

Attachment C-3: RCC Services User Questionnaire items

Form Approved OMB No. 0920-0943

Exp. Date xx/xx/xxxx

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Were you able to prepare a list of current [residents/participants] as of midnight yesterday?

IF YES: Using the list that you have prepared, I will talk you through a few steps to determine which two [residents/participants] currently [living/enrolled] at this [residential care community/adult day services center] to select. PROCEED TO SAMPLING INSTRUCTIONS.

IF NO: I can stay on the line now while you print or write a list of your current [residents/participants] [living/enrolled] at this [residential care community/adult day services center] as of midnight yesterday.

IF ABLE TO DRAFT LIST WHILE ON THE PHONE PROCEED TO SAMPLING INSTRUCTIONS.

IF NEEDS TIME TO DRAFT LIST: Is this a good time of day to call back or is there a better time to reach you? Thank you very much for your time. I will call you back. END CALL

SAMPLING INSTRUCTIONS

1. Starting at the top of the list, number each [resident/participant] and please let me know when you are done.
2. WHEN RESPONDENT IS DONE NUMBERING: How many residents/participants are on the list?
3. BASED ON THE NUMBER OF RESIDENTS/PARTICIPANTS REPORTED, CATI WILL GENERATE A LIST OF THOSE NUMBERS IN RANDOM ORDER USING THE RANDOM FUNCTION. PROVIDE THE 2 NUMBERS THAT ARE AT THE TOP OF THE LIST YOU

RANDOMLY GENERATED. Please circle the two [residents/participants] that correspond with [number 1] and [number 2]. Our system randomly picked these two numbers.

4. Please record the first and last initials of the two [residents/participants] that you circled. What are the initials you recorded?
5. I will ask you questions about these two [residents/participants] that we have just selected using only their initials. You may need to access their records to answer some of the questions. OFFER TO WAIT WHILE R RETRIEVES RECORDS.

COMPLETE QUESTIONNAIRE FOR EACH RESIDENT/PARTICIPANT SELECTED

What is [SAMPLED PERSON'S INITIALS]'s gender?

- 1 MALE
- 2 FEMALE

What is [SAMPLED PERSON'S INITIALS]'s age in years?

Is [SAMPLED PERSON'S INITIALS] of Hispanic, Latino, or Spanish origin or descent?

- 1 YES
- 2 NO
- 3 DON'T KNOW

Please look at the show card titled "Race" to answer this question. Which one or more of the following would you say is [SAMPLED PERSON'S INITIALS]'s race? Please tell me the numbers that apply from the show card. SELECT ALL THAT APPLY Any others?

1. AMERICAN INDIAN OR ALASKA NATIVE
2. ASIAN
3. BLACK
4. NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
5. WHITE

Please look at the show card titled "Moved into Community" to answer this question. Approximately how long ago did [SAMPLED PERSON'S INITIALS] move to this residential community? Please tell me the number that applies from the show card.

1. 0 TO 3 MONTHS
2. MORE THAN 3 MONTHS TO 1 YEAR
3. MORE THAN 1 YEAR TO 5 YEARS
4. MORE THAN 5 YEARS

Please look at the show card titled "Live Before" to answer this question. Where did [SAMPLED PERSON'S INITIALS] live immediately before moving to this residential care community? Please tell me the number that applies from the show card.

1. PRIVATE RESIDENCE (HOUSE, APARTMENT, ROOM)
2. RETIREMENT OR INDEPENDENT LIVING COMMUNITY
3. DIFFERENT ASSISTED LIVING OR RESIDENTIAL CARE COMMUNITY OR GROUP HOME
4. ACUTE CARE HOSPITAL
5. LONG-TERM CARE HOSPITAL OR INPATIENT REHABILITATION FACILITY
6. SKILLED NURSING FACILITY (SNF) FOR SHORT-TERM REHABILITATION
7. NURSING HOME OR OTHER INSTITUTIONAL SETTING
8. OTHER

At this residential care community, does [SAMPLED PERSON'S INITIALS] currently share "his"/ "her" room or apartment with another person?

