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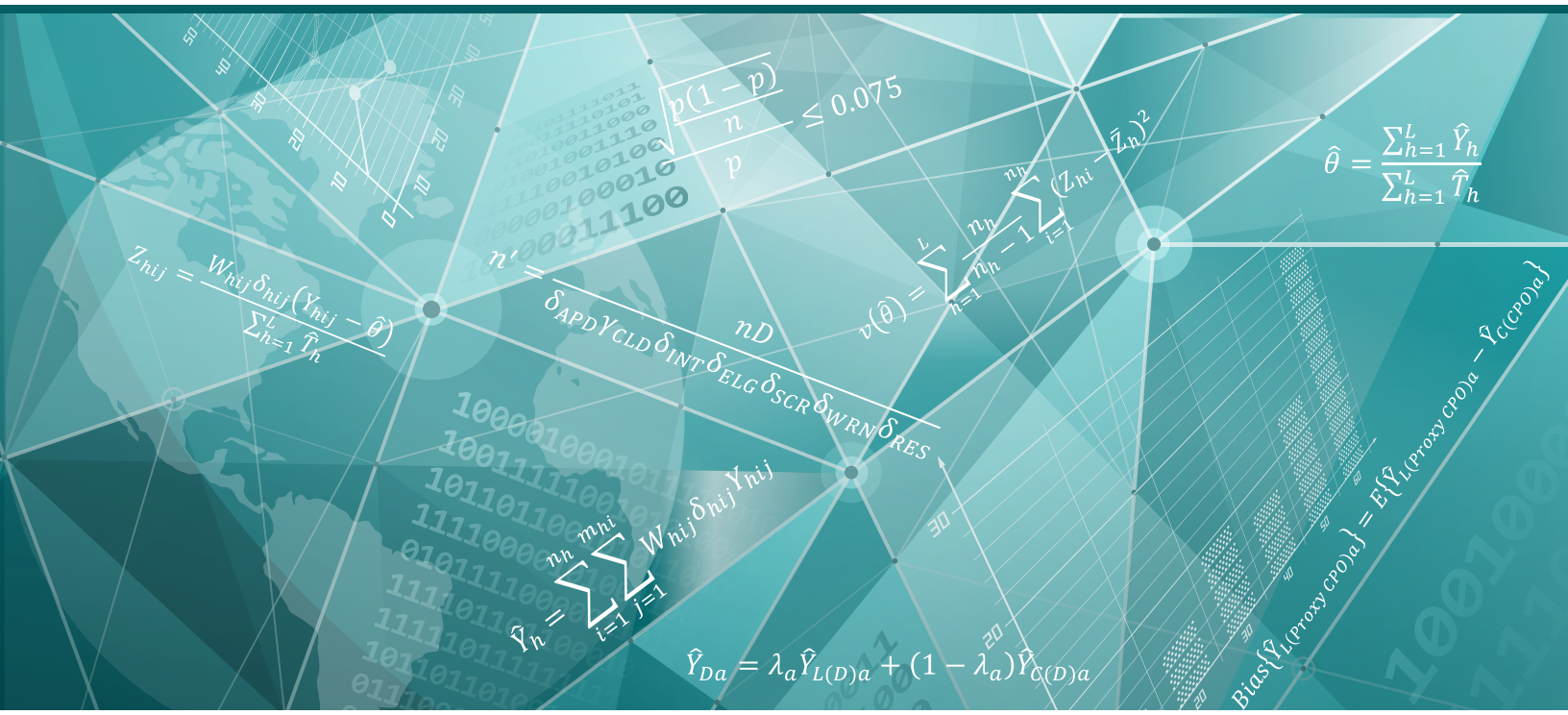

Eligibility Rate Differences Among Residential Care Communities: 2010 National Survey of Residential Care Facilities and 2012–2018 National Study of Long-Term Care Providers

Data Evaluation and Methods Research

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Health Statistics

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Data Evaluation and Methods Research

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Health Statistics

Hyattsville, Maryland
May 2022

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Dedication

This report is dedicated to Lauren Harris-Kojetin, Ph.D.
August 19, 1963–January 29, 2020

Lauren Harris-Kojetin was Chief of the Division of Health Care Statistics' Long-Term Care Statistics Branch for 14 years. During this time, she led four national survey waves of the National Study of Long-Term Care Providers and spearheaded multiple innovative redesigns of NCHS' long-term care surveys that captured the intricacies of each sector while producing reliable, accurate, and timely data for researchers, policy makers, and providers of these services. Lauren was particularly interested in survey methodology and operations. This report is the result of multiple enriching discussions with Lauren about survey design and related eligibility differences. Lauren's passion, insight, and dedication to survey statistics, aging, and long-term care services and supports will be greatly missed by her colleagues at the National Center for Health Statistics.

Acknowledgments

The authors are grateful to the many people who provided technical expertise and assistance in implementing the 2010 National Survey of Residential Care Facilities (NSRCF) and the 2012, 2014, 2016, and 2018 National Study of Long-Term Care Providers (NSLTCP), and in developing this report. NCHS Office of Information Services, Information Design and Publishing Staff edited and produced this report: editor Jane Sudol and typesetter and graphic designer Odell D. Eldridge (contractor).

The authors are indebted to the directors and administrators of the assisted living and similar residential care communities and their designated staff who took time to complete the questionnaires.

Under a contract with NCHS, RTI International implemented the 2010 NSRCF and the 2012–2018 NSLTCP surveys. The authors gratefully acknowledge the talented and dedicated staff at RTI International for their contributions to the design and successful implementation of the surveys, especially Angela Greene, Melissa Hobbs, Katherine Mason, Mai Nguyen, Linda Lux, Kristie Porter, Rebecca Powell, and Celia Eicheldinger.

Special thanks are extended to Christine Caffrey and Jessica Lendon in the NCHS Division of Health Care Statistics' Long-Term Care Statistics Branch for reviewing drafts of this report and providing valuable feedback.

Eligibility Rate Differences Among Residential Care Communities: 2010 National Survey of Residential Care Facilities and 2012–2018 National Study of Long-Term Care Providers

by Manisha Sengupta, Ph.D., Priyanka Singh, M.P.H., and Amanuel Melekin, Ph.D.

