

Attachment B: RCC Questionnaire Items



Form Approved
OMB No. XXXX-XXXX
Exp. Date __xx/xx/20xx

2012 National Study of Long-Term Care Providers (NSLTCP)

Dear Administrator/Executive Director,

The Centers for Disease Control and Prevention's National Center for Health Statistics is conducting the National Study of Long-Term Care Providers (NSLTCP), a new national survey to be conducted every two years on a sample of about 11,000 residential care communities. RTI International has been contracted to carry out the data collection.

Please answer all of the questions in reference to this **residential care community**. If your residential care community is part of a multi-facility campus, please only answer for the residential care portion of the campus. The accuracy of your answers is important to this voluntary survey.

Residential care places are known by many different names. Just a few terms used to refer to these places are assisted living, personal care, and adult care homes, facilities, and communities, adult family and board care homes, adult foster care, homes for the aged and housing with service establishments. For this study we refer to these places and others like them as residential care communities. Nursing homes are excluded.

If you need assistance or have any questions while completing this questionnaire, please call 1-800-###-#### to speak to a member of the NSLTCP project team.

Thank you for taking the time to complete this questionnaire.

Sincerely,

Angela M. Greene

Project Director, RTI International

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INSTRUCTIONS:

- Please clearly mark your responses in the boxes provided → Examples or
- Written answers should be printed in the space provided → Example

1. Study Eligibility

The answers to the questions below determine if THIS residential care community is eligible to participate in the 2012 National Study of Long-Term Care Providers.

FIRST, please answer the following question(s). Then follow the instructions provided next to the answer box(es) you mark.

1. Is this residential care community licensed, registered, listed, certified, or otherwise regulated by the state?

- Yes (*continue*)
- No (*skip to* → *BOX A*)

2. Does this residential care community have 4 or more licensed, registered, or certified beds?

- Yes (*continue*)
- No (*skip to* → *BOX A*)

3. Is there at least one resident living at this residential care community?

- Yes (*continue*)
- No (*skip to* → *BOX A*)


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

- Yes (*continue*)
- No (*skip to* → *BOX A*)


5a. Does this residential care community offer help with activities of daily living, such as help with bathing, either directly or arranged through an outside vendor?

- Yes (*skip to question 6*)
- No (*continue*)


5b. Does this residential care community offer assistance with the administration of medications, give reminders, or provide central storage of medications?

- Yes (*continue*)
- No (*skip to*  **BOX A**)




6. Does this residential care community provide or arrange for a personal care aide, RN, LPN, or the director or assistant director (if they provide personal care or nursing services to residents) to be on site 24 hours a day, 7 days a week to meet any resident needs that arise? Onsite means they are located in the same building, in an attached building or next door, or on the same campus.

- Yes (*continue*)
- No (*skip to*  **BOX A**)

7a. Does this residential care community exclusively serve adults with mental retardation or a developmental disability, such as Down syndrome or autism?

- Yes (*skip to*  **BOX A**)
- No (*continue*)

7b. Does this residential care community exclusively serve adults with severe mental illness, such as schizophrenia or psychosis? Please do not include Alzheimer's disease or other dementias.

- Yes (*skip to*  **BOX A**)
- No- This residential care community exclusively serves both persons with mental retardation/a developmental disability and severe mental illness. (*skip to*  **BOX A**)
- No- (**Go now to next page- QUESTION 1**) 
YOUR COMMUNITY IS ELIGIBLE TO PARTICIPATE IN THIS STUDY.

BOX A

Thank you very much for answering these questions. Unfortunately, this residential care community does not qualify for our study which is focused on communities that are in some way regulated by the State and provide a broader array of residential care services.

Please return this questionnaire in the enclosed return envelope so we will know that this community is not eligible to participate in the 2012 National Study of Long-Term Care Providers. After receiving this questionnaire, we will not need to contact you again.

Residential care places are known by many different names. Just a few terms used to refer to these places are assisted living, personal care, and adult care homes, facilities, and communities, adult family and board care homes, adult foster care, homes for the aged and housing with service establishments. For this study we refer to these places and others like them as residential care communities. Nursing homes are excluded.

Please refer to community records or request assistance from other staff if you need help answering any question.

2. Background Information

Please provide answers only for the residential care portion of your campus.

1. Is this residential care community part of a continuing care retirement community, that is, a community that offers multiple levels of care such as independent living, residential care and skilled nursing care, and provides residents the opportunity to remain in the same community as their needs change?

