

Residential Care Provider Survey

Bureau of Elderly and Adult Services
New Hampshire Department of Health and Human Services
July 2010



Description of Your Residential Care Facility

- a. How many years have you been in operation? Check one.
1-2 years _____ 3-5 years _____ 6-10 years _____ More than 10 years _____
- b. What is the total number of beds for which your facility is licensed? Please check one.
1-3 beds _____ 4-6 beds _____ 7-10 beds _____ 11-16 beds _____ More than 16 beds _____
- c. Is your facility currently at maximum capacity? Yes _____ No _____
- d. Do you currently have individuals waiting to move into your facility? Yes _____ No _____
- e. If your facility is not at maximum capacity, how many vacancies do you have? _____
- f. Of the total number of beds for which your facility is licensed, how many, do you consider available for people eligible for the Choices for Independence (CFI) program? _____
- g. If you have fewer residents than desired, are you able to identify the reasons why? Yes _____ No _____
If yes, please give reasons:
- 1) _____
 - 2) _____
 - 3) _____

Service Needs

- a. Please indicate the reasons why you have had to deny admission to a prospective applicant. Please check all that apply.
- _____ S/he was unable to climb stairs.
_____ S/he was unable to evacuate the building.
_____ S/he required the use of continuous oxygen.
_____ S/he demonstrated behaviors that exceeded those your facility could safely supervise.
_____ S/he had health needs beyond what your facility could safely manage.
_____ Other (Please specify.) _____
- b. What do you see as your biggest challenges in meeting resident or applicant needs? Please check all that apply.
- | | | |
|----------------------------------|-------------------------------------|-------------------------------|
| _____ building maintenance | _____ recruitment of staff | _____ staff retention |
| _____ cost of care | _____ training of staff | _____ reimbursement structure |
| _____ level of individual acuity | _____ local regulatory requirements | _____ other (explain) _____ |
| | _____ State regulatory requirements | _____ |

c. What do you believe are your best selling points as a residential facility?

- 1) _____
- 2) _____
- 3) _____

Relationship with Other Service Providers

a. Do residents from your facility attend community functions?

Yes _____ How often? _____ No _____

If yes, which ones? _____

b. Do residents from your facility use community resources?

Yes _____ How often? _____ No _____

If yes, which ones? _____

c. Do your residents from your facility attend events at senior centers?

Yes _____ How often? _____ No _____

If yes, which ones? _____

d. Does the staff of community agencies or programs come to your facility?

Yes _____ How often? _____ No _____

If yes, please describe the type(s) of agencies/programs. _____

e. Each resident who is a participant of the CFI program has a designated case manager. For your residents who are CFI participants:

Have you met each case manager? Yes _____ No _____

In the past 60 days, how often, on average, did each case manager visit the residents of your facility?

Weekly _____ Monthly _____ Bi-Monthly _____ Not at all _____ Other (explain) _____

If you have more than one resident who is enrolled in the CFI program, do they have different case managers? Yes _____ No _____

If yes, how many different case managers visit your facility? _____

Are you informed of changes in the case manager(s) assigned to the participant(s) at your facility?

Yes _____ No _____ Sometimes _____

Please describe what you see as the advantage of the case management service provided to residents of your facility. _____

Please describe what you see as the disadvantage of the case management service provided to residents of your facility. _____

Please describe any challenges and successes that you have encountered in working with other service providers who serve your residents. _____

Financial Considerations

a. Do you accept Medicaid payment for CFI participants? Yes _____ No _____

b. Do you try to maintain a mix of payer sources, private pay plus Medicaid? Yes _____ No _____
If yes, what combination is your goal? (i.e.: percent of each) _____

c. Please describe your experiences with billing the Medicaid Program for CFI participants.

d. What recommendations do you have to improve the billing process?

Your Relationship with BEAS

a. Have you been able to reach someone at BEAS when you have had questions or concerns ?
Always _____ Sometimes _____ Never _____

b. Have your questions been answered? Always _____ Sometimes _____ Never _____

c. Have your questions been addressed in a timely manner? Always _____ Sometimes _____ Never _____

d. How could BEAS improve its working relationship with you? _____

Other

Please add any comments or suggestions for program or service improvements.



Thank you for completing this survey.

Please return your response in the enclosed envelope.

*If you are not answering anonymously and you prefer, you may fax the completed survey to
271-4346, Attn: Susan Lombard*

or

you may e-mail your response to slombard@dhhs.state.nh.us

