Department of Human Services requires adult foster homes to complete this questionnaire. Please return your completed questionnaire to PSU by February 28th, 2017.

Once complete, please choose one of the following to return the questionnaire:

1. Scan and email to: cbcor@pdx.edu
   (Be sure to include both sides of paper, if printed double-sided)

2. Fax to: 503.725.9927
   (Be sure to include both sides of paper, if printed double-sided)

3. Mail to: CBC Project - Institute on Aging
           Portland State University
           PO BOX 751
           Portland, Oregon 97207

If you would prefer to complete the questionnaire over the phone, please email or call Sarah at: sdys@pdx.edu or 503.725.9252.

If you have questions concerning completing this questionnaire, please contact: Sheryl Elliott at cbcor@pdx.edu or 503.725.2130
Oregon Department of Human Services (DHS) requires adult foster homes to complete the questionnaire because it is an important way for DHS to collect information about residents.

PSU does not publish or share responses from individual Adult Foster Homes. DHS receives a summary report posted on these websites: http://www.oregon.gov/DHS/SENIORS-DISABILITIES/Pages/publications.aspx & https://www.pdx.edu/ioa/oregon-community-based-care-project

Instructions:

First, write your home’s license number and other information on page 1, then go to page 3.

We expect that the owner/operator will complete this questionnaire. If you operate more than one adult foster home, complete the questionnaire only for the license number and address on the envelope.

Some questions ask about “staff” who work at your home—this means anyone who is paid by you to provide services, such as caregivers, resident managers, and your family members who serve as qualified caregivers.

For some questions, you might need to look at information in current resident files and provide a total for all residents.

Most questions ask you to write the number based on your current residents, in a box like this: 4

Please provide your best answer for each question. For boxes like the one above, if the answer is “none” or “0”, please write “0”. If the question does not apply to your home, please write “N/A.”

Some questions ask you to check a box like this: ☒

We appreciate your time and the work that you do on behalf of older adults and persons with disabilities. The study results will be most accurate if everyone participates. We look forward to hearing from you by February 28th, 2017.
1. How many of your current residents are:

- Female
- Male
- Transgender
- **TOTAL # OF CURRENT RESIDENTS**

2. How many of your current residents are:  
   [Please count each resident only once.]  

- Hispanic/Latino (any race)
- American Indian or Alaska Native, not Hispanic or Latino
- Asian, not Hispanic or Latino
- Black, not Hispanic or Latino
- Native Hawaiian or Other Pacific Islander, not Hispanic or Latino
- White, not Hispanic or Latino
- Two or more races
- Other/unknown/or resident would most likely choose not to answer
- **TOTAL [Should match total in question #1.]**

3. What is the age of each of your current residents?  

- Resident 1
- Resident 2
- Resident 3
- Resident 4
- Resident 5

4. During 2016, how many residents had family or friends call or visit at least once per month?  

- Number of residents [Write 0 if none]

5. In the past 90 days, how many new residents moved in (for the first time) from the following places?  
   [If no new residents in past 90 days, write “N/A”.]  

<table>
<thead>
<tr>
<th># of residents</th>
<th>Moved in from:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home (alone or with spouse or partner)</td>
</tr>
<tr>
<td></td>
<td>Home of child, other relative</td>
</tr>
<tr>
<td></td>
<td>Independent living apartment in senior housing</td>
</tr>
<tr>
<td></td>
<td>Assisted living/residential care</td>
</tr>
<tr>
<td></td>
<td>Memory care facility</td>
</tr>
<tr>
<td></td>
<td>Hospital</td>
</tr>
<tr>
<td></td>
<td>Adult foster care</td>
</tr>
<tr>
<td></td>
<td>Nursing facility (NF) or Skilled nursing facility (SNF)</td>
</tr>
<tr>
<td></td>
<td>Other, specify:</td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
</tr>
<tr>
<td></td>
<td><strong>TOTAL new residents, past 90 days</strong></td>
</tr>
</tbody>
</table>

---

Thank you for taking the time to complete this questionnaire.
6. In the **past 90 days**, how many residents moved out *(permanently)* to the following places, or died?
   ➤ If no residents moved out in past 90 days, write “N/A” and **SKIP to question #9.**

