Results of a Cognitive Testing Study to Examine the Impact of Record Keeping Practices in Long-term Care Facilities

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I. Introduction

This report summarizes the findings of a cognitive interviewing study conducted by the Collaborating Center for Questionnaire Design and Evaluation Research (CCQDER) using questions from the 2016 National Study of Long-term Care Providers (NSLTCP) to examine the impact of record keep practices on survey response in long-term care facilities. The NSLTCP was a biennial study begun in 2012 that was conducted by the Long-Term Care Statistics Branch in the Division of Health Care Statistics at the National Center for Health Statistics (NCHS) and was designed to provide national and state representative statistical information about the supply and use of long-term care (LTC) service providers in the United States. Starting in January of 2020, the NSLTCP was renamed the National Post-Acute and Long-Term Care Study (NPALS). However, for purposes of this report, which describes the testing of questions that were used in 2016, the survey will be referred to throughout as the NSLTCP. The NSLTCP includes five provider sectors: residential care communities (RCC), adult day services centers (ADSC), nursing homes, home health agencies, and hospices. The NSLTCP comprises two components: (1) primary data collected by NCHS through surveys of RCC and ADSC facilities, and (2) administrative data on nursing homes, home health agencies, and hospices obtained from the Centers for Medicare & Medicaid Services. Please see https://www.cdc.gov/nchs/npals/about_npals.htm for more details about the survey.

The overall purpose of this project was to investigate how record keeping practices at RCC/ADSC facilities impact data quality and respondent burden for the survey portion of the NSLTCP. Specifically, this project assessed 1) record keeping practices and response generation (data quality) for current aggregate-level service user survey questions and their (2) variation among providers (e.g., by sector and size), to determine the extent to which the current record keeping practices impact data quality or cause undue burden, and whether this varies by survey question or survey question type. A primary aim was to identify potential data quality (measurement and response generation) and burden challenges related to administrative record keeping in order to inform future study design and questionnaire development through a better understanding of record keeping practices among providers.

There are two versions of the NSLTCP: a version for RCC facilities and a version for ADSC facilities. The survey content differs slightly by version, but both versions have four sections. First the background section asks about licensing, corporate structure and facility specialization. Second, the participant profile section asks about resident/participant demographics, conditions, required assistance and living situation. Third, the services offered section asks about fall prevention, medical services, transportation and hospice. Finally, the staff profile section asks about full and part-time employees, contract employees and number of employees in certain positions. The ADSC version of the NSLTCP is available in Appendix A. The RCC version of the NSLTCP appears in Appendix B.

II. Methods

Cognitive Interviewing: As a question evaluation method, cognitive interviewing studies typically investigate how respondents answer survey questions although these studies can be used to examine any aspect of the survey process. Cognitive interviewing studies involve semi-structured interviews with a small sample of respondents (~20) with the goal of understanding the cognitive processes of question response: comprehension, retrieval, judgment and response (Tourangeau, 1984). Sample selection for cognitive interviewing projects is purposive; that is, the sample is theoretically driven. Respondents are selected based on particular characteristics to address the questions being evaluated within the context of the overall objectives of the study. Analysis for a cognitive interviewing study is conducted through a process of data synthesis and reduction (Miller, Willson, Chepp, & Padilla, 2014). Interviews are conducted and summarized, emerging themes and patterns are noted across questions and then these patterns are compared across sub-groups of respondents. This data reduction process leads to an in-depth understanding of the performance of each question including how each question is understood by respondents, how each question functions as a part of the whole survey and how respondents access the information necessary to provide their responses.

Overview. This study built on results of a previous cognitive interview study of the NSLTCP (Scanlon, 2014). Although cognitive interview studies often focus primarily on the question response process, the main goal of the current study was to examine how administrative record-keeping practices at long-term care facilities impacted respondents' responses on the NSLTCP. The data collected provide an in-depth understanding of how respondents used administrative records to respond to each item on the survey. A total of 17 cognitive interviews were conducted with administrators from both RCC and ADSC facilities.

Recruitment and sample: For this study, the CCQDER research team recruited a purposive sample of 17 long-term care facility administrators from both ADSC and RCC facilities. The administrators held various job titles including owner, manager and director. Respondents were initially recruited from a list of respondents who had responded to the 2017 NSLTCP, and who had indicated in the open comment box that they would be available for follow-up. Pre-recruitment letters were sent to the facility addresses on record and these were followed up with phone calls during which respondents were screened for eligibility to participate. Additional respondents were recruited through word of mouth in the Washington, DC metropolitan area. An attempt was made to recruit respondents from facilities that varied in type, location and size. As detailed in Table 1, 12 of the 17 facilities were ADSC facilities and ten of the 17 were located in Maryland. Forty-one percent (n=7) of the facilities were large (i.e. serving more than 75 participants).

Table 1. Facility Characteristics

Characteristic		**n=17**
Type*	**ADSC**	**12**
	RCC	**5**
Location	**Maryland**	**10**
	District of Columbia	**2**
	Virginia	**2**
	Alabama	**1**
	Kansas	**1**

	Washington	**1**
Size	**Small (<20)**	**4**
	Medium (20-75)	**6**
	Large (>75)	**7**

***Adult Day Services Center (ADSC) or Residential Care Community (RCC)**

Respondents were more likely to identify as Black or African American, be of non-Hispanic ethnicity, and to be aged 56 years or older compared to the other race, ethnicity, and age groups. Demographic characteristics for the full sample are shown in Table 2.

Table 2. Respondent Demographics

Characteristic		**n=17**
Race	**Black or African American**	**8**
	White	**5**
	Asian	**4**
Ethnicity	**Hispanic**	**2**
	Non-Hispanic	**15**
Age (in years)	**< 36**	**4**
	36-55	**5**
	> 56	**8**
Gender	**Female**	**10**
	Male	**7**

Interviewing procedures: Interviews were conducted in person at the facilities where the respondents worked. The NSLTCP was designed to be a paper-and-pencil (PAPI) survey, but for the purposes of this study, the questions were interviewer administered. Respondents from ADSC facilities were administered the ADSC version of the survey while respondents from RCC facilities were administered the RCC version. After respondents answered each question or group of questions, the interview then asked a series of intensive probe questions. Probe questions were related to the question response process and particularly focused on how respondents used administrative records to answer the

survey questions. Interviews lasted up to 60 minutes, and respondents were given $100 once the interviews were completed.

Data Analysis: Interviewers used video recordings and written notes taken during the interviews as the basis for analysis. After completing each interview, researchers compiled question summaries for each cognitive interview. Summary notes were then compared across interviews to identify common themes related to each question. Analysis was conducted using Q-Notes, a CCQDER data entry and analysis tool (www.cdc.gov/qnotes). Q-Notes provides a systematic and transparent way to document each stage of data synthesis and reduction described earlier. Q-Notes also provides analysts with an audit trail to demonstrate how findings were generated from the raw interview data.

III. Overall Findings

Data Sources, Format and Organization

Accessing the data required to fill out the NSLTCP can be difficult and time consuming for respondents. Long-term care facilities (i.e., Residential Care Communities and Adult Day Service Centers) do not keep records for the purpose of filling out surveys, so, although they keep abundant records, the information required to fill out the NSLTCP is rarely easily or efficiently accessible from a single record source. Records are kept for a variety of reasons including for compiling reports for state and local agencies, for requesting program funds, for insurance requirements, for billing and reimbursement, for communicating with healthcare providers and for maintaining participants' care plans. However, there is little standardization of what records are kept, how they are kept or how they are organized across facilities.

Data Sources: Respondents relied on a variety of data sources to gather information when responding to the survey questions, including:

- *General knowledge:* Respondents often relied on their own or other staff knowledge of their facilities. Respondents and other employees often gained detailed knowledge of their facilities through performing the tasks of day-to-day operations such as renewing licenses, preparing meals, processing invoices and paying employees. This type of knowledge did not rely on formal record keeping but rather on experiential or anecdotal awareness.

