Form Approved
OMB No. 0920-0943
Exp. Date: 09/30/2023

National Post-Acute and Long-Term Care Study

2020 Adult Day Services Center Questionnaire

Dear Director,

The Centers for Disease Control and Prevention conducts the National Post-Acute and Long-Term Care Study (formerly known as the National Study of Long-Term Care Providers or NSLTCP). 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 1-877-256-8171.

Label here

FOR VIEWING PURPOSES ONLY

Thank you for taking the time to complete this questionnaire.

Notice – CDC estimates the average public reporting burden for this collection of information as 30 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information needed, and completing and reviewing the collection of information. 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 Information Collection Review Office, 1600 Clifton Road, MS D-74, Atlanta, GA 30333; ATTN: PRA (0920-0943).

Assurance of Confidentiality – We take your privacy very seriously. All information that relates to or describes identifiable characteristics of individuals, a practice, or an establishment will be used only for statistical purposes. NCHS staff, contractors, and agents will not disclose or release responses in identifiable form without the consent of the individual or establishment in accordance with section 308(d) of the Public Health Service Act (42U.S.C. 242m) and the Confidential Information Protection and Statistical Efficiency Act (Title III of the Foundations for Evidence-Based Policymaking Act of 2018 (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.

Background Information

1. Is this adult day services center located in the same building as, on the grounds of, or immediately adjacent to each of the following settings?
MARK YES OR NO IN EACH ROW

	Yes	No
a. Independent living residences	☐	☐
b. Hospital	☐	☐
c. Nursing home or skilled nursing facility	☐	☐
d. Home health agency	☐	☐
e. Hospice agency	☐	☐
f. Assisted living or similar residential care community	☐	☐
g. A specific unit where subacute or rehabilitation care is provided	☐	☐

If you answered "Yes" to any item in question 1, please answer all questions only for the adult day services center portion operating at the location on the cover page of this questionnaire.

2. 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

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

	Yes	No
a. licensed or certified by your State specifically to provide adult day services, or accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF)?	☐	☐
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-inclusive Care for the Elderly (PACE)?	☐	☐

→ *If you answered "No" to both 3a and 3b, skip to* ***question 40.***

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 and at place of residence
- ☐ Physical center is temporarily closed—but serving participants at place of residence
- ☐ Physical center is temporarily closed—not serving participants
- ☐ Physical center is permanently closed—no longer serving participants → *Skip to* ***question 40***

5. 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 due to COVID-19.* If none, enter "0."

☐ Number of participants

→ *If you answered "0," skip to* ***question 40.***

6. 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 participants

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

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

- ☐ Yes
- ☐ No → *Skip to question 11*

10. 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)	☐	☐

11. 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

12. Does this adult day services center typically maintain documentation of participants' advance directives or have documentation that an advance directive exists in participant files?

- ☐ Yes
- ☐ No → *Skip to question 14*

13. Of the current participants, how many have documentation of an advance directive in their file? If none, enter "0."

☐ Number of participants

14. 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

15. 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	☐	☐
b. Pharmacy	☐	☐
c. Hospital	☐	☐
d. Skilled nursing facility, nursing home, or inpatient rehabilitation facility	☐	☐
e. Other long-term care provider	☐	☐

16. 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 regional centers)	☐ %
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 100 %	

NOTE: Your entries should add up to 100%.

17. 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	☐	☐

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Services Offered

18. 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	Arranges for the service to be provided by outside service providers	Refers participants or family to outside service providers	Temporarily does not provide, arrange, or refer for this service	Does not provide, arrange, or refer for this service
a. Hospice 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 conditions	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐

Participant Profile

When answering the questions in the Participant Profile section, 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.

19. Of the participants currently enrolled at this center, what is the sex breakdown? Enter "0" for any categories with no participants.

	Number of Participants
a. Male	
b. Female	
TOTAL	

NOTE: Total should be the same as the number of participants provided in question 5.

20. 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 5.

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21. **Of the participants currently enrolled at 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 Participants
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 5.

22. **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 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, heart attack, stroke)	
i. High blood pressure or hypertension	
j. Intellectual or developmental disability	
k. Osteoporosis	

23. **For about how many of your currently enrolled participants do you help store or manage their opioid pain medications?** *Include reminders to take the opioid pain medication or handing the opioid pain medication to the participants to take. Examples include morphine, hydrocodone, oxycodone, codeine, fentanyl, and methadone, and combination opioid pain medications like hydrocodone, oxycodone, and codeine with acetaminophen.* *If none, enter "0."*

Number of participants

24. **Of the participants currently enrolled at this center, how many live in each of the following places?** Enter "0" for any categories with no participants.