<table>
<thead>
<tr>
<th># of residents</th>
<th>Moved out to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home <em>(alone or with spouse or partner)</em></td>
</tr>
<tr>
<td></td>
<td>Home of child, other relative</td>
</tr>
<tr>
<td></td>
<td>Independent living apartment in senior housing</td>
</tr>
<tr>
<td></td>
<td>Assisted living/residential care</td>
</tr>
<tr>
<td></td>
<td>Memory care facility</td>
</tr>
<tr>
<td></td>
<td>Hospital</td>
</tr>
<tr>
<td></td>
<td>Adult foster care</td>
</tr>
<tr>
<td></td>
<td>Nursing facility *(NF) or Skilled nursing facility <em>(SNF)</em></td>
</tr>
<tr>
<td></td>
<td>Other, specify:</td>
</tr>
<tr>
<td></td>
<td>Resident died</td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
</tr>
<tr>
<td><strong>TOTAL Residents who moved out, past 90 days</strong></td>
<td></td>
</tr>
</tbody>
</table>

7. For the residents who moved out in the past 90 days, what was the length of stay for each resident?

<table>
<thead>
<tr>
<th># of residents</th>
<th>Length of Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 - 7 days</td>
</tr>
<tr>
<td></td>
<td>8 - 13 days</td>
</tr>
<tr>
<td></td>
<td>14 - 30 days</td>
</tr>
<tr>
<td></td>
<td>31 - 90 days</td>
</tr>
<tr>
<td></td>
<td>91 - 180 days <em>(3-6 months)</em></td>
</tr>
<tr>
<td></td>
<td>181 days - 1 year <em>(6-12 months)</em></td>
</tr>
<tr>
<td></td>
<td>More than 1 but less than 2 years</td>
</tr>
<tr>
<td></td>
<td>More than 2 but less than 4 years</td>
</tr>
<tr>
<td></td>
<td>More than 4 years</td>
</tr>
<tr>
<td><strong>TOTAL</strong> [Should match total in question #6 above]</td>
<td></td>
</tr>
</tbody>
</table>

8. Of the residents who moved out in the past 90 days, how many were in your home for a planned short-stay *(respite or similar care)*?

   □ Number of residents [Write 0 if none]

9. Did any residents receive a move-out notice in the **last year** for any of the following reasons? [Check all that apply.]
   □ Two-person transfer
   □ Wandering outside
   □ Sliding-scale insulin shots
   □ Hitting/acting out with anger to other residents or staff
   □ Lease violation
   □ Non-payment
   □ None
   □ Other – please explain: ____________________________

Section B. Resident Health, Acuity & Service Use

10. During the past 90 days, how many residents were in the following categories?
    □ Residents with 0 (zero) falls
    □ Residents who fell one time
    □ Residents who fell more than once
    □ **TOTAL** [Should match total in question #1.]

   ➤ If no residents fell during the past 90 days, **SKIP to 12**

*Thank you for taking the time to complete this questionnaire.*
11. Of the residents who fell in the past 90 days:
   a. How many had a fall resulting in some kind of injury?
      - Number of residents
   b. How many residents went to the hospital (emergency room or admitted) because of the fall?
      - Number of residents

12. Does your home assess a resident’s risk for falling using a fall risk assessment? [Examples include Stopping Elderly Accidents, Deaths, & Injuries (STEADI) and Timed Up and GO (TUG)]
   - Yes, as a standard practice with every resident
   - Yes, only case-by-case depending on each resident
   - No
   - Don’t know

13. How many of your current residents that have been assessed for fall risk did not fall in the last 90 days?
    - Number of residents

14. Do you use a standard tool for assessing cognitive impairment? [Examples: The General Practitioner Assessment of Cognition (GPCOG), the Mini-Cog, the Mini-Mental State Examinations (MMSE)]
    - Yes
    - No

15. How many of your current residents regularly use a mobility aid [e.g., cane, walker, wheelchair] to get around?
    - Number of residents

