

Attachment 1b: Residential Care Community (RCC) Questionnaire to be Evaluated

CDC estimates the average public reporting burden for this collection of information as 60 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information 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 Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0222).

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(d)) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).



National Study of Long-Term Care Providers

2016 Residential Care Community Questionnaire

Dear Administrator or Executive Director,

The Centers for Disease Control and Prevention conducts the National Study of Long-Term Care Providers. Please complete this questionnaire about the residential care community at the location listed below.

- **If this residential care community is part of a multi-facility campus or has more than one residential care license, answer only for the place listed below.**
- Please consult records and other staff as needed to answer questions.
- If you need assistance or have questions, go to <http://www.cdc.gov/nchs/nsltcp.htm> or call 1-866-245-8078.

(B)

Label here



Residential care places are known by different names in different states. We refer to all of these places and others like them as residential care communities.

Just a few terms used to refer to these places are assisted living, personal care, and adult care homes, facilities, and communities; adult family and board and care homes; adult foster care; homes for the aged; and housing with services establishments.

Thank you for taking the time to complete this questionnaire.

1 Background Information

1. Is this residential care community currently licensed, registered, certified, or otherwise regulated by the State?

- Yes
 No

If you answered “No,” skip to question 35 on page 8.

2. At this residential care community, what is the number of licensed, registered, or certified residential care **beds**? Include both occupied and unoccupied beds.

If this residential care community is licensed, registered, or certified by **apartment or unit**, please count the number of single-resident apartments or units as one bed each, two-bedroom apartments or units as two beds each, and so forth.

If none, enter “0.”

Number of beds

If you answered fewer than 4 beds, skip to question 35 on page 8.

3. Does this residential care community **only** serve adults with...

MARK YES OR NO IN EACH ROW

	Yes	No
a. an intellectual or developmental disability?	<input type="checkbox"/>	<input type="checkbox"/>
b. severe mental illness, such as schizophrenia and psychosis?	<input type="checkbox"/>	<input type="checkbox"/>

Do not include Alzheimer’s disease or other dementias.

If you answered “Yes” to either 3a or 3b, skip to question 35 on page 8.

4. Does this residential care community offer at least two meals a day to residents?

- Yes
 No

If you answered “No,” skip to question 35 on page 8.

5. What is the total number of residents currently living at this residential care community? Please include residents for whom a bed is being held while in the hospital. If you have respite care residents, please include them. **If none, enter “0.”**

Number of residents

If you answered “0,” skip to question 35 on page 8.

6. Does this residential care community provide or arrange for **any** of the following types of staff to be on site 24 hours a day, 7 days a week to meet any resident needs that may arise?

On site means the staff are located in the same building, in an attached building or next door, or on the same campus.

MARK A RESPONSE IN EACH ROW

	On an as-needed basis		
	Yes		No
a. Personal care aide or staff caregiver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Director, assistant director, administrator or operator (if they provide personal care or nursing services to residents)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered “No” to 6a, 6b, and 6c, skip to question 35 on page 8.

7. Does this residential care community offer...

MARK YES OR NO IN EACH ROW

	Yes	No
a. help with activities of daily living (ADLs), such as help with bathing, either directly or arranged through an outside vendor?	<input type="checkbox"/>	<input type="checkbox"/>
b. assistance with medications, such as the administration of medications, give reminders, or provide central storage of medications?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered “No” to 7a and 7b, skip to question 35 on page 8.

8. What is the type of ownership of this residential care community?

MARK ONLY ONE ANSWER

- Private—nonprofit
- Private—for profit
- Publicly traded company or limited liability company (LLC)
- Government—federal, state, county, or local

9. Is this residential care community authorized or otherwise set up to participate in Medicaid?

- Yes
- No

If you answered “No,” skip to question 11.

10. During the **last 30 days**, for how many of the residents currently living at this residential care community did Medicaid pay for some or all of their services received at this community? **If none, enter “0.”**

Number of residents

11. An electronic health record (EHR) is a computerized version of the resident’s health and personal information used in the management of the resident’s health care. Other than for accounting or billing purposes, does this residential care community use electronic health records?

- Yes
- No

12. Does this residential care community’s computerized system support **electronic health information exchange** with each of the following providers? Do not include faxing.

MARK YES OR NO IN EACH ROW

	Yes	No
a. Physician	<input type="checkbox"/>	<input type="checkbox"/>
b. Pharmacy	<input type="checkbox"/>	<input type="checkbox"/>
c. Hospital	<input type="checkbox"/>	<input type="checkbox"/>

13. Is this residential care community owned by a person, group, or organization that owns or manages **two or more residential care communities**? This may include a corporate chain.

