expiration 12/31/2009), is a national data collection. NSRCF will complement the National Center for Health Statistics' (NCHS) National Nursing Home Survey (NNHS) (OMB No. 0920-0353, expired 02/28/2007) and National Home and Hospice Care Survey (NHHCS) (OMB No.0920-0298, expired 07/31/09). Together these surveys comprised the long-term care (LTC) component of the National Health Care Surveys (NHCS).

In 2008, OMB approved the pretest only for NSRCF which has been successfully completed. This statement proposes a data collection effort to conduct a full national survey. The data from NSRCF will allow the government to make national estimates of the number of residential care facilities operating in the United States, the number of residents receiving care, and the characteristics of both the facilities and their residents. Minor changes have been made as a result of the pretest; those details can be found in section B.4.

NCHS and the Office of the Assistant Secretary for Planning and Evaluation (ASPE), in the Department of Health and Human Services (DHHS), collaborated extensively on the design and data collection phases of NSRCF. ASPE worked in collaboration with NCHS on previous LTC provider surveys to examine the direct care workforce in LTC work settings, adding the nursing assistant supplement to the 2004 NNHS and the home health aide supplement to the 2007 NHHCS.

The well-documented aging of the population, particularly those aged 85 years and older, will lead to an increase in the number of people who need LTC services. Although most people who need LTC services receive them in their own homes, personal care received outside both the home and traditional nursing facilities is an important and growing service option. This is especially the case for people who can no longer live alone but do not require the skilled level of care provided by a nursing home. This type of care—broadly referred to here as residential care—includes congregate settings that provide both housing and supportive services. Supportive services typically include protective oversight and help with instrumental activities of daily living (IADLs), such as transportation, meal preparation, and taking medications, and more basic activities of daily living (ADLs), such as eating, dressing, and bathing.

The following criteria will be used to determine the universe of residential care facilities which are eligible for selection in NSRCF:

> Residential care facilities are places that are licensed, registered, listed, 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 activities of daily living (e.g., bathing, eating, dressing) or health-related services (e.g., medication

supervision); serve primarily an adult population; and have at least four beds. Nursing facilities and facilities licensed to serve exclusively persons with mental illness or individuals with mental retardation or developmental disabilities are excluded.

A. Justification

1. Circumstances Making the Collection of Information Necessary

Background

Section 306 [342k] (a) & (b) of the Public Health Service Act provides for the establishment of the National Center for Health Statistics (NCHS) and requires that NCHS perform statistical and epidemiological activities for the purpose of improving the effectiveness, efficiency, and quality of health services in the United States. A copy of this authorization is provided as Attachment A. NCHS performs these activities by collecting statistics on health care professionals; utilization of health care; and health care costs and financing. NCHS collects information from health care establishments within the major sectors of the health care system, including ambulatory care, inpatient care, and LTC.

Three issues underlie the need for information about residential care facilities. First, there are concerns about services provided to residents. An ASPE-funded study of six states using Medicaid to pay for services in residential care settings found stakeholders almost universally concerned about perceptions of insufficient and untrained staff and the potential impact on quality of care (O'Keeffe, et al., 2003). The National Study of Assisted Living for the Frail Elderly in 1998 (Hawes, Phillips, and Rose, 2000) reported many positive aspects but also found that residents reported unmet needs for assistance with using the toilet (26%), locomotion (12%), and dressing (12%). Most residents (58%) also reported that adequate numbers of staff were not always available.

Second, although definitive data are not available, many residential care facilities serve very disabled residents. Several factors account for this, including the aging-in-place of residents and the increased use of residential care facilities by Medicaid beneficiaries (O'Keeffe and Wiener, 2005). States use Medicaid research and demonstration waivers, home and community-based services waivers, and state-plan personal care to pay for services in residential care facilities. Medicaid payments may not be used to cover room and board in residential care facilities. In 2004, 41 states reported that approximately 121,000 residents had their services paid, at least in part, by Medicaid (Mollica and Johnson-Lamarche, 2004).