16. How many of your current residents need staff assistance to use a mobility aid?
    - Number of residents

17. How many of your current residents have been diagnosed with each of the following conditions? [Include all diagnoses for each resident even if controlled by diet, medication or other treatment. Enter “0” for any categories with no residents.]
    - Heart disease (e.g., congestive heart failure, coronary or ischemic heart disease, heart attack, stroke)
    - Alzheimer’s disease and other dementias
    - High blood pressure/hypertension
    - Depression
    - Serious mental health illness (such as bipolar disorder, schizophrenia)
    - Diabetes
    - Cancer
    - Osteoporosis
    - COPD and allied conditions
    - Current drug and/or alcohol abuse
    - Intellectual/developmental disability
    - Arthritis
    - Traumatic brain injury

Thank you for taking the time to complete this questionnaire.
Thank you for taking the time to complete this questionnaire.

18. How many of your current residents were:
   - [ ] Treated in a hospital emergency room (ER) in the last 90 days?
   - [ ] Hospitalized overnight in the last 90 days?  
     [Exclude trips to ER that did not result in an overnight hospital stay.]
   - [ ] How many of these residents went back to the hospital within 30 days?
   - [ ] Receiving hospice care in the last 90 days?

19. How many of your current residents regularly receive staff assistance because of the following behavioral symptoms:
   - [ ] Lack of awareness of safety concerns, or poor judgment, decision making, or inability to orient to surroundings
   - [ ] Wandering
   - [ ] Is a danger to self or others [disruptive, aggressive, abusive, sexually inappropriate]

20. How many current residents regularly receive assistance from NOC (night shift) staff during the night (for example, from 11 pm to 6 am)?
   - [ ] Number of Residents

21. How many current residents regularly receive assistance for physical and/or cognitive health needs from two staff?
   - [ ] Number of Residents

21a. Please describe reasons for two-person assistance:

   __________________________________________________________
   __________________________________________________________

22. How many of your current residents need regular and ongoing staff assistance with each of the following:

<table>
<thead>
<tr>
<th>ADL</th>
<th># Full assist</th>
<th># Standby</th>
<th>Total # (both)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathing &amp; grooming</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using the bathroom</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobility/Walking</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

23. How many of your current residents regularly receive any of the following from their family member(s) or friend(s):

| Help with personal care such as eating, dressing, bathing & grooming, using the bathroom, or mobility & walking | # residents |
| Help taking medications                              |             |
| Help getting to medical appointments                  |             |
| Social visits                                        |             |
| Phone calls                                          |             |
| Going on outings [i.e., meals, walks, shopping, activities] |             |

24. In the past 90 days, how many of your current residents received assistance with behavioral health symptoms [e.g. mental health treatment, addiction services] from a State or County behavioral health specialist or other service provider?
   - [ ] Number of residents (Write 0 if none, DK if don’t know)
25. How many of your current residents take no medications and no injections?

Number of residents [Write 0 if none]

26. For each item below, please write the number of current residents [write 0 if none] who...

- Take 9 or more medications
- Take antipsychotic medication [Common examples: Haldol (Haloperidol); Quetiapine (Seroquel), Olanzapine (Zyprexa), Ariprazole (Abilify), Risperidone (Risperdal).]
- Self-administer most of their medications
- Receive staff assistance to take oral medications
- Receive staff assistance with subcutaneous injection medications
- Receive injections from a licensed nurse
- Receive nurse treatments from a licensed nurse [Common examples: oxygen and respiratory treatments, such as nebulizers; rectal medications; suctioning mouth with bulb syringes; wound care, such as staging pressure ulcers & dressing changes]

Section C. About You: Adult Foster Home Owner/Licensee

27. How many years have you (owner/licensee) been a licensed AFH operator?

_________________ years

28. Do you have any of the following certifications?

- CNA
- LPN/LVN
- RN
- Respiratory Therapist
- MSW
- None
- Other: ____________________

Section D. Household Characteristics & Staffing

29. How many residents are you licensed to care for?

Number of residents

30. What is the highest class level that your home is licensed to provide for any current resident?

- Class 1
- Class 2
- Class 3
- Other: ____________________

31. Do you live at this adult foster home?

- Yes
- No

Thank you for taking the time to complete this questionnaire.
32. How many of your family members (e.g., spouse, children) who are not residents:
   - [ ] Live at this address?
   - [ ] Are 17 or younger
   - [ ] Are 18 or older?
   [If none write 0]