Abstract

Background

Over the last decade, the National Survey of Residential Care Facilities (NSRCF) and multiple waves of the National Study of Long-Term Care Providers (NSLTCP) (renamed National Post-acute and Long-term Care Study in 2020) have collected data about residential care communities (RCCs). This report provides a review of RCC eligibility rates over survey years and describes design differences and methodological changes—including minor wording changes to screener questions and placement of question-specific instructions—that may be related to observed differences in eligibility rates.

Methods

The National Center for Health Statistics contracted with RTI International to conduct the onetime NSRCF in 2010 and the biennial NSLTCP starting in 2012. NSRCF and the residential care component of NSLTCP collected data on residential care providers and their service users. The residential care sector includes settings such as assisted living facilities, residential care homes, personal care homes, residential care facilities, and adult family homes. To be eligible to participate in the surveys, an RCC had to meet a set of criteria. Selected RCC characteristics (as in bed size, U.S. Census Bureau region, and metropolitan statistical area status) and differences in design and methodology are examined to explain observed differences in eligibility rates.

Results

Over the survey years, eligibility rates have varied overall as well as by bed size and mode of survey. The 2012 wave presented the lowest eligibility rate among all survey years. Eligibility rates increased when modifications were made based on respondent comments, field staff observations, and cognitive testing. Differences in eligibility rates have an impact on the estimated size of the residential care sector.

Keywords: aging • eligibility rates • long-term services and supports • post-acute care • National Survey of Residential Care Facilities • National Study of Long-Term Care Providers

Introduction

Over the years, the Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS) has conducted a series of long-term care studies, such as several waves of the National Nursing Home Survey (NNHS), National Home and Hospice Care Survey (NHHCS), and National Survey of Residential Care Facilities (NSRCF). In 2012, NCHS launched the biennial National Study of Long-Term Care Providers (NSLTCP) to monitor trends in the supply, provision, and use of paid, regulated long-term care services and supports. NSLTCP replaced NCHS' previous surveys such as NNHS, NHHCS, and NSRCF. NSLTCP is unique in providing national and state data on multiple long-term care sectors using a combination of administrative data on home health, hospice, and nursing homes, and survey data on adult day services centers and assisted living and similar residential care communities (RCCs).

RCCs are an important component of the spectrum of long-term care services and supports, providing care to people who cannot live independently but generally do not require the skilled level of care provided by nursing homes (1). The residential care sector includes settings such as assisted living facilities, residential care homes, personal care homes, residential care facilities, and adult family homes (1,2). NSRCF and the residential care component of NSLTCP collected data on residential care providers and their service users. These surveys included questions on provider characteristics such as size, ownership, staffing,

and services provided. The surveys also collected data on service user characteristics such as demographics, selected health conditions, physical functioning, and adverse health outcomes.

A standard federal definition of residential care has not been developed, and state regulations that govern this sector vary between states (2,3). NCHS developed a set of criteria to define RCCs and determine whether they are eligible to participate in the surveys. The eligibility criteria, substantially similar for NSRCF and NSLTCP, were used first during sampling frame development and then during data collection to screen out RCCs that did not meet the inclusion criteria. Although the inclusion criteria have remained essentially similar over the survey waves, with minor adjustments to question sequence and wording and in instructions to respondents, the screener-based eligibility rate dropped from 81.0% in 2010 to 67.1% in 2012. Fluctuations in the eligibility rate continued in subsequent NSLTCP waves, although the 2012 eligibility rate was the lowest among all survey years.

This report summarizes the eligibility rate of RCCs across survey years 2010–2018 by selected RCC characteristics (as in bed size, U.S. Census Bureau region, and metropolitan statistical area [MSA] status) and describes differences in design and methodological changes, including minor wording changes to screener questions and placement of question-specific instructions, that may be related to observed differences in eligibility rates. In January 2020, NSLTCP was renamed the National Post-acute and Long-term Care Study (NPALS) with the addition of more post-acute sectors (inpatient rehabilitation facilities and long-term care hospitals), while keeping the same sectors that have been in the study since it was launched in 2012. This report focuses on the residential care sector and uses the study name NSLTCP because the information presented here refers to survey waves before the 2020 name change.

This report's objectives are threefold: First, assess overall differences in eligibility rates over time by selected characteristics including bed size, region, and MSA status; second, assess whether specific reasons for ineligibility varied across survey years; and third, describe the linkage of the 2012 and 2014 samples to assess whether changes occurred in eligibility status for individual RCCs that were sampled in both years.

Design and Operations

National Survey of Residential Care Facilities

The 2010 NSRCF was a first-ever national probability sample survey designed to provide national estimates of the number of RCCs operating in the United States, the number of residents receiving care, and characteristics of both the communities and residents. Data were collected through in-person interviews with RCC directors and their designated staff. No interviews were conducted with residents. Using a stratified two-stage probability sampling design, RCCs were selected in the first stage followed by selection of current residents in the second stage. Although residents were not interviewed as part of the survey, resident-based second-stage sampling collected information about resident characteristics within facilities. Three to six current residents were randomly selected per RCC depending on the size of the community, and either administrators or directors, or designated caregivers, completed the resident surveys. Using computer-assisted personal interviews (CAPI), NSRCF collected information about provider characteristics such as physical structure and environment, types of services offered, types of staff who were employed, and policies on admission, retention, and discharge. For residents, data included demographics, living arrangements, involvement in inside and outside activities, use of services, charges for care, health status, health conditions, and cognitive and physical functioning. A detailed methodology report on the 2010 NSRCF is available from: https://www.cdc.gov/nchs/data/series/sr_01/sr01_054.pdf, and on the NSRCF website at: https://www.cdc.gov/nchs/nsrcf.htm.

National Study of Long-Term Care Providers

Introduced in 2012, NSLTCP is a biennial study of major regulated long-term care providers and their service users. NSLTCP replaced NCHS' previous long-term care surveys including NSRCF. Using a combination of primary surveys and administrative data, the first three waves of NSLTCP conducted in 2012, 2014, and 2016 were designed to provide national and state estimates of five major long-term care sectors, including administrative data on home health, hospice, and nursing homes, and primary survey data on adult day services centers and RCCs. For the primary surveys, data were collected using a multimode survey protocol with mail, Internet, and telephone follow-up for nonresponse. NSLTCP used a combination of sample and census for RCCs: Using a stratified probability sampling design, a state was sampled if it had enough such communities to enable state-level estimation. In states with an insufficient number of RCCs to attain at least the minimum number of completions for state-level estimates, a census was conducted. The questionnaires included survey items on provider characteristics such as ownership, size, number of years in operation, services offered, selected practices, and staffing, in addition to aggregate user characteristics such as age, sex, race, and the number of residents needing assistance with activities of daily living. More details about NSLTCP are available from the study website at: https://www.cdc.gov/nchs/npals/index.htm.