- 1 YES
- 2 NO

Is this person [SAMPLED PERSON'S INITIALS]'s partner, spouse, or other relative?

- 1 YES
- 2 NO

Does [SAMPLED PERSON'S INITIALS] live in a distinct unit, wing, or floor that is designated as an Alzheimer's Disease, dementia, or memory care unit at this residential care community?

- 1 YES
- 2 NO

During the last complete month, what was the total monthly charge for [SAMPLED PERSON'S INITIALS] to live in this residential care community? Include the basic monthly charge and charges for any additional services.

RECORD DOLLAR AMOUNT WITHOUT CENTS

During the last complete month, did Medicaid pay for any of the services that [SAMPLED PERSON'S INITIALS] received at this residential care community? Please include any funding from a Medicaid state plan, Medicaid waiver, Medicaid managed care.

- 1 YES
- 2 NO
- 3 DON'T KNOW

Please look at the show card titled "Conditions" to answer this question. As far as you know, has a doctor or other health professional ever diagnosed [SAMPLED PERSON'S INITIALS] with any of the following conditions? Please tell me the numbers that apply from the show card. SELECT ALL THAT APPLY. Any others?

1. ALCOHOL ABUSE
2. ALZHEIMER'S DISEASE OR OTHER DEMENTIA
3. ANEMIA
4. ANXIETY DISORDER
5. ARTHRITIS OR RHEUMATOID ARTHRITIS
6. ASTHMA
7. CANCER OR MALIGNANT NEOPLASM OF ANY KIND
8. CEREBRAL PALSY
9. COPD (CHRONIC BRONCHITIS OR EMPHYSEMA)
10. COVID-19
11. DEPRESSION
12. DIABETES
13. EPILEPSY
14. GLAUCOMA
15. GOUT, LUPUS, OR FIBROMYALGIA
16. HEART DISEASE (CONGESTIVE HEART FAILURE, CORONARY OR ISCHEMIC, HEART ATTACK)
17. HIGH BLOOD PRESSURE OR HYPERTENSION
18. INTELLECTUAL OR DEVELOPMENTAL DISABILITIES
19. KIDNEY DISEASE
20. MACULAR DEGENERATION
21. OBESITY
22. OSTEOPOROSIS
23. PARKINSON'S DISEASE
24. PARTIAL OR TOTAL PARALYSIS
25. PRESSURE WOUND/INJURY
26. SEVERE MENTAL ILLNESS SUCH AS SCHIZOPHRENIA OR PSYCHOSIS OR BIPOLAR DISORDER (EXCLUDES DEPRESSION OR ANXIETY DISORDER)
27. STROKE
28. TRAUMATIC BRAIN INJURY
29. NONE OF THESE

The next question asks about prescription medications [SAMPLED PERSON'S INITIALS] may take. Include standing and PRN or as needed medications, but exclude over-the-counter medications or supplements, unless they have been prescribed by a health care provider. About how many prescription medications does [SAMPLED PERSON'S INITIALS] currently take on a typical day? Would you say...

- 1 0
- 2 1-2
- 3 3-4
- 4 5-6
- 5 7-8
- 6 9-10, or
- 7 more than 10

Do you help store or manage opioid pain medications for [SAMPLED PERSON'S INITIALS]? Include reminders to take the opioid pain medication or handing the opioid pain medication to the residents to take. Examples include morphine, hydrocodone, oxycodone, codeine, fentanyl, and methadone.

- 1 YES
- 2 NO

The next questions ask about difficulties (SAMPLED PERSON'S INITIALS) may have doing certain activities because of a health problem. How much difficulty does (SAMPLED PERSON'S INITIALS) have remembering or concentrating? Would you say no difficulty, some difficulty, a lot of difficulty, or cannot do at all?