	Number of Participants
a. Private residence (house or apartment)	
b. Assisted living or similar residential care community	
c. Nursing home or other institutional setting	
d. Other place	
TOTAL	

NOTE: Total should be the same as the number of participants provided in question 5.

→ *If you answered "0" to 24a, skip to* ***question 26***

25. **Of the participants currently enrolled at this center who live in a private residence, how many live with each of the following people?** *Assign each participant to only one category.* Enter "0" for any categories with no participants.

	Number of Participants
a. Alone	
b. With relative(s) (such as a spouse, partner, adult child including son or daughter-in-law, parent, or other relative)	
c. With non-relative(s)	

NOTE: Total should be the same as the number of participants provided in question 24a.

26. **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?** *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

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27. Assistance refers to needing any help or supervision from another person, or use of assistive devices. 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. With using the bathroom (toileting)	
f. With locomotion or walking—this includes using a cane, walker, or wheelchair and/or help from another person	

28. As best you know, 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

29. As best you know, 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

30. As best you know, about how many of your current participants had a fall in the last 90 days? *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

Staff Profile

31. An individual is considered an employee if the center is required to issue a Form W-2 federal tax form on their behalf. For each staff type below, indicate how many full-time employees and part-time employees this center currently 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 Employees	Number of Part-Time Employees
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		

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32. 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 34***

33. 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 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 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		

Information on COVID-19

34. Since January 2020, how many coronavirus disease (COVID-19) cases did this center have among participants and among employees or contract staff? *Include only presumptive positive and confirmed cases.* Enter "0" if none or select don't know if you do not know the number.

	COVID-19 cases		COVID-19 cases that resulted in a hospitalization		COVID-19 cases that resulted in death	
				Don't Know		Don't Know
a. Participants		If 1 or more →		☐		☐
b. Employees or contract staff		If 1 or more →		☐		☐

35. Since January 2020, how many participants with presumptive positive or confirmed COVID-19 infection did this center need to turn away or refer elsewhere? If none, enter "0".

☐ Number of participants

36. Since January 2020, did this center experience any of the following in your prevention, response, or management of COVID-19 infections? MARK YES, NO, OR DON'T KNOW IN EACH ROW

	Yes	No	Don't Know
a. Screening of participants daily for fever or respiratory symptoms	☐	☐	☐
b. Notifying all participants or families of a case in the center within 24 hours	☐	☐	☐
c. Use of telephonics or audio-only calls to assess, diagnose, monitor, or treat participants with presumptive positive or confirmed COVID-19 infection	☐	☐	☐
d. Use of telemedicine or telehealth (i.e., audio with video, web videoconference) to assess, diagnose, monitor, or treat participants with presumptive positive or confirmed COVID-19 infection	☐	☐	☐
e. Limiting of hours or temporary closure of this center	☐	☐	☐

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37. Since January 2020 to now, did this center experience a shortage of the following personal protective equipment?
MARK YES, NO, OR DON'T KNOW FOR EACH TIME PERIOD

	January 2020 to March 2020			April 2020 to June 2020			July 2020 to September 2020			October 2020 to now		
	Yes	No	Don't know	Yes	No	Don't know	Yes	No	Don't know	Yes	No	Don't know
a. Eye protection, gloves, face masks, or isolation gowns	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
b. N95 respirators	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

38. Since January 2020, how many participants with presumptive positive COVID-19 infection was this center not able to test due to shortages of test kits? If none, enter "0".

☐ Number of participants

39. Since January 2020, did this center impose restrictions on the following individuals from entering the building? MARK NEVER, SOMETIMES, OFTEN, ALWAYS, OR DON'T KNOW IN EACH ROW

	Never	Sometimes	Often	Always	Don't know
a. Family and relatives	☐	☐	☐	☐	☐
b. Visitors	☐	☐	☐	☐	☐
c. Volunteers	☐	☐	☐	☐	☐
d. Non-essential consultant personnel (e.g., barbers, delivery personnel)	☐	☐	☐	☐	☐

Contact Information

40. We would like to keep your name, telephone number, work e-mail address, and job title for possible future contact related to participation in current and future National Post-Acute and Long-Term Care Study (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 Name	
Your work telephone number, with extension	☐☐☐ – ☐☐☐ – ☐☐☐☐		Ext.	
Your work e-mail address				
Your job title				

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

NPALS
RTI International
ATTN: Data Capture
5265 Capital Boulevard
Raleigh, NC 27690

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Thank you for participating in the 2020 National Post-Acute and Long-Term Care Study.