In 2018, two new sectors were added to NSLTCP: Administrative data were acquired for long-term care hospitals and inpatient rehabilitation facilities. In addition, the data collection protocol for the two survey sectors

of adult day services centers and RCCs was redesigned to provide only national estimates. A separate module, designed to sample two service users and collect data about them, was also added.

Residential Care Eligibility Criteria

Residential care has no standard federal definition (2). Because RCCs are regulated by the states, the definitions and terms used to describe them vary between states, as do the licensing categories and characteristics of RCCs. In the absence of a standard federal definition, a set of criteria was used to define RCCs for NSRCF and NSLTCP (4). RCCs were eligible to participate if they met the following criteria:

- Licensed, registered, certified, listed, or otherwise regulated by their state within their specific licensing category
- Had four or more licensed, certified, or registered residential care beds
- Had at least one resident currently living in the RCC
- Provided room and board with at least two meals a day
- Provided around-the-clock onsite supervision
- Provided help with activities of daily living (as in bathing, eating, or dressing) or health-related services (as in medication management)
- Served primarily an adult population
- Did not exclusively serve the severely mentally ill (SMI), the intellectually or developmentally disabled, or both.

Sampling Frame and Sample

The sampling frame construction approach was similar across surveys and years of NSLTCP. The frames for each wave were constructed from lists of licensed RCCs—facilities that are licensed, registered, listed, certified, or otherwise regulated by the state—obtained from the state licensing agencies in each of the 50 states and the District of Columbia. The state lists were in different formats and needed to be standardized, assessed for completeness, cleaned of duplicate entries, and merged to create a preliminary file. Because of differences in the terms and definitions used to describe residential care across states, the first step was to identify licensing categories in each state that met the study definition. The inclusion criteria were then applied to individual communities to ensure they met the study definition. The 2010 NSRCF frame consisted of 39,635 RCCs. The NSLTCP frame ranged from 39,779 RCCs in 2012 to 40,583 in 2014, 42,149 in 2016, and 43,770 in 2018.

The sampling designs for NSRCF and NSLTCP differed: NSRCF and the 2018 wave of NSLTCP were designed to provide only national estimates, while the 2012, 2014, and 2016 waves of NSLTCP were designed to provide state and national estimates. NSRCF used a stratified two-stage sampling design with the primary sampling strata of RCCs defined by bed size (as in 4–10 beds, 11–25 beds, 26–100 beds, and more than 100 beds) and census region (Northeast, Midwest, South, and West). Within these sampling strata, RCCs were sorted by MSA status and state and then systematically and randomly sampled. This first stage of NSRCF yielded a sample of 3,605 RCCs. In the second stage, current residents were randomly selected by a computer algorithm, based on a census list provided by each RCC. Three to six residents were selected depending on the size of the community (three residents for facilities with fewer than 26 beds, four residents for those with 26–100 beds, and six residents for those with more than 100 beds).

Because the first three waves of the RCC component of NSLTCP were designed to provide national as well as state estimates, the sample sizes were larger than in NSRCF: 11,690 RCCs were sampled in 2012, 11,618 in 2014, and 11,688 in 2016. In these survey years, NSLTCP used a combination of sample and census; sampling was used in states that had enough RCCs on the frame to meet the minimum number of completions for state-level estimates. In the sampled states, RCCs were randomly selected from the primary sampling strata defined by state and community bed size. For each primary stratum defined by state and bed size, and within these sampling strata, RCCs were sorted by MSAs and then randomly ordered within each MSA.

In 2018, NSLTCP was redesigned to provide only national estimates and had a relatively smaller sample of 2,090 RCCs. Comparable with NSRCF, the 2018 NSLTCP used a two-stage probability sample design. In the first stage, stratified RCCs (by census region) were selected using systematic random sampling and sorted by bed size categories and MSA. The second stage involved the random sampling of two current residents from eligible and participating RCCs.

Screener-based Eligibility

During frame development, RCCs were screened for eligibility, but determining whether an RCC on the frame met the study definition was not always straightforward because of incomplete information on the frame. Consequently, a second screening was done during data collection. For data collection, a set of eligibility questions was prepared based on the same eligibility criteria used during frame development. These questions were used to screen out service providers that did not meet the study definition but were included on the frame due to incomplete data or unclear designation of specific licensing categories at the time of frame development. Responses to the screener eligibility questions for RCCs that completed the screener were used to calculate the screener-based eligibility rate using:

$$ELR = \frac{S_{elig}}{S_{elig} + S_{inelig}}$$

where:

ELR = Eligibility rate

S_{elig} = Completed screening questions and determined to be eligible

S_{inelig} = Completed screening questions and determined to be ineligible.

Table 1 presents the size of the sampling frame and sample along with the eligibility rates by survey years. The screener-eligibility rates varied over the survey years: 81.0% of sampled RCCs that completed the screener were eligible in 2010, while 67.1%, 80.7%, 73.8%, and 77.0% were found to be eligible in 2012, 2014, 2016, and 2018, respectively (Table 1). Differences in eligibility rates over the years had an impact on estimates of the size of the residential care sector. The estimated national number of RCCs was 31,100 in 2010, 22,200 in 2012, 30,200 in 2014, 28,900 in 2016, and 31,400 in 2018 (Table 2). The number of beds was estimated at 971,900 in 2010, 851,400 in 2012, 1,006,300 in 2014, 996,100 in 2016, and 1,183,600 in 2018. With the lowest eligibility rate in 2012, the estimated size of the residential care sector was smallest for that year among all survey years.

