Attachment 1 – Long Term Care Items to be cognitively tested

The Public Health Service Act provides us with the authority to do this research (42 United States Code 242k). All information which would permit identification of any individual, a practice, or an establishment will be held confidential, will be used for statistical purposes only by NCHS staff, contractors, and agents only when required and with necessary controls, and will not be disclosed or released to other persons without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).

Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0222).

OMB #0920-0222; Expiration Date: 03/31/2013

2012 National Survey of Long-Term Care Providers (NSLTCP) Questions

1. Ownership status
   a. What is the type of ownership of this facility/ center?
      1=For profit
      2=Private nonprofit
      3=State, county or local government
      4=Other (Please specify______________________)

2. Chain status
   a. Is this facility/ center owned by a chain, group, or multi-facility system? A chain means more than one facility under common ownership or management.
      1=Yes
      2=No

3. Joint affiliation
   a. [Residential Care Facilities] Is this facility 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?
      1=Yes
      2=No

b. Is this facility/ center owned by or in operation or affiliated with any other type of place or organization?
   2=No
   1=Yes: If yes, which one(s)?
      1=Hospital
      2=Skilled nursing facility/ Nursing home
      3=Home Health Agency
      7=Other (Please specify)________________________

4. Medicaid
   a. Does Medicaid pay for any of the long-term care services that this residential care facility/ adult day care center provides its participants?
      1=Yes
      2=No

5. Size
   a. [Residential Care Facilities] At this facility, what is the number of licensed, registered, or certified residential care beds? Include both occupied and unoccupied beds.
      _________ Beds

   b. [Adult Day Services Center] What is the maximum number of participants that this adult day services center can serve on a given day?
      _________ Participants

6. Number of residents/ participants
   a. [Residential Care Facilities] What is the current number of residents living at this residential care facility?
      _________ Residents

   b. [Adult Day Services Center] In total, how many different participants did this center provide services to last week?
      _________ Participants

7. Years in operation
   a. What is the total number of years this facility/ center has been operating as a residential care facility/ adult day services center at this location?
      ______ Year(s)

8. Revenue mix

a. About what percentage of this facility's/ center's total revenue comes from the following payment sources? If none, please enter "0." Your entries should add up to 100%.

____ % Private insurance
____ % Resident/ participant/family payments (e.g., out-of-pocket payment)
____ % Government/public program payment source (e.g., Medicaid Home and Community-Based Waiter programs, Veteran's Administration, state and local funding)
____ % Other (obtain source(s) during cognitive testing)

Total 100 %

9. [Residential Care Facilities only] Dedicated dementia/Alzheimer's disease care units

a. Does this residential care facility have a distinct unit, wing, or floor that is designated as a dementia or Alzheimer's special care unit?

1= Yes
2= No

b. (If yes to 9a), in the dementia or Alzheimer's special care units, please tell me the number of licensed beds.

______ Beds

c. (If yes to 9a) What is the current number of residents living n the dementia/ Alzheimer's unit?

______ Residents

10. Electronic health records

a. Other than for accounting or billing purposes, does this facility/ center use Electronic Health Records? This is a computerized version of the resident's/client's health and personal information used in the management of the resident's/client's health care.

1= Yes

2= No

b. Which of the following computerized capabilities does this facility/center have? Please select all that apply.
___ Resident/Client demographics
___ Medical provider information
___ Functional assessments
___ Individual service plans
___ Clinical notes, such as medical history and daily progress notes
___ Patient problems list
___ Medication administration
___ Maintaining list of resident's/client's medications
___ Maintaining active medication allergy list
___ Orders for prescriptions
___ Warning of drug interactions or contraindications
___ Orders for tests
___ Viewing laboratory/imaging results
___ Reminders for guideline based interventions or screening tests
___ Discharge and transfer summaries
___ Public health reporting
___ None of the above

11. Services

a. Does this facility/ center provide any of the following services to residents/ participants of this facility?