Finally, prior studies have found heterogeneity among residential care facilities. These facilities vary in size, ownership, resident case mix, staffing levels and staff mix, accommodations, services, and price (Hawes, et al., 2003). Considerable variation also exists among their residents' care needs, as these facilities serve not only frail elders with limitations in physical and cognitive functioning but also nonelderly adults with cognitive impairments and severe mental illness (Hawes, et al., 1995). These residential care facilities also appear to vary in terms of resident outcomes and level of resident satisfaction—all affected by the type of facility (Curtis,

et al., 2005; Hedrick, et al., 2003; Phillips, et al., 2003; Zimmerman, et al., 2003). Although NSRCF will be limited to facilities that serve predominantly the adult population, residential care facilities may include other populations as well.

All of these factors make it critical to examine residential care facilities comprehensively and systematically. Current national data collection efforts are limited in their ability to estimate the size and characteristics of residential care settings and the number and characteristics of residents. The Medicare Current Beneficiary Survey, the National Long-Term Care Survey, and the Health and Retirement Survey cover the residential care population to varying degrees, but their small sample sizes of persons in residential care facilities limit the conduct of in-depth analyses by type of residential care setting or specific subpopulations of residents (Spillman and Black, 2005). Estimates of the size of the residential care population vary depending on how a facility is defined and how data are collected, and range from 400,000 to 800,000 persons aged 65 or older (Spillman and Black, 2005). A recent study of state-licensed residential care concluded that there were 36,451 residential care facilities nationally with 937,601 units/beds (Mollica and Johnson-Lamarche, 2005). Thus, residential care facilities play a significant role in providing LTC services.

According to data from the 2004 NNHS, there are an estimated 16,100 nursing homes with 1,492,200 residents. No national data collection effort similar to NNHS exists for residential care settings and their residents. NSRCF will complement other federal surveys and fill a significant data gap about a major portion of the LTC population. Data from NSRCF will allow the government to make national estimates of the number of residential care facilities operating in the United States, the number of residents receiving care, and the characteristics of both the facilities and their residents.

A pretest was successfully conducted in 2009 with 72 facilities in 6 states. Recruiting methods, screening procedures, computer-assisted personal interviewing (CAPI) software applications, and questionnaire content were tested and assessed for quality, timeliness, and minimization of respondent burden. The sample management and data transmission systems were fully employed for the pretest and challenged for functionality and utility. Data collected during the pretest were reviewed for item non-response issues and data quality. Item non-response issues were minimal. Data quality issues were also minimal. The variation in responses for each item was adequate.

Privacy Impact Assessment

Overview of the Data Collection System

For the national implementation of NSRCF, 2,250 facilities are expected to participate. Information on an average of four residents per facility will be collected from directors and staff members, resulting in a maximum sample of 8,450 residents. Residents themselves will not be interviewed. The survey will utilize a CAPI system to collect information about facility and resident characteristics. This computerized system speeds the flow of data and makes it possible to release information on a timelier basis and easier for respondents to participate in the survey. The CAPI system may also enhance data quality, because it eliminates an additional step of

keying the data into computerized files.

Items of Information to be Collected

The facility questionnaire will collect data about facility characteristics (e.g., size, age, types of rooms), services offered, characteristics of the resident population, facility policies and services, charges for services, and background of the director. The resident questionnaire will collect information on resident demographics; current living arrangements within the facility; involvement in activities; use of services; charges for care; health status; hospitalizations; and cognitive and physical functioning.

Information in Identifiable Form (IIF)

There is no Information in Identifiable Form (IIF).

Identification of Website(s) and Website Content Directed at Children Under 13 Years of Age

The NSRCF website at http://www.cdc.gov/nchs/nsrcf.htm will describe the survey, answer questions facilities may have on why they should participate, and describe how the Privacy Rule permits data collection for NSRCF. There will be no websites directed at children under 13 years of age.

2. Purpose and Use of the Information Collection

The primary purpose of this survey is to provide a database on residential care facilities for adults that researchers and policymakers can use to address a wide variety of questions. As a general purpose survey, it will provide broad descriptive data and does not presuppose any particular typology of facilities or residents. The main focus is on characteristics of the facilities, with the survey gathering as much information about residents as is possible within the budget constraint.

Important research and policy questions these data will help answer include the following:

- *What are the number and characteristics of residential care facilities?* Characteristics include number of units and beds; occupancy rate; ownership (profit/nonprofit, chains/stand-alone small businesses); location (urban/rural); and type of facility (e.g., the extent to which facilities provide private rooms and bathrooms and a high level of services). What are admission and discharge policies? What ~~proportion of facilities serve~~proportion of facilities serves Medicaid beneficiaries? What proportion of facilities use negotiated risk contracts? What proportion of facilities use appropriate safety features (e.g., grab bars and smoke detectors)?