Screener Protocol

To introduce the study to sampled RCCs, an advance mailing was used in NSRCF and NSLTCP. For NSRCF, the advance package included an invitation to participate in the survey signed by the NCHS director, a letter of support from leading provider organizations, and a confidentiality brochure. Five business days after the advance package was mailed out, recruiters called sampled RCCs and asked to speak with the director or administrator to complete the screener questionnaire and set an appointment for in-person interviews. On average, these calls took 10 minutes to complete. However, recruiters found it challenging to reach the directors either because the directors in small RCCs also provided direct care to the residents and did not have time to respond, or because gatekeepers in larger RCCs resisted contacting the director.

For the first three waves of NSLTCP (2012, 2014, and 2016), the screening questions were included as the first set of questions in the provider questionnaire. The first questionnaire packet was mailed about a week after the advance letter and included 1) a cover letter with log-in information to complete the survey via the Internet; 2) a provider association letter of support; 3) an *NCHS Data Brief* summarizing key findings from an earlier wave; 4) a confidentiality brochure; 5) an Internet participation insert card printed with the case's unique log-in credentials; 6) a hard-copy questionnaire; and 7) a preaddressed, postage-paid business reply envelope. If RCCs did not submit a questionnaire by a designated date, two follow-up questionnaire packets were mailed to them. Materials in the follow-up mailings contained the same information provided in the initial questionnaire packet mailing. Computer-assisted telephone interview (CATI) was used as a follow-up mode for nonrespondents to the mail or Internet survey. If hard-copy questionnaires returned by mail had missing responses to one or more of the screener questions, these cases were sent to CATI for data retrieval. For RCCs that did not respond to any of the questionnaire mailings by a designated date, a final opportunity to complete the questionnaire (including screener) was offered using CATI. On average, these calls took about 30 minutes to complete if RCCs were eligible and about 5 minutes if they only completed the screener and were found to be ineligible.

In 2016, the protocol prioritized CATI calls for small RCCs (4–10 beds). These calls started about 6 weeks earlier than they started for RCCs of larger bed size categories, giving small RCCs more time to complete the questionnaire by CATI. Because small RCCs were prioritized for CATI calls, nonresponding small RCCs were excluded from the second follow-up mailing. As with NSRCF, the 2018 NSLTCP had a separate screener module that was conducted by CATI. On average, these calls took about 6 minutes to complete. CATI calls were challenging particularly with small RCCs, where owners or directors could not be reached or had little time to spare because of their caregiving responsibilities.

Screener Questions

No substantive differences were found in the screener questions over the survey waves. However, formatting and wording of the questions were altered based on respondent comments, interviewer observations, and cognitive testing results. The Appendix shows the screener eligibility questions for the 2010 NSRCF and the 2012, 2014, 2016, and 2018 NSLTCP.

NSRCF had a set of nine questions to determine eligibility. In a pretest for NSRCF, the screener questions were tested along with the provider and resident questions before including them in the national survey. During fielding, recruiters found that three screener questions were difficult to administer: the questions asking whether the facility exclusively served a population with mental retardation and intellectual or developmental disabilities (MR/DD), whether the facility exclusively served a population with SMI, and whether the facility offered 24-hour supervision. Respondents found these questions to be complicated and difficult to process. When planning for the first wave of NSLTCP in 2012, NSRCF screener questions were used as the starting point. Respondent comments and field interviewer experiences during NSRCF were reviewed, and the wording for some questions was revised while other questions were combined. For instance, the separate questions about exclusively serving populations with MR/DD or SMI were combined into a single question with two parts, and the wording of the 24-hour supervision question was revised for more clarity (Appendix).

Eligibility rates were lower for the 2012 wave and led to a closer scrutiny of the screener questions. Respondent comments, help desk questions, and telephone interviewer observations indicated that some eligibility questions were difficult for respondents to comprehend. Cognitive testing identified Question 4 as the most confusing question: *"Does this … provide or arrange for a personal care aide, registered nurse* (*RN*)*, licensed practical nurse* (*LPN*) *...?"* The question was long and contained a lot of text, likely making it hard to read and comprehend for the self-administered Internet and mail modes as well as the interviewer-administered CATI mode. Respondents may have overlooked the reference to "personal care aide" and appeared to answer the question based on RN and LPN considerations, potentially wrongly disqualifying them from the survey. Second, respondents failed to read instructions, in part due to the high number of instructions provided. The pilot test also identified some issues with following skip instructions. Interpretation of some terms such as "on-site" varied among respondents, which may have affected how they responded to the screener questions. Based on results from cognitive testing of the 2012 screener questions, several adjustments were made to the 2014 screener questions. The 24-hour supervision question was formatted so that it split the question into three subcategories: personal care aides, RNs, and LPNs. Additionally, the format of skip instructions was modified and placed immediately after the question to make them more visible and easier for respondents to follow. To bring more clarity, the question was revised to include "… *provide or arrange for* ***any*** *of the following types of staff …*" and a response category was also added to indicate "on an as-needed basis."

During the 2012 wave, field staff reported that some respondents were confused by the question about number of beds, because some RCCs had "licensed units" or "licensed apartments" and they were not as familiar with the term "licensed beds." For 2014, the following explanation was included in the question to help minimize confusion: "*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*." The 2012 field staff also reported that some respondents did not understand the intent of the word "exclusively" in the MR/DD question. Based on these observations and the results of cognitive testing, the word "exclusively" was replaced by "only." In addition, because mental retardation was no longer the appropriate term to describe this population, the term "MR/DD" indicating "mental retardation with intellectual or developmental disabilities" was replaced by ID/DD indicating "intellectual disability/developmental disability."

The revisions made to the 2014 survey were intended to reduce varying interpretation of questions that the cognitive testing identified. No changes were made to the screener questions after the 2014 wave, except for an additional instruction to respondents to "include residents for whom a bed is being held while in the hospital" when reporting the total number of residents.

Differences in Eligibility by Frame Characteristics

The RCC sampling frames for NSRCF and NSLTCP included the number of beds, geographic region, MSA status, and ownership status for the communities listed. Using sampling frame variables, screener eligibility was assessed by bed size (small, medium, large, and very large), geographic region (Northeast, Midwest, South, and West), and MSA status (metropolitan or nonmetropolitan). Screener eligibility was not assessed by ownership status because of the large number of cases that were missing ownership information on the sampling frame.

