

Attachment C: ADSC Questionnaire Items



Form Approved
OMB No. XXXX-XXXX
Exp. Date __xx/xx/20xx

2012 National Study of Long-Term Care Providers (NSLTCP)

Dear Administrator/Executive Director,

The Centers for Disease Control and Prevention's National Center for Health Statistics is conducting the National Study of Long-Term Care Providers (NSLTCP), a new national survey to be conducted every two years on about 5,000 adult day services centers. RTI International has been contracted to carry out the data collection.

Please answer all of the questions in reference to this adult day services center. If this center is part of a multi-facility campus, please only answer for the adult day services center portion of the campus. The accuracy of your answers is important to this voluntary survey.

If you need assistance or have any questions while completing this questionnaire, please call 1-800-###-#### to speak to a member of the NSLTCP project team.

Thank you for taking the time to complete this questionnaire.

Sincerely,

Angela M. Greene
Project Director, RTI International

NOTICE – Public reporting burden of this collection of information is estimated to average 30 minutes per response. 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 (XXXX-XXXX).

Assurance of Confidentiality – All information which would permit identification of an 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 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).

INSTRUCTIONS:

- Please clearly mark your responses in the boxes provided _____ Examples or
- Written answers should be printed in the space provided _____ Example

25

Please refer to center records or request assistance from other staff if you need help answering any question.

1. Background Information

Please provide answers only for the adult day services portion of your campus.

1. Is this adult day services center part of 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 provides participants the opportunity to remain in the same community as their needs change?

- Yes
- No

2. What is the type of ownership of this adult day services center?

- Private, nonprofit
- Private, for profit
- Publically traded or limited liability company (LLC)
- Government – federal, state, county or local government

3. Is this center owned by a person, group or organization that owns or manages **two or more adult day services centers**? This may include a corporate chain.

- Yes
- No

4. Is this adult day services center owned by any other type of organization?

- No, not part of another organization
- Yes



4a. For each item below, please indicate whether or not this type of organization owns this center.

	Yes	No
a. Hospital	•	•
b. Nursing Home or Skilled Nursing Facility	•	•
c. Home Health Agency	•	•
d. Hospice Agency	•	•
e. Assisted living or Residential Care Community	•	•
f. Other	•	•

5. What is the total number of years this center has been operating as an adult day services provider at this location?

_____ Year(s)

6. Is this adult day services center certified or otherwise set up to participate in Medicaid, either through the Medicaid State Plan or a home and community-based services waiver program?

- Yes
- No

7. What is the total number of participants currently enrolled at this center?

_____ Number of participants

8. During the last 30 days, how many of your participants currently enrolled at this center had some or all of their long-term care services paid by Medicaid?

_____ Number of participants (or) None

10. Of the center's revenue from paid participant fees, about what percentage comes from each of the following sources? Your entries should add up to 100%.

- | | |
|--|--------|
| a. Medicaid? | _____% |
| b. Medicare? | _____% |
| c. Other government? | _____% |
| d. Out-of-pocket payment by participant or family? | _____% |
| e. Private insurance? | _____% |
| f. Other source? | _____% |
| TOTAL | 100% |

11. Is this center **specifically** licensed or certified by the state to provide adult day services?

- Yes
- No

12. Is this center licensed or certified under some other type of provider? For example: nursing home, rehabilitation center, or hospital.




- Yes
- No






14. **Other than from Medicaid**, does this adult day services center receive funding from any federal, state, county or city community care agencies? For example, Older American Act Funding, State Unit on Aging, Area Agencies on Aging, or Councils on Aging.




- Yes
- No

2. Services Offered at this Adult Day Services Center
Please provide answers only for the adult day services portion of your campus.

15. For each service listed below, please indicate whether or not this service is provided directly or through arrangement. Providing services through arrangement excludes referring participants to service providers.