- *Daily Roster:* All facilities kept daily rosters of residents/participants, and respondents often consulted these for general information about attendance, billing and medical needs.

- *Resident/Participant Charts:* Charts are comprehensive records that are kept for every resident/participant. Some of the information asked for on the survey can only be found in the resident/participant charts. These charts often take the form of paper folders kept in filing cabinets or file boxes. Respondents reported that going through the paper charts can be quite time consuming.

- *Care Plans:* Many facilities have a care plan for each resident/participant. The care plans are usually kept and maintained by the nursing staff and provide information on resident/participant medical conditions, medication, physicians' reports and details of any assistance needed.

- *Intake records:* These forms collect information on residents/participants when they first come to a facility. Intake records are often the only record of a resident/participant's demographic information.

- *Dietary notes:* Facilities that provide meals for residents/participants keep detailed records that contain information about medical conditions, dietary restrictions and number of meals served. These records may be kept in individual resident/participant charts or may be kept in a separate database or paper folder.

- *Billing records:* Respondents often consulted billing records for information about attendance, Medicaid and resident/participant demographics.
- *Corporate human resources systems and payroll records:* These are records of who is employed, what jobs they are doing and when and how much they are paid. These systems were often used to gather information on the number and type of employees at a particular facility.

- *Daily/weekly/monthly/annual reports:* Facilities are often required to compile reports for government agencies, corporate owners or funding sources. These reports compile information gathered from many of the sources described above. Respondents often consulted these reports where the needed information had already been compiled and aggregated.

Format (Paper/Electronic): Records at LTC facilities are kept on paper, in electronic databases or through a hybrid of the two. Many facilities rely solely on paper records. In these facilities, all information on residents/participants is recorded on paper, and then filed in large filing cabinets. One respondent described her facility's paper system saying, "I'm old-fashioned. I do everything by hand. I have all my life, with all my businesses… there aren't many systems for day care. There are a few that are supposed to be very, very good, but I've never looked at them."

Other respondents had switched over to electronic systems. One said, "We spent 8 years and a lot of money to get it running. It's called ADS. It does everything including marketing leads, billing, medication, transport, client info-everything!"

However, most facilities used a combination of paper and electronic records. Usually this was because they were used to using paper systems and had not figured out how to integrate the electronic systems into their day-to-day operations. One respondent described this dilemma, "[the EHR] includes a care plan, progress notes, interests and assessment tools. It can do a lot more, but we've had it for 9 years and don't use most of it… we also keep the paper charts. That's just easier…. They're easier to use."

Respondents who relied on paper records reported that gathering information through the paper files ("charts") was often a time consuming and laborious process. One respondent described this process, "We go in the conference room and pull the files. It's 80 charts, and we go through them by hand and tally the information. All the information is there, but it just takes a long time to sort through all the paper." When asked how long it would take to go through all of the charts, she said, "Oh hours. Many hours. It's a long process," In contrast, the few respondents who kept all records electronically reported that it was relatively quick and easy to access the information needed on the NSLTCP. However, some facilities that use electronic records don't have direct access to the records. At these facilities, respondents have to send a request for specific information to their IT department or database manager and wait for the information to be provided. One respondent noted that this system "is not difficult, but it does take time."

Organization of Information: Regardless of the format of the records, there were large differences in how records were organized across facilities. Some facilities organized records at the individual level. That is, in these facilities, most information about an individual resident/participant (such as medical conditions, emergency contacts, dietary

information and activity limitations) is kept together in an individual's "chart." At other facilities, basic information is kept in the resident's/participant's charts, but most other information is compiled separately. For example, in these facilities, there may be separate databases for medical conditions, billing, dietary restrictions and emergency contacts.

Threats to Data Quality

One of the aims of this project was to investigate how record keeping practices at long-term care facilities impact data quality. Findings indicate that there are several potential threats to data quality:

Reliance on general knowledge: As described above, respondents often relied on general knowledge rather than on formal records when responding to the NSLTCP. In many cases, reliance on general knowledge did not lead to response error. However, the potential for response error is greater when respondents rely on general knowledge. Additionally, respondents who relied on general knowledge tended to estimate or guess about data more than those who relied on formal records.

Record comparability. Because facilities keep records in different ways and for different purposes, data keeping practices across facilities are not comparable. For example, facilities may keep records over different time periods or using different metrics.

Incomplete or missing data: As noted above, facilities do not keep records for the purpose of filling out the NSLTCP survey. Therefore, facilities do not always have the complete information required to answer some survey questions. In these cases, respondents usually estimate or extrapolate from available data. However, in some cases, facilities do not keep any data related to certain questions. For example, many facilities do not keep official records of resident/participant race or information on medical conditions that don't require specific care protocols.

Mismatch to response categories: Again, because facilities keep records for their own purposes, the categories provided on the NSLTCP do not always correspond to the ways in which the data are recorded at the facilities. For example, the NSLTCP asks for resident/participant ages in specific ranges. Many facilities use different ranges to record resident/participant ages or only record this information as birth dates. Therefore, time-consuming data searches and calculations have to be performed to make the data match the available response categories.

Survey section: These threats to data quality were evident in all sections of the instrument but seen particularly in the participant profile section which focuses on resident/participant demographics and medical conditions.

No differences in data quality were observed between RCC and ADSC facilities.

Factors that increase burden

Examining respondent burden was another aim of this project. Findings demonstrate that there are several factors that increase burden for respondents filling out the NSLTCP:

Facility size: In general, respondents from larger facilities found it more difficult to gather all of the information necessary to answer the questions on the NSLTCP. Respondents from smaller facilities often had much of the information readily available whereas respondents from larger facilities had to locate the information or make complicated calculations.

Access to records: Increased burden was seen in facilities where the respondent did not have access to all the data. For example, in some facilities, the respondent might have to consult the nursing staff for information on resident/participant conditions or the respondent might have to consult the payroll office for information on staffing.

Location of records: Respondents from facilities that kept data in more than one location had a more difficult time finding all the information needed to complete the survey. Respondents from facilities that had a centralized location (either electronic or paper) for all records could easily locate the necessary information whereas respondents from facilities that kept records in multiple places (e.g. nurses office, off-site corporate office and director's office) found it much more time consuming to locate all the needed information.

Electronic vs. paper: Respondents from the few facilities that kept comprehensive and centralized electronic records were able to quickly and easily locate the information needed to accurately complete the survey. Respondents from facilities that relied on paper records reported that it took a lot of time to gather the needed information from the paper records.

Question type: Some of the questions on the NSLTCP such as those that asked for percentages required calculations that could be challenging for respondents. Other questions required significant time to tally the information gathered from various sources.

These issues were similar between RCC and ADSC facilities.

IV. Question by Question Findings

- Curated general-purpose repository that makes data discoverable, freely usable, and citable

This question was asked of respondents from ADSC facilities. Respondents all understood this question as asking about facility licensing and certification and Medicaid participation. The various locations had different licensing requirements, but according to the respondents, each facility was fully licensed and/or certified. One respondent was not familiar with PACE and did not provide a response to part b.

Data Sources: Respondents all relied on their own knowledge of the licensing requirements and procedures to answer this question. The owner of one facility answered "yes" and said, "We've been licensed by the state of Maryland for 19 years. It used to be renewable but now it's a permanent thing." The manager of a facility in Virginia said, "Well in Virginia, all facilities have to be licensed, so yes."

RCC1 Is this residential care community currently licensed, registered certified or otherwise regulated by the state? Yes/No.