- *What services and staff are available?* What services do residential care facilities provide and at what level and cost? What services are included in the basic rate? What services are available for additional charges? What skilled services are available and who provides them? Does the facility use or allow outside providers, such as hospice and

home health agencies? What is the staff turnover rate? Do facilities that serve residents with a high level of impairment and health needs have more and better trained staff? What medication administration and management services are provided?

- *What are the characteristics of residents?* What are residents' sociodemographic characteristics (e.g., age, sex, race, education, ethnic group, family, income, and assets)? What are residents' health conditions and cognitive and functional status? What is the average length of stay in residential care facilities and the reasons for entering and exiting? How do people pay for residential care? How do resident characteristics and outcomes vary by type of facility?

<u>Privacy Impact Assessment Information</u>

National data on the characteristics of residential care facilities will be used by DHHS for program planning and to inform national policies. Data from NSRCF will be available to analyze relationships that exist among utilization, services offered, and charges for care. NSRCF will provide the Department of Veterans Affairs (VA) with unique and critical data and information on the health care needs and service use, including long-term care of veterans and non-veterans in the U.S. NSRCF data will be subjected to a risk disclosure review and any "risky" data will be masked to ensure privacy.

3. Use of Improved Information Technology and Burden Reduction

Data will be collected using CAPI software on laptop computers, administered by professionally-trained interviewers. The CAPI system allows interviewers to move quickly through the questionnaire and will modify questions based on responses to prior questions. Only questions specific to the individual facility or resident characteristics are asked, skipping unnecessary questions. The CAPI system incorporates edit checks during data collection and eliminates the need to enter data from a hard copy questionnaire, thereby reducing data entry errors and improving data quality. The NSRCF CAPI instrument is programmed to enable the interviewer to compete the facility questionnaire or the resident selection and resident questionnaires in any order, to accommodate the schedules of the facility director and staff.

To decrease the time spent administering the questionnaire while at the ~~facility,~~facility; respondents are given the option to gather information that may require record searches prior to the interview appointment through the use of a Pre-Interview Worksheet sent prior to the interview. The Pre-Interview Worksheet contains items from the facility questionnaire that may require data retrieval from a variety of sources, such as resident or facility records, and is intended to increase efficiency by having data readily available and accessible during the CAPI interview. It is not used as a self-administered questionnaire that would take the place of items in the Facility Questionnaire. The Pre-Interview Worksheet will be retained by the facility director.

4. Efforts to Identify Duplication and Use of Similar Information

In the past decade, a number of federally funded efforts have been initiated to address data needs

about residential care facilities and residents. These efforts provide important building blocks for NSRCF and have been used to inform and guide the design of this study.

National Study of Assisted Living for the Frail Elderly
(OMB Number: 0990-0217, Expired: 12/31/98)
ASPE sponsored the first national survey of residential care in 1998 (Hawes, et al. 2000). This survey focused exclusively on one component of residential care—assisted living. Hawes, et al. found that there was significant variability in the assisted living industry.

Inventory of Long-Term Care Residential Places, 2003
NCHS, the Agency for Healthcare Research and Quality (AHRQ), and ASPE funded a project to develop an inventory of residential places that provide personal assistance. This project developed a methodology for constructing a list of LTC residential places that will be used to develop a sampling frame for NSRCF.

Typology of Long-Term Care Residential Places, 2004
In 2003, NCHS used state licensing criteria and state regulations obtained in the Inventory of Long-Term Care Residential Places, a review of relevant literature, expert opinions, and work by Mollica (2002) describing state residential care and assisted living policy to develop a provider-based typology of LTC places. The typology was further refined during the course of a two-day expert meeting convened by NCHS in January 2004.

State Residential Care and Assisted Living Policy, 2004
ASPE provided funding to RTI International to update a 2002 compendium on assisted living. The compendium described regulatory provisions and Medicaid policy for residential care settings in all 50 states and the District of Columbia. The report summarized state licensing and regulatory approaches, and described various aspects of residential care including negotiated risk agreements, occupancy requirements and privacy provision, disclosure requirements and residency agreements, admission and retention criteria, levels of licensure, services, quality assurance and monitoring, medication administration, training requirements, provisions for residents with Alzheimer's Disease and dementia, staffing and training, and public financing (Mollica and Johnson-Lamarche, 2005).