33. Do you currently care for an elderly or disabled relative in your adult foster home?
   - [ ] Yes → How many? [ ]
   - [ ] No

34. Does your home currently employ a resident manager?
   - [ ] Yes → continue to question #34 a. & b.
   - [ ] No → SKIP to question #35

   a. How many resident managers does your home currently employ?
      - [ ] Number of resident managers

   b. When on duty, how many hours a week does your resident manager(s) work?
      - [ ] Number of hours worked by resident manager
      - [ ] Number of hours worked by second resident manager (if 2 are employed)

35. How many caregivers (not resident managers) does your home currently employ? [If none, write 0]
   - [ ] Number of caregivers

36. Did you receive a flu vaccination this past fall?
   [While flu vaccines are not mandatory, they are strongly encouraged by the Centers for Disease Control. You will not be penalized for your response to this or any other question.]
   - [ ] Yes
   - [ ] No

37. How many of your current staff (all resident managers and caregivers described in numbers 34-35 above) received a flu vaccine this past fall?
   - [ ] Number of current staff who got a flu vaccine this past fall
   - [ ] Don’t know
   - [ ] N/A

38. What is the level of certification for each of your current staff? [Note: AFH staff are not required to be licensed or certified.]

<table>
<thead>
<tr>
<th># of staff</th>
<th>Staff Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Licensed practical or vocational nurses (LPNs)/(LVNs)</td>
</tr>
<tr>
<td></td>
<td>Certified nursing assistants (CNAs)</td>
</tr>
<tr>
<td></td>
<td>Certified medication aides (CMAs)</td>
</tr>
<tr>
<td></td>
<td>Other:</td>
</tr>
</tbody>
</table>

39. Have you had difficulty, for any reason, hiring or contracting with any of the following:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNAs/CMAs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident managers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregivers who are not certified or licensed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LPN/LVN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN consultant</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

   N/A = not applicable

40. If yes, please describe reasons:

   ____________________________________________________________
   ____________________________________________________________

Thank you for taking the time to complete this questionnaire.
41. In the past 90 days, have you hired contract care staff (including nurses) to cover **unplanned** staff absences?

☐ Yes  ☐ No

42. In the last 90 days, have staff missed work due to any of the following problems? [Check all that apply]

☐ Transportation problems
☐ Family illness or other family issues
☐ Personal health issues
☐ Other ____________________________

43. Do you offer a transportation benefit to staff such as a transit pass (for bus or other transit), car pools, ride share, or other assistance to help staff get to and from work?

☐ Yes  ☐ No  ☐ N/A

Please describe: __________________________________________

____________________________________________

44. Which of these topics have been covered in staff trainings during the past year? [Check all that apply.]

☐ Alzheimer’s and related dementia
☐ Mental illness (e.g., depression, substance abuse)
☐ Disease-specific (e.g., stroke, diabetes)
☐ Medication administration
☐ Safety (fire safety, emergency preparedness)
☐ Communication and problem solving
☐ Nutrition and food management
☐ Residents’ rights
☐ How to prevent communicable diseases
☐ Person-directed or person-centered care
☐ Resident abuse or neglect
☐ Working with resident families
☐ Other; specify: ________________________________

45. Does your home have any ways to retain staff and reduce staff turnover?

☐ Yes  ☐ No  ☐ Not applicable

➔ If yes, please list what you believe to be 2-3 good ways to retain staff and reduce turnover.

1. __________________________________________

2. __________________________________________

3. __________________________________________

Thank you for taking the time to complete this questionnaire.
46. How often do you assess caregivers’ and resident managers’ competency, including their knowledge, skills and abilities, to do their work?

☐ Annually (once a year)
☐ At least every 6 months
☐ At least 3 times a year
☐ Monthly
☐ As needed
☐ Don’t know/not applicable
☐ Never
☐ Other; specify: ______________________

Section E. Monthly Rates, Fees & Policies

47. **Last month**, how many residents paid using the following payment type(s)?