- 1 NO DIFFICULTY
- 2 SOME DIFFICULTY
- 3 A LOT OF DIFFICULTY
- 4 CANNOT DO AT ALL

How much difficulty does (SAMPLED PERSON'S INITIALS) have seeing, even if wearing glasses? Would you say no difficulty, some difficulty, a lot of difficulty, or cannot do at all?

- 1 NO DIFFICULTY
- 2 SOME DIFFICULTY
- 3 A LOT OF DIFFICULTY
- 4 CANNOT DO AT ALL

How much difficulty does (SAMPLED PERSON'S INITIALS) have hearing, even if using a hearing aid? Would you say no difficulty, some difficulty, a lot of difficulty, or cannot do at all?

- 1 NO DIFFICULTY
- 2 SOME DIFFICULTY
- 3 A LOT OF DIFFICULTY
- 4 CANNOT DO AT ALL

How much difficulty does (SAMPLED PERSON'S INITIALS) have walking or climbing steps? Would you say no difficulty, some difficulty, a lot of difficulty, or cannot do at all?

- 1 NO DIFFICULTY
- 2 SOME DIFFICULTY
- 3 A LOT OF DIFFICULTY
- 4 CANNOT DO AT ALL

How much difficulty does (SAMPLED PERSON'S INITIALS) have self-care such as washing all over or dressing? Would you say no difficulty, some difficulty, a lot of difficulty, or cannot do at all?

- 1 NO DIFFICULTY
- 2 SOME DIFFICULTY
- 3 A LOT OF DIFFICULTY
- 4 CANNOT DO AT ALL

Using "his"/"her" usual customary language, how much difficulty does (SAMPLED PERSON'S INITIALS) have communicating, for example understanding or being understood? Would you say no difficulty, some difficulty, a lot of difficulty, or cannot do at all?

- 1 NO DIFFICULTY
- 2 SOME DIFFICULTY
- 3 A LOT OF DIFFICULTY
- 4 CANNOT DO AT ALL

The next questions ask about assistance [SAMPLED PERSON'S INITIALS] may need to perform certain activities.

Which types of assistance, if any, does [SAMPLED PERSON'S INITIALS] currently need to transfer in and out of a bed or chair? Does [SAMPLED PERSON'S INITIALS] need any help or supervision from another person, use an assistive device, both, or need no assistance?

- 1 NEED HELP OR SUPERVISION FROM ANOTHER PERSON
- 2 USE OF AN ASSISTIVE DEVICE
- 3 BOTH
- 4 NEED NO ASSISTANCE

Which types of assistance, if any, does [SAMPLED PERSON'S INITIALS] currently need to eat, like cutting up food? Does [SAMPLED PERSON'S INITIALS] need any help or supervision from another person, use an assistive device, both, or need no assistance?

- 1 NEED HELP OR SUPERVISION FROM ANOTHER PERSON
- 2 USE OF AN ASSISTIVE DEVICE
- 3 BOTH
- 4 NEED NO ASSISTANCE

Which types of assistance, if any, does [SAMPLED PERSON'S INITIALS] currently need to dress? Does [SAMPLED PERSON'S INITIALS] need any help or supervision from another person, use an assistive device, both, or need no assistance?

- 1 NEED HELP OR SUPERVISION FROM ANOTHER PERSON
- 2 USE OF AN ASSISTIVE DEVICE
- 3 BOTH
- 4 NEED NO ASSISTANCE

Which types of assistance, if any, does [SAMPLED PERSON'S INITIALS] currently need to bathe or shower? Does [SAMPLED PERSON'S INITIALS] need any help or supervision from another person, use an assistive device, both, or need no assistance?

- 1 NEED HELP OR SUPERVISION FROM ANOTHER PERSON
- 2 USE OF AN ASSISTIVE DEVICE
- 3 BOTH
- 4 NEED NO ASSISTANCE

Which types of assistance, if any, does [SAMPLED PERSON'S INITIALS] currently need to use the bathroom or toileting? Does [SAMPLED PERSON'S INITIALS] need any help or supervision from another person, use an assistive device, both, or need no assistance?