This question was asked of respondents from RCC facilities. Respondents all understood this question as a question about licensing. All respondents indicated that their facilities were licensed and that they complied with all state and local regulations. For example, one respondent said, "This is a continuum of care community with three levels of service. We are licensed by the

District of Columbia with yearly renewals. We are Medicare certified and have a CMS 5-star quality of care rating."
Data Sources: Respondents all relied on their own knowledge of their facilities' licensing to answer this question.

ADSC2 Based on a typical week, what is the approximate average daily attendance at this adult day services center at this location?

Respondents understood this question to be asking for an estimate of the number of people who attend their facilities each day. Most indicated that the number of participants fluctuated based on factors such as "weather, holidays and health."

Data Sources: Respondents relied on a variety of sources to provide estimates of average daily attendance. Some were able to answer based on their own knowledge of daily attendance. For example, one respondent answered "170" and said, "We're full every day. I could look at the attendance record, but I don't need to."

Other respondents consulted electronic or manual records of attendance. One respondent answered "36" and said, "I get the exact number through our software system." He went on to explain that they use ADS which is an internal electronic health record (EHR) system. Another respondent said, "We do a roll call every day, so I would look at the daily roster." This roster is a manual record of attendance. A few respondents indicated that they would consult monthly director's reports which provide a summary of daily attendance.

Two respondents consulted billing records. One respondent explained that they have roll call receipts which they attach to billing forms which they submit to the Department of Human Resources and Medicaid for reimbursement.

RCC2 At this residential care community, what is the number of licensed, registered or certified residential care beds? Include both occupied and unoccupied beds.
If this residential care community is licensed, registered or certified by apartment or unit, please count the number of single-resident apartments or units as one bed each, two-bedroom apartments or units as two beds each, and so forth.

This question was asked of respondents from RCC facilities. All respondents understood this question as asking how many beds their facilities were licensed for. Respondents answered based on the number of beds permitted under their licenses regardless of how many beds were occupied. For example, one respondent answered "110" even though only 39 of her facilities beds were occupied.

Data Sources: All respondents relied on their own knowledge to answer this question. All respondents also indicated that licensing records were kept on file and that any information about the number of beds could be verified by checking the licensing information. However, none of the respondents felt it necessary to check. One said, "We just went through our renewal. I'm sure that we have 78 beds."

ADSC3 What is the total number of participants currently enrolled at this adult day services center at this location?

Respondents understood this as a question about how many participants were enrolled at their facilities.

Data Sources: All respondents were able to answer using their own knowledge of total enrolled participants. Most facilities enroll more participants than their capacity because most participants don't attend every day. For example, one owner explained why they have 62 participants enrolled when their daily maximum is only 40. She said, "The reason for that is many of our clients are part time; they don't come here five days a week. So for every slot you may have 2 or even 3. It can be a real puzzle."

A few facilities were under-enrolled. Respondents at these facilities were acutely aware of their enrollment numbers and their need to increase enrollment in order to increase revenue. One respondent answered 69 and went on to explain, "We usually try to have 80 but have lost 19 this year due to death or nursing home placement. We are currently marketing to get new clients. You know, pounding the pavement so we can stay in business."

RCC3 Does this residential care community only serve adults with… a. an intellectual or developmental disability? b. severe mental illness such as schizophrenia and psychosis? Do not include Alzheimer's disease or other dementias. Yes/No.

This question was asked of all respondents from residential care facilities. All respondents understood this as a question about whether their facilities are exclusively for certain types of residents. All respondents answered "no." Some respondents explained that their facilities were open to everyone including those with intellectual disabilities or mental illness. For example, one respondent explained, "We serve seniors 62 and older, multiple diagnoses. If their physician says they need to be here, they can be here." Another said, "We take pretty much everyone." Other respondents were at facilities that specifically excluded residents with intellectual disabilities or severe mental illness. One respondent said, "During the admissions process, there is a screening and if they have one of those, they can't pass through. There are other services for them."

Data Sources: All respondents used their own knowledge to respond to this question.

- Curated general-purpose repository that makes data discoverable, freely usable, and citable

Respondents understood this as a question about the facility's maximum capacity. For some facilities, this was based on the maximum allowable under their license. For other facilities, this was based on the size limitations of the facility (square footage) while for others, it was a programming decision based on staffing.

Data Sources: All respondents used their own knowledge of facility operations in order to answer the question.

RCC4 Does this residential care community offer at least two meals a day to residents? Yes/No.

This question was asked of all respondents from residential care facilities. All respondents understood this as a question about whether they serve meals. All respondents answered "yes" and stated that they provide their residents with all meals. For example, one respondent said, "All meals are provided and co+oked by the staff. They can eat more if they get hungry. We want it to feel like this is their home."

Data Sources: All respondents used their own knowledge to respond to this question.

ADSC5 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.

Respondents understood this as a question about whether their facility was a singular facility or part of a group owned or managed by the same person/people. One respondent answered "yes" and said, "It's a corporation that owns two. It's a non-profit corporation."

Data Sources: All respondents used their own knowledge of the facility's ownership structure in order to answer the question.

ADSC6 Which one of the following best describes the participant needs that the services of this center are designed to meet? [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]

Respondents understood this as a question about the primary focus of the services provided by their facilities.

Some respondents answered based on the services offered at their facilities. This was an easy question for the respondent in Alabama who answered "ONLY social." She explained, "Alabama does not license adult daycares that are not a social model. So we don't do health care." Other facilities offered both social and medical. One respondent answered "EQUALLY social/recreational and health/medical" and said, "Participants choose their activities and we also have a full-time nurse here."

Other respondents understood this as a somewhat subjective question about the needs of their present population. For example, one respondent who answered "PRIMARILY social" explained, "Currently, we are primarily social and recreational needs, but that can vary…If you have people that are sicker. In other words, the group that is here does not need that much medical help. However, they could leave and other people could come in that require more nursing." Similarly, another respondent who also answered "PRIMARILY social" said, "That's a little bit tricky because it fluctuates based on the clients we have. Right now, knowing my population, I would select #2, 'Primarily social/recreational,' but other times we might get people that are

more chronic: COPD, congestive heart failure. And in that case we do a little more health and medical and it would be a different answer."

Data Sources: All respondents answered based on their own knowledge of the services offered or needed at their facilities.

RCC6 Does this residential care community provide or arrange for any of the following types of staff to be on site 24 hours a day, 7 days a week to meet any resident needs that may arise? On site means the staff are located in the same building, in an attached building or next door, or on the same campus. a. personal care aide or staff caregiver; b. Registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN); c. Director, assistant director, administrator or operator (if they provide personal care or nursing services to residents) Yes/On an as needed basis/No.

This question was asked of all respondents from residential care facilities. All respondents understood this as a question about 24/7 staffing coverage at their facilities. A few respondents were confused by the part of the question that specified "in an attached building or next door" and wondered if the question was referring only to staff who lived near the facility. Despite this confusion, all respondents were able to answer the question without evidence of response error. One respondent explained that her facility provides skilled nursing which requires 24/7 coverage. "We have a nurse and a CNA here at all times. They work shifts."

Data Sources: All respondents used their own knowledge of staffing to respond to this question. A few noted that this information was also part of the personnel records.

ADSC7 Is this a specialized center that serves only participants with a particular diagnosis, condition or disability? Yes/No.

This question was asked of all respondents from adult day services centers. All respondents understood this as a question about specialized focus at their facilities. All respondents answered "no." One respondent explained that her facility provides services for anyone. She said, "Easy question. There are places in Virginia that only serve people with developmental disabilities, but we take anyone." Another respondent said, "We're open. The only people we don't do are people with higher acuity medical needs like somebody who had a tracheostomy or who needs an IV or really intense wounds are someone who needs special equipment to function beyond normal oxygen and stuff."

Data Sources: All respondents used their own knowledge of their facilities' specializations to respond to this question.

