Attachment D-3
National Study of Long-Term Care Providers----2016 Adult Day Services Center Questions-Version A

Form Approved
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Background Information

1. Is this adult day services center …

MARK YES OR NO IN EACH ROW

	Yes	No
a. licensed or certified by the State specifically to provide adult day services?	☐	☐
b. authorized or otherwise set up to participate in Medicaid?	☐	☐

If you answered "No" to both 1a and 1b, skip to question 35 on page X.

2. Based on a typical week, what is the approximate average daily attendance at this adult day services center at this location?
If none, enter "0."

☐ Average daily attendance of participants

If you answered "0," skip to question 35 on page X.

3. What is the total number of participants currently enrolled at this adult day services center at this location? ***If none, enter "0."***

☐ Number of participants

If you answered "0," skip to question 35 on page X.

4. What is the maximum number of participants allowed at this 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.
If none, enter "0."

☐ Maximum number of participants allowed

5. Which **one** of the following best describes the participant needs that the **services of this center** are designed to meet?

MARK ONLY ONE ANSWER

- ☐ ONLY social/recreational needs—NO health/medical needs.
- ☐ PRIMARILY social/recreational needs and SOME health/medical needs
- ☐ EQUALLY social/recreational and health/medical needs
- ☐ PRIMARILY health/medical needs and SOME social/recreational needs
- ☐ ONLY health/medical needs— NO social/recreational needs

6. Is this a **specialized** center that serves **only** participants with a particular diagnosis, condition, or disability?

- ☐ Yes
- ☐ No

If you answered "No," skip to question 8.

7. In which of the following diagnoses, conditions, or disabilities does this center specialize?

SELECT ALL THAT APPLY

- ☐ Alzheimer's disease or other dementias
- ☐ HIV/AIDS
- ☐ Intellectual and other developmental disabilities
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Post-stroke physical and/or mental impairments with a need for rehabilitative therapies
- ☐ Severe mental illness
- ☐ Traumatic brain injury
- ☐ Other (please specify) _____

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

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 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

10. Of this center's revenue from paid participant fees, about what percentage comes from each of the following sources? Your entries should add up to 100%. ***Enter "0" for any sources that do not apply.***

a.	Medicaid (include revenue from Medicaid waivers, Medicaid managed care, or California regional centers)	%
b.	Medicare	%
c.	Older Americans Act	
d.	Veteran's Administration	
e.	Other federal, state or local government	%
f.	Out-of-pocket payment by the participant or family	%
g.	Private insurance	%
h.	Other source	%
	TOTAL	%

NOTE: Your entries should add up to 100%.

Services Offered

11. Fall risk assessment tools often address gait, mobility, strength, balance, cognition, vision, medications, and environmental factors. Examples of tools include but are not limited to CDC's "**St**opping **E**lderly **A**ccidents, **D**eaths & **I**njuries" or STEADI; **T**imed **U**p and **G**o or TUG test; 30-second chair stand test; and 4-stage balance test. Does this center typically evaluate each participant's risk for falling using **any fall risk assessment tool**? (Version A)

- ☐ Yes, as a standard practice with every participant
- ☐ Case-by-case depending on each participant
- ☐ No

12. Fall reduction interventions may include but are not limited to environmental safety measures; medication reconciliation; exercise, gait, or balance training; and participant or family education. Does this center currently use **any formal falls reduction interventions**? (Version A)

- ☐ Yes
- ☐ No

13. For **each** service listed below, **MARK ALL THAT APPLY.**

Service	This adult day services center. . .			
	Provides the service by paid center employees	**Arranges** for the service to be provided by outside service providers	**Refers** participants or family to outside service providers	**Does not provide, arrange, or refer for this service**
a. **Hospice services**	☐	☐	☐	☐
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	☐	☐	☐	☐
c. **Mental health services**—target participants' mental, emotional, psychological, or psychiatric well-being and may include diagnosing, describing, evaluating, and treating mental conditions	☐	☐	☐	☐
d. **Any therapeutic services**—physical, occupational, or speech	☐	☐	☐	☐
e. **Pharmacy services**—including filling of or delivery of prescriptions	☐	☐	☐	☐
f. **Dietary and nutritional services**	☐	☐	☐	☐
g. **Skilled nursing services**—must be performed by an RN or LPN and are medical in nature	☐	☐	☐	☐
h. **Transportation services** for medical or dental appointments	☐	☐	☐	☐
i. **Daily round trip transportation services** to/from this center	☐	☐	☐	☐

Staff Profile

14. An individual is considered an **employee** if the center is required to issue a **Form W-2** federal tax form on their behalf. For **each** staff type below, indicate whether or not this center **currently** has **any full-time employees or part-time employees**. ***Enter "0" for any categories with no employees.***

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

15. **Contract or agency staff** refer to individuals or organization staff under contract with and working at this center but are not directly employed by the center.

Does this center have any nursing, aide, social work, or activities contract or agency staff?

☐ Yes
☐ No

If you answered 'No," skip to question 17.

16. For **each** staff type below, indicate whether or not this center currently has **any full-time contract or agency staff or part-time contract or agency staff.** ***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)		
b. Licensed practical nurses (LPNs)/ licensed vocational nurses (LVNs)		
c. Certified nursing assistants, nursing assistants, home health aides, home care aides, personal care aides, personal care assistants, and medication technicians or medication aides		
d. Social workers – licensed social workers or persons with a bachelor's or master's degree in social work		
e. Activities directors or activities staff		

Participant Profile

17. Of the participants currently enrolled at this center, what is the racial-ethnic breakdown? Count each participant only once.
Enter "0" for any categories with no participants.

