Form Approved OMB No. 0920-0943 Exp. Date: XX/XX/XXXX

ɔnal Post-Acute and Long-Term Care Study

2022 Adult Day Services Center Questionnaire

The Centers for Disease Control and Prevention conducts the National Post-Acute and Long-Term Care Study (NPALS). Please complete this questionnaire about the adult day services center at the location listed below.

- **Due to the COVID-19 pandemic, we understand services at this center may be temporarily or permanently suspended, reduced, or offered through alternative methods, and fewer people may be receiving services on a regular basis. Although some questions may be difficult to answer at this time, please complete the survey to the best of your ability.**
- If this adult day services center is associated with another adult day services center or is part of a facility or campus that offers multiple levels of care, please answer only for the adult day services portion operating at the location listed below.
- Please consult records and other staff as needed to answer questions.
- If you need assistance or have questions, go to https://www.cdc.gov/nchs/npals/index.htm or call 1-XXX-XXX-XXXX.
- **Thank you for taking the time to complete this questionnaire.**

CASE ID
DIRECTOR'S NAME OR "CURRENT DIRECTOR"
FACILITY NAME, LICENSE NUMBER
FACILITY PHYSICAL STREET ADDRESS
CITY, ST ZIP

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

Your name	First Name		Last Nam	
Your work telephone number, with	☐☐☐ – ☐☐☐ – ☐☐☐☐		Ext.	
Your work e-mail address				
Your job title				

National Center for Health Statistics
Division of Health Care Statistics

Public Health Service Act (42 U.S.C. 242m(d)) and the Confidential Information Protection and Statistical Efficiency Act of 2018 (CIPSEA Pub. L. No. 115-435, 132 Stat. 5529 § 302). In accordance with CIPSEA, every NCHS employee, contractor, and agent has taken an oath and is subject to a jail term of up to five years, a fine of up to $250,000, or both if he or she willfully discloses ANY identifiable information about you. In addition to the above cited laws, NCHS complies with the Federal Cybersecurity Enhancement Act of 2015 (6 U.S.C. §§ 151 and 151 note) which protects Federal information systems from cybersecurity risks by screening their networks.

1. 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,

2. Is this adult day services center… MARK YES OR NO IN EACH ROW

	Y	N
a. licensed or certified by your State specifically to provide adult day services, or accredited by the Commission on Accreditation of	○	○
b. authorized or otherwise set up to participate in Medicaid (Medicaid state plan, Medicaid waiver, or Medicaid managed care) or part of a Program of All-	○	○

→ *If you answered "No" to both 2a and 2b, skip to* ***question 36***

3. What is the total number of participants currently enrolled at this adult day services center? *Include all participants on this center's roster, no matter how frequently they attend, if they share an enrollment spot, or if the center has temporarily closed or suspended services due to COVID-19.*
If none, enter "0."

☐☐☐☐ Number of participants

→ *If you answered "0," skip to* ***question 36***

4. Due to the challenges presented by COVID-19, many adult day services centers have altered how they serve their participants. Which of the following best describes the current operating status of this adult day services center? MARK ONLY ONE ANSWER

- ○ Physical center is open—only serving participants onsite
- ○ Physical center is open—serving participants onsite, at place of
- ○ Physical center is temporarily closed—but serving participants at place of
- ○ Physical center is temporarily closed—not
- ○ Physical center is permanently closed—no longer serving

→ *Skip to* ***question 36***

5. Based on a typical week, what is the approximate average number of participants this adult day services center serves daily, either at this physical location, at the participant's residence, or virtually (on-line or by telephone)? *If your center is temporarily closed due to COVID-19 and not serving participants at their residences or virtually, please report the average daily number you typically serve when you are open.*
If none, enter "0."

☐☐☐☐ Average daily attendance of

6. 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

7. 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

8. 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

9. 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 state plans, Medicaid waivers, Medicaid managed care, or California	___ %
b. Medicare (include Medicare Advantage and Traditional or Original Medicare)	___ %
c. Older Americans Act/Title III	___ %
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%

10. 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 → *Skip to* ***question 14***

11. What is the name of your Electronic Health Records system? MARK ALL THAT APPLY. IF OTHER IS CHECKED, PLEASE SPECIFY THE NAME.

- ☐ American HealthTech
- ☐ CADCARE (RTZ Systems)
- ☐ Eldermark
- ☐ MatrixCare
- ☐ PointClickCare
- ☐ Storricare
- ☐ WellSky (formerly ADS data systems)
- ☐ Yardi
- ☐ Other (please specify) ▼
- ○ Don't know

12. Does this adult day services center's use Electronic Health Records for each of the following? MARK YES OR NO IN EACH ROW

	Ye	No
a. Record participant	○	○
b. Record clinical notes	○	○
c. Record participant medications and allergies	○	○
d. Record participant	○	○
e. Record individual service	○	○
f. View lab results	○	○
g. View imaging results	○	○
h. Order prescriptions	○	○