Type of service	Does this center provide or arrange for this service for its participants?	IF YES Is this service provided directly by residential care community employees, provided by others through arrangement, or both?
a. Routine and emergency dental services by a licensed dentist	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Provided directly by center employees <input type="checkbox"/> Provided by others through arrangement <input type="checkbox"/> Provided by center employees and by others through arrangement
b. Hospice services	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Provided directly by center employees <input type="checkbox"/> Provided by others through arrangement <input type="checkbox"/> Provided by center employees and by others through arrangement
c. Social work services Social work services are provided by licensed social workers or persons with a bachelor's or master's degree in social work, and include an array of services such as psychosocial assessment, individual or group counseling, and referral services.	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Provided directly by center employees <input type="checkbox"/> Provided by others through arrangement <input type="checkbox"/> Provided by center employees and by others through arrangement

<p>d. Any case management services</p> <p>Case management is generally a process of assessment, planning, and facilitation of options and services for an individual.</p>	<p>Yes</p> <p>No</p>	<p>Provided directly by center employees</p> <p>Provided by others through arrangement</p> <p>Provided by center employees and by others through arrangement</p>
<p>e. Mental health services</p> <p>Mental health services are services that target participants' mental, emotional, psychological, or psychiatric well-being and include diagnosing, describing, evaluating, and treating mental conditions.</p>	<p><input type="checkbox"/> Yes </p> <p><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Provided directly by center employees</p> <p><input type="checkbox"/> Provided by others through arrangement</p> <p><input type="checkbox"/> Provided by center employees and by others through arrangement</p>
<p>f. Any therapeutic services- physical, occupational, or speech</p>	<p><input type="checkbox"/> Yes </p> <p><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Provided directly by center employees</p> <p><input type="checkbox"/> Provided by others through arrangement</p> <p><input type="checkbox"/> Provided by center employees and by others through arrangement</p>
<p>g. Pharmacy services- including filling of and delivery of prescriptions</p>	<p><input type="checkbox"/> Yes </p> <p><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Provided directly by center employees</p> <p><input type="checkbox"/> Provided by others through arrangement</p> <p><input type="checkbox"/> Provided by center employees and by others through arrangement</p>
<p>h. Podiatry services</p>	<p><input type="checkbox"/> Yes </p> <p><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Provided directly by center employees</p> <p><input type="checkbox"/> Provided by others through arrangement</p> <p><input type="checkbox"/> Provided by center employees and by others through arrangement</p>
<p>i. Skilled nursing services</p> <p>Skilled nursing services are services that must be performed by a registered nurse (RN) or a licensed practical nurse (LPN) and are medical in nature.</p>	<p><input type="checkbox"/> Yes </p> <p><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Provided directly by center employees</p> <p><input type="checkbox"/> Provided by others through arrangement</p> <p><input type="checkbox"/> Provided by center employees and by others through arrangement</p>

j. Transportation services for medical or dental appointments	<input type="checkbox"/> Yes  <input type="checkbox"/> No	Provided directly by center employees <input type="checkbox"/> Provided by others through arrangement <input type="checkbox"/> Provided by center employees and by others through arrangement
k. Transportation services for social and recreational activities, or shopping	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Provided directly by center employees <input type="checkbox"/> Provided by others through arrangement <input type="checkbox"/> Provided by center employees and by others through arrangement
l. Daily round trip transportation to/from this center	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Provided directly by center employees <input type="checkbox"/> Provided by others through arrangement <input type="checkbox"/> Provided by center employees and by others through arrangement

16. Of the participants currently enrolled at this center, for about how many do you manage, supervise, or store medications, administer medications, or provide assistance with self-administration of medications?

_____ Number of participants (or) None

17. As a part of admission process, does this center screen participants for **depression** with a standardized tool such as the Geriatric Depression Scale, Beck Depression Inventory, or Center for Epidemiological Studies-Depression screen?