- 1 NEED HELP OR SUPERVISION FROM ANOTHER PERSON
- 2 USE OF AN ASSISTIVE DEVICE
- 3 BOTH
- 4 NEED NO ASSISTANCE

Which types of assistance, if any, does [SAMPLED PERSON'S INITIALS] currently need for locomotion or to walk? Does [SAMPLED PERSON'S INITIALS] need any help or supervision from another person, use an assistive device, both, or need no assistance?

- 1 NEED HELP OR SUPERVISION FROM ANOTHER PERSON
- 2 USE OF AN ASSISTIVE DEVICE
- 3 BOTH
- 4 NEED NO ASSISTANCE

Please look at the show card titled "Incontinence" to answer this question. As far as you know, has [SAMPLED PERSON'S INITIALS] had any episode of incontinence during the last seven days? Please tell me the number that applies from the show card.

1. YES, BOWEL ONLY
2. YES, URINARY ONLY
3. YES, BOTH BOWEL AND URINARY
4. NO, NEITHER
5. NOT APPLICABLE (COLOSTOMY, ILEOSTOMY)
6. NOT APPLICABLE (INDWELLING CATHETER, UROSTOMY)

[During the past 90 days/since admission], was [SAMPLED PERSON'S INITIALS] treated in a hospital emergency department?

- 1 YES
- 2 NO
- 3 DON'T KNOW

Was [SAMPLED PERSON'S INITIALS] discharged from an overnight hospital stay [during the past 90 days/since admission]? Exclude trips to the hospital emergency department that did not result in an overnight hospital stay.

- 1 YES
- 2 NO
- 3 DON'T KNOW

What was the one primary reason for [SAMPLED PERSON'S INITIALS]'s hospitalization? If “he”/“she” had more than one hospital discharge in the past 90 days, answer for the most recent hospital discharge. Please tell me the number that applies from the show card.

1. CONGESTIVE HEART FAILURE (CHF)
2. COVID-19
3. DIABETES—SHORT-TERM COMPLICATION
4. FALLS OR TRAUMA
5. MENTAL STATUS CHANGES
6. PNEUMONIA
7. URINARY TRACT OR KIDNEY INFECTION
8. NONE OF THE ABOVE

Was [SAMPLED PERSON'S INITIALS] re-admitted to the hospital for an overnight stay within 30 days of this hospital discharge? Include outpatient observation and inpatient admission.

- 1 YES
- 2 NO
- 3 DON'T KNOW

The next section asks whether [SAMPLED PERSON'S INITIALS] has had any falls. By falls we mean any fall, slip, or trip in which [SAMPLED PERSON'S INITIALS] lost “his”/“her” balance and landed on the floor or ground or at a lower level. Please include falls that occurred at your residential care community or off-site, whether or not [SAMPLED PERSON'S INITIALS] was injured, and whether or not anyone saw [SAMPLED PERSON'S INITIALS] fall or caught them. As best you know, [during the past 90 days/since admission], how many falls has [SAMPLED PERSON'S INITIALS] had?

Number of falls _____

As best you know, did the fall/any of these falls that [SAMPLED PERSON'S INITIALS] had [during the past 90 days/since admission] occur at the residential care community?

- 1 YES
- 2 NO
- 3 DON'T KNOW

Please look at the show card titled “Fall Injury” to answer this question. Did [SAMPLED PERSON'S INITIALS]'s fall/any of these falls [SAMPLED PERSON'S INITIALS] had result in a minor injury, a major injury, or no injury? Please tell me the numbers that apply from the show card. SELECT ALL THAT APPLY

1. MINOR INJURY - ABRASION, CUT, HEMATOMA, LACERATION, SCRATCH, SKIN TEAR, SPRAIN, SUPERFICIAL BRUISE
2. MAJOR INJURY - BONE FRACTURE, BROKEN BONE, CLOSED HEAD INJURY WITH ALTERED CONSCIOUSNESS, JOINT DISLOCATION, SUBDURAL HEMATOMA
3. NO INJURY

Please look at the show card titled “Services” to answer this question. The following services may be offered by residential care community staff or provided at the community by non-community staff. Which of these services does [SAMPLED PERSON’S INITIALS] currently use? Please tell me the numbers that apply from the show card. SELECT ALL THAT APPLY. Any others?