*More than one payment category is possible for each resident, so the number might be higher than the total number of residents. [Write “0” for any categories with no residents.]*

<table>
<thead>
<tr>
<th>PAYMENT TYPE</th>
<th># of Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident and/or family pay using private resources</td>
<td></td>
</tr>
<tr>
<td>Resident’s long-term care insurance</td>
<td></td>
</tr>
<tr>
<td>Veteran’s (Aid &amp; Attendance)</td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td></td>
</tr>
<tr>
<td>Other, specify:</td>
<td></td>
</tr>
</tbody>
</table>

48. Do you currently have a Medicaid contract or accept Medicaid payment for any of your residents?

☐ Yes   ☐ No

a. **If yes**, how many of your current residents are Medicaid beneficiaries/clients?

☐ Number of residents

b. **If no**, have you had a Medicaid contract or accepted Medicaid in the past?

☐ Yes   ☐ No

49. Do you currently have private-pay residents?

☐ Yes   ☐ No

⇒ **If NO, SKIP to #54**

a. **If yes**: If a private-pay resident spends down their assets, may they stay in the home and pay via Medicaid, if they qualify?

☐ Yes   ☐ No

50. How many of your current residents who pay privately had a rate increase in the past 12 months?

☐ Number of residents

51. For the last month, what was the average **total monthly charge** for a single resident living alone in a **private room** and receiving the lowest level of care? **(Private-pay only)**

$ __________ / month

Thank you for taking the time to complete this questionnaire.
52. How many of your current residents who pay privately were charged in the following ways: [Write "0" for any categories with no residents.]

[ ] Paid a flat monthly rate
[ ] Base rate plus additional fees based on services provided
[ ] Monthly rate based on care needs
[ ] Rate negotiated with resident (or payee) based on ability to pay
[ ] Other method (Specify): __________________________

53. Which services does your home provide and, for the services provided, what are the additional fees charged? [Please check all boxes that apply. [Y= yes and N= no]]

<table>
<thead>
<tr>
<th>Available: Y or N</th>
<th>Charge Fee: Y or N</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Night-time care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advanced memory care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Two or more person transfer assistance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Obesity care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Catheter, colostomy or similar care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advanced diabetes care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other, specify:</td>
</tr>
</tbody>
</table>

54. Is Medicaid transport available to your residents?

[ ] Yes  [ ] No  [ ] Not applicable

55. If Medicaid transport is provided by a third-party company, what is the quality of that service?

[ ] Good  [ ] Fair  [ ] Poor  [ ] Not applicable

56. Is HIPAA a barrier in communicating with your residents’ primary care office staff? [Note, HIPAA is a law that requires health care providers to keep patient information private.]

[ ] Yes  [ ] No  [ ] Don’t know

Thank you for taking the time to complete this questionnaire.
57. In general, how satisfied are you with your residents’ primary care office staff in the following areas:

<table>
<thead>
<tr>
<th></th>
<th>Very satisfied</th>
<th>Somewhat satisfied</th>
<th>Neither satisfied or dissatisfied</th>
<th>Somewhat dissatisfied</th>
<th>Very dissatisfied</th>
<th>*NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Efficiency of communicating between your contract RN and residents’ primary care offices</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Efficiency of communicating between your staff [e.g., resident manager, caregivers] and residents’ primary care office staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Response time regarding notices from your home to the primary care office about a resident’s change in condition</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Response time to requests for changes in residents’ medication orders and other physician orders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Exchange of care-related information following a hospitalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Exchange of care-related information following a stay in a rehabilitation or skilled nursing facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*NA=Not applicable

58. What concerns do you or your staff have about communicating with resident’s primary care office staff?
____________________________________________________________________________________________
____________________________________________________________________________________________

59. How have you and your staff partnered with primary care office staff to address a resident’s health needs?
____________________________________________________________________________________________
____________________________________________________________________________________________

60. What advice do you have about communicating with resident’s primary care office staff?
____________________________________________________________________________________________
____________________________________________________________________________________________

61. What are some ways to improve communication between adult foster homes and primary care offices?
____________________________________________________________________________________________
____________________________________________________________________________________________

Thank you for taking the time to complete this questionnaire.