The Size of the Long-Term Care Population in Residential Care: A Review of Estimates and Methodology, 2005
ASPE contracted with the Urban Institute to understand how different definitions and variations in methodology used in national surveys and the Decennial Census contributed to a range of estimates of the LTC population in residential care (Spillman and Black, 2005). The definitional and methodological issues discussed in the report provided valuable information in developing the survey design, sampling frame, and questionnaires for NSRCF.

AHRQ Efforts Related to Assisted Living/Residential Care, 2005
AHRQ has funded three relevant projects. The first project, conducted by Westat, Inc., reviewed LTC tools and instruments that have been developed to (1) determine the availability and types of services provided in assisted living/residential care, (2) assess the quality of care and services delivered, and (3) develop quality of life measures that could be used or adapted for assisted

living. The second project, conducted through AHRQ's CAHPS® Consortium (a series of cooperative agreements with the American Institutes for Research, Harvard Medical School, and RAND) used a series of focus groups of assisted living stakeholders to determine the needs and priorities for developing improved consumer information and tools. The third project, conducted by Westat and the National Academy for State Health Policy, reviewed how states monitored assisted living and disseminated information to consumers. The study also identified barriers to providing information and identified tools that states could use to help consumers choose facilities that met their needs.

Although the Medicare Current Beneficiary Survey, the National Long-Term Care Survey, and the Health and Retirement Survey cover the residential care population to varying degrees, their small sample sizes of persons in residential care facilities limit the ability to conduct in-depth analyses by type of residential care facility or specific subpopulations of residents (Spillman & Black, 2005). These surveys rarely collect data that distinguish between different types of community-based long-term care residences and frequently lack sufficient sample size to examine the health care status, use, and needs of persons living in residential care communities. Moreover, residents may not be the most appropriate respondents to answer questions about the range of services available to them or provide the information needed to evaluate service quality.

The U.S. Census Bureau conducts two surveys which focus on housing, the American Housing Survey (AHS) and the American Community Survey (ACS). AHS has been conducted on a biannual basis since 1997 and focuses on housing units. A housing unit is a house, apartment, flat, manufactured home, or group of rooms. AHS does not include residential care facilities. ACS collects information such as age, race, income, commute time to work, home value, and other data from U.S. households. In 2006 ACS expanded its definition of U.S. households and now includes some residential care facilities. However, ACS is a population-based survey that cannot produce national estimates of the number of residential care facilities in the United States.

NSRCF will focus directly on residential care facilities and their residents, and will enable analysis on a range of issues of interest to federal and state policymakers, researchers, and providers. Data from NSRCF will give DHHS a database that complements other federal surveys and fills a significant data gap about a major portion of the LTC population.

5. Impact on Small Businesses or Other Small Entities

In order to keep burden a minimum, only a small sample of residential care facilities will be asked to participate in NSRCF. Questions contained in the data collection questionnaires have been held to the minimum required to describe the characteristics of residential care facilities and the residents who live in them. In addition, the number of residents about whom information will be collected is based on the size of the facility. For small (4-10 beds) and medium (11-25 beds) sized facilities, data will be collected for only three residents, compared to four for large facilities (26-100 beds), and six for very large facilities (more than 100 beds).

Field staff will be flexible and adjust to the time constraints of the directors and staff members in all facilities, including small facilities. Administrative burden will be reduced in smaller facilities because they have fewer residents and are likely to know the residents better than in

larger facilities, minimizing the need to review records to obtain answers to many resident questionnaire items.

6. Consequences of Collecting the Information Less Frequently

This survey has not been conducted in the past; only a pilot and pretest have been conducted. Approval is sought for a one-time data collection. The data collected will provide the most current national data possible for health policy analysts, researchers, and numerous other users.

7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

This request fully complies with the regulation 5 CFR 1320.5.

8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

A. The 60-day notice soliciting comments on this new data collection project named National Survey of Residential Care Facilities was posted on June 9, 2009 (Vol. 74, No. 109, pages 27324-27325). A copy of the Federal Register notice can be found in Attachments B. No comments were received.