RCC7 Does this residential care community offer… a. help with activities of daily living (ADLs), such as help with bathing, either directly or arranged through an outside vendor? b. assistance with medications, such as the administration of medications, give reminders , or provide central storage of medications? Yes/No.

This question was asked of all respondents from residential care facilities. All respondents understood this as a question about assistance provided at their facilities. All respondents

answered "yes" to both parts of the question. One respondent explained that assistance with ADLs is given by "personal care aides or care givers." Another respondent described how medication is dispensed, "Everyone has a schedule with what time and day they take their medication, so we make sure they take it at the right time and day and every time we give it to them, we mark the book saying, 'All right. We gave it to them at this time.'" Like this respondent, several other respondents noted that they are required to record this information. One said, "Every facility has a 'medications book' where facility staff record all this information."

Data Sources: All respondents used their own knowledge to respond to this question.

ADSC8 In which of the following diagnoses, conditions, or disabilities does this center specialize? [Alzheimer's disease or other dementias; Human immunodeficiency virus (HIV)/AIDS; Intellectual or developmental disabilities; Multiple sclerosis; Parkinson's disease; Post-stroke physical or cognitive impairments with a need for rehabilitative therapies; Severe mental illness, such as schizophrenia and psychosis; Traumatic brain injury; Other (please specify)]

Respondents answered based on their facilities' areas of specialization.

Some facilities had areas of specialization that catered to clients with particular conditions. For example, one respondent who answered "severe mental illness" and "traumatic brain injury" described how her facility's focus on specialization attracted participants with these conditions.

Other facilities received specialized training to meet the needs of their clients. For example, one respondent who answered "Alzheimer's disease or other dementias" explained how the majority of her facility's participants had this condition, so they made sure to have extra training in Alzheimer's care. She explained, saying:

> Specialized is tricky, since, again, we are not a specialized center. We are here for everyone with pretty much all of these conditions. The only one I would say we have some specialty is Alzheimer's because it is just the majority of the folks we take care of. So we spend a lot of time training for that.

Respondents from facilities with no particular specialization either chose none of the answer categories or all of the answer categories. For example, the respondent from Alabama chose none of the answer categories and explained that in his state, Adult Day Services Centers are either medical or social, but never both. His facility is not licensed to provide any type of medical service. He said, "This is not applicable to us because we don't specialize." In contrast, a different respondent chose all of the answer categories saying, "We don't specialize in any one condition. We're open to all."

Data Sources: All respondents answered based on their own knowledge of their facilities' specializations.

ADSC9 What is the type of ownership of this adult day services center?

RCC8 What is the type of ownership of this residential care community? [Private—nonprofit; Private—for profit; Publicly traded company or limited liability company (LLC); Government—federal, state, county, or local]

All respondents understood this as a question about the corporate structure of their facilities. For example, one respondent, who answered "private- for profit" said, "We're for profit although we don't make a profit. Haha. Our attendance is low." Another respondent answered "Government-federal, state, county, or local" and explained that 75% of their funding comes from the county which also owns the facility.

Data Sources: All respondents answered based on their own knowledge of their facilities' ownership.

RCC9 Is this residential care community authorized or otherwise set up to participate in Medicaid? Yes/No.

This question was asked of all respondents from residential care facilities. Almost all respondents understood this as a question about whether their facilities take Medicaid. One respondent was confused between Medicare and Medicaid. He initially answered "yes" but then realized he was confused. He said, "So I'm sorry. I was thinking it was Medicare." However, his facility is authorized to participate in Medicaid, so his response stayed the same once he realized his confusion.

Some respondents answered "yes" and explained that their facilities are authorized to participate in Medicaid. Others responded "no" because their facilities don't accept Medicaid patients. One said, "We only take private pay patients."

A single respondent answered "no" but then explained that he didn't know. He said, "The county provides the placements through adult foster care. The county does all the billing and we are reimbursed by the county."

Data Sources: All respondents used their own knowledge to respond to this question.

ADSC10 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%. [a. Medicaid (include revenue from a Medicaid state plan, Medicaid waiver, Medicaid managed care, or California regional center) b. Medicare c. Older Americans Act d. Veterans Administration e. Other federal, state, or local government f. Out-of-pocket payment by the participant or family g. Private insurance h. Other source]

Respondents all understood this as a question about the various sources of their facilities' revenue. While most respondents immediately provided their responses in percentages, some respondents thought of this question in terms of number of respondents for each funding source rather than by percentage. For example, one respondent said, "Ummm, we have about 11 or 12. No, it's 14 on Medicaid." Additionally, at least one respondent noted that it would be difficult to calculate the percentages because the cost is not the same across all payment types. This

respondent said that there are at least 6 different payment rates based on per diem support, level of care required and funding source.

Response Categories: Respondents also reported some ambiguity or overlap in the response categories. One respondent said that she lumps out-of-pocket together with private insurance, explaining, "The way we do it, they pay us and we help them get their insurance claim."

Another respondent was not sure which category to choose for participants that are paid for by workers compensation. She said, "We do also have workers comp. I'm not sure where that fits in." Ultimately, she left them out of her calculation.

A different respondent wasn't sure about funding from the Older Americans Act. She explained "It's a tricky one to answer because it's trickle down funding. We do have two clients that receive money through a program that is funded through the Older American's Act. So I would say 1%." This same respondent also confused out-of-pocket with private insurance because her facility refers to out-of-pocket as "private pay."

Data Sources: Respondents consulted different sources of data in order to provide their responses to this question. A few were able to rely on their own knowledge of the source of funding for each of their clients. One answered "Medicaid: 99%" and explained that they only have two clients who pay out-of-pocket so it was an easy calculation.

Several respondents said they could consult the attendance roster to find this information as their clients were listed according to funding source.

Other respondents said they would need to look up the billing records to find exact numbers to answer this question. Some of these respondents had access to this information themselves. For example, one respondent pulled up the information from the billing database during the interview. However, a few respondents did not have direct access to this information. One respondent explained, "Honestly, I would just call our accounts receivable people. I don't have access to the accounts payable database. That's at the corporate level."

RCC10 During the last 30 days, for how many of the residents currently living at this residential care community did Medicaid pay for some or all of their services received at this community?

This question was asked of all respondents from residential care facilities. Almost all respondents understood this as a question about how many of their facilities' residents are covered by Medicaid. One respondent was confused between Medicare and Medicaid. He initially answered based on Medicare coverage but then changed his response to "none" since none of the residents at his facility are paid for by Medicaid. He explained, "So for Medicaid, I think once you are over a certain age, Medicaid automatically kicks in for you as far as when you pay for your medication. So, most of the residents we get are over the age of 65. So, when they are getting their medication, that part of Medicaid we don't really deal with. That part is already taken care of through their family member or whoever is in charge of their finances."

Other respondents answered "yes" and explained that some or all of their residents are covered by Medicaid. One said, "Most have Medicaid with at least partial pay."

Data Sources: A few respondents used their own knowledge to answer this question. One said, "I'm the administrator so I'm deep in all this stuff." Other respondents would need to access billing records to find this information. One said, "It's in the system so I could just run the report." Another said, "I would have to call our billing office to get the exact number."

ADSC11 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?

RCC11 An electronic health record (EHR) is a computerized version of the resident's health and personal information used in the management of the resident's health care. Other than for accounting or billing purposes, does this residential care community use electronic health records? Yes/No.

Almost all respondents understood this as a question about whether they have an EHR system in place. One respondent said, "Yes! We spent 8 years and a lot of money getting it running. It does everything. The system will eventually be a statewide system but right now it's just internal." Another respondent said, "No! I'm old-fashioned. I do everything by hand. I have all my life with all my businesses."