1. ASSISTANCE FROM A PERSON WITH AT LEAST ONE ACTIVITY OF DAILY LIVING (*BATHING, DRESSING, EATING, TOILETING, TRANSFERRING*)
2. BEHAVIORAL OR MENTAL HEALTH—TARGET RESIDENTS' MENTAL, EMOTIONAL, PSYCHOLOGICAL, OR PSYCHIATRIC WELL-BEING, AND MAY INCLUDE DIAGNOSING, DESCRIBING, EVALUATING, AND TREATING MENTAL CONDITIONS
3. CONTINENCE MANAGEMENT (*E.G., ABSORBENT PADS, BLADDER OR BOWEL RETRAINING, CATHETER, MEDICATION, TOILETING REGIME*)
4. DENTAL (*ROUTINE OR EMERGENCY BY LICENSED DENTIST*)
5. DIETARY OR NUTRITIONAL
6. HOSPICE
7. MANAGE, SUPERVISE, OR STORE MEDICATIONS; ADMINISTER MEDICATIONS; OR PROVIDE ASSISTANCE WITH SELF-ADMINISTRATION OF MEDICATIONS
8. OCCUPATIONAL THERAPY
9. PAIN MANAGEMENT (*MEDICATION OR NON-PHARMACOLOGICAL APPROACHES*)
10. PALLIATIVE CARE (*RELIEF FROM SYMPTOMS, PAIN, AND STRESS OF SERIOUS ILLNESS, REGARDLESS OF DIAGNOSIS*)
11. PHARMACY--INCLUDING FILLING OF OR DELIVERY OF PRESCRIPTIONS
12. PHYSICAL THERAPY
13. PODIATRY
14. SKILLED NURSING--MUST BE PERFORMED BY AN RN OR LPN/LVN AND ARE MEDICAL IN NATURE
15. SKIN WOUND/INJURY CARE
16. SOCIAL WORK—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
17. SPEECH THERAPY
18. TRANSPORTATION FOR MEDICAL OR DENTAL APPOINTMENTS
19. TRANSPORTATION FOR SOCIAL AND RECREATIONAL ACTIVITIES OR SHOPPING
20. NONE OF THE ABOVE

Please look at the show card titled "Documentation" to answer this question. For which of the following items does this residential care community have documentation in [SAMPLED PERSON'S INITIALS]'s file? Please tell me the numbers that apply from the show card. SELECT ALL THAT APPLY. Any others?

1. ADVANCE DIRECTIVE OR LIVING WILL
2. DURABLE MEDICAL POWER OF ATTORNEY
3. HEALTH CARE PROXY/SURROGATE/AGENT
4. PHYSICIAN DOCUMENTATION OF CONDITION THAT MAY RESULT IN LIFE EXPECTANCY LESS THAN 6 MONTHS
5. PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) OR MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT (MOLST)
6. DO NOT RESUSCITATE (DNR) ORDER
7. DO NOT INTUBATE (DNI) ORDER
8. DO NOT HOSPITALIZE/DO NOT SEND TO EMERGENCY ROOM
9. SOME OTHER TYPE OF DOCUMENTATION
10. NONE OF THESE

Please look at the show card titled "Verbal or Behavioral Symptoms" to answer this question. As far as you know, at any time in the last seven days [SAMPLED PERSON'S INITIALS] exhibited any verbal or physical behavioral symptoms directed toward others, for example threatening, screaming, cursing, hitting, kicking, pushing, scratching, grabbing, or abusing others sexually? Please tell me the number that applies from the show card.

1. YES, VERBAL ONLY
2. YES, PHYSICAL ONLY
3. YES, BOTH VERBAL AND PHYSICAL
4. NO, NEITHER