

**2018 National Study of Long-Term Care Providers
ADSC Services User Questionnaire**

What is [SAMPLED PERSON'S INITIALS]'s gender?

- 1 MALE
- 2 FEMALE

What is [SAMPLED PERSON'S INITIALS]'s age in years?

Is [SAMPLED PERSON'S INITIALS] of Hispanic, Latino, or Spanish origin or descent?

- 1 YES
- 2 NO
- 3 DON'T KNOW

Please look at the show card titled "Race" to answer this question. Which one or more of the following would you say is [SAMPLED PERSON'S INITIALS]'s race? Please tell me the numbers that apply from the show card. Any others?

- 1. AMERICAN INDIAN OR ALASKA NATIVE
- 2. ASIAN
- 3. BLACK
- 4. NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- 5. WHITE

When did [SAMPLED PERSON'S INITIALS] first become enrolled at this center?

MONTH AND YEAR

Please look at the show card titled "Enrolled at this Center" to answer this question. Approximately how long? Please tell me the number that applies from the show card.

- 1. 0 TO 3 MONTHS
- 2. MORE THAN 3 MONTHS TO 6 MONTHS
- 3. MORE THAN 6 MONTHS TO 1 YEAR
- 4. MORE THAN 1 YEAR TO 3 YEARS
- 5. MORE THAN 3 YEARS TO 5 YEARS
- 6. MORE THAN 5 YEARS

Please look at the show card titled "Now Live" to answer this question. Where does [SAMPLED PERSON'S INITIALS] now live? Please tell me the number that applies from the show card.

- 1. PRIVATE RESIDENCE (HOUSE, APARTMENT, ROOM)
- 2. RETIREMENT OR INDEPENDENT LIVING COMMUNITY
- 3. ASSISTED LIVING, RESIDENTIAL CARE COMMUNITY, OR GROUP HOME
- 4. NURSING HOME OR OTHER INSTITUTIONAL SETTING (> 100 DAYS)
- 5. INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES
- 6. OTHER

Who does [SAMPLED PERSON'S INITIALS] live with? Do they live ... SELECT ALL THAT APPLY

1. Alone
2. With a relative such as a spouse, partner, adult child including in-law, parent, or other relative
3. With a non-relative

In a typical week, how many days does [SAMPLED PERSON'S INITIALS] attend the adult day services center?

- 1 DAY
- 2 DAYS
- 3 DAYS
- 4 DAYS
- 5 DAYS
- 6 DAYS
- 7 DAYS

On the day(s) when [SAMPLED PERSON'S INITIALS] attends the adult day services center, does "he"/ "she" typically attend 5 hours or more, or less than 5 hours?

- 1 5 HOURS OR MORE
- 2 LESS THAN 5 HOURS

During the last complete month, what was the typical daily charge for [SAMPLED PERSON'S INITIALS] to attend this adult day services center? Include the basic daily charge and charges for any additional services.

Please look at the show card titled "Primary Payment Source" to answer this question. During the last complete month, what was the one primary payment source for [SAMPLED PERSON'S INITIALS]'s adult day services charges? Please tell me the number that applies from the show card. SELECT ONLY ONE

1. MEDICAID (INCLUDE MEDICAID STATE PLAN, MEDICAID WAIVER, MEDICAID MANAGED CARE, OR CALIFORNIA REGIONAL CENTER)
2. MEDICARE (INCLUDE MEDICARE ADVANTAGE MANAGED CARE PLAN)
3. OLDER AMERICANS ACT/TITLE III
4. VETERANS ADMINISTRATION
5. PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)
6. OTHER FEDERAL, STATE, OR LOCAL GOVERNMENT
7. OUT-OF-POCKET PAYMENT BY THE PARTICIPANT OR FAMILY
8. PRIVATE INSURANCE
9. OTHER SOURCE

During the last complete month, did Medicaid pay for any of the services that [SAMPLED PERSON'S INITIALS] received at this center? Please include any funding from a Medicaid state plan, Medicaid waiver, Medicaid managed care, or California regional center.