Across all survey years, screener eligibility increased with bed size, with small RCCs having the lowest eligibility and extra-large RCCs the highest eligibility. The difference in eligibility (difference between the highest and lowest eligibility rates across survey years) was higher among small and medium RCCs than among larger RCCs. For all bed size categories, differences in screener eligibility between 2010 and 2012 and between 2012 and 2014 were similar because of the lowest screener eligibility in 2012 (Table 3). The differences in screener eligibility rates between 2010 and 2012 as well as between 2012 and 2014 were highest for RCCs with 4–10 beds: a decrease from 63.6% in 2010 to 45.8% in 2012 and an increase from 45.8% in 2012 to 65.3% in 2014 (Table 3). The difference in screener eligibility rates was most pronounced in the West between 2012 and all other survey years under review in this report.

Differences in Eligibility by Survey Mode and Design and Bed Size

For the first three waves of NSLTCP (2012–2016) when the screener was administered by different modes, differences in eligibility by mode were largest among medium and small RCCs. Eligibility was highest for the Internet submissions in 2012 and 2016, while eligibility was similar for Internet and CATI submissions in 2014 (Table 4). The difference in eligibility rate by mode was generally larger among small bed size categories than other size categories (Table 5). Among small, medium, and extra-large RCCs in 2012, eligibility rates were highest for CATI. For large RCCs in 2012, eligibility rates were similar for mail and CATI. The eligibility rate for small RCCs in 2012 was lowest for the mail mode, while the eligibility rate for medium and very large RCCs was lowest for the Internet mode. Overall, in 2014, the eligibility rate was lowest for the mail mode, and responses through the CATI mode had the highest eligibility across bed size strata. In 2016, the eligibility rate was lowest for the CATI mode and highest for the Internet mode (Table 4). Although eligibility across all

bed size categories declined between 2014 and 2016, the most noticeable decline was among small RCCs—a decline of about 10 percentage points. To increase participation of small RCCs, the 2016 protocol included an increase in calling effort for small RCCs. This provided additional time to contact small RCCs, resulting in a larger number of small RCCs that were screened.

Reasons for Ineligibility

Apart from the 2012 wave of NSLTCP, the common reason for ineligibility was that the RCC exclusively served populations with MR/DD or SMI (Table 6). In 2012, not providing 24-hour supervision was the most common reason for RCCs to be ineligible.

Comparing merged samples from 2012 and 2014—The 2012 and 2014 sample files were matched by a unique identification number, and 6,003 RCCs were found to have been sampled in both years. Of these RCCs, eligibility could be determined for 3,601 in 2012 and 3,370 in 2014. Using the merged file, 38.9% (174 out of 447) of RCCs that were ineligible in 2014 responded as ineligible in 2012, and 12.3% (359 out of 2,923) of RCCs that were found to be eligible in 2014 had responded as ineligible in 2012. A review of the reasons for ineligibility indicated that a majority of RCCs (65.5%) that were ineligible in 2014 but eligible in 2012 reported exclusively serving the population with MR/DD as the reason for ineligibility in 2014. Among RCCs that were eligible in 2014 but ineligible in 2012, 285 (79.4%) reported providing 24-hour supervision in 2014 (unlike in 2012), and 60 RCCs (16.7%) reported having four or more beds in 2014 (unlike in 2012).

Discussion

In the absence of a federal definition for RCCs, NCHS uses a set of eligibility criteria to identify RCCs that meet the study definition. Eligibility rates influence the estimated size of the residential care sector. Over the years, eligibility rates have varied overall, as well as by bed size and mode of survey. Ineligibility can increase if respondents misunderstand the intent of one or more screener questions, particularly if the questions are complex and have many parts. Using an interviewer-administered mode (CATI), where an interviewer may clarify the intent of questions, can also result in higher eligibility compared with a self-administered mode (mail or Internet). An evaluation of the screener questions over the years suggests that eligibility rates increased when modifications were made based on respondent comments, field staff observations, and cognitive testing. After the drop in eligibility between 2010 and 2012 following a change in mode (from CATI in 2010 to mail, Internet, and CATI in 2012), some screener questions were reworded for clarity in 2014 based on the 2012 experience. Following these changes, the eligibility rate increased from 67.1% in 2012 to 81.7% in 2014, indicating that the reworded screener questions may have provided more clarity for the respondents. Moreover, eligibility rates in 2016 and 2018 were higher than eligibility rates in 2012, which may provide additional evidence of the effects of screener adjustments on eligibility. Among small RCCs, the eligibility differences by mode were also reduced, indicating that respondents using both self- and interview-administered modes understood the questions. Other studies have shown that simplifying questions and making them less ambiguous can help respondents better comprehend the intent of the questions, resulting in increased participation and improved data quality (5–10).

Eligibility rates of small and medium RCCs have varied more over the years than large and extra-large RCCs. The frame development process involves a thorough application of the exclusionary criteria used to identify RCCs that meet the definition of the study. However, given regulatory differences among states and changes in regulations, some RCCs on the frame are found to be ineligible during data collection. A more thorough review of state regulations before frame development for each wave of the study may help to better identify RCCs that meet the study definition.

In general, CATI can be an effective mode of data collection, particularly if the questions are complex and can be misinterpreted by self-administered respondents. However, differences in eligibility by mode also vary by bed size and are most pronounced among small and medium providers. Large and very large RCCs show small variations in eligibility by mode. In 2016, implementing the strategy to start CATI earlier with small RCCs slightly improved participation (increasing by 4 percentage points in 2016 [51.8%] from 2014 [47.6%] among small RCCs), but identifying more of the ineligible small RCCs in the sample may also have helped.

A high proportion of RCCs were screened as ineligible because they exclusively served populations with SMI or MR/DD. Small RCCs are more likely than large RCCs to serve these special populations exclusively (11). Findings from the 2012 and 2014 merged data also indicate that some small RCCs may make a change in the type of populations they serve, resulting in the same RCC being eligible in one wave and ineligible in another. A higher percentage of residents in small RCCs also have health and functional needs (1,12). Directors and administrators of these RCCs may provide direct care to their residents and may not have the time to carefully read instructions in the questionnaires, resulting in misinterpretation of the eligibility questions. These respondents may benefit from using interviewer-administered modes over self-administered modes.