- Yes
- No

2. What is the type of ownership of this residential care community?

- Private, nonprofit
- Private, for profit
- Publically traded or limited liability company (LLC)
- Government – federal, state, county or local government

3. 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

4. Is this residential care community owned by any other type of organization?

- No, not part of another organization
- Yes



4a. For each item below, please indicate whether or not this type of organization owns this residential care community.

	Yes	No
a. Hospital	•	•
b. Nursing Home or Skilled Nursing Facility	•	•
c. Home Health Agency	•	•
d. Hospice Agency	•	•
e. Adult day services center	•	•
f. Other	•	•

5. What is the total number of years this community has been operating as a residential care community at this location?

_____ Year(s)

6. At this residential care community, what is the number of licensed, registered, or certified **residential care beds**? Include both occupied and unoccupied beds.

_____ Beds

7. Is this residential care community certified or otherwise set up to participate in Medicaid, either through the Medicaid State Plan or a home and community-based services waiver program?

- Yes
- No

8. During the last 30 days, how many of this residential care community's residents had some or all of their long-term care services paid by Medicaid?

_____ Number of residents (or) None

3. Services Offered at this Residential Care Community

Please provide answers only for the residential care portion of your campus.

9a. Does this residential care community only serve adults with dementia or Alzheimer's disease?

- Yes
- No (skip to question 10)

9b. Does this residential care community have specially trained staff for residents with dementia or Alzheimer's disease?

- Yes (skip to question 13)
- No (skip to question 13)

10. Does this residential care community have a distinct unit, wing, or floor that is designated as a dementia or Alzheimer's Special Care Unit?

- Yes
- No (skip to question 13)

11. How many licensed beds are in the dementia or Alzheimer's special care unit?

_____ Beds







12. Does this Dementia or Alzheimer's Special Care unit have . . .



MARK YES OR NO IN EACH ROW

- | | Yes | No |
|--|--------------------------|--------------------------|
| a. Higher staff-to resident ratios compared to other units? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Specially trained staff for residents with dementia or Alzheimer's disease? | <input type="checkbox"/> | <input type="checkbox"/> |

13. For each service listed below, please indicate whether or not this service is provided directly or through arrangement. Providing services through arrangement excludes referring residents to service providers.

Type of service	Does this residential care community provide or arrange for this service for its residents?	Is this service provided directly by residential care community employees, provided by others through arrangement, or both?
a. Routine and emergency dental services by a licensed dentist	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> Provided directly by residential care community employees <input type="checkbox"/> Provided by others through arrangement <input type="checkbox"/> Provided by residential care community employees and by others through arrangement
b. Hospice services	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> Provided directly by residential care community employees <input type="checkbox"/> Provided by others through arrangement <input type="checkbox"/> Provided by residential care community employees and by others through arrangement
c. Social work services Social work services are provided by licensed social workers or persons with a bachelor's or master's degree in social work, and include an array of services such as psychosocial assessment, individual or group counseling, and referral services.	<input type="checkbox"/> Yes → <input type="checkbox"/> No	<input type="checkbox"/> Provided directly by residential care community employees <input type="checkbox"/> Provided by others through arrangement <input type="checkbox"/> Provided by residential care community employees and by others through arrangement

<p>d. Any case management services</p> <p>Case management is generally a process of assessment, planning, and facilitation of options and services for an individual.</p>	<p><input type="checkbox"/> Yes </p> <p><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Provided directly by residential care community employees</p> <p><input type="checkbox"/> Provided by others through arrangement</p> <p><input type="checkbox"/> Provided by residential care community employees and by others through arrangement</p>
<p>e. Mental health services</p> <p>Mental health services are services that target residents' mental, emotional, psychological, or psychiatric well-being and include diagnosing, describing, evaluating, and treating mental conditions.</p>	<p><input type="checkbox"/> Yes </p> <p><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Provided directly by residential care community employees</p> <p><input type="checkbox"/> Provided by others through arrangement</p> <p><input type="checkbox"/> Provided by residential care community employees and by others through arrangement</p>
<p>f. Any therapeutic services-physical, occupational, or speech</p>	<p><input type="checkbox"/> Yes </p> <p><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Provided directly by residential care community employees</p> <p><input type="checkbox"/> Provided by others through arrangement</p> <p><input type="checkbox"/> Provided by residential care community employees and by others through arrangement</p>
<p>g. Pharmacy services- including filling of and delivery of prescriptions</p>	<p><input type="checkbox"/> Yes </p> <p><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Provided directly by residential care community employees</p> <p><input type="checkbox"/> Provided by others through arrangement</p> <p><input type="checkbox"/> Provided by residential care community employees and by others through arrangement</p>
<p>h. Podiatry services</p>	<p><input type="checkbox"/> Yes </p> <p><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Provided directly by residential care community employees</p> <p><input type="checkbox"/> Provided by others through arrangement</p> <p><input type="checkbox"/> Provided by residential care community employees and by others through arrangement</p>
<p>i. Skilled nursing services</p> <p>Skilled nursing services are services that must be performed by a registered nurse (RN) or a licensed practical nurse (LPN) and are medical in nature.</p>	<p><input type="checkbox"/> Yes </p> <p><input type="checkbox"/> No</p>	<p><input type="checkbox"/> Provided directly by residential care community employees</p> <p><input type="checkbox"/> Provided by others through arrangement</p> <p><input type="checkbox"/> Provided by residential care community employees and by others through arrangement</p>