- 1 YES
- 2 NO
- 3 DON'T KNOW

Please look at the show card titled "Conditions" to answer this question. As far as you know, has a doctor or other health professional ever diagnosed [SAMPLED PERSON'S INITIALS] with any of the following conditions? Please tell me the numbers that apply from the show card. SELECT ALL THAT APPLY. Any others?

1. ALCOHOL ABUSE
2. ALZHEIMER'S DISEASE OR OTHER DEMENTIA
3. ANEMIA
4. ANXIETY DISORDER
5. ARTHRITIS OR RHEUMATOID ARTHRITIS
6. ASTHMA
7. CANCER OR MALIGNANT NEOPLASM OF ANY KIND
8. CEREBRAL PALSY
9. CONGESTIVE HEART FAILURE
10. COPD (CHRONIC BRONCHITIS OR EMPHYSEMA)
11. DEPRESSION
12. DIABETES
13. EPILEPSY
14. GLAUCOMA
15. GOUT, LUPUS, OR FIBROMYALGIA
16. HEART ATTACK (MYOCARDIAL INFARCTION)
17. HEART DISEASE (CORONARY OR ISCHEMIC)
18. HIGH BLOOD PRESSURE OR HYPERTENSION
19. HUMAN IMMUNODEFICIENCY VIRUS (HIV)/AIDS
20. HUNTINGTON'S DISEASE
21. INTELLECTUAL OR DEVELOPMENTAL DISABILITIES
22. KIDNEY DISEASE
23. MACULAR DEGENERATION
24. MUSCULAR DYSTROPHY
25. MULTIPLE SCLEROSIS
26. OBESITY
27. OSTEOPOROSIS
28. PARKINSON'S DISEASE
29. PARTIAL OR TOTAL PARALYSIS
30. PRESSURE WOUND/INJURY
31. SEVERE MENTAL ILLNESS SUCH AS SCHIZOPHRENIA OR PSYCHOSIS OR BIPOLAR DISORDER (EXCLUDES DEPRESSION OR ANXIETY DISORDER)
32. SPINAL CORD INJURY
33. STROKE
34. TRAUMATIC BRAIN INJURY
35. NONE OF THESE

The next question asks about prescription medications [SAMPLED PERSON'S INITIALS] may take. Include standing and PRN or as needed medications, but exclude over-the-counter medications or supplements, unless they have been prescribed by a health care provider. About how many prescription medications does [SAMPLED PERSON'S INITIALS] currently take on a typical day? Would you say...

- 1 0
- 2 1-2
- 3 3-4
- 4 5-6
- 5 7-8
- 6 9-10, or
- 7 more than 10

Please look at the show card titled "Antipsychotic Medications" to answer this question. The following is a list of the generic and brand names of antipsychotic medications. In the past 7 days, which, if any, of these medications did [SAMPLED PERSON'S INITIALS] receive, either on an as needed basis or on a routine basis? Please tell me the numbers that apply from the show card. SELECT ALL THAT APPLY. Any others?

- 1. ABILIFY (ARIPIRAZOLE)
- 2. CLOZARIL OR FAZACLO (CLOZAPINE)
- 3. FANAPT (ILOPERIDON)
- 4. GEODON (ZIPRASIDONE)
- 5. HALDOL (HALOPERIDOL)
- 6. INVEGA (PALIPERIDONE)
- 7. LOXITANE (LOXAPINE)
- 8. NAVANE (THIOTHIXENE)
- 9. ORAP (PIMOZIDE)
- 10. RISPERDAL (RISPERIDONE)
- 11. SAPHRIS (ASENAPINE)
- 12. SEROQUEL (QUETIAPINE)
- 13. ZYPREXA (OLANZAPINE)
- 14. NONE OF THE ABOVE

The next questions ask about difficulties (SAMPLED PERSON'S INITIALS) may have doing certain activities because of a health problem. How much difficulty does (SAMPLED PERSON'S INITIALS) have remembering or concentrating? Would you say no difficulty, some difficulty, a lot of difficulty, or cannot do at all?

- 1 NO DIFFICULTY
- 2 SOME DIFFICULTY
- 3 A LOT OF DIFFICULTY
- 4 CANNOT DO AT ALL

How much difficulty does (SAMPLED PERSON'S INITIALS) have seeing, even if wearing glasses? Would you say no difficulty, some difficulty, a lot of difficulty, or cannot do at all?