	Not provided	Who provides?		Where provided?	
		Employees	Contract workers	On-site	Off-site
Dental/ oral hygiene services					
Dietary/ nutritional services					
Hospice					
Medical social worker services					
Mental health services					
Occupational therapy					
Personal care (i.e., assistance with activities of daily living)					
Pharmacy services					
Physical therapy					
Physician services					

Skilled nursing services					
Speech therapy					

12. Staff type
    a. How many full-time and part-time employees work in this facility/ center? Please make an entry for each type of employee. Please do not include contract workers. If the answer is "None," enter "0" in the answer space for the type of employee.

	Number of full-time employees		Number of part-time employees		FTE employees
Administrators/ Assistant administrators					
Registered Nurses (RN)					
Licensed Practical Nurses (LPN) or Licensed Vocational Nurses (LVN)		AND		OR	
Certified Nursing Assistants (CNA) or Certified Nurse Aides					
Non-certified Nurse Aides					
Dieticians/Nutritional counselors					
Occupational therapists					
Medical social workers					
Pharmacists					
Physical therapists					

13. [Residential Care Facilities only] Admissions
    a. How many residents moved into this facility over the past 12 months? Please count each couple as 2 residents. Also, do not include someone returning from a hospital stay if this facility held the bed for the resident.
    _____ Residents

14. [Residential Care Facilities only] Discharges
    a. Over the last 12 months, how many residents moved out of this facility? Exclude someone who has moved out if the facility is currently holding a bed for the resident. Exclude deaths.

    _____ Residents

15. Demographic characteristics of LTC recipients
    a. Gender
        i. How many residents/participants are male?
        ii. How many residents/participants are female?
    b. How many residents/participants are in the following age categories?
        i. 17 and under
        ii. 18-54 years
        iii. 55-64 years
        iv. 65-74 years
        v. 75-84 years
        vi. 85 years and older
    c. Race
        i. How many residents are White or Caucasian?
        ii. How many residents are Black or African American?
        iii. How many residents are Asian?
        iv. How many residents are Native Hawaiian or other Pacific Islander?
        v. How many residents are American Indian or Alaska Native?
    d. Ethnicity
        i. How many residents are of Hispanic, Latino, or Spanish origin or descent?
    e. Primary payment source (ADS)
        i. What percentage of participants has Medicaid as their primary source of payment for fees?

16. Physical functioning of LTC recipients
    a. What percentage of residents/ participants currently receive assistance in:
        i. Transferring in and out of bed or a chair?
        ii. Eating?
        iii. Dressing
        iv. Toileting
        v. Bathing?
        vi. Walking?

17. Cognitive functioning of LTC recipients
    a. What percentage of current residents/participants has short-term memory problems or seems disoriented most of the time?

18. Tenure of administrator or director

a. How long have you worked at this residential care facility/ adult day service center as the administrator or director? Please include the total time worked even if you have left the facility and then returned.

____ Year(s) and _____ Month(s)

b. [Residential care facility] How long, in total, have you worked at this and other residential care facilities or nursing homes in an administrative position?

____ Year(s) and _____ Month(s)

c. [Adult day service center] How long, in total, have you worked at this and other adult day service center in an administrative position?

____ Year(s) and _____ Month(s)

19. Educational background of administrator or director

a. What is the highest degree of any kind that you hold? Please select one.

__ Diploma Degree in Nursing
__ Associates Degree in Nursing
__ Associates Degree in health related (Please specify: ___________________)
__ Associates Degree in not health related (Please specify: ________________)
__ Bachelors Degree in Nursing
__ Bachelors Degree in health related (Please specify: ____________________)
__ Bachelors Degree not health related (Please specify: ___________________)
__ Masters Degree in Nursing
__ Masters Degree in health related (Please specify: ______________________)
__ Masters Degree in not health related (Please specify: ___________________)
__ Other (Please specify _________________)