j. Transportation services for medical or dental appointments	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Provided directly by residential care community employees <input type="checkbox"/> Provided by others through arrangement <input type="checkbox"/> Provided by residential care community employees and by others through arrangement
k. Transportation services for social and recreational activities, or shopping	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Provided directly by residential care community employees <input type="checkbox"/> Provided by others through arrangement <input type="checkbox"/> Provided by residential care community employees and by others through arrangement

14. Of the residents currently living in this residential care community, for about how many do you manage, supervise, or store medications, administer medications, or provide assistance with self-administration of medications?

____ Number of residents (or) None

15. As a part of admission process, does this community screen residents for **depression** with a standardized tool such as the Geriatric Depression Scale, Beck Depression Inventory, or Center for Epidemiological Studies-Depression screen?

- Yes
- No

16. Disease-specific programs may include one or more of the following services—educational programs, physical activity programs, diet/nutrition programs, medication management programs, and weight management programs. For each condition below, please indicate whether or not this residential care community offers **any** of these to residents?

	Yes	No
a. Alzheimer’s disease and other dementias	•	•
d. Depression	•	•
e. Diabetes	•	•
f. Cardiovascular disease (e.g., heart disease, high blood pressure, stroke)	•	•

17. On a regular basis, does this residential care community create daily schedules based on individual resident's life history, abilities, and interests?

- Yes
- No

18. On a regular basis, does this community seek input from residents and their families into...

	Yes	No
b. What personal care services are received by the resident?	<input type="checkbox"/>	<input type="checkbox"/>
c. How the resident's room is decorated?	<input type="checkbox"/>	<input type="checkbox"/>

19. Does this residential care community give residents choices in each of the following ways?

	Yes	No
a. Meal times?	<input type="checkbox"/>	<input type="checkbox"/>
c. Meal types/menus?	<input type="checkbox"/>	<input type="checkbox"/>

4. Staff Profile

Please consult records as needed to answer questions.

Please provide answers only for the residential care portion of your

community

The next questions are about staff that currently works at this residential care community.

This includes:

- both full-time and part-time residential care community employees, and
- other individual or organization staff under contract with and working at this residential care community full-time and part-time.

An individual is considered a community employee if the community is required to issue a Form W-2 on their behalf

20. How many of the following staff currently work at this residential care community?

Current Residential Care Community Staff		Number of Full Time Staff	Number of Part Time Staff		Number of FTE (Full-time equivalent) staff
If you do not have any staff for a specific category, enter "0" under number of full time / part time staff.					
a. Registered Nurses (RN)	Community employee	___	___	(or)	___
	Contract staff	___	___	(or)	___
b. Licensed Practical Nurses (LPN) / Licensed Vocational Nurses (LVN)	Community employee	___	___	(or)	___
	Contract staff	___	___	(or)	___
e. Social Workers Licensed social workers or persons with a bachelor's or master's degree in social work	Community employee	___	___	(or)	___
	Contract staff	___	___	(or)	___
i. Certified nursing assistants, nursing assistants, home health aides, home care aides, personal care assistants, and medication technicians or medication aides. * Note: Exclude employees/staff that were included in previous rows.	Community employee	___	___	(or)	___
	Contract staff	___	___	(or)	___

ADD: ON an average shift, how many activities director or activity staff are on site providing services? Include community employees and contract staff.

_____ Number of activities director or activities staff

5. Resident Profile

Please consult records as needed to answer questions.

Please provide answers only for the residential care portion of your campus.