	NUMBER OF PARTICIPANTS
a. Hispanic or Latino, of any race	
b. American Indian or Alaska Native, not Hispanic or Latino	
c. Asian, not Hispanic or Latino	
d. Black, not Hispanic or Latino	
e. Native Hawaiian or Other Pacific Islander, not Hispanic or Latino	
f. White, not Hispanic or Latino	
g. Two or more races, not Hispanic or Latino	
h. Some other category reported in this center's system	
i. Not reported (race and ethnicity unknown)	
TOTAL	

NOTE: Total should be the same as the number of participants provided in question 3.

18. Of the participants currently enrolled at this center, what is the sex breakdown?
Enter "0" for any categories with no participants.

	NUMBER OF PARTICIPANTS
a. Male	
b. Female	
TOTAL	

NOTE: Total should be the same as the number of participants provided in question 3.

19. Of the participants currently enrolled at this center, what is the age breakdown?
Enter "0" for any categories with no participants.

	NUMBER OF PARTICIPANTS
a. 17 years or younger	
b. 18–44 years	
c. 45–54 years	
d. 55–64 years	
e. 65–74 years	
f. 75–84 years	
g. 85 years or older	
TOTAL	

NOTE: Total should be the same as the number of participants provided in question 3.

20. Of the participants currently enrolled at this center, about how many have been diagnosed with each of the following conditions? ***Enter "0" for any categories with no participants.***

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

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

Of the participants currently enrolled at this center, about how many now need **any assistance at their usual residence or this center** in each of the following activities? ***Enter "0" for any categories with no participants.***

	NUMBER OF PARTICIPANTS
a. With transferring in and out of a chair	
b. With eating, like cutting up food	
c. With dressing	
d. With bathing or showering	
e. With using the bathroom (toileting)	
f. With locomotion or walking- this includes using a cane, walker, or wheelchair and/or help from another person.	

22. Of the participants currently enrolled at this center, how many live in each of the following places? (Version A)

	NUMBER OF PARTICIPANTS
a. Private residence (house or apartment)	
b. Assisted living or similar residential care community	
c. Nursing home or other institutional setting	
d. Some other place	

If you answered "0" to 22a, skip to question 24.

23. Of the participants currently enrolled at this center who **live in a private residence**, how many live with each of the following people? Assign each participant to only one category. ***Enter "0" for any categories with no participants.*** (Version A)

		NUMBER OF PARTICIPANTS
a.	Alone	☐
b.	With relative (such as a spouse, partner, adult child including son or daughter-in-law, parent, or other relative	☐
c.	With non-relative(s)	☐

24. During the **last 30 days**, for how many of the participants currently enrolled at this adult day services center, did Medicaid pay for some or all of their services received at this center? (Please include any participants that received funding from Medicaid waivers, or Medicaid managed care, or any of the California regional centers). ***If none, enter "0."***

☐ Number of participants

25. Of the participants currently enrolled at this center, about how many were treated in a hospital emergency department in the **last 90 days**? ***If none, enter "0."***

☐ Number of participants

26. Of the participants currently enrolled at this center, 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 participants

If you answered "0," skip to question 28.

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

☐ Number of participants

28. As best you know, about how many of your current participants had a fall in the last 90 days? Please include falls that occur in your center or off-site, whether or not the participant was injured, and whether or not anyone saw the participant fall or caught them. Please just count one fall per participant who fell, even if the participant fell more than one time. If one of your participants fell during the last 90 days, but is currently in the hospital or rehabilitation facility, please include that person in your count. ***If no participants had a fall, enter "0."*** (Version A)

☐ Number of participants

If you answered "0," skip to question 30.

29. As best you know, **of the participants who fell in the last 90 days**, about how many are in each of the following categories? If a participant had more than one fall in the last 90 days, count only their most serious fall. ***Enter "0" for any categories with no participants.*** (Version A)

	NUMBER OF PARTICIPANTS
a. had a **fall resulting in some kind of injury**, such as a broken bone (for example in a wrist, arm, or ankle), hip fracture, or head injury	☐
b. had a fall that **did not result in some kind of injury**	☐
NOTE: Total should be the same as provided in question 28. TOTAL	☐

30. As best you know, **of the participants who fell in the last 90 days**, about how many went to a **hospital emergency department or were hospitalized as a result of the fall**? Include hospital admissions and observation stays. If a participant had more than one fall in the last 90 days, count only their most serious fall. ***If none, enter "0."*** (Version A)

☐ Number of participants

Record keeping

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

☐ Yes
☐ No

32. Does this adult day services center'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	☐	☐
b. Pharmacy	☐	☐
c. Hospital	☐	☐

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 participants of centers use. In order to link in future surveys, we would need the information below about your current participants. 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 center has this information about its current participants**. For **each "yes" in column 1**, in **Column 2** indicate **whether or not this center is willing to provide this information** about participants.

	Column 1 This community has…	**Column 2** I would be willing to provide…
a. Full names	☐ Yes → ☐ Yes ☐ No ☐ No	
b. Dates of birth	☐ Yes → ☐ Yes ☐ No ☐ No	
c. Last four digits of Social Security numbers	☐ Yes → ☐ Yes ☐ No ☐ No	
d. Full Social Security numbers	☐ Yes → ☐ Yes ☐ No ☐ No	

34. Is this adult day services center a Health Insurance Portability and Accountability Act- (**HIPAA-) covered entity?**

☐ Yes
☐ No
☐ Do not know

Contact Information

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

SELECT ALL THAT APPLY

☐ Desktop or Laptop
☐ Smartphone
☐ Tablet
☐ 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:

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Please tell us about your experience participating in this study

If you have additional comments, concerns, or suggestions for improving our survey, please let us know! You can write your comments in the box below and submit them with your completed questionnaire in the enclosed postage-paid return envelope.

Thank you for your participation and feedback.