This study had some limitations. First, only the 2012 and 2014 files could be matched because the unique identifiers were the same only for these two waves. Second, the eligibility questions in 2012 and 2014 did not allow for identifying all of the individual reasons for ineligibility for each case. Respondents were coded as ineligible with the first ineligible response to the series of screener questions, so they

stopped responding to the rest of the screener questions if they were already found ineligible. Third, minor changes to question wording and protocol were made simultaneously, confounding the results and making it difficult to tease out the separate impact of these changes. Despite these limitations, this analysis provides a comprehensive description of the differences in RCC eligibility and identifies probable reasons for these differences over nearly 10 years of the only national data collection of RCCs in the United States.

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Table 1. Residential care community frame, sample, and eligibility rate, by survey year

Survey	Frame	Sample	Percent eligible
National Survey of Residential Care Facilities			
2010	39,635	3,605	81.0
National Study of Long-Term Care Providers			
2012	39,779	11,690	67.1
2014	40,583	11,618	80.7
2016	42,149	11,688	73.8
2018	43,770	2,090	77.0

NOTE: The eligibility rate is calculated by dividing the number of known eligible residential care communities (RCCs) by the total number of RCCs with known eligibility status.

SOURCES: National Center for Health Statistics, National Survey of Residential Care Facilities, 2010, and National Study of Long-Term Care Providers, 2012, 2014, 2016, and 2018.

Table 2. Residential care communities and beds, by bed size and survey year

Characteristic	National Study of Long-Term Care Providers								National Survey of Residential Care Facilities	
	2018		2016		2014		2012		2010	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Number of residential care communities (RCCs)										
All RCCs[1]	31,400	100.0	28,900	100.0	30,200	100.0	22,200	100.0	31,100	100.0
Small (4–10 beds)[1]	14,700	46.7	13,200	45.6	14,500	47.9	9,000	41.7	15,400	50.0
Medium (11–25 beds)[2]	4,000	12.8	4,400	15.3	4,500	14.9	3,600	16.8	4,900	16.0
Large (26–100 beds)[2]	9,800	31.1	9,100	31.5	9,100	30.1	7,600	32.7	8,700	28.0
Extra large (more than 100 beds)[3]	2,900	9.3	2,200	7.7	2,100	7.0	2,000	8.7	2,100	7.0
Number of beds										
All RCCs[4]	1,183,600	100.0	996,100	100.0	1,000,000	100.0	851,400	100.0	971,900	100.0
Small (4–10 beds)[1]	90,400	7.6	81,800	8.2	89,600	9.0	64,700	7.6	96,700	9.9
Medium (11–25 beds)[2]	71,900	6.1	76,500	7.7	76,900	7.7	86,900	10.2	86,800	8.9
Large (26–100 beds)[2]	565,300	47.8	518,300	52.0	522,600	52.3	434,800	51.1	493,800	50.8
Extra large (more than 100 beds)	456,000	38.5	319,500	32.1	310,900	31.1	265,000	31.1	294,600	30.3

[1]Significant difference between all survey years.
[2]Significant difference between all years except between 2014 and 2016.
[3]Significant difference between 2012 and 2016.
[4]Significant difference between 2012 and all other years.

NOTE: All estimates are adjusted for the probability of selection and nonresponse.

SOURCES: National Center for Health Statistics, National Survey of Residential Care Facilities, 2010, and National Study of Long-Term Care Providers, 2012, 2014, 2016, and 2018.

Table 3. Eligibility rates of residential care communities, by bed size, region and area, and survey year

Eligible residential care communities (RCCs)	National Study of Long-Term Care Providers				National Survey of Residential Care Facilities
	2018	2016	2014	2012	2010
All RCCs	77.0	73.8	80.7	67.1	81.0
Bed size					
Small (4–10 beds)	61.3	55.5	65.3	45.8	63.6
Medium (11–25 beds)	75.0	74.5	81.0	68.5	82.8
Large (26–100 beds)	85.1	86.9	91.7	82.4	94.5
Extra large (more than 100 beds)	92.1	91.2	93.8	85.5	95.9
Region					
Northeast	72.2	72.5	85.7	73.4	75.7
Midwest	85.4	76.5	81.2	73.8	77.8
South	75.1	74.1	81.2	66.9	85.3
West	73.7	72.0	77.2	57.8	82.2
Metropolitan statistical area (MSA) status					
MSA	76.8	72.8	79.9	65.5	82.4
Non-MSA	78.1	78.6	83.1	73.4	82.2
Neither	76.1	73.6	82.6	68.1	†

† The frame included only two categories, MSA and Non-MSA.

NOTE: The eligibility rate is calculated by dividing the number of known eligible RCCs by the total number of RCCs with known eligibility status.

SOURCES: National Center for Health Statistics, National Survey of Residential Care Facilities, 2010, and National Study of Long-Term Care Providers, 2012, 2014, 2016, and 2018.

Table 4. Eligibility rates of residential care communities, by interview mode and survey year

Eligible residential care communities (RCCs)	National Study of Long-Term Care Providers				National Survey of Residential Care Facilities
	2018	2016	2014	2012	2010
All RCCs	77.0	73.8	80.7	67.1	81.0
Interview mode					
CATI or CAPI[1]	77.0	68.5	85.4	69.6	81.0
Mail	…	73.9	81.4	67.0	…
Internet	…	80.4	84.5	72.0	…
Census or sample					
Census	…	77.6	86.8	73.0	…
Sample	77.0	70.0	75.8	61.1	81.0

… Category not applicable.

[1]Computer-assisted telephone interview (CATI) for National Study of Long-Term Care Providers, 2012–2018; computer-assisted personal interview (CAPI) for National Survey of Residential Care Facilities, 2010.

NOTE: The eligibility rate is calculated by dividing the number of known eligible RCCs by the total number of RCCs with known eligibility status.

SOURCES: National Center for Health Statistics, National Survey of Residential Care Facilities, 2010, and National Study of Long-Term Care Providers, 2012, 2014, 2016, and 2018.