- Yes
- No

18. Disease-specific programs may include one or more of the following services—educational programs, physical activity programs, diet/nutrition programs, medication management programs, and weight management programs. For each condition below, please indicate whether or not this center offers any of these services to participants.

	Yes	No
a. Alzheimer’s disease and other dementias	•	•
b. Depression	•	•
c. Diabetes	•	•
d. Cardiovascular disease (e.g., heart disease, high blood pressure, stroke)	•	•

19. On a regular basis, does this center create daily schedules based on individual participant's life history, abilities, and interests?

- Yes
- No

20. On a regular basis, does this center seek input from participants and their families into...

- | | Yes | No |
|---|--------------------------|--------------------------|
| a. What personal care services are received by the participant? | <input type="checkbox"/> | <input type="checkbox"/> |

21. Does this community give participants choices in each of the following ways?

- | | Yes | No |
|----------------------|--------------------------|--------------------------|
| a. Meal times? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Meal types/menus? | <input type="checkbox"/> | <input type="checkbox"/> |

3. Staff Profile
Please consult records as needed to answer questions.
Please provide answers only for the adult day services portion of your campus.

The next questions are about center staff that currently works at this adult day services center.

This includes:

- both full-time and part-time center employees, and
- other individual or organization staff under contract with and working at this center full-time and part-time.

An individual is considered a center employee if the center is required to issue a Form W-2 on their behalf

22. How many of the following staff currently work at this adult day services center?

Current Center Staff		Number of Full Time Staff	Number of Part Time Staff		Number of FTE (Full-time equivalent) staff
If you do not have any staff for a specific category, please enter "0" under number of full time / part time staff.					
a. Registered Nurses (RN)	Center employee	___	___	(or)	___
	Contract staff	___	___	(or)	___
b. Licensed Practical Nurses (LPN) / Licensed Vocational Nurses (LVN)	Center employee	___	___	(or)	___
	Contract staff	___	___	(or)	___
e. Social Workers Licensed social workers or persons with a bachelor's or master's degree in social work	Center employee	___	___	(or)	___
	Contract staff	___	___	(or)	___
i. Certified nursing assistants, nursing assistants, home health aides, home care aides, personal care assistants, and medication technicians or medication aides. Note: Exclude employees/staff that were included in previous rows.	Center employee	___	___	(or)	___
	Contract staff	___	___	(or)	___

ADD: ON an average shift, how many activities director or activity staff are on site providing services? Include community employees and contract staff

4. Resident Profile
 Please consult records as needed to answer questions.
 Please provide answers only for the adult day services portion of your campus.

23. What is the maximum number of participants allowed at your adult day services center at this location? This may be called the allowable daily capacity and is usually determined by law or by fire code, but may also be a program decision.

____ Maximum number of participants allowed

24. Based on a typical week, what is your approximate average daily attendance at this location?

____ Average daily attendance of participants

25. Of the participants currently enrolled at this center, how many are...		
<p>25a. Of the participants currently enrolled at this center, how many are in each of the following categories? Count each participant only once. Enter "0" for any categories with no participants. Total should be the same as the total number of participants currently enrolled in this center.</p> <p>____ Hispanic or Latino, of any race ____ American Indian or Alaska Native, not Hispanic or Latino ____ Asian, not Hispanic or Latino ____ Black, not Hispanic or Latino ____ Native Hawaiian or Other Pacific Islander, not Hispanic or Latino ____ White, not Hispanic or Latino ____ Two or more races, not Hispanic or Latino ____ Some other category reported in this center's system ____ Not reported (race and ethnicity unknown)</p> <p>____ TOTAL</p>	<p>25b. Gender distribution</p> <p>____ Male ____ Female</p> <p>____ TOTAL</p>	<p>25c. Age distribution</p> <p>____ 17 or less ____ 18 - 44 years ____ 44 - 54 ____ 55 - 64 years ____ 65 - 74 years ____ 75 - 84 years ____ 85 years and older</p> <p>____ TOTAL</p>