Several respondents noted that their facilities use an EHR, as required by the state, as well as paper records, which they find more useful. Most of these respondents answered "yes" to the question based on having the state mandated EHR in place. However, a single respondent answered "no" despite having the EHR in place since they prefer their paper records.

Data Sources: All respondents relied on their own knowledge of their facilities' use of EHRs to answer this question.

ADSC12 Does this adult day services center's computerized system support electronic health information exchange with each of the following providers? Do not include faxing.

RCC12 Does this residential care community's computerized system support electronic health information exchange with each of the following providers? Do not include faxing. a. Physician b. Pharmacy c. Hospital. Yes/No.

Respondents understood this as a question about whether their facilities communicated with physicians, pharmacies and hospitals through an EHR system. One respondent said "no" and explained, "All our records are on paper, so no. We don't do that."

A few respondents noted that they COULD use their EHRs to do this, but that fax and email are generally preferred. One respondents said, "We could do that but the physicians prefer fax. It's easier to use fax to get a doctor to sign an order." These respondents all answered "no." However, one respondent answered "yes" to all based on his facility's use of e-faxes to communicate with physicians, pharmacies and hospitals.

Data Sources: All respondents relied on their own knowledge of their facilities' communication through EHRs to answer this question.

RCC13 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.

This question was asked of all respondents from residential care facilities. All respondents understood this as a question about whether the owner of their facilities owned other facilities as well. Some respondents answered "yes" because the owners of their facilities owned multiple facilities. One said, "We're part of a group across 8 states." Others answered "no" because their facilities were owned as single facilities. One said, "We're a stand-alone facility."

Data Sources: All respondents used their own knowledge to respond to this question.

ADSC13 Of the participants currently enrolled at this center, what is the racial-ethnic breakdown? Count each participant only once.

RCC14 Of the residents currently living in this residential care community, what is the racial-ethnic breakdown? Count each resident only once. [a. Hispanic or Latino, of any race b. American Indian or Alaska Native, not Hispanic or Latino c. Asian, not Hispanic or Latino d. Black, not Hispanic or Latino e. Native Hawaiian or other Pacific Islander, not Hispanic or Latino f. White, not Hispanic or Latino g. Two or more races, not Hispanic or Latino h. Some other category reported in this center's/residential care community's system i. Not reported (race and ethnicity unknown)]

All respondents understood this as a question about the race and ethnicity of the participants at their facilities.

Data Sources: Most respondents indicated that this would be a difficult question to answer accurately because they do not systematically collect or use this information, or they are not required to report it.

Most respondents indicated that their facilities did make some effort to collect this information at intake. A few respondents indicated that they were required to collect these data. For example, one respondent said, "In this state, for our department of human resources, we go by gender and race. There is a summary for each month." Another said, "There is a federal program that requires this information for meal subsidies." Most, however, indicated that the data, even if collected, were never used. Facilities that collected the data relied on physician reports, participant self-report and observation of the intake staff.

A few facilities collected these data incompletely or not at all. For example, one respondent explained that the information is collected at her facility for the sole purpose of meeting food or language preferences. She said, "You know, they may need to have Spanish food and the like."

Some respondents indicated that even though they do collect these data, it would be difficult to access. One said, "I could find it in the charts, but that's 80 charts I'd have to go through. It

would take a long time." However, the few respondents from facilities that use EHRs said the information would be easy to access.

A few respondents, particularly those from facilities that do not collect these data or where data access be difficult indicated that they would just answer the question based on their own observation. Several noted that this was an imprecise method. One said, "I have no idea!" She then went on to explain, "You know, race is a 'guestimation'. I was just wrong about one of our participants. I thought he was a cute little white man, but I should have known from his name that he was Hispanic."

ADSC14 Of the participants currently enrolled at this center, what is the sex breakdown?

RCC15 OF the residents currently living in this residential care community, what is the sex breakdown?
a. Male b. Female

All respondents understood this as a question about participants'/residents' sex; all stated that this information was collected at intake and kept on file. Since most respondents referred to medical intake records and nurses' reports when answering this question, it appears that respondents understood this almost exclusively as a question about biological sex. Only one respondent noted a difference between biological sex and gender stating that her facility had previously had a non-binary participant.

Data Sources: Quite a few respondents stated that information on the sex breakdown of participants was required for periodic reporting. Therefore, this information was familiar and often already known. In contrast to their uncertainty about their perceptions of participants' race, respondents felt more certain of their perceptions of participants' sex. Therefore, in smaller facilities, respondents answered this question by rostering based on their own knowledge of participants. Other respondents stated that they would rely on information in participants' electronic or paper records such as medical intake records or nurses' reports.

ADSC15 Of the participants currently enrolled at this center, what is the age breakdown?

RCC16 Of the residents currently living in this residential care community, what is the age breakdown? a. 17 years or younger b. 18–44 years c. 45–54 years d. 55–64 years e. 65–74 years f. 75–84 years g. 85 years or older

All respondents understood this as a question about participants'/residents' age and all stated that this information was collected at intake and kept in the participants'/residents' paper or electronic records.

Data Sources: Most respondents indicated that they would use information in participants'/residents' paper or electronic records while others would gather the information from billing records or the daily roster. Respondents in smaller facilities used their own knowledge to answer this question through rostering. One such respondent said, "I don't have it on a list. I just know each person's age and their birth date." A single respondent demonstrated that her facility keeps a "birthday list" for celebrating birthdays and said that she would use this list to calculate the response categories.

Indeed, several respondents noted that they would have to perform calculations in order to answer this question because the age ranges in the response categories do not match how the information is kept at their facilities. Some facilities only record birthdates while others report using age ranges that differ from those in the response categories. One respondent said, "It is intimidating to have to report exact numbers. They are hard to get and they fluctuate so it's hard to be accurate." This respondent would have to ask the facility's database manager to pull this information from the database and then would calculate how many participants go in each category. She said, "It would be time consuming."

ADSC16 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?

RCC17 Assistance refers to needing any help or supervision from another person, or use of assistive devices. Of the residents currently living in this residential care community, about how many now need any assistance in each of the following activities? 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, or help from another person

There were differences in the ways RCC respondents and ADSC respondents understood and answered this question.

RCC respondents understood this question as asking about types of assistance their residents require at their facilities. RCC respondents also indicated that this information was in their electronic records, in the residents' charts or in the residents' care plans. One respondent described their system saying, "For us, we have a form called a 9-1-1. And on there it lists all their medications, all their symptoms, their personal information, their doctor, and what their behaviors are and what type of assistance they need. It would tell you everything you need to know without even seeing that resident."

Some respondents from ADSC facilities weren't sure whether to answer based on assistance needed at home or only assistance needed in their facilities. Most indicated that they could not provide information about what participants need at home. One said, "I can't tell you what happens at home, but I know what goes on here at the center."

Data Sources: Unlike RCC respondents, most ADSC respondents said that they did not record this information in any formal way. Therefore, most respondents from ADSCs answered based on their knowledge of their participants' needs. One respondent thought through the question and said, "We have a few people on wheelchairs. For the rest, I would have to go down the roster and figure out what we have to do for each one. Like dressing, I know a few of them have to get dressed in the mornings. They can't stand and do things on their own." Another ADSC director confirmed that her facility does not formally record this information. She said, "It's just something we know from working with them." A few of the ADSC respondents said they could find the information somewhere, often by combining information from two sources. One said, "I can get this information from billing and the electronic records. It would take some work to get people into these categories but it's not that hard."

ADSC17 Of the participants currently enrolled at this center, about how many have been diagnosed with each of the following conditions?