21. What is the total number of residents currently living at this residential care community?

_____ Residents

22. Of the residents currently living in this residential care community, how many are...

22a. Of the residents currently living in this residential care community, how many are in each of the following categories? Count each resident only once. Enter "0" for any categories with no residents. Total should be the same as the total number of residents currently living in this residential care community.

- ___ Hispanic or Latino, of any race
- ___ American Indian or Alaska Native, not Hispanic or Latino
- ___ Asian, not Hispanic or Latino
- ___ Black, not Hispanic or Latino
- ___ Native Hawaiian or Other Pacific Islander, not Hispanic or Latino
- ___ White, not Hispanic or Latino
- ___ Two or more races, not Hispanic or Latino
- ___ Some other category reported in this residential care community's system
- ___ Not reported (race and ethnicity unknown)

___ **TOTAL**

22b. Gender distribution

- ___ Male
- ___ Female

___ **TOTAL**

22c. Age distribution

- ___ 17 or less
- ___ 18 - 44 years
- ___ 45 - 54 years
- ___ 55 - 64 years
- ___ 65 - 74 years
- ___ 75 - 84 years
- ___ 85 years and older

___ **TOTAL**

NOTE: Please make sure that the total number of residents for each of the 3 columns is the same as the number provided in question 21.

23a. Of the residents currently living in this residential care community, 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)?

___ Number of residents (*continue*)

None (*skip to question 25*)

23b. Of the residents who were discharged from an overnight hospital stay in the last 90 days, how many of those residents were **re-admitted** to the hospital for an overnight stay within 30 days of their hospital discharge?

___ Number of residents (*or*) None

24. Of the residents currently living in this residential care community, how many were treated in a hospital emergency department in the last 90 days?

___ Number of residents (*or*) None

ADD: Of the residents currently living in this residential care community, how many are respite care residents?

_____ Residents

Now please think about the last 12 months.

25. In the last 12 months, how many residents living in this residential care community died?

___ Number of residents (*or*) None

26. In the last 12 months, how many residents moved out of this residential care community? Include all departures, regardless of reason, but **exclude deaths**. Also **do not include** residents for whom the community is currently holding a bed for the resident and respite care residents.

___ Number of residents (*continue*)

None (*skip to question 30*)

27. Where did these residents go immediately after they moved out?

Number of Residents

- a. Another assisted living or similar residential care community (e.g. adult care or personal care residence) _____
- b. Hospital _____
- c. Nursing home _____

- d. Private residence _____
 - e. Some other place _____
- TOTAL _____

NOTE: Total should be the same as provided in question 27.

28. In the last 12 months, of those residents who moved elsewhere, how many left because the cost of care, including housing, meals, and services required to meet their needs, exceeded their ability to pay?

____ Number of residents left due to cost of care (or) None

29. In the last 12 months, how many residents moved into this residential care community?

Count all residents who moved in- including persons who later died and residents who no longer live here, regardless of the reason.

____ Number of residents (or) None

These next questions ask about the number of residents at this residential care community who currently need assistance in activities of daily living (ADLs). **Assistance refers to needing any help or supervision from another person, or use of special equipment.**

As a reminder, please provide answers only for the **residential care portion** of your campus.

30. Of the residents currently living in this residential care community, **about** how many need **any assistance...**

Number of Residents

- a. transferring in and out of bed? _____ (or) None
- b. transferring in and out of a chair? _____ (or) None
- c. with eating, like cutting up food? _____ (or) None
- d. with dressing? _____ (or) None
- e. with bathing or showering? _____ (or) None
- f. in using the bathroom (toileting)? _____ (or) None
- g. with locomotion or walking? This includes using a cane, walker, or wheelchair and/or help from another person. _____ (or) None

31. Of the residents currently living in this residential care community, about how many use a manual, electric, or motorized wheelchair or scooter?

____ Number of residents (or) None

32. Of the residents currently living in this residential care community, about how many have been diagnosed with each of the following conditions?

	Number of Residents	
a. Alzheimer's disease or other dementia	_____	(or) <input type="checkbox"/> None
b. Developmental disability, such as mental retardation, autism, or Down Syndrome	_____	(or) <input type="checkbox"/> None
c. Severe mental illness, such as schizophrenia and psychosis	_____	(or) <input type="checkbox"/> None
d. Depression	_____	(or) <input type="checkbox"/> None

33a. Before or upon admission, does this residential care community conduct a formal assessment of its residents using a standardized tool to identify anyone with a cognitive impairment?