<p>NOTE: Please make sure that the total number of participants for each of the 3 columns is the same as the number provided in question 7.</p>		

26. Of the participants currently enrolled at this center, how many live in:

- | | Number of participants |
|---|------------------------|
| a. an assisted living or similar residential care community (e.g. adult care or personal care residence)? | _____ |
| b. a private residence (house or apartment)? | _____ |
| c. a nursing home or other institutional setting? | _____ |
| d. some other place? | _____ |
| TOTAL | _____ |

NOTE: Please make sure that the total number of participants is the same as the number provided in question 7.

ADD: Based on a typical week, how many participants attend the program so that their caregivers can receive respite?

_____ Number of participants (or) None

Now please think about the last 12 months.

27. In the last 12 months, how many participants died? Exclude respite care participants.

_____ Number of participants (or) None

28. In the last 12 months, how many participants permanently stopped using this adult day services center? Include all departures, regardless of reason, but exclude deaths and respite care participants.

_____ Number of participants (continue)

None (skip to question 32)

29. In the last 12 months, of those participants who stopped using this center, how many left because the cost of attending the center, including meals and services required to meet their needs, exceeded their ability pay? Exclude respite care participants.

_____ Number of participants (or) None

30. Where did each of these participants go immediately after they stopped using the center?

Number of Participants

- a. Another adult day services center _____
 - b. an assisted living or similar residential care
community (e.g. adult care or personal care residence)? _____
 - c. A hospital _____
 - d. A nursing home _____
 - e. A private residence (house or apartment) _____
 - f. Some other place _____
- TOTAL _____

NOTE: Total should be the same as provided in question 29.

31. In the last 12 months, how many participants were newly enrolled into this center? Count all participants who were newly enrolled- including participants who later died and participants who are no longer enrolled, regardless of the reason

_____ Number of participants (or) None

These next questions ask about the number of participants at this adult day services center who currently need assistance in activities of daily living (ADLs). **Assistance refers to needing any help or supervision from another person, or use of special equipment.** As a reminder, please provide answers only for **adult day services center portion** of your campus.

32. Of the participants currently enrolled at this center, **about** how many need **any assistance...**

Number of Participants

- a. transferring in and out of bed? _____ (or) None
- b. transferring in and out of a chair? _____ (or) None
- c. with eating, like cutting up food? _____ (or) None
- d. with dressing? _____ (or) None
- e. with bathing or showering? _____ (or) None
- f. in using the bathroom (toileting)? _____ (or) None
- g. with locomotion or walking? This includes using a cane,
walker, or wheelchair and/or help from another person? _____ (or) None

33. Of the participants currently enrolled at this center, about how many use a manual, electric, or motorized wheelchair or scooter?

____ Number of participants (or) None

34. Of the participants currently enrolled at this center, about how many have been diagnosed with each of the following conditions?

	Number of participants	
a. Alzheimer's disease or other dementia	_____	(or) <input type="checkbox"/> None
b. Developmental disability, such as mental retardation, autism, or Down Syndrome	_____	(or) <input type="checkbox"/> None
c. Severe mental illness, such as schizophrenia and psychosis	_____	(or) <input type="checkbox"/> None
d. Depression	_____	(or) <input type="checkbox"/> None

35a. Before or upon admission, does this center conduct a formal assessment of its participants using a standardized tool to identify anyone with a cognitive impairment?

- Yes (*continue*)
- No (*skip to question 38a*)

36b. Of the participants currently enrolled at this center, based on this assessment about how many have been identified as having a cognitive impairment?

_____ Number of participants (or) None

37a. Of the participants currently enrolled in this center, how many were discharged from an overnight hospital stay in the last 90 days (exclude trips to the hospital emergency department that did not result in an overnight hospital stay)?