Table 5. Eligibility rates of residential care communities, by bed size, interview mode, and survey year

Bed size and interview mode	National Study of Long-Term Care Providers				National Survey of Residential Care Facilities
	2018	2016	2014	2012	2010
Small (4–10 beds)	61.3	55.5	65.3	45.8	63.6
Mail	…	58.9	67.1	45.9	…
Internet	…	57.0	68.7	47.1	…
CATI or CAPI[1]	61.3	56.8	71.1	53.6	63.6
Medium (11–25 beds)	75.0	74.5	81.0	68.5	82.8
Mail	…	73.7	86.8	69.8	…
Internet	…	81.7	78.6	67.7	…
CATI or CAPI[1]	75.0	68.8	91.1	73.5	82.8
Large (26–100 beds)	85.1	86.9	91.7	82.4	94.5
Mail	…	86.9	92.4	82.9	…
Internet	…	89.5	91.6	84.1	…
CATI or CAPI[1]	85.1	84.5	94.9	82.8	94.5
Extra large (more than 100 beds)	92.1	91.2	93.8	85.5	95.9
Mail	…	90.9	94.9	85.9	…
Internet	…	92.0	93.9	85.0	…
CATI or CAPI[1]	92.1	91.5	95.5	86.6	95.9

… Category not applicable.
[1]Computer-assisted telephone interview (CATI) for National Study of Long-Term Care Providers, 2012–2018; computer-assisted personal interview (CAPI) for National Survey of Residential Care Facilities, 2010.

NOTE: The eligibility rate is calculated by dividing the number of known eligible residential care communities (RCCs) by the total number of RCCs with known eligibility status.

SOURCES: National Center for Health Statistics, National Survey of Residential Care Facilities, 2010, and National Study of Long-Term Care Providers, 2012, 2014, 2016, and 2018.

Table 6. Percentage of ineligible residential care communities, by reason for ineligibility and survey year

Reason for ineligibility	National Study of Long-Term Care Providers[1,2]				National Survey of Residential Care Facilities[3]
	2018	2016	2014	2012	2010
Not licensed, registered, listed, certified, or otherwise regulated by the state	5.4	2.5	3.7	2.5	…
Exclusively serves those with intellectual or developmental disability, severe mental illness, or both	99.1	89.2	84.5	37.6	63.6
Less than four beds	2.7	2.4	3.4	9.6	†
No 24-hour supervision	8.1	1.8	2.3	48.7	†
No help with activities of daily living or assistance with medication	2.7	0.3	0.4	0.1	†
Not serving two meals a day	5.0	1.8	2.6	0.5	†
No current residents	5.9	2.0	3.2	1.3	7.6

… Category not applicable.
† Coded together as having less than four beds, no 24-hour supervision, no help with activities of daily living or assistance with medication, and not serving two meals a day.
[1]In 2018, cases were coded as ineligible after all screener questions were answered. Totals may sum to more than 100% because a residential care community may be ineligible for multiple reasons.
[2]In 2016, 2014, and 2012, cases were coded as ineligible based on the first ineligible response to a screener question.
[3]Cases were coded into three ineligibility categories, based on responses to survey questions: 1) less than four beds, no 24-hour supervision, no help with activities of daily living or assistance with medication, and not serving two meals a day; 2) no current residents; and 3) exclusively serves intellectually or developmentally disabled persons with severe mental illness. Only one code was assigned per case. When multiple reasons for ineligibility were given, the following order of precedence determined which of two equally applicable codes should be assigned: Category 3 was ranked first, category 1 second, and category 2 third.

SOURCES: National Center for Health Statistics, National Survey of Residential Care Facilities, 2010, and National Study of Long-Term Care Providers, 2012, 2014, 2016, and 2018.

Appendix. Screener Eligibility Questions for 2010 National Survey of Residential Care Facilities and 2012–2018 National Study of Long-Term Care Providers

Residential care community (RCC) eligibility questions from survey years 2010, 2012, 2014, 2016, and 2018 are provided as reference for this report. These questions were used to determine eligibility for RCCs to participate in the 2010 National Survey of Residential Care Facilities (NSRCF) and the 2012–2018 National Study of Long-Term Care Providers (NSLTCP).

2010 NSRCF Screener Questions

S_I_Statement_A	I would like to verify some information we have about *[SAMPLED FACILITY]*. The questions I have right now should take just a few minutes. Your facility was chosen by a random selection process to represent residential care facilities like yours. All information you provide will be held in strict confidence and only will be used for statistical purposes. All published information will be presented in such a way that no individual facility, staff, or residents can be identified. Your participation is voluntary and there are no penalties for not participating in the survey; however, data from your facility are necessary to accurately portray residential care facilities.
S_1	Our records show that this facility is currently licensed, registered, or certified in *[STATE]* as a [*LICENSURE CATEGORY]*. Is this correct?
S_1_MULT	Our records show that this facility has multiple [licenses/registrations/certifications] in *[STATE]* as a *[LICENSE CATEGORIES]*. Is this correct?
S_1A	Is this facility licensed as... READ THIS STATE'S LICENSE CATEGORIES TO RESPONDENT... IF NONE OF THE LISTED CATEGORIES APPLY TO THE FACILITY, SELECT 'NONE OF THE ABOVE'

S_1_MULT	Does this residential care facility have 4 or more licensed, registered, or certified beds?
S_4	Does this facility exclusively serve adults with mental retardation or a developmental disability, such as Down syndrome or autism?
S_5	Does this facility exclusively serve adults with severe mental illness, such as schizophrenia or psychosis? Please do not include Alzheimer's disease or other dementias.
S_6	Does this facility provide or arrange for a personal care aide, RN, or LPN to be located in the same building, in an attached building or next door, or on the same campus 24 hours a day, 7 days a week, to meet any resident needs that may arise? These needs can be met by the director or assistant director, if they provide personal care or nursing services to residents.
S_7	Does this facility offer help with activities of daily living, such as help with bathing, either directly or arranged through an outside vendor?
S_8	Does this facility offer assistance with the administration of medications, give reminders, or provide central storage of medications?
S_9	Does this facility offer at least 2 meals a day to residents?
S_10	Is there at least one resident living at this residential care facility?
S_ELIG_1	INTERVIEWER: READ A CLOSING STATEMENT AS APPROPRIATE. (Are there any questions I can answer for you?) (IF APPOINTMENT WAS SET: We look forward to seeing you.) (Thank you. Good bye.)
S_ELIG_2	Thank you very much for answering these questions. Unfortunately, this facility does not qualify for our study which is focused on facilities that are in some way regulated by the State and provide a broader array of residential care services. I appreciate your time today.