B. (1) On March 21, 2006, ASPE convened a Technical Expert Panel consisting of experts in the field of residential care, survey design, and statistical methods to discuss the Survey Design Options Memo and a Survey Domains Memo developed by RTI International under ASPE's NSRCF Design contract. During this one-day meeting, the group of experts discussed the content of these materials and provided input on topics, such as the following:

- How the universe of residential care facilities should be defined;
- What the sample design, sample size, and statistical power should be for both facilities and resident surveys;
- What survey domains should be included, and the best source of information for the data elements; and,
- What design option should be used for the ~~survey.~~survey?

A list of panel members is included as Attachment C.

(2) In August 2006, RTI International consulted with two experts in residential care on the process for constructing a sample frame of residential care places.

(3) In September 2006, a subset of the panel provided written comments on the draft survey questionnaires, paying particular attention to the content and the wording of questions in the facility and resident questionnaires. Revisions were made to the questionnaires based on their comments and circulated to the ASPE, AHRQ, and NCHS project staff for review and comment. All the major problems with the survey questionnaires were addressed. A list of those who reviewed and provided input into the

content of the survey questionnaires is included in Attachment D.

(4) The 2008 OMB package for the pretest was reviewed by members of the Interagency Forum on Aging who represent non-DHHS agencies. Representatives of a few agencies requested the two major questionnaires (facility and resident). Minor changes to the supporting statement were made, and suggested changes to the questionnaires were incorporated.

(5) NCHS, ASPE, VA, and AHRQ have collaborated extensively on the design and implementation of NSRCF. More recently, bi-weekly conference calls and meetings have been held with NCHS, ASPE, and the contractor to discuss and prepare for the national data collection effort based on pretest findings.

(6) A joint letter of support has been obtained from associations that represent the residential care and assisted living industries, as was done for the pretest. We have sought support from the following organizations:

- American Association of Homes and Services for the Aging (AAHSA)
- American Seniors Housing Association (ASHA)
- Assisted Living Federation of America (ALFA)
- Board and Care Quality Forum, and
- National Center for Assisted Living (NCAL).

(7) NCHS has met multiple times over the past two years with board members of the Center for Excellence in Assisted Living (CEAL). CEAL is a non-profit collaborative of 11 national organizations whose aim is to promote high-quality assisted living. Representatives from AAHSA, ASHA, ALFA, and NCAL serve on the CEAL board. The goal of these meetings with CEAL board members has been to solicit information from them on 1) best practices for recruiting facilities to participate in NSRCF and 2) ways we can collaborate to inform their respective provider memberships about the importance of NSRCF. Representatives from AAHSA, ASHA, ALFA, and NCAL have agreed to work with NCHS for the national implementation to raise awareness of NSRCF using selected communication channels with their provider members, e.g., association newsletters and websites. The Board and Care Quality Forum, which caters largely to the small-sized facilities, has also pledged support for the national survey, and will work with NCHS to spread the word about the survey among the small facilities.

9. Explanation of Any Payments or Gifts to Respondents

Payments, gifts, or incentives will not be made to directors for agreeing to participate and completing the facility questionnaire in the national study. Likewise, no payments will be offered to staff caregivers who agree to complete questionnaires for sampled residents.

10. Assurance of Confidentiality Provided to Respondents

Confidentiality protection will be provided to respondents as assured by Section 308(d) of the Public Health Service Act (42 USC 242m) as follows:

> "No information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under section... 306 may be used for any purpose other than the purpose for which it was supplied unless such establishment or person has consented (as determined under regulations of the Secretary) to its use for such other purpose and (1) in the case of information obtained in the course of health statistical or epidemiological activities under section... 306 such information may not be published or released in other form if the particular establishment or person supplying the information or described in it is identifiable unless such establishment or person has consented (as determined under regulations of the Secretary) to its publication or release in other form."

In addition, legislation covering confidentiality is provided according to section 513 of the Confidential Information Protection and Statistical Efficiency Act (PL-107-347) which states:

> "Whoever, being an officer, employee, or agent of an agency acquiring information for exclusively statistical purposes, having taken and subscribed the oath of office, or having sworn to observe the limitations imposed by section 512, comes into possession of such information by reason of his or her being an officer, employee, or agent and, knowing that the disclosure of the specific information is prohibited under the provisions of this title, willfully discloses the information in any manner to a person or agency not entitled to receive it, shall be guilty of a class E felony and imprisoned for not more than 5 years, or fined not more than $250,000, or both."