- Yes
- No

2 Resident Profile

14. Of the residents currently living in this residential care community, what is the racial-ethnic breakdown? Count each resident only once. **Enter “0” for any categories with no residents.**

	NUMBER OF RESIDENTS
a. Hispanic or Latino, of any race	<input type="text"/>
b. American Indian or Alaska Native, not Hispanic or Latino	<input type="text"/>
c. Asian, not Hispanic or Latino	<input type="text"/>
d. Black, not Hispanic or Latino	<input type="text"/>
e. Native Hawaiian or other Pacific Islander, not Hispanic or Latino	<input type="text"/>
f. White, not Hispanic or Latino	<input type="text"/>
g. Two or more races, not Hispanic or Latino	<input type="text"/>
h. Some other category reported in this residential care community’s system	<input type="text"/>
i. Not reported (race and ethnicity unknown)	<input type="text"/>
TOTAL	<input type="text"/>

NOTE: Total should be the same as the number of residents provided in question 5.

15. Of the residents currently living in this residential care community, what is the sex breakdown? **Enter “0” for any categories with no residents.**

	NUMBER OF RESIDENTS
a. Male	<input type="text"/>
b. Female	<input type="text"/>
TOTAL	<input type="text"/>

NOTE: Total should be the same as the number of residents provided in question 5.

16. Of the residents currently living in this residential care community, what is the age breakdown?
Enter "0" for any categories with no residents.

	NUMBER OF RESIDENTS
a. 17 years or younger	<input type="text"/>
b. 18–44 years	<input type="text"/>
c. 45–54 years	<input type="text"/>
d. 55–64 years	<input type="text"/>
e. 65–74 years	<input type="text"/>
f. 75–84 years	<input type="text"/>
g. 85 years or older	<input type="text"/>
TOTAL	<input type="text"/>

NOTE: Total should be the same as the number of residents provided in question 5.

17. Assistance refers to **needing any help or supervision from another person, or use of assistive devices.**

Of the residents currently living in this residential care community, about how many now **need any assistance** in each of the following activities?
Enter "0" for any categories with no residents.

	NUMBER OF RESIDENTS
a. With transferring in and out of a bed or chair	<input type="text"/>
b. With eating, like cutting up food	<input type="text"/>
c. With dressing	<input type="text"/>
d. With bathing or showering	<input type="text"/>
e. With using the bathroom (toileting)	<input type="text"/>
f. With locomotion or walking—this includes using a cane, walker, or wheelchair, or help from another person	<input type="text"/>

18. Of the residents currently living in this residential care community, about how many have been diagnosed with each of the following conditions?
Enter "0" for any categories with no residents.

	NUMBER OF RESIDENTS
a. Alzheimer's disease or other dementias	<input type="text"/>
b. Arthritis	<input type="text"/>
c. Asthma	<input type="text"/>
d. Cancer	<input type="text"/>
e. Chronic kidney disease	<input type="text"/>
f. COPD (chronic bronchitis or emphysema)	<input type="text"/>
g. Depression	<input type="text"/>
h. Diabetes	<input type="text"/>
i. Heart disease (for example, congestive heart failure, coronary or ischemic heart disease, heart attack, stroke)	<input type="text"/>
j. High blood pressure or hypertension	<input type="text"/>
k. Human immunodeficiency virus (HIV)/AIDS	<input type="text"/>
l. Intellectual or developmental disability	<input type="text"/>
m. Multiple sclerosis	<input type="text"/>
n. Obesity	<input type="text"/>
o. Osteoporosis	<input type="text"/>
p. Parkinson's disease	<input type="text"/>
q. Severe mental illness, such as schizophrenia and psychosis	<input type="text"/>
r. Traumatic brain injury	<input type="text"/>

19. Of the residents currently living in this residential care community, about how many were treated in a hospital emergency department in the **last 90 days**? *If none, enter "0."*

Number of residents

20. Of the residents currently living in this residential care community, about 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. *If none, enter "0."*

Number of residents

If you answered "0," skip to question 22.

21. Of the residents who were discharged from an overnight hospital stay in the last 90 days, about how many of those residents were **re-admitted** to the hospital for an overnight stay **within 30 days** of their hospital discharge? *If none, enter "0."*

Number of residents

22. Of the residents currently living in this residential care community, about how many have elected and are now receiving hospice care? *If none, enter "0."*

Number of residents

23. Advance directives are written documentation and may include health care proxies, durable power of attorney, living wills, do not resuscitate (DNR) orders, or physician or medical orders for life-sustaining treatments (POLST or MOLST).

Does this residential care community provide any information about advance directives to residents or their families?

Yes

No

24. Does your state require your residential care community to provide information about advance directives to residents or their families?

Yes

No

Do not know

25. Does this residential care community typically maintain documentation of residents' advance directives or have documentation that an advance directive exists in resident files?

Yes

No

If you answered "No," skip to question 27.

