Attachment D-1:

National Study of Long-Term Care Providers----2016 Residential Care Community Questions-Version A

Form Approved
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Exp. Date XX/XX/XXXX

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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 33 on page X.

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 33 on page X.

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?	☐	☐
b.	severe mental illness? **Do not include Alzheimer's disease or other dementias**.	☐	☐

If you answered "Yes" to <u>either</u> 3a or 3b, skip to question 33 on page X.

4. Does this residential care community offer at least 2 meals a day to residents?

☐ Yes
☐ No

If you answered "No," skip to question 33 on page X.

5. What is the total number of residents currently living in 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 33 on page X.

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

	Yes	On an as needed basis	No
a. Personal care aide or staff caregiver	☐	☐	☐
b. Registered Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN)	☐	☐	☐
c. Director, Assistant Director, Administrator or Operator (if they provide personal care or nursing services to residents)	☐	☐	☐

If you answered "No" to 6a, 6b, and 6c, skip to question 33 on page X.

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?	☐	☐
b. assistance with medications, such as the administration of medications, give reminders, or provide central storage of medications?	☐	☐

If you answered "No" to 7a and 7b, skip to question 33 on page X.

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 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

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

- ☐ Yes
- ☐ No

If you answered 'No," skip to question 12.

11. During the **last 30 days**, for how many of the residents currently living in 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

Services Offered

12. 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/residential care community typically evaluate each participant's/resident's risk for falling using **any fall risk assessment tool**? (Version A)

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

13. 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/residential care community currently use **any formal falls reduction interventions**? (Version A)

- ☐ Yes
- ☐ No

14. 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**	☐	☐	☐	☐
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, or referral services	☐	☐	☐	☐
c. **Mental health services**—target residents' mental, emotional, psychological, or psychiatric well-being and may include diagnosing, describing, evaluating, or 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	☐	☐	☐	☐

Staff Profile

15. An individual is considered an **employee** if the residential care community is required to issue a **Form W-2** federal tax form on their behalf. For **each** staff type below, indicate whether or not this residential care community **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		

16. **Contract or agency staff** refer 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 have any nursing, aide, social work, or activities contract or agency staff?

☐ Yes

☐ No

If you answered 'No," skip to question 18.

17. For **each** staff type below, indicate whether or not this residential care community 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		

Resident Profile

18. 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	
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 residential care community's system	
i. Not reported (race and ethnicity unknown)	
TOTAL	

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

19. 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	
b. Female	
TOTAL	

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

20. 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	
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 residents provided in question 5.

21. 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	
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	

22. 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	
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.	

23. 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

24. 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 "No," skip to question 26.

25. 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

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

☐ Number of residents

If you answered "0," skip to question 29.

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

	NUMBER OF RESIDENTS
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 26. TOTAL	☐

28. As best you know, **of the residents 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 resident had more than one fall in the last 90 days, count only their most serious fall. ***If none, enter "0."*** (Version A)

☐ Number of residents

Record keeping

29. 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

30. 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	☐	☐
b. Pharmacy	☐	☐
c. Hospital	☐	☐

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

31. 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 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.

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

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

☐ Yes
☐ No
☐ Do not know

Contact Information

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

SELECT ALL THAT APPLY

- ☐ Desktop or Laptop
- ☐ Smartphone
- ☐ Tablet/iPad
- ☐ Other
- ☐ No internet access at work

34. 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.