RCC18 Of the residents currently living in this residential care community, about how many have been diagnosed with each of the following conditions? a. Alzheimer's disease or other dementias b. Arthritis c. Asthma d. Cancer e. Chronic kidney disease f. COPD (chronic bronchitis or emphysema) g. Depression h. Diabetes i. Heart disease (for example, congestive heart failure, coronary or ischemic heart disease, heart attack, stroke) j. High blood pressure or hypertension k. Human immunodeficiency virus (HIV)/AIDS l. Intellectual or developmental disability m. Multiple sclerosis n. Obesity o. Osteoporosis p. Parkinson's disease q. Severe mental illness, such as schizophrenia and psychosis r. Traumatic brain injury

Most respondents understood this as a question about any conditions their residents/participants currently have. However, a few respondents wondered if this question was asking about current conditions only or conditions their residents/participants have had at any time. For example, one respondent asked, "I mean for cancer… do you mean a current diagnosis. We had one who used to have cancer but that was treated, so she doesn't have it now."

Most respondents were familiar with the conditions listed. However, a few respondents were not familiar with some or all of the conditions listed. For example, one respondent, the manager of an ADSC facility serving Chinese immigrants did not speak English as a first language. Even though he was proficient in English, he had to use a translator to look up each condition listed. Although the translator clarified some conditions, he was unsure of others. Other respondents were also unfamiliar with some of the conditions such as multiple sclerosis, ischemic heart disease, and COPD. A few respondents thought about obesity as a subjective condition rather than as a medically defined condition.

Data Sources: All respondents indicated that they keep records of most of these conditions in their paper or electronic records. Information on any conditions is generally recorded in residents'/participants' intake records and then updated periodically (e.g., every 120 days, every 6 months, yearly, as needed) by a nurse or physician. For example, one respondent described how it works at her facility saying, "We have an assessment that the nurse has to complete with every client every 120 days and that would give us a detailed breakdown of this information." Another respondent said, "Every 6 months, we get a report from the physicians so we are up to date on all their diagnoses." Some respondents said they don't track some of these conditions such as arthritis, cancer or asthma. Almost all respondents said that information about diabetes and hypertension was the most carefully tracked and easiest to find because it was necessary to know about these conditions for meals and nutrition.

For some respondents, this information would be easily accessible through a search of the EHR database. For others, collecting this information would require consulting each paper or electronic record and tabulating the results by hand. One director of a small facility indicated that she knew this information about each of her residents off hand and would rely on her own knowledge to fill out the survey. Another respondent, the director of a large residential facility, asked her staff to provide the numbers and then, realizing that she didn't know where the numbers came from, began asking questions of the staff about where the numbers came from and how the records were kept.

ADSC18 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? Please include any participants that received funding from a Medicaid state plan, Medicaid waiver, Medicaid managed care, or California regional center.

This question was asked of all ADSC respondents. All respondents understood the question as asking how many of their participants were currently funded by Medicaid.

Data Sources: Most respondents indicated that this information was available through the billing records. A few respondents were in charge of billing so they knew the number readily based on their billing activities. One respondent said that she would have to consult the "corporate accounts payable people" to get the correct information.

Some respondents said that this information was part of the daily roster, so these respondents would flip back through the rosters for the last 30 days to find the information.

For a few respondents this was an easy question to answer based on their own knowledge because they were certain that either all or none of their participants were paid through Medicaid. For example, one respondent said, "That's easy. We're not covered by Medicaid so that's zero."

ADSC19 Of the participants currently enrolled at this center, about how many were treated in a hospital emergency department in the last 90 days?

RCC19 Of the residents currently living in this residential care community, about how many were treated in a hospital emergency department in the last 90 days?

The same question was asked of both ADSC and RCC respondents. There were differences in the ways RCC respondents and ADSC respondents understood and answered this question.

RCC respondents understood this question as asking about resident visits to the emergency department (ED) in the past 90 days. RCC respondents also indicated that they kept full records of all hospital visits for every resident, so this information would be readily available through paper or electronic records. For example, one respondent said, "This is part of our census reporting. I could easily run a 'in the last 90 days'…I could put a sample out. I could say 'from this date to this date I want to see any transfers to the hospital.'" This respondent indicated that all incidents would be reported and input into their system. They might not know about a hospital visit if it occurred while a resident was already discharged from the facility. But that is "highly unlikely" since the facility is their home.

Respondents from ADSC facilities had a harder time answering this question. Some were not sure if the question was asking about all participant ED visits or only those initiated from their facilities. In the end, all respondents answered based on all of the ED visits they were aware of but emphasized that they often don't know about ED visits. One respondent said, "Now that we wouldn't know unless we send them or if someone tells us. We wouldn't know if it was done through the Emergency Department or if it was something that was planned. Like a routine submission."

Most respondents indicated that even though they are required to report all ED visits, even those that occur outside of their facilities, family members often don't communicate this information. One respondent said, "This is a figure that's hard to get because families try not to tell you. Of the ones I know…I know 2. I only know if they tell us if it's outside." Another said, "We keep that info in the chart. The family supposed to tell us. Sometimes they do. Sometimes they don't."

Data Sources: ADSC facilities record information about participants' ED visits in their paper or electronic charts but are acutely aware that these records are likely incomplete.

ADSC20 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.

RCC20 Of the residents currently living in this residential care community, 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.

The same question was asked of both ADSC and RCC respondents. Although both RCC respondents and ADSC respondents understood the question as asking about how many of their participants/residents had left the hospital after staying at least one night, there were differences in how they answered the question.

Unlike RCC facilities where residents live full time, ADSC facilities only see participants on a part-time basis. Therefore, ADSC facilities rely on family members to update them on any medical events that occur when they are not at the facilities.

As seen with the previous question which asked about ED visits (ADSC19/RCC19), respondents from ADSC facilities were not always informed about things that happened to participants when they were away from their facilities. For example, when asked this question, one respondent just shook his head and said, "We wouldn't know…unless we sent them to the hospital and the family calls to tell us they will be there for a few days, we just don't know."

Several of the ADSC facilities had low confidence that they would be informed at all, even going so far as to speculate that family members actively avoided providing information. However, other facilities had more confidence that families would keep them informed. Even these more confident respondents acknowledged that there could be a gap in the information so almost all respondents from ADSC facilities qualified their responses with statements like, "As far as we know…"

Data Sources: When they were informed, most, though not all of the ADSC facilities noted this information in participants' paper or electronic charts. One said, "They [the families] do try to let us know. We keep records of when they went to the hospital, how long they were there, and things like that." A few facilities noted that they were required to keep or report this information. One respondent called it a "reportable event." One facility indicated that they did not keep records of hospital visits that did not originate from their facility.

Since RCC respondents have full-time responsibility for their residents' care, they were all certain that they would know about any hospital admittances. They all indicated that they kept

complete records of hospital stays and discharges in their residents' paper or electronic charts. One respondent described how he could access this information from his facility's electronic record keeping system, "This is part of our census reporting. I could easily run a 'in the last 90 days'…I could pull a sample out. I could say 'from this date to this date I want to see any transfers to the hospital.'"

ADSC21 Of the participants who were discharged from an overnight hospital stay in the last 90 days, about how many of those participants were re-admitted to the hospital for an overnight stay within 30 days of their hospital discharge?

RCC21 Of the residents who were discharged from an overnight hospital stay in the last 90 days, about how many of those residents were re-admitted to the hospital for an overnight stay within 30 days of their hospital discharge?

The same question was asked to both ADSC and RCC respondents. Although both RCC respondents and ADSC respondents understood the question as asking about how many of their participants/residents had been discharged and then readmitted to the hospital, there were differences in how they answered the question.

As seen with previous questions on ED visits and hospitalization (ADSC19/RCC19 and ADSC20/RCC20, respectively), respondents from ADSC facilities were not always confident that participants' family members would share relevant information with them. Therefore, ADSC respondents were less certain about their responses than respondents from RCC facilities. Having just expressed uncertainty about the previous two questions, one respondent said, "Again, I'm really just not totally sure about that but 'none' as far as I know."

