



National Study of Long-Term Care Providers

2014 Adult Day Services Center Questionnaire

Dear Director,

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

- **If this adult day services center is part of a multi-facility campus or has more than one adult day license, answer only for the place listed below.**
- Please consult records and other staff as needed to answer questions.
- If you need assistance or have questions, go to <http://www.cdc.gov/nchs/nsltcp.htm> or call 1-877-225-4434.

Label here

Thank you for taking the time to complete this questionnaire.

NOTICE – Public reporting burden of this collection of information is estimated to average 30 minutes per response. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0943).

Assurance of Confidentiality – All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used for statistical purposes only by NCHS staff, contractors, and agents only when required and with necessary controls, and will not be disclosed or released to other persons without the consent of the individual or establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).

National Center for Health Statistics
Division of Health Care Statistics



1 Background Information

1. Is this adult day services center ...

MARK YES OR NO IN EACH ROW

	Yes	No
a. licensed or certified by the State specifically to provide adult day services?	<input type="checkbox"/>	<input type="checkbox"/>
b. authorized or otherwise set up to participate in Medicaid?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "No" to both 1a and 1b, skip to question 27 on page 8.

2. Based on a typical week, what is the approximate average daily attendance at this adult day services center at this location? If none, enter "0."

Average daily attendance of participants

If you answered "0," skip to question 27 on page 8.

3. What is the total number of participants currently enrolled at this adult day services center at this location? If none, enter "0."

Number of participants

If you answered "0," skip to question 27 on page 8.

4. 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

5. 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, or local

6. 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

7. During the last 30 days, for how many of the participants currently enrolled at this adult day services center, did Medicaid pay for some or all of their services received at this center? If none, enter "0."

Number of participants

8. What is the total number of years this center has been operating as an adult day services center at this location?

MARK ONLY ONE ANSWER

- Less than 1 year
- 1 to 4 years
- 5 to 9 years
- 10 to 19 years
- 20 or more years

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 (including Medicaid managed care programs) %
 - b. Medicare %
 - c. Other government %
 - d. Out-of-pocket payment by the participant or family %
 - e. Private insurance %
 - f. Other source %
- TOTAL %

10. As a part of the admission process, does this adult day services center . . .

MARK YES OR NO IN EACH ROW

- | | Yes | No |
|--|--------------------------|--------------------------|
| a. screen participants for depression with a standardized tool or scale? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. accept results from depression screenings performed by other health care providers? | <input type="checkbox"/> | <input type="checkbox"/> |

11. Disease-specific programs may include one or more of the following services—education, physical activity, diet/nutrition, medication management, or weight management.

Does this adult day services center offer **any disease-specific programs** for participants with the following conditions?

MARK YES OR NO IN EACH ROW

- | | Yes | No |
|--|--------------------------|--------------------------|
| a. Alzheimer's disease and other dementias | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Cardiovascular disease (e.g., heart disease, stroke, high blood pressure) | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |

2 Services Offered

12. For each row, mark if this adult day services center provides the service by . . .

- Paid center employees
- Arranging for and paying outside vendors
- Arranging for outside vendors paid by others
- Referral
- **NONE OF THESE APPLY / NOT PROVIDED**

Type of Service	This adult day services center provides the service by . . . (MARK ALL THAT APPLY)				NONE OF THESE APPLY/ NOT PROVIDED
	Paid center employees	Arranging for and paying outside vendors	Arranging for outside vendors paid by others	Referral	
a. Routine and emergency dental services by a licensed dentist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Hospice services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Social work services—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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Mental health services—target participants' mental, emotional, psychological, or psychiatric well-being and include diagnosing, describing, evaluating, and treating mental conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Any therapeutic services—physical, occupational, or speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Pharmacy services—including filling of and delivery of prescriptions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Podiatry services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Skilled nursing services—must be performed by an RN or LPN and are medical in nature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Transportation services for medical or dental appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Transportation services for social and recreational activities, or shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Daily round trip transportation services to/from this center	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3 Staff Profile

13a. What is the **maximum** number of hours per week that **part-time staff** can work at this adult day services center?

Hours per week

13b. What is the **minimum** number of hours per week that **full-time staff** can work at this adult day services center?

Hours per week

14. For each category of staff listed below, please indicate the number of staff that currently work at this adult day services center full-time and part-time. Please include:

- both full-time and part-time **adult day services center employees** (an individual is considered a center employee if the center is required to issue a Form W-2 on their behalf), and
- other individuals or organization **staff under contract** with and working at this adult day services center full-time and part-time.

Enter "0" for any categories with no employees or staff.

