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

ɔnal Post-acute and Long-term Care Study

2024 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.

- 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 1-855-500-1435.
- **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

Please provide your contact information. Your information may be used for contact related to participation in current and future NPALS waves and will be kept confidential. 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

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.

Background Information

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 37***

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 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.*
If none, enter "0."

☐☐☐☐ Number of participants

→ *If you answered "0," skip to* ***question 37***

4. 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 none, enter "0."

☐☐☐☐ Average daily attendance of

5. What is the <u>maximum</u> 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

6. Is this center owned by a person, group, or organization that owns or manages <u>two or more adult day services centers</u>? *This may include a corporate chain.*

- ○ Yes
- ○ No

7. Which <u>one</u> of the following best describes the participant needs that the <u>services of this center</u> 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

8. 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%

9. 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 11***

10. Does this adult day services center's Electronic Health Records system support <u>electronic health information exchange</u> 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	○	○

11. Is this a <u>specialized</u> center that serves <u>only</u> participants with particular diagnoses, conditions, or disabilities?

- ◯ Yes
- ◯ No → *Skip to* ***question 13***

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

	Ye	N
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)	◯	◯

13. In the <u>last 12 months</u>, did this center use any of the following types of <u>telehealth tools</u> 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)	○	○	○

14. 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	○	○
g. Screen participants daily for infection (e.g., screen for fever or respiratory symptoms) if an outbreak occurs	○	○
h. Limit hours or temporarily close this center if an outbreak occurs	○	○
i. Impose restrictions on family, relatives, visitors, volunteers, or non-essential consultant personnel (e.g., barbers, delivery personnel) entering the building	○	○
j. Masking if an outbreak occurs	○	○

Services Offered

15. Services currently offered by this center can include services offered at this physical location, at a participant's residence, or virtually (on-line 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 or palliative care 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, support groups, and referral services	☐	☐	○
c. Mental or behavioral health services—target participants' mental, emotional, psychological, or psychiatric well-being and may include diagnosing, describing, evaluating, and treating mental	☐	☐	○

d. Therapy services—physical, occupational, or speech therapies	☐	☐	○
e. Pharmacy services—including filling of or delivery of prescriptions	☐	☐	○
f. Dietary and nutritional services—including meal pickup or delivery	☐	☐	○
g. Skilled nursing services—must be performed by an RN, LPN, or LVN and are medical in nature	☐	☐	○
h. Transportation services for medical or dental appointments	☐	☐	○
i. Daily round trip transportation services to or from this center	☐	☐	○
j. Routine and emergency dental services by a licensed dentist	☐	☐	○
k. Home health care—medical, therapeutic, and other health care services to help with post-acute and chronic illnesses	☐	☐	○
l. Home care—assistance with completing self-care, activities of daily living, and instrumental activities of daily living such as housekeeping, errands, and appointments	☐	☐	○

Participant Profile

When answering questions 16-26, 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.

16. Of the participants <u>currently enrolled at</u> 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.

17. 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 Participan
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.

18. Of the participants <u>currently enrolled</u> at this center, what is the gender identity breakdown? Enter "0" for any categories with no participants.

	Number of Participant
a. Male	
b. Female	
c. Transgender, non-binary, or another gender	
TOTAL	

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

19. Of the participants <u>currently enrolled</u> 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
a. Alzheimer disease or other dementias	
b. Arthritis	
c. Asthma	
d. Chronic kidney disease	
e. COPD (chronic bronchitis or emphysema)	
f. Depression	
g. Diabetes	
h. Heart disease (for example, congestive heart failure, coronary or ischemic heart disease,	
i. High blood pressure or hypertension	
j. Intellectual or developmental disability	
k. Osteoporosis	

20. As best you know, of the participants <u>currently enrolled</u> at this center, about how many were treated in a hospital emergency department in the <u>last 90 days</u>? If none, enter "0."