- 1 NO DIFFICULTY
- 2 SOME DIFFICULTY
- 3 A LOT OF DIFFICULTY
- 4 CANNOT DO AT ALL

How much difficulty does (SAMPLED PERSON'S INITIALS) have hearing, even if using a hearing aid? Would you say no difficulty, some difficulty, a lot of difficulty, or cannot do at all?

- 1 NO DIFFICULTY
- 2 SOME DIFFICULTY
- 3 A LOT OF DIFFICULTY
- 4 CANNOT DO AT ALL

How much difficulty does (SAMPLED PERSON'S INITIALS) have walking or climbing steps? Would you say no difficulty, some difficulty, a lot of difficulty, or cannot do at all?

- 1 NO DIFFICULTY
- 2 SOME DIFFICULTY
- 3 A LOT OF DIFFICULTY
- 4 CANNOT DO AT ALL

How much difficulty does (SAMPLED PERSON'S INITIALS) have with self-care such as washing all over or dressing? Would you say no difficulty, some difficulty, a lot of difficulty, or cannot do at all?

- 1 NO DIFFICULTY
- 2 SOME DIFFICULTY
- 3 A LOT OF DIFFICULTY
- 4 CANNOT DO AT ALL

Using "his"/"her" usual customary language, how much difficulty does (SAMPLED PERSON'S INITIALS) have communicating, for example understanding or being understood? Would you say no difficulty, some difficulty, a lot of difficulty, or cannot do at all?

- 1 NO DIFFICULTY
- 2 SOME DIFFICULTY
- 3 A LOT OF DIFFICULTY
- 4 CANNOT DO AT ALL

The next questions ask about assistance [SAMPLED PERSON'S INITIALS] may need to perform certain activities.

Which types of assistance, if any, does [SAMPLED PERSON'S INITIALS] currently need to transfer in and out of a chair at their usual residence or this adult day services center? Does [SAMPLED PERSON'S INITIALS] need any help or supervision from another person, use an assistive device, both, or need no assistance?

- 1 NEED HELP OR SUPERVISION FROM ANOTHER PERSON
- 2 USE OF AN ASSISTIVE DEVICE
- 3 BOTH
- 4 NEED NO ASSISTANCE

Which types of assistance, if any, does [SAMPLED PERSON'S INITIALS] currently need to eat, like cutting up food at their usual residence or this adult day services center? Does [SAMPLED PERSON'S INITIALS] need any help or supervision from another person, use an assistive device, both, or need no assistance?

- 1 NEED HELP OR SUPERVISION FROM ANOTHER PERSON
- 2 USE OF AN ASSISTIVE DEVICE
- 3 BOTH
- 4 NEED NO ASSISTANCE

Which types of assistance, if any, does [SAMPLED PERSON'S INITIALS] currently need to dress at their usual residence or this adult day services center? Does [SAMPLED PERSON'S INITIALS] need any help or supervision from another person, use an assistive device, both, or need no assistance?

- 1 NEED HELP OR SUPERVISION FROM ANOTHER PERSON
- 2 USE OF AN ASSISTIVE DEVICE
- 3 BOTH
- 4 NEED NO ASSISTANCE

Which types of assistance, if any, does [SAMPLED PERSON'S INITIALS] currently need to bathe or shower at their usual residence or this adult day services center? Does [SAMPLED PERSON'S INITIALS] need any help or supervision from another person, use an assistive device, both, or need no assistance?

- 1 NEED HELP OR SUPERVISION FROM ANOTHER PERSON
- 2 USE OF AN ASSISTIVE DEVICE
- 3 BOTH
- 4 NEED NO ASSISTANCE

Which types of assistance, if any, does [SAMPLED PERSON'S INITIALS] currently need to use the bathroom or toileting at their usual residence or this adult day services center? Does [SAMPLED PERSON'S INITIALS] need any help or supervision from another person, use an assistive device, both, or need no assistance?

- 1 NEED HELP OR SUPERVISION FROM ANOTHER PERSON
- 2 USE OF AN ASSISTIVE DEVICE
- 3 BOTH
- 4 NEED NO ASSISTANCE

Which types of assistance, if any, does [SAMPLED PERSON'S INITIALS] currently need for locomotion or to walk at their usual residence or this adult day services center? Does [SAMPLED PERSON'S INITIALS] need any help or supervision from another person, use an assistive device, both, or need no assistance?)