- Yes (continue)
- No (skip to question 36)

33b. Of the residents currently living in this residential care community, based on this assessment about how many have been identified as having a cognitive impairment?

_____ Number of residents (or) None

6. Record Keeping






Please provide answers only for the residential care portion of your campus.

34. Other than for accounting or billing purposes, does this residential care community use Electronic Health Records? This is a computerized version of the resident's health and personal information used in the management of the resident's health care.

- Yes
- No

35. For each item (a – s) below, please indicate in column 1 whether or not this residential care community **collects or tracks this information** about residents. If this community does collect or track the information, please indicate in Column 2 whether this community has the **computerized capability** to collect or track it.

	<u>Column 1</u>			<u>Column 2</u>	
	Does this community collect/track this information?		IF YES IN COLUMN 1	Does this community have the computerized capability to collect/track this information?	
a. Contact information for the resident’s medical providers	<input type="checkbox"/> No	<input type="checkbox"/> Yes	—————▶	<input type="checkbox"/> No	<input type="checkbox"/> Yes
b. Resident demographics	<input type="checkbox"/> No	<input type="checkbox"/> Yes	—————▶	<input type="checkbox"/> No	<input type="checkbox"/> Yes
c. Functional assessments	<input type="checkbox"/> No	<input type="checkbox"/> Yes	—————▶	<input type="checkbox"/> No	<input type="checkbox"/> Yes
d. Individual service plans	<input type="checkbox"/> No	<input type="checkbox"/> Yes	—————▶	<input type="checkbox"/> No	<input type="checkbox"/> Yes
e. Resident service records (a record of the services being provided to each resident)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	—————▶	<input type="checkbox"/> No	<input type="checkbox"/> Yes
f. Clinical notes, such as medical history and daily progress notes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	—————▶	<input type="checkbox"/> No	<input type="checkbox"/> Yes
g. Resident problem list (medical and behavioral concerns)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	—————▶	<input type="checkbox"/> No	<input type="checkbox"/> Yes
h. Advance directives	<input type="checkbox"/> No	<input type="checkbox"/> Yes	—————▶	<input type="checkbox"/> No	<input type="checkbox"/> Yes
i. Automatic reminders for updating records, scheduling screening tests or guidelines based interventions	<input type="checkbox"/> No	<input type="checkbox"/> Yes	—————▶	<input type="checkbox"/> No	<input type="checkbox"/> Yes
j. Lists of medications	<input type="checkbox"/> No	<input type="checkbox"/> Yes	—————▶	<input type="checkbox"/> No	<input type="checkbox"/> Yes
k. Medication administration records	<input type="checkbox"/> No	<input type="checkbox"/> Yes	—————▶	<input type="checkbox"/> No	<input type="checkbox"/> Yes
l. Active medication allergy lists	<input type="checkbox"/> No	<input type="checkbox"/> Yes	—————▶	<input type="checkbox"/> No	<input type="checkbox"/> Yes
m. Warning of drug interactions or contraindications	<input type="checkbox"/> No	<input type="checkbox"/> Yes	—————▶	<input type="checkbox"/> No	<input type="checkbox"/> Yes
n. Discharge and transfer summaries	<input type="checkbox"/> No	<input type="checkbox"/> Yes	—————▶	<input type="checkbox"/> No	<input type="checkbox"/> Yes

- o. Outside health care visits: [] No [] Yes  [] No [] Yes
including emergency room
visits and overnight hospital
admissions
- p. Orders for prescriptions [] No [] Yes  [] No [] Yes
- q. orders for tests [] No [] Yes  [] No [] Yes
- r. Viewing laboratory / [] No [] Yes  [] No [] Yes
imaging results (seeing and
reading test results)
- s. Public health reporting [] No [] Yes  [] No [] Yes

36. For each item below, please indicate whether or not this residential care community's computerized system support **electronic health information exchange**.

- | | <u>Yes</u> | <u>No</u> |
|--------------|------------|-----------|
| a. Physician | • | • |
| b. Pharmacy | • | • |

7. Contact Information

We would like to reach you if we have questions about your answers. Please provide your name, telephone number, and job title. Your contact information will be kept confidential and will not be shared with anyone.

Your name: _____

Your work telephone number: (____) ____ - _____

Your job title: _____

Thank you for participating in the NSLTCP. Please return your completed survey in the postage-paid self-addressed envelope provided to:

NSLTCP
RTI International
Suite 100 Imperial Court Business Park
1000 Parliament Court
Durham, NC 27703