Data Sources: Most respondents from ADSC facilities indicated that they would keep a record of any medical information they received from participants' families in participants' paper or electronic charts. One facility said that they did not record this information. The respondent said, "Nope. We don't have that information" and went on to explain that they were not required to keep that information and only recorded information that was relevant to participant care at the facility.

Respondents from RCC facilities felt confident that they could provide accurate responses to this question. They indicated that their facilities kept detailed records of hospital visits and admits in their residents' paper or electronic charts. One respondent said, "Yes. We keep full records of when they go in and out of the hospital and things like that."

ADSC22 Of the participants currently enrolled at this center, about how many have elected and are now receiving hospice care?

RCC22 Of the residents currently living in this residential care community, about how many have elected and are now receiving hospice care?

This question was asked of all respondents. All respondents understood this as a question about how many of their residents/participants were currently getting hospice services.

Respondents from ADSC facilities indicated that hospice was not very common at their facilities. Several said they never had hospice patients because if a participant was well enough to attend the day center, they were not sick enough to qualify for hospice. However, other ADSC facilities did have some participants who had received hospice care while at their facilities. One respondent noted, "Hospice isn't always terminal these days."

Data Sources: All respondents indicated that they were certain they would know if a resident/participant were receiving hospice care and that their facilities would keep a record of this information in the paper or electronic charts. One respondent from an RCC facility said, "We would know that, and we have separate charts for third party providers, so we can go and see exactly who's on that service at any point in time."

ADSC23 Of the participants currently enrolled at this center, how many live in each of the following places? a. Private residence (house or apartment) b. Assisted living or similar residential care community c. Nursing home or other institutional setting d. Some other place

This question was asked of all respondents from ADSC facilities. Respondents understood this as a question about where their participants live.

A few respondents noted that they are not always aware when participants' living situations change. One respondent said, "Usually we know, but sometimes the family moves them or they go into a facility and we don't know. Usually we know."

Data Sources: All respondents indicated that they could provide this information. However, respondents accessed the information from different sources such as billing records, participant charts, transportation routes and respondent knowledge. For example, one respondent said, "We have to know where they live because we provide transportation." Another said, "That information is in the billing records, so I look there." Several respondents relied on their own knowledge of their facilities' participants when answering.

ADSC24 Of the participants currently enrolled at this center who live in a private residence, how many live with the following people? Assign each participant to only one category. a. Alone b. With relative (such as a spouse, partner, adult child including son or daughter-in-law, parent, or other relative) c. With non-relative(s)

This question was asked of all respondents from ADSC facilities who indicated in question ADSC23 that any of their participants live in private residences. All respondents understood this as a question about who their participants live with.

Data Sources: Most respondents indicated that they do not formally record this information but most thought they could answer the question based on their informal knowledge of their participants. One respondent said that her facility didn't write who their participants lived with but she knew the information because, "Well, we just know our people." A few respondents indicated that their facilities did record this information in participants' paper or electronic charts.

ADSC25 As best you know, about how many of your current participants had a fall in the last 90 days? Please 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.

RCC23 As best you know, about how many of your current residents had a fall in the last 90 days? Please include falls that occurred in your residential care community or off-site, whether or not the resident was injured, and whether or not anyone saw the resident fall or caught them. Please just count one fall per resident who fell, even if the resident fell more than one time. If one of your residents fell during the last 90 days, but is currently in the hospital or rehabilitation facility, please include that person in your count.

This question was asked of all respondents. All respondents understood this as a question about how many of their residents/participants had fallen in the previous 90-day period.

Data Sources: All respondents indicated that their facilities keep records of falls through incident reports or notes on residents'/participants' charts. While respondents from RCC facilities were certain that they would know about all resident falls, respondents from ADSC facilities were only aware of falls that occurred in their facilities. One respondent said, "If the family tells us and they're not injured, we would know. If they fall here, of course we're going to know. And if they fall and they receive medical care, we're going to know. But families are cagey. A lot of times they don't want to tell you. They think you're going to kick them out or something."

ADSC26 - As best you know, about how many of the participants who fell in the last 90 days are in each of the following categories? If a participant had more than one fall in the last 90 days, count only their most serious fall.

RCC24 As best you know, about how many of the residents who fell in the last 90 days are in each of the following categories? If a resident had more than one fall in the last 90 days, count only their most serious fall. a. Had a fall resulting in some kind of injury, such as a broken bone (for example in a wrist, arm, or ankle); hip fracture; or head injury b. Had a fall that did not result in some kind of injury

This question was asked of all respondents who answered more than zero to the initial question on falls (ADSC25/RCC23). All respondents understood this as a question about whether participants/residents who had fallen in the previous 90 days had been injured.

Data Sources: All respondents indicated that their facilities keep records of injuries due to falls through incident reports or notes on residents'/participants' charts. As in the previous question, respondents from RCC facilities were certain that they would know about all resident falls and any resulting injuries. Most respondents from ADSC facilities indicated that they could only be aware of falls that occurred in their facilities. However, one respondent said, **"**You would know if they've had an injury. They would be going to the doctor, or they would end up in the hospital. And then they would go to rehab. So, we would know." Therefore, this respondent felt that she could confidently answer about injuries due to falls but not about falls that did not result in any injuries.

ADSC27 As best you know, of the participants who fell in the last 90 days, about how many went to a hospital emergency department or were hospitalized as a result of the fall? Include hospital admissions and observation stays. If a participant had more than one fall in the last 90 days, count only their most serious fall.

RCC25 As best you know, of the residents who fell in the last 90 days, about how many went to a hospital emergency department or were hospitalized as a result of the fall? Include hospital admissions and observations stays. If a resident had more than one fall in the last 90 days, count only their most serious fall.

This question was asked of all respondents who answered more than zero to the initial question on falls (ADSC25/RCC23). All respondents understood this as a question about whether participants/residents who had fallen in the previous 90 days had gone to the hospital.

Data Sources: All respondents indicated that their facilities keep records of fall-related hospital visits through incident reports or notes on residents'/participants' charts. As in the previous questions on falls, respondents from RCC facilities were certain that they would know about all resident falls and any resulting visits to the hospital. Most respondents from ADSC facilities indicated that they could only be aware of falls that occurred in their facilities. One respondent said she was aware of a recent fall that resulted in a hospital stay only because the participant was badly injured and had to un-enroll from the center. The respondent explained, "She fell and cracked her skull, so we refunded her money. I don't know if she's still in the hospital. That's all I know; the family wanted privacy."

ADSC28 Fall risk assessment tools often address gait, mobility, strength, balance, cognition, vision, medications, and environmental factors. Examples of tools include but are not limited to CDC's Stopping Elderly Accidents, Deaths & Injuries or STEADI; Timed Up and Go or TUG test; 30-second chair stand test; and 4-stage balance test. Does this center typically evaluate each participant's risk for falling using any fall risk assessment tool? Yes, as a standard practice with every participant/Case by case depending on each participant/No.

RCC26 Fall risk assessment tools often address gait, mobility, strength, balance, cognition, vision, medications, and environmental factors. Examples of tools include but are not limited to CDC's "Stopping Elderly Accidents, Deaths & Injuries" or STEADI; Timed Up and Go or TUG test; 30-second chair stand test; and 4-stage balance test. Does this residential care community typically evaluate each resident's risk for falling using any fall risk assessment tool? Yes, as a standard practice with every resident/Case by case depending on each resident/No.