- 1 NEED HELP OR SUPERVISION FROM ANOTHER PERSON
- 2 USE OF AN ASSISTIVE DEVICE
- 3 BOTH
- 4 NEED NO ASSISTANCE

Please look at the show card titled "Incontinence" to answer this question. As far as you know, has [SAMPLED PERSON'S INITIALS] had any episodes of incontinence during the past seven days either at their usual residence or this adult day services center? Please tell me the number that applies from the show card.

1. YES, BOWEL ONLY
2. YES, URINARY ONLY
3. YES, BOTH BOWEL AND URINARY
4. NO, NEITHER
5. NOT APPLICABLE (COLOSTOMY, ILEOSTOMY)
6. NOT APPLICABLE (INDWELLING CATHETER, UROSTOMY)

During the past 12 months, was [SAMPLED PERSON'S INITIALS] treated in a hospital emergency department?

- 1 YES
- 2 NO
- 3 DON'T KNOW

During the past 90 days, was [SAMPLED PERSON'S INITIALS] treated in a hospital emergency department?

- 1 YES
- 2 NO
- 3 DON'T KNOW

During the past 12 months, was [SAMPLED PERSON'S INITIALS] discharged from an overnight hospital stay? Exclude trips to the hospital emergency department that did not result in an overnight hospital stay.

- 1 YES
- 2 NO
- 3 DON'T KNOW

Was [SAMPLED PERSON'S INITIALS] discharged from an overnight hospital stay in the past 90 days? Exclude trips to the hospital emergency department that did not result in an overnight hospital stay.

- 1 YES
- 2 NO
- 3 DON'T KNOW

Please look at the show card titled "Reason for Hospitalization" to answer this question. What was the one primary reason for [SAMPLED PERSON'S INITIALS]'s hospitalization? If "he"/"she" had more than one hospital discharge in the past 90 days, answer for the most recent hospital discharge. Please tell me the number that applies from the show card.

1. ASTHMA
2. BRONCHITIS
3. C. DIFFICILE INFECTION
4. CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)
5. CONGESTIVE HEART FAILURE (CHF)
6. CONSTIPATION/INTESTINAL IMPACTION
7. DEHYDRATION
8. DIABETES—SHORT-TERM COMPLICATION
9. DISEASES OF THE SKIN
10. FALLS OR TRAUMA
11. HYPERTENSION OR HYPOTENSION
12. MENTAL STATUS CHANGES
13. PNEUMONIA
14. PRESSURE INJURY/ULCER
15. URINARY TRACT OR KIDNEY INFECTION
16. NONE OF THE ABOVE

Was [SAMPLED PERSON'S INITIALS] re-admitted to the hospital for an overnight stay within 30 days of this hospital discharge? Include outpatient observation and inpatient admission.

- 1 YES
- 2 NO
- 3 DON'T KNOW

The next section asks whether [SAMPLED PERSON'S INITIALS] has had any falls. By falls we mean any fall, slip, or trip in which [SAMPLED PERSON'S INITIALS] lost "his"/"her" balance and landed on the floor or ground or at a lower level. Please include falls that occurred at your adult day services center or off-site, whether or not [SAMPLED PERSON'S INITIALS] was injured, and whether or not anyone saw [SAMPLED PERSON'S INITIALS] fall or caught them. As best you know, in the past 90 days, how many falls has [SAMPLED PERSON'S INITIALS] had?

Number of falls _____

As best you know, did the fall/any of these falls that [SAMPLED PERSON'S INITIALS] had in the past 90 days occur at the adult day services center?