☐☐☐☐ Number of participants

21. **As best you know, of the participants <u>currently enrolled</u> at this center, about how many were discharged from an overnight hospital stay in the <u>last 90 days</u>?** *Exclude trips to the hospital emergency department that did not result in an overnight hospital stay.* **If none, enter "0."**

☐☐☐☐ Number of participants

22. **During the <u>last 30 days</u>, for how many of the participants <u>currently enrolled at</u> 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 a Medicaid state plan, Medicaid waiver, Medicaid managed care, or California regional center.* **If none, enter "0."**

☐☐☐☐ Number of participants

23. **In the <u>last 12 months</u>, how many coronavirus disease (COVID-19) cases did this center have among participants? If none, enter "0."**

☐☐☐ Number of COVID-19 ses

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

24. **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	☐☐☐	○

25. **Assistance refers to needing any help or supervision from another person, or use of assistive devices. Of the participants <u>currently enrolled</u> at this center, about how many now need <u>any assistance at their usual residence or this center</u> in each of the following activities? Enter "0" for any categories with no participants.**

	Number of
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	

26. As best you know, of the participants <u>currently enrolled</u> at this center, about how many had a fall in the <u>last 90 days</u>? *Include falls that occurred 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."**

☐☐☐☐ Number of participants

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-	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		
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. 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? *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 each staff type below, indicate how many full-time contract or agency staff and part-time contract or agency staff this center currently 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	Number of Part-Time Contract or
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		

30. In the last 12 months, how often was this center short-staffed?

- ○ Always
- ○ Sometimes
- ○ Never

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 ***not*** *to be included in your answers.*

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

	Ye	No
a. Health insurance for the employee only	○	○
b. Health insurance that includes family coverage	○	○
c. Dental, vision, or prescription drug benefits	○	○
d. Life insurance	○	○
e. A pension, a 401(k), or a 403(b)	○	○
f. Paid childcare, childcare subsidies, or assistance	○	○
g. Paid personal time off, vacation time, or sick leave	○	○
h. Overtime pay	○	○
i. Bonuses or regular pay increases	○	○
j. Reimburse/pay for initial training	○	○

32. How many hours of training does this center require aide employees to have for each of the following?
Enter "0" if no hours of training are required.

	Number of hours
a. Initial training prior to providing care	
b. Continuing education, on-going, or on-the-job training	

33. Does this center provide assistive devices, such as lifting aides, belts, trapeze bars, or other assistive equipment, to your aide employees when moving or lifting participants who cannot move around on their own?

- ◯ Yes
- ◯ No

34. How often does this center offer training to prepare aide employees for each of the following aspects of their jobs? *Include any training offered when becoming an aide and any training offered since aides started working.*

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	○	○	○	○
g. Infection control (putting on and taking off personal protective equipment, hand washing)	○	○	○	○

These next questions ask for information to help inform planning for future waves of NPALS. The National Center for Health Statistics (NCHS) recently conducted a Direct Care Worker (DCW) Pilot Study as part of NPALS. We asked directors of adult day services centers to sample and provide contact information for two direct care employees or contract staff. We then invited the sampled direct care workers to complete a questionnaire by mail or web.

35. If we were to invite you to participate in a future DCW Study, would you have access to the following information for your direct care <u>employees</u>? If yes, would you be able to provide us with this information to contact your direct care <u>employees</u>?

	Have Access?		If yes →	Able to Provide	
	No	Yes		No	Yes
a. Full name	○	○	→	○	○
b. Mailing address	○	○	→	○	○
c. Email address	○	○	→	○	○

36. Would you have access to the following information for your direct care <u>contract staff</u>? If yes, would you be able to provide us with this information to contact your direct care <u>contract staff</u>?

	Have Access?		*If yes* →	Able to Provide?	
	No	**Yes**		**No**	**Yes**
a. Full name	○	○	→	○	○
b. Mailing address	○	○	→	○	○
c. Email address	○	○	→	○	○

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

NPALS