This question was asked of all respondents. All respondents understood this as a question about any fall risk assessment tools that are used at their facilities. All respondents understood the idea of performing fall risk assessments, but most had not heard of the specific assessments presented in the question. Most respondents indicated that their facilities performed these assessments either for all participants/residents or on a case-by-case basis. For example, one respondent said, "The nurses are supposed to do it for each person as they come in." Another respondent described

how the assessments were done on a case-by-case basis. She said, "If the nurse does a regular head to toe assessment and it triggers that this person is in real high risk of falling, then they will do a fall evaluation." Two respondents indicated that their facilities did not do these assessments. One said that these assessments were done by an outside agency and that the results were provided to the facility. The other said that such assessments were not done at all.

Data Sources: All facilities that conducted assessments (as well as the one that received reports of assessments done by an outside agency) kept records of the assessments in participants'/residents' charts or in the nurses' notes. Some respondents said that they could access records of the fall assessments while others said that they would have to get this information from the nurses.

ADSC29 Fall reduction interventions may include but are not limited to environmental safety measures; medication reconciliation; exercise, gait, or balance training; and participant or family education. Does this center currently use any formal fall reduction interventions? Yes/No.

RCC27 Fall reduction interventions may include but are not limited to environmental safety measures; medication reconciliation; exercise, gait, or balance training; and resident or family education. Does this residential care community currently use any formal fall reduction interventions? Yes/No.

This question was asked of all respondents. However, the concept of formal fall reduction interventions was not uniformly understood by all respondents. A few respondents mentioned examples of fall reduction strategies that were mentioned in the question such as hand rails or a specific exercise program. A few thought about individual care plans based on a nurse's fall assessment. One respondent thought about staff training. This respondent answered "no" and said, "I'd say no because it's not something that we planned we are going to do every year or where we require each of our staff to have that training. It's just part of our normal rotation of trainings."

The word "formal" was problematic for several respondents. One respondent answered "yes" because they formally recommend that participants who are at risk of falls receive physical therapy. This respondent said, "I would say yes because we make a formal referral. If we feel a participant would benefit from balance training or gait training, we recommend it to the family. It's up to them to get the service." Another respondent was unable to answer because she was not sure if the program at her facility was "formal" or not. She said, "The word formal would cause me to pause to answer that. We do environmental safety all the time. We're always reconciling medication; we exercise every day. We would do participant or family education…suggest a walker, whatever we might think. Is it formal, I don't know."

Data Sources: Regardless of how they understood the question, respondents relied on their own knowledge to answer the question.

ADSC30 For each service listed below . . . 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, and referral services c. Mental health services—target participants' mental,

emotional, psychological, or psychiatric well-being, and may include diagnosing, describing, evaluating, and treating mental conditions d. Any therapeutic services—physical, occupational, or speech e. Pharmacy services—including filling of or delivery of prescriptions f. Dietary and nutritional services g. Skilled nursing services—must be performed by an RN or LPN and are medical in nature h. Transportation services for medical or dental appointments i. Daily round trip transportation services to or from this center. 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; Does not provide, arrange, or refer for this service

RCC28 For each service listed below . . . 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, and referral services c. Mental health services—target residents' mental, emotional, psychological, or psychiatric well-being, and may include diagnosing, describing, evaluating, and treating mental conditions d. Any therapeutic services—physical, occupational, or speech e. Pharmacy services—including filling of or delivery of prescriptions f. Dietary and nutritional services g. Skilled nursing services—must be performed by an RN or LPN and are medical in nature h. Transportation services for medical or dental appointments. This residential care community. . . Provides the service by paid residential care community employees; Arranges for the service to be provided by outside service providers; Refers residents or family to outside service providers; Does not provide, arrange, or refer for this service

This question was asked of all respondents and all respondents understood it as a question about services offered by their facilities. However, respondents were not always clear on the subtle difference between "provide," "arrange" and "refer." For example, one respondent wasn't sure which to answer for pharmacy services. He said, "We usually tell the family, 'This is the pharmacy we use. Are you guys ok with it?' So that's my way of saying provide." He went on to clarify that participants' families fill the prescriptions and deliver them to the facility to be administered by nurses. Therefore, this respondent answered "provide" because his facility *provides the name* of a pharmacy for families to use. In another example, a respondent was not sure whether to answer arrange or refer for transportation services. Her facility helps participants fill out metro access forms. Ultimately this respondent decided that helping fill out the forms was a way of arranging for the service, so she answered "arrange." Similar ambiguity between these choices was seen in other respondents.

Data Sources: All respondents relied on their own knowledge of services offered by their facilities to answer this question.

ADSC31 An individual is considered an employee if the center is required to issue a 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. 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

RCC29 An individual is considered an employee if the residential care community is required to issue a W-2 federal tax form on their behalf. For each staff type below, indicate how many full-time employees and part-time employees this residential care community currently has. 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

This question was asked of all respondents and all respondents understood it as a question about total numbers of full and part-time staff. For most facilities, staffing was fairly straightforward, for example, one facility was very small and only hired workers on a temporary basis so it was very easy for the respondent to answer "zero." Other facilities also had few employees that were easy to tally. For example, another facility had employed 2 full-time CNAs and one part-time RN consistently for several years.

Other respondents reported that the employment categories at their facilities were less consistent or straightforward. For example, one respondent said that his facility employed three part-time nurses to fill one full-time position. "What should I put there," he asked. Ultimately, he decided to answer "one" full-time RN. "They work part-time but the total of them is one full-time position, so I would put one," he decided. Another respondent explained that the driver at his facility also works on the activities staff. Combining the two positions, the staff member is full-time but only works part-time on the activities staff. This respondent wasn't sure to count the staff member as full-time or part time but ultimately decided to answer full-time.

Other respondents reported overlap between the categories. That is, some employees perform multiple roles. This resulted in some staff being counted twice. For example, at one facility, one of the activities staff was also the CNA. The respondent counted the employee once under full-time activities staff and once under full-time CNA.

Data Sources: All respondents from facilities that had employees said that they keep detailed Human Resources records. Some respondents had access to these records. In fact, many of the respondents were responsible for staffing and payroll. Respondents from other facilities indicated that they would have to contact payroll or HR personnel to get accurate information about staffing. One said, "For this information, I have to go to the HR folks. They could run a module and get me the information."

ADSC32 Contract or agency staff refers to individuals or organization staff under contract with and working at this center, but are not directly employed by the center. Does this center currently have any nursing, aide, social work, or activities contract or agency staff? Yes/No.

RCC30 Contract or agency staff refers to individuals or organization staff under contract with and working at this residential care community, but are not directly employed by the residential care community. Does this residential care community currently have any nursing, aide, social work, or activities contract or agency staff? Yes/No.

This question was asked of all respondents, and all respondents understood it as a question about whether they employee contract staff. A few facilities frequently employed contract staff. One respondent said, "Someone is always in here on a contract because we're having to fill a gap." However, most facilities said that they rarely or never use contract staff. One said, "They might work three times a year. For example, if my nurse goes on vacation for a week, then they might come in for that week."

Data Sources: All respondents used their own knowledge of their facilities' staffing practices to answer this question although all also indicated that there were comprehensive Human Resources records that would include any information about contract staffing.

ADSC33 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. 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

RCC31 For each staff type below, indicate how many full-time contract or agency staff and part-time contract or agency staff this residential care community currently has. 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

This question was asked of all respondents who answered "yes" to the previous question on contract or agency staff (ADSC32/RCC30). All respondents understood it as a question about how many contract staff their agencies employee. This question was sometimes difficult for respondents due to the temporary or transient nature of contract employees. For example, one respondent explained that they use an agency for contract staff. He said, "We just call them and they send a CNA if we need one, but we don't hardly ever use them. In fact, I think it was just eight hours in the last month." This respondent answered "one" for part-time CNA. He said, "I guess eight hours is part time, so probably just one for CNA."

Data Sources: All respondents used their own knowledge of their facilities' staffing practices to answer this question although all also indicated that there were comprehensive Human Resources records that would include any information about contract staffing that they could consult if needed.

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