13. 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**

	Ye	No
a. Physician	○	○
b. Pharmacy	○	○
c. Hospital	○	○
d. Skilled nursing facility, nursing home, or inpatient rehabilitation facility	○	○
e. Other long term care	○	○

14. Is this a specialized center that serves only participants with particular diagnoses, conditions, or disabilities?

- ○ Yes
- ○ No → *Skip to* ***question 16***

15. In which of the following diagnoses, conditions, or disabilities does this center specialize? MARK YES OR NO IN EACH ROW

	Yes	No
a. Alzheimer disease or other dementias	○	○
b. Intellectual and other developmental disabilities	○	○
c. Multiple sclerosis	○	○
d. Parkinson's disease	○	○
e. Severe mental illness	○	○
f. Traumatic brain injury	○	○
g. Other (please specify)	○	○

16. **In the last 12 months, did this center use any of the following types of telehealth tools to assess, diagnose, monitor, or treat participants? MARK YES, NO, OR DON'T KNOW IN EACH ROW**

	Yes	No	Don't Know
a. Telephone audio	○	○	○
b. Videoconference software with audio (e.g., Zoom, Webex, FaceTime)	○	○	○

17. **In the last 12 months, did this center have any of the following challenges in implementing or using telehealth? MARK YES, NO, DON'T KNOW, OR NOT APPLICABLE IN EACH ROW**

	Yes	No	Don't Know	Not Applicabl
a. Limited internet access and/or speed issues	○	○	○	○
b. Tools not easy to use or did not meet your needs	○	○	○	○
c. Not appropriate for serving your participants	○	○	○	○
d. Limitations in access to technology (e.g., smartphone, computer, tablet, Internet)	○	○	○	○
e. Participants' difficulty using technology/telehealth platform	○	○	○	○
f. Staff difficulty using technology/telehealth platform	○	○	○	○
g. Reimbursement or cost issues associated with devices or telehealth platform	○	○	○	○
h. Limited staff available to provide telehealth services	○	○	○	○

18. **Does this center have the following infection control policies and practices? MARK YES OR NO IN EACH ROW**

	Yes	No
a. Have a written Emergency Operations Plan that is specific to or includes pandemic response	○	○
b. Have a designated staff member or consultant responsible for coordinating the infection control program	○	○
c. Offer annual influenza vaccination to participants	○	○

d. Offer annual influenza vaccination to all employees or contract staff	○	○
e. Offer COVID-19 vaccination to participants	○	○
f. Offer COVID-19 vaccination to all employees or contract staff	○	○

Services Offered

19. When does this adult day services center screen each participant with a standardized tool for each of the following? MARK ALL THAT APPLY IN EACH ROW

	Routinely at or after	Routinely when	Case by case	Does not screen
a. Cognitive impairment	☐	☐	☐	○
b. Fall risk	☐	☐	☐	○

20. Services currently offered by this center can include services offered at this physical location, at a participant's residence, or virtually (online or by telephone). For each service listed below… MARK ALL THAT APPLY IN EACH ROW

This adult day services center…	Provides the service by paid center employees or Arranges for the service to be	Refers participants or family to outside service providers	Does not provide, arrange, or refer for this service
a. Hospice services	☐	☐	○
b. Palliative care services—treatment of the pain, discomfort, and symptoms of	☐	☐	○
c. 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	☐	☐	○
d. Mental or behavioral health services—target participants' mental, emotional, psychological, or psychiatric well-being and may include diagnosing,	☐	☐	○
e. Therapy services—physical, occupational, or speech	☐	☐	○
f. Pharmacy services—including filling of or delivery of	☐	☐	○
g. Dietary and nutritional services—including meal pickup or delivery	☐	☐	○
h. Skilled nursing services—must be performed by an RN, LPN or LVN and are medical in nature	☐	☐	○
i. Transportation services for medical or dental appointments	☐	☐	○
j. Daily round trip transportation services to or from this center	☐	☐	○

k. Routine and emergency dental services by a licensed dentist	☐	☐	○

Participant Profile

When answering questions 21-26, include all participants on this center's roster, no matter how frequently they attend, if they are receiving services at their residence or virtually (on-line or by telephone), if they share an enrollment spot, or if the center has temporarily closed or suspended services due to COVID-19.

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

☐☐☐☐ Number of participants

22. Of the participants currently enrolled at this center, about how many have been diagnosed with dementia or Alzheimer's disease? If none, enter "0".

☐☐☐☐ Number of participants

23. In the last 12 months, how many coronavirus disease (COVID-19) cases did this center have among participants? Enter "0" if none.

☐☐☐ Number of participants

➔ *If you answered "0", skip to* ***question 25***

24. Of the COVID-19 cases in your center in the last 12 months, how many cases resulted in each of the following?
Enter "0" if none or select don't know if you do not know the number.