Privacy Impact Assessment Information

A. This submission has been reviewed for Privacy Act applicability and it has been determined that the Privacy Act applies under 09-20-0167 Health Care Statistics.

B. Data will be treated in a confidential manner. The process of informing respondents of the procedures used to keep information confidential begins with materials mailed in advance to facility directors, and will carry through to interviewer training and all communications with the facility staff. Materials will include specific references to protections for the facility and residents. These materials will include all elements of informed consent, including the purpose of the data collection, the voluntary nature of the survey, with whom the information will be shared, and the effect upon the respondent for not participating. These materials will also emphasize and detail procedures intended to keep facility and resident information confidential by the data collectors.

To further aid interviewers in guarding the confidentiality and security of data, all data collected in this project will be collected on laptops that are secured with encryption software. RTI International, the data collection contractor, requires PointSec® software (www.pointsec.com) to be installed on every computer used for data collection. This software encrypts data contained on the computer, and has two levels of password

protection. In the event of computer theft or other loss of the computer, the PointSec® software prevents unauthorized access to any data on the computer, thereby adding an extra layer of security and confidentiality to the data.

C. All informed consent procedures and methods for maintaining confidentiality have been reviewed and approved by the NCHS's Ethics Review Board (see Attachment E).

In the advance package (see Attachment F), the advance letter will inform facility directors that a representative from the data collection contractor will call to ask their permission to visit the facility to conduct the survey. During the call, the recruiter will use a screening questionnaire (see Attachment G) which will outline all informed consent procedures and methods for maintaining confidentiality. All elements of consent will have been covered with the facility director by this point in the process; therefore if the director agrees to set an appointment for the in-person interview, the facility director has effectively consented to participate in the survey.

D. The survey will begin with an initial telephone call to the facility to obtain or confirm the director's name and to confirm the facility mailing address, followed by the mailing of the advance package (see Attachment F). The advance package will contain an advance letter introducing the study, a Frequently Asked Questions document, a letter of support from key associations that represent residential care providers, a Confidentiality brochure, and an NSRCF brochure. The advance letter will inform the director of the purpose and content of the survey. In addition to explaining the confidentiality of the information provided and voluntary participation, the letter includes a reference to the legislative authority for the survey, and an explanation of how the data will be used. This letter will also emphasize that data collected about the facility and its residents will never be linked to their names or other identifying features. If necessary, a copy of this letter will be mailed to corporate offices of sampled facilities that are part of a chain of facilities. The letter will serve to inform corporate office staff about the survey so that if facilities say that they need permission to participate, the corporate office will have knowledge of the study.

11. Justification for Sensitive Questions

The majority of items on the questionnaires for residential care facilities and their residents are not sensitive in nature. Data collected in the resident questionnaire will not include protected health information or resident identifiers. Our study protocols and questionnaires do not contain questions about sensitive issues, such as sexual preferences or attitudes, or about potentially illegal behaviors, such as use of illicit drugs. Nor do we ask about religious preferences or beliefs. We do ask facility staff for information about residents that may be considered private, such as continence, and resident's behavior, which includes socially inappropriate or physically abusive behaviors. Since one of the expected uses of the data collected in this survey is to understand the nature of the disabilities and care needs of individuals in residential care facilities, it is important to collect this information.

Questions that may appear sensitive, such as charges for services, are included in the

questionnaires. These are well-established questions similar to those used extensively in previously OMB approved surveys with no evidence of harm. As described earlier, all respondents are assured of the confidentiality of the data at the outset of the interview and informed that they do not have to answer any questions with which they are uncomfortable.

Since NSRCF does not involve collecting protected health information (e.g., personal identifiers such as name, social security number, birth date, or Medicare/Medicaid numbers), the survey is not subject to the Privacy Rule, mandated by the Health Insurance Portability and Accountability Act (HIPAA).