Current Adult Day Services Center Staff		Number of Full-Time Staff If none, enter "0"	Number of Part-Time Staff If none, enter "0"
a. Registered nurses (RNs)	a. Adult day services center employee(s)	<input type="text"/>	<input type="text"/>
	b. Contract staff	<input type="text"/>	<input type="text"/>
b. Licensed practical nurses (LPNs)/ licensed vocational nurses (LVNs)	a. Adult day services center employee(s)	<input type="text"/>	<input type="text"/>
	b. Contract staff	<input type="text"/>	<input type="text"/>
c. Certified nursing assistants, nursing assistants, home health aides, home care aides, personal care aides, personal care assistants, and medication technicians or medication aides	a. Adult day services center employee(s)	<input type="text"/>	<input type="text"/>
	b. Contract staff	<input type="text"/>	<input type="text"/>
d. Social workers—licensed social workers or persons with a bachelor's or master's degree in social work	a. Adult day services center employee(s)	<input type="text"/>	<input type="text"/>
	b. Contract staff	<input type="text"/>	<input type="text"/>
e. Activities directors or activities staff	a. Adult day services center employee(s)	<input type="text"/>	<input type="text"/>
	b. Contract staff	<input type="text"/>	<input type="text"/>

4 Participant Profile

15. Of the participants currently enrolled at this center, how many are in each of the following categories? Count each participant only once. Enter “0” for any categories with no participants.

	NUMBER OF PARTICIPANTS
a. Hispanic or Latino, of any race	<input type="text"/>
b. American Indian or Alaska Native, not Hispanic or Latino	<input type="text"/>
c. Asian, not Hispanic or Latino	<input type="text"/>
d. Black, not Hispanic or Latino	<input type="text"/>
e. Native Hawaiian or Other Pacific Islander, not Hispanic or Latino	<input type="text"/>
f. White, not Hispanic or Latino	<input type="text"/>
g. Two or more races, not Hispanic or Latino	<input type="text"/>
h. Some other category reported in this center’s system	<input type="text"/>
i. Not reported (race and ethnicity unknown)	<input type="text"/>
TOTAL	<input type="text"/>

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

16. Of the participants currently enrolled at this center, how many are in each of the following categories? Enter “0” for any categories with no participants.

	NUMBER OF PARTICIPANTS
a. Male	<input type="text"/>
b. Female	<input type="text"/>
TOTAL	<input type="text"/>

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

17. Of the participants currently enrolled at this center, how many are in each of the following age categories? Enter “0” for any categories with no participants.

	NUMBER OF PARTICIPANTS
a. 17 years or younger	<input type="text"/>
b. 18–44 years	<input type="text"/>
c. 45–54 years	<input type="text"/>
d. 55–64 years	<input type="text"/>
e. 65–74 years	<input type="text"/>
f. 75–84 years	<input type="text"/>
g. 85 years or older	<input type="text"/>
TOTAL	<input type="text"/>

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

18. Of the participants currently enrolled 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 PARTICIPANTS
a. Alzheimer’s disease or other dementias	<input type="text"/>
b. Intellectual/developmental disability	<input type="text"/>
c. Severe mental illness	<input type="text"/>
d. Depression	<input type="text"/>
e. Cardiovascular disease (e.g., heart disease, stroke, high blood pressure)	<input type="text"/>
f. Diabetes	<input type="text"/>

- 19.** Assistance refers to **needing any help or supervision from another person, or use of special equipment.**

Of the participants currently enrolled at this center, about how many now need **any assistance at their usual residence or this center** in each of the following activities? **Enter "0" for any categories with no participants.**

NUMBER OF PARTICIPANTS

- 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. In using the bathroom (toileting)
- f. With locomotion or walking

- 20.** Of the participants currently enrolled at this center, 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 participants

- 21.** Of the participants currently enrolled at this center, about how many were treated in a hospital emergency department in the last 90 days? **If none, enter "0."**

Number of participants

- 22.** Of the participants currently enrolled at this center, about how many had any falls in the last 90 days? Include on-site and off-site falls. **If none, enter "0."**

Number of participants

- 23.** For about how many of the currently enrolled participants does this adult day services center provide medication-related services, such as storing medications; administering medications; or providing assistance to participants with self-administration of medications? **If none, enter "0."**

Number of participants

- 24.** Of participants who stopped using this adult day services center in the last 12 months, did **any** leave because the cost of attending the center, including meals and services required to meet their needs, exceeded their ability to pay?

- Yes
- No

5 Record keeping

- 25.** An Electronic Health Record 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

- 26.** 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

- | | Yes | No |
|--------------|--------------------------|--------------------------|
| a. Physician | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Pharmacy | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Hospital | <input type="checkbox"/> | <input type="checkbox"/> |

6 Contact Information

- 27.** In case we need to reach you, please provide your name, telephone number, work e-mail address, and job title. Your contact information will be kept confidential and will not be shared with anyone outside the project team.

PLEASE PRINT

Your full name:

Your work telephone number, with extension:

Your work e-mail address:

Your job title:

Thank you for participating.

Please return this questionnaire in the enclosed return envelope.