	Number of COVID-19	Don't Know
a.	☐☐☐	○
b. Death	☐☐☐	○

25. 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. Under 65 years	☐☐☐☐
b. 65–74 years	☐☐☐☐
c. 75–84 years	☐☐☐☐
d. 85 years or older	☐☐☐☐
TOTAL	☐☐☐☐

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

26. Of the participants <u>currently enrolled at</u> this center, what is the racial-ethnic breakdown? *Count each participant only once. If a non-Hispanic participant falls under more than one category, please include them in the "Two or more races" category.* Enter "0" for any categories with no participants.

	Number of Participant
a. Hispanic or Latino, of any race	
b. Two or more races, not Hispanic or Latino	
c. American Indian or Alaska Native, not Hispanic or Latino	
d. Asian, not Hispanic or Latino	
e. Black, not Hispanic or Latino	
f. Native Hawaiian or Other Pacific Islander, not Hispanic or Latino	
g. White, 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.

27. An individual is considered an <u>employee</u> if the center is required to issue a <u>Form W-2</u> federal tax form on their behalf. For <u>each</u> staff type below, indicate how many <u>full-time employees and part-time employees</u> this center <u>currently</u> has. *Include employees who work at this physical location, at a participant's residence, or virtually (on-line or by telephone).* **Enter "0" for any categories with no employees.**

	Number of Full-Time	Number of Part-Time
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		

28. <u>Contract or agency staff</u> 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? *Include contract staff who work at this physical location, at a participant's residence, or virtually (on-line or by telephone).*

- ○ Yes
- ○ No → *Skip to* ***question 30***

29. For <u>each</u> staff type below, indicate how many <u>full-time contract or agency staff and part-time contract or agency staff</u> this center <u>currently</u> has. *Do not include individuals directly employed by this center.* **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	☐☐☐	☐☐☐
d. Social workers—licensed social workers or persons with a bachelor's or master's degree in	☐☐☐	☐☐☐
e. Activities directors or activities staff	☐☐☐	☐☐☐

30. In the <u>last 12 months</u>, how many coronavirus disease (COVID-19) cases did this center have among employees or contract staff? Enter "0" if none.

☐☐☐ Number of COVID-19 cases

*The next series of questions asks about aide employees, which includes certified nursing assistants, nursing assistants, home health aides, home care aides, personal care aides, personal care assistants, and medication technicians or medication aides. Contract workers are **<u>not</u>** to be included in your answers.*

➔➔*If you answered "0", skip to **question 32***

31. Of the COVID-19 cases in your center in the <u>last 12 months</u>, how many cases resulted in each of the following? Enter "0" if none or select don't know if you do not know the number.

	Number of COVID-19	Don't Know
a.	☐☐☐	○
b. Death	☐☐☐	○

32. Does this center offer the following benefits to full-time aide employees? MARK YES OR NO IN EACH ROW

	Yes	No
a. Health insurance for the employee only	○	○
b. Health insurance that includes family coverage	○	○
c. Life insurance	○	○
d. A pension, a 401(k), or a 403(b)	○	○
e. Paid personal time off, vacation time, or sick leave	○	○
f. Reimburse/pay for initial training	○	○

33. How many hours of training does this center require aide employees to have for each of the following? If none, enter "0".

	Number of hours
a. Prior to providing care to participants	☐☐☐
b. On-going continuing education or annual in-service training	☐☐☐

34. How often does this center offer training to prepare aide employees for each of the following aspects of their jobs? MARK ONLY ONE RESPONSE IN EACH ROW

	Training is always offered	Training is offered occasionally or as needed	Training is offered rarely or never	Don't Know
a. Discussing participant care with participants' families	○	○	○	○
b. Dementia care	○	○	○	○
c. Working with participants that act out or are abusive	○	○	○	○
d. Preventing personal injuries at work	○	○	○	○
e. End of life issues (advance care planning and help families cope with grief)	○	○	○	○
f. Relating to participants of different cultures or ethnicities, or with different values or beliefs	○	○	○	○

Information on COVID-19

35. In the last 12 months, how often did this center use each of the following practices or policies to prevent or manage COVID-19 infections, whether or not there were any presumptive positive or confirmed COVID-19 cases? MARK ONLY ONE RESPONSE IN EACH ROW

	Always	Some of the time or as	Rarely or never	Don't Know
a. Screened participants daily for fever or respiratory symptoms	○	○	○	○
b. Limited of hours or temporary closure of this center	○	○	○	○
c. Experienced shortages of eye protection, gloves, face masks, or isolation gowns	○	○	○	○
d. Experienced shortages of N95 respirators	○	○	○	○
e. Experienced shortages of test kits	○	○	○	○
f. Imposed restrictions on family and relatives entering the building	○	○	○	○
g. Imposed restrictions on visitors or volunteers entering the building	○	○	○	○
h. Imposed restrictions on non-essential consultant personnel (e.g., barbers, delivery personnel) entering the building	○	○	○	○

36. Please return your questionnaire in the enclosed return envelope or mail it to:

NPALS
RTI International
ATTN: Data Capture

Thank you for participating in the 2022 National Post-Acute

5265 Capital Boulevard
Raleigh, NC 27690