12. Estimates of Annualized Burden Hours and Costs

A. Burden Hours

For the national survey it is expected that 2,250 facilities will respond from a sample of 3,600 facilities drawn for the survey, over the two year clearance period. A total of 2,250 facility directors will be interviewed, and information will be collected on a maximum sample of 8,450 residents. Information about residents will be obtained from facility staff serving as respondents to complete a questionnaire on each sampled resident. Residents will not be interviewed. Table 1 includes the average annual burden for the national survey over the two year clearance. The estimate of annualized burden for the national survey is 3,572 hours.

Table 1: Estimated Annualized Burden Hours

Type of Respondent	Name of Form	Number of Responses/ Respondent	Average Burden/ Response (in hours)	Average Burden/ Response[1] (in hours)	Response Burden in Hours
Facility Director	Facility Screener	1125	1	10/60	188
Facility Director	Resident Selection	1125	1	10/60	188
Facility Director	Pre-Interview Worksheet	1125	1	15/60	281
Facility Director	Facility Questionnaire	1125	1	1.25	1,406
Facility Director or Staff Member	Resident Questionnaire	1125	4	20/60	1,500
Facility Director	Verification Form	113	1	5/60	9
Total					**3,572**

[1]based on results from the pretest

B. Cost to Respondents

The only cost to facilities is the time of directors and facility staff used to prepare for and participate in the survey. The estimated annualized cost for the national survey is $112,530 (Table 2).

Table 2: Estimated Annualized Costs for the National Survey[1, 2, 3]

Type of respondent	Total Burden Hours	Hourly Wage Rate	Total Respondent Cost
Facility Director	2,822	$37.04	$104,527
Facility Staff	750	$10.67	$8,003
Total			**$112,530**

Information on May 2008 salaries of facility directors was obtained from the following website http://www.bls.gov/oes/current/oes119111.htm#ind. Accessed on July 15, 2009. The closest description to residential care facility directors is the nursing facility management category. According to the website, Nursing Care Facilities is part of NAICS 623000 - Nursing and Residential Care Facilities.

2 Information on salaries of direct care workers was obtained from the following web site http://www.directcareclearinghouse.org/s_state_det.jsp?action=view&res_id=52&x=13&y=13. Accessed on July 15, 2009. The hourly rate for a Certified Nurse Assistant was used to calculate the total cost to the respondent.

3 Data in table based on pretest findings that 60 percent of the time the facility director responded to all parts of the survey and 40 percent of the time a facility director responded to the facility screener, resident selection, pre-interview worksheet, and facility questionnaire, and a staff member responded to the resident questionnaire.

13. Estimates of Other Total Annual Cost Burden to Respondents and Record Keepers

Not applicable to this survey. There are no additional costs to the respondents.

14. Annualized Cost to the Federal Government

The estimated total cost to the Government is shown in Exhibit 1.

Exhibit 1: Estimated Annualized Costs to the Government

Item/Activity	Details	$ Amount
NCHS oversight of contractor and project, editing, weighting, and analyzing data	Cost for staff, travel, and supplies	$662,758
Data Collection (Contractor)	Field staff costs, including training, travel, data collection costs, and other direct costs	$2,404,334

Estimated Total Cost	**$3,067,092**

15. Explanation for Program Changes or Adjustments

The estimated annual burden has changed from 2,778 hours to 3,572 hours, an increase of 794 hours. The current annualized burden estimates are just for the national survey, since the pretest has already been completed. The national survey has a higher burden because the facility questionnaire in the pretest took longer than expected, by 35 minutes on average. The annualized burden also now covers a two year period rather than a three year period.

16. Plans for Tabulation and Publications and Project Time Schedule

OMB clearance is requested for a period of two years. Major milestones and the corresponding due dates are shown in Exhibit 2.

Exhibit 2: Major Milestones and Planned Dates

Major NSRCF Milestones	Due Dates
Draw sample for National Survey	12/2009
Train Supervisors, Recruiters, and Interviewers	02/2010-4/2010
National Survey Begins	04/2010
National Survey Ends	10/2010
Final Data Collection Report from the Contractor	12/2010
Public-Use Data File Complete	02/2012

A public use data file with no identifiers and no linking information will be made available from the national survey. NCHS will also release standard publications based on the data collected in the national survey.

17. Reason(s) Display of OMB Expiration Date is Inappropriate.

No exemption requested.

18. Exceptions to Certification for Paperwork Reduction Act Submission

There are no exceptions to the certification.