_____ Number of participants (*continue*)
 None (*skip to question 39*)

37b. Of the participants who were discharged from an overnight hospital stay in the last 90 days, how many of those participants were **re-admitted** to the hospital for an overnight stay within 30 days of their hospital discharge?

_____ Number of participants (or) None

38. Of the participants currently enrolled at this center, how many were treated in a hospital emergency department in the last 90 days?

_____ Number of participants (or) None










5. Record Keeping

Please provide answers only for the adult day services portion of your campus.











39. Other than for accounting or billing purposes, does this adult day services center use Electronic Health Records? This is a computerized version of the participant's health and personal information used in the management of the participant's health care.

- Yes
 No

40. For each item (a – s) below, please indicate in column 1 whether or not this adult day services center **collects or tracks this information** about residents. If this center does collect or track the information, please indicate in Column 2 whether this community has the **computerized capability** to collect or track it.

	<u>Column 1</u>			<u>Column 2</u>	
	Does this center collect/track this information?		IF YES IN COLUMN 1	Does this center have the computerized capability to collect/track this information?	
	[] No	[] Yes		[] No	[] Yes
a. Contact information for the participant's medical providers	[] No	[] Yes		[] No	[] Yes
b. Participant demographics	[] No	[] Yes		[] No	[] Yes
c. Functional assessments	[] No	[] Yes		[] No	[] Yes
d. Individual service plans	[] No	[] Yes		[] No	[] Yes
e. Participant service records (a record of the services being provided to each participant)	[] No	[] Yes		[] No	[] Yes
f. Clinical notes, such as medical history and daily progress notes	[] No	[] Yes		[] No	[] Yes
g. Participant problem list (medical and behavioral concerns)	[] No	[] Yes		[] No	[] Yes
h. Advance directives	[] No	[] Yes		[] No	[] Yes
i. Automatic reminders for updating records, scheduling screening tests	[] No	[] Yes		[] No	[] Yes

or guidelines based interventions

- | | | | | | |
|--|-----------------------------|------------------------------|--|-----------------------------|------------------------------|
| j. Lists of medications | <input type="checkbox"/> No | <input type="checkbox"/> Yes |  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| k. Medication administration records | <input type="checkbox"/> No | <input type="checkbox"/> Yes |  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| l. Active medication allergy lists | <input type="checkbox"/> No | <input type="checkbox"/> Yes |  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| m. Warning of drug interactions or contraindications | <input type="checkbox"/> No | <input type="checkbox"/> Yes |  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| n. Discharge and transfer summaries | <input type="checkbox"/> No | <input type="checkbox"/> Yes |  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| o. Outside health care visits: including emergency room visits and overnight hospital admissions | <input type="checkbox"/> No | <input type="checkbox"/> Yes |  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| p. Orders for prescriptions | <input type="checkbox"/> No | <input type="checkbox"/> Yes |  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| q. Orders for tests | <input type="checkbox"/> No | <input type="checkbox"/> Yes |  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| r. Viewing laboratory / imaging results (seeing and reading test results) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| s. Public health reporting | <input type="checkbox"/> No | <input type="checkbox"/> Yes |  | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

41. For each item below, please indicate whether or not this adult day services center’s computerized system support **electronic health information exchange**.

- | | <u>Yes</u> | <u>No</u> |
|--------------|--------------------------|--------------------------|
| a. Physician | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Pharmacy | <input type="checkbox"/> | <input type="checkbox"/> |

7. Contact Information

We would like to reach you if we have questions about your answers. Please provide your name, telephone number, and job title. Your contact information will be kept confidential and will not be shared with anyone.

Your name: _____

Your work telephone number: (____) ____ - _____

Your job title: _____

Thank you for participating in the NSLTCP. Please return your completed survey in the postage-paid self-addressed envelope provided to:

NSLTCP, RTI International,
Suite 100 Imperial Court Business Park, 1000 Parliament Court,
Durham, NC 27703