- 1 YES
- 2 NO
- 3 DON'T KNOW

Please look at the show card titled "Fall Injury" to answer this question. Did [SAMPLED PERSON'S INITIALS]'s fall/any of these falls [SAMPLED PERSON'S INITIALS] had result in a minor injury, a major injury, or no injury? Please tell me the numbers that apply from the show card. SELECT ALL THAT APPLY

- 1. MINOR INJURY - ABRASION, CUT, HEMATOMA, LACERATION, SCRATCH, SKIN TEAR, SPRAIN, SUPERFICIAL BRUISE
- 2. MAJOR INJURY - BONE FRACTURE, BROKEN BONE, CLOSED HEAD INJURY WITH ALTERED CONSCIOUSNESS, JOINT DISLOCATION, SUBDURAL HEMATOMA
- 3. NO INJURY

Please look at the show card titled “Services” to answer this question. The following services may be offered adult day services center staff or provided at the center by non-center staff. Which of these services does [SAMPLED PERSON’S INITIALS] currently use? Please tell me the numbers that apply from the show card. SELECT ALL THAT APPLY. Any others?

1. ASSISTANCE FROM A PERSON WITH AT LEAST ONE ACTIVITY OF DAILY LIVING (*BATHING, DRESSING, EATING, TOILETING, TRANSFERRING*)
2. BEHAVIORAL OR MENTAL HEALTH—TARGET PARTICIPANTS' MENTAL, EMOTIONAL, PSYCHOLOGICAL, OR PSYCHIATRIC WELL-BEING, AND MAY INCLUDE DIAGNOSING, DESCRIBING, EVALUATING, AND TREATING MENTAL CONDITIONS
3. CONTINENCE MANAGEMENT (*E.G., ABSORBENT PADS, BLADDER OR BOWEL RETRAINING, CATHETER, MEDICATION, TOILETING REGIME*)
4. DENTAL (*ROUTINE OR EMERGENCY BY LICENSED DENTIST*)
5. DIETARY OR NUTRITIONAL
6. HOSPICE
7. MANAGE, SUPERVISE, OR STORE MEDICATIONS; ADMINISTER MEDICATIONS; OR PROVIDE ASSISTANCE WITH SELF-ADMINISTRATION OF MEDICATIONS
8. OCCUPATIONAL THERAPY
9. PAIN MANAGEMENT (*MEDICATION OR NON-PHARMACOLOGICAL APPROACHES*)
10. PALLIATIVE CARE (*RELIEF FROM SYMPTOMS, PAIN, AND STRESS OF SERIOUS ILLNESS, REGARDLESS OF DIAGNOSIS*)
11. PHARMACY--INCLUDING FILLING OF OR DELIVERY OF PRESCRIPTIONS
12. PHYSICAL THERAPY
13. PODIATRY
14. SKILLED NURSING--MUST BE PERFORMED BY AN RN OR LPN/LVN AND ARE MEDICAL IN NATURE
15. SKIN WOUND/INJURY CARE
16. SOCIAL WORK—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
17. SPEECH THERAPY
18. TRANSPORTATION FOR MEDICAL OR DENTAL APPOINTMENTS
19. TRANSPORTATION FOR SOCIAL AND RECREATIONAL ACTIVITIES OR SHOPPING
20. TRANSPORTATION TO/FROM THIS CENTER
21. NONE OF THESE

Please look at the show card titled "Documentation" to answer this question. For which of the following items does this adult day services center have documentation in [SAMPLED PERSON'S INITIALS]'s file?

Please tell me the numbers that apply from the show card. SELECT ALL THAT APPLY. Any others?

1. ADVANCE DIRECTIVE
2. HEALTH CARE PROXY OR DURABLE MEDICAL POWER OF ATTORNEY
3. PHYSICIAN DOCUMENTATION OF CONDITION THAT MAY RESULT IN LIFE EXPECTANCY LESS THAN 6 MONTHS
4. PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (*POLST*)
5. NONE OF THESE

Please look at the show card titled "Verbal or Physical Behavioral Symptoms" to answer this question. As far as you know, at any time in the last 7 days has [SAMPLED PERSON'S INITIALS] exhibited any verbal or physical behavioral symptoms directed toward others, for example threatening, screaming, cursing, hitting, kicking, pushing, scratching, grabbing, or abusing others sexually, either at their usual residence or this center? Please tell me the number that applies from the show card.

- 1 1. YES, VERBAL ONLY
- 2 2. YES, PHYSICAL ONLY
- 3 3. YES, BOTH VERBAL AND PHYSICAL
- 4 4. NO, NEITHER

FOR VIEWING PURPOSES ONLY