26. Of the current residents, how many have documentation of an advance directive in their file? *If none, enter "0."*

Number of residents

3

Services Offered

27. Does this residential care community **only** serve adults with dementia or Alzheimer’s disease?

Yes

No

If you answered “Yes,” skip to question 29.

28. Does this residential care community have a distinct unit, wing, or floor that is designated as a dementia or Alzheimer’s care unit?

Yes

No

29. For **each** service listed below . . . **MARK ALL THAT APPLY**

Type of Service	This residential care community. . .			
	Provides the service by paid residential care community employees	Arranges for the service to be provided by outside service providers	Refers residents or family to outside service providers	Does not provide, arrange, or refer for this service
a. Hospice services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Social work services —provided by licensed social workers or persons with a bachelor’s or master’s degree in social work, and may include an array of services such as psychosocial assessment, individual or group counseling, and referral services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Mental health services —target residents’ mental, emotional, psychological, or psychiatric well-being, and may include diagnosing, describing, evaluating, and treating mental conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Any therapeutic services —physical, occupational, or speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Pharmacy services —including filling of or delivery of prescriptions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Dietary and nutritional services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Skilled nursing services —must be performed by an RN or LPN and are medical in nature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Transportation services for medical or dental appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4 Staff Profile

30. An individual is considered an **employee** if the residential care community is required to issue a **W-2** federal tax form on their behalf. For **each** staff type below, indicate how many **full-time employees and part-time employees** this residential care community **currently** has. *Enter "0" for any categories with no employees.*

	Number of Full-Time Employees	Number of Part-Time Employees
a. Registered nurses (RNs)	<input type="text"/>	<input type="text"/>
b. Licensed practical nurses (LPNs) / licensed vocational nurses (LVNs)	<input type="text"/>	<input type="text"/>
c. Certified nursing assistants, nursing assistants, home health aides, home care aides, personal care aides, personal care assistants, and medication technicians or medication aides	<input type="text"/>	<input type="text"/>
d. Social workers—licensed social workers or persons with a bachelor's or master's degree in social work	<input type="text"/>	<input type="text"/>
e. Activities directors or activities staff	<input type="text"/>	<input type="text"/>

31. **Contract or agency staff** refers to individuals or organization staff under contract with and working at this residential care community, but are not directly employed by the residential care community. Does this residential care community **currently** have any nursing, aide, social work, or activities contract or agency staff?

Yes

No

If you answered "No," skip to question 33.

32. For **each** staff type below, indicate how many **full-time contract or agency staff and part-time contract or agency staff** this residential care community **currently** has. *Enter "0" for any categories with no contract or agency staff.*

	Number of Full-Time Contract or Agency Staff	Number of Part-Time Contract or Agency Staff
a. Registered nurses (RNs)	<input type="text"/>	<input type="text"/>
b. Licensed practical nurses (LPNs) / licensed vocational nurses (LVNs)	<input type="text"/>	<input type="text"/>
c. Certified nursing assistants, nursing assistants, home health aides, home care aides, personal care aides, personal care assistants, and medication technicians or medication aides	<input type="text"/>	<input type="text"/>
d. Social workers—licensed social workers or persons with a bachelor's or master's degree in social work	<input type="text"/>	<input type="text"/>
e. Activities directors or activities staff	<input type="text"/>	<input type="text"/>

The following questions ask for information to help inform planning for future waves of NSLTCP.

33. The National Center for Health Statistics (NCHS) links person-level survey data with health records from other data sources, such as Medicare or Medicaid data. Linking allows NCHS to better understand the services residents of residential care communities use. In order to link data in future surveys, we would need the information below about your current residents. We would use this information for research purposes only. Federal laws authorize NCHS to ask for this information and require us to keep it strictly private.

To help NCHS plan for future surveys, please answer the following questions: For **each item** below, in **Column 1**, indicate **whether or not this residential care community has this information about its current residents**. For each **“yes”** in **Column 1**, in **Column 2**, indicate **whether or not this residential care community is willing to provide this information** about residents.

	<u>Column 1</u> This community has . . .	<u>Column 2</u> I would be willing to provide . . .
a. Full names	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Dates of birth	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Last four digits of Social Security numbers	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Full Social Security numbers	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

34. Is this residential care community a Health Insurance Portability and Accountability Act (HIPAA)–covered entity?

- Yes
- No
- Do not know

5 Contact Information

35. In which of the following ways do you have Internet access at work?

MARK ALL THAT APPLY

- Desktop or laptop
- Smartphone
- Tablet/iPad
- Other
- No Internet access at work

36. We would like to keep your name, telephone number, work e-mail address, and job title for possible future contact related to participation in current and future NSLTCP waves. Your contact information will be kept confidential and will not be shared with anyone outside this project team.

PLEASE PRINT

Your full name:

Your work telephone number, with extension:

Your work e-mail address:

Your job title:

Thank you for participating.

Please return this questionnaire in the enclosed return envelope.

**NSLTCP
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