2012 NSLTCP Screener Questions

NSLTCP was launched in 2012, and a new eligibility question was added to ask whether an RCC exclusively served both people with mental retardation or a developmental disability and people with severe mental illness (3b).

INSTRUCTIONS:

- Please clearly mark your responses in the boxes provided. → Examples ☑ or ☒
- Written answers should be printed in the space provided. → Example 25

Residential care places are known by many different names. Just a few terms used to refer to these places are assisted living, personal care, and adult care homes, facilities, and communities; adult family and board and care homes; adult foster care; homes for the aged; and housing with service establishments. For this study, we refer to these places and others like them as residential care communities. Nursing homes are excluded.

1 Study Eligibility

The answers to the questions below determine if **this** residential care community meets the study definition for the 2012 National Study of Long-Term Care Providers. Please answer the following question(s) and follow the instructions next to the answer you mark.

1. Is this residential care community currently licensed, registered, listed, certified, or otherwise regulated by the state?

- ☐ Yes → CONTINUE
- ☐ No → SKIP TO BOX A

2. Does this residential care community have 4 or more licensed, registered, or certified beds?

- ☐ Yes → CONTINUE
- ☐ No → SKIP TO BOX A

3. Does this residential care community **exclusively** serve adults with mental retardation or a developmental disability, such as Down's syndrome or autism?

- ☐ Yes → SKIP TO BOX A
- ☐ No → CONTINUE

3a. Does this residential care community **exclusively** serve adults with severe mental illness, such as schizophrenia or psychosis? Please do not include Alzheimer's disease or other dementias.

- ☐ Yes → SKIP TO BOX A
- ☐ No → CONTINUE

3b. Does this residential care community **exclusively** serve **both** persons with mental retardation/a developmental disability **and** persons with severe mental illness?

- ☐ Yes → SKIP TO BOX A
- ☐ No → CONTINUE

4. Does this residential care community provide or arrange for a personal care aide, registered nurse (RN), licenses practical nurse (LPN), or the director or assistant director (if they provide personal care or nursing services to residents) to be on-site 24 hours a day, 7 days a week to meet any resident needs that may arise? On-site means they are located in the same building, in an attached building or next door, or on the same campus.

- ☐ Yes → CONTINUE
- ☐ No → SKIP TO BOX A

5. Does this residential care community offer help with activities of daily living, such as help with bathing, either directly or arranged through an outside vendor?

- ☐ Yes → SKIP TO QUESTION 6
- ☐ No → CONTINUE

5a. Does this residential care community offer assistance with the administration of medications, give reminders, or provide central storage of medications?

- ☐ Yes → CONTINUE
- ☐ No → SKIP TO BOX A

6. Does this residential care community offer at least 2 meals a day to residents?

- ☐ Yes → CONTINUE
- ☐ No → SKIP TO BOX **A**

7. Is there at least one resident living at this residential care community?

- ☐ Yes → SKIP TO QUESTION **8**

  THIS RESIDENTIAL CARE COMMUNITY IS ELIGIBLE TO PARTICIPATE IN THIS STUDY.
- ☐ No → SKIP TO BOX **A**

2014 NSLTCP Screener Questions

In 2014, some NSLTCP eligibility questions for RCCs were formatted differently from the 2012 survey wave. Questions 3, 6, and 7 were formatted as a grid.

1 Background Information

1. Is this residential care community currently licensed, registered, listed, certified, or otherwise regulated by the State?

☐ Yes

☐ No

If you answered No, skip to question 30 on page 8.

2. 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. **If none, enter "0."**

☐ Number of beds

If you answered fewer than 4 beds, skip to question 30 on page 8.

3. Does this residential care community **only** serve adults with…

MARK YES OR NO IN EACH ROW

	Yes	No
a. an intellectual or developmental disability?	☐	☐
b. severe mental illness? **Do not include Alzheimer's disease or other dementias.**	☐	☐

If you answered Yes to either 3a or 3b, skip to question 30 on page 8.

4. Does this residential care community offer at least 2 meals a day to residents?

☐ Yes

☐ No

If you answered No, skip to question 30 on page 8.

5. What is the total number of residents currently living in this residential care community? If you have respite care residents, please include them. **If none, enter "0."**

☐ Number of residents

If you answered "0," skip to question 30 on page 8.

6. 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.

MARK A RESPONSE IN EACH ROW

	Yes	On an as needed basis	No
a. Personal care aide or staff caregiver	☐	☐	☐
b. Registered Nurse (RN) or Licensed Practical Nurse (LPN)	☐	☐	☐
c. Director, Assistant Director, Administrator or Operator (if they provide personal care or nursing services to residents)	☐	☐	☐

If you answered No to 6a, 6b, and 6c, skip to question 30 on page 8.

7. Does this residential care community offer…

MARK YES OR NO IN EACH ROW

	Yes	No
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?	☐	☐

If you answered No to 7a and 7b, skip to question 30 on page 8.

2016 NSLTCP Screener Questions

The 2016 NSLTCP eligibility questions for RCCs were similar to the 2014 survey questions.

1 Background Information

1. Is this residential care community currently licensed, registered, certified, or otherwise regulated by the State?

☐ Yes
☐ No

If you answered "No," skip to question 34 on page 8.

2. 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.
If none, enter "0."

☐ Number of beds

If you answered fewer than 4 beds, skip to question 34 on page 8.

3. Does this residential care community **only** serve adults with…

MARK YES OR NO IN EACH ROW

	Yes	No
a. an intellectual or developmental disability?	☐	☐
b. severe mental illness, such as schizophrenia and psychosis?	☐	☐

Do not include Alzheimer's disease or other dementias.

If you answered "Yes" to either 3a or 3b, skip to question 34 on page 8.

4. Does this residential care community offer at least two meals a day to residents?

☐ Yes
☐ No

If you answered "No," skip to question 34 on page 8.

5. What is the total number of residents currently living at this residential care community? Please include residents for whom a bed is being held while in the hospital. If you have respite care residents, please include them. ***If none, enter "0."***

☐ Number of residents

If you answered "0," skip to question 34 on page 8.

6. 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.

MARK A RESPONSE IN EACH ROW

	Yes	On an as-needed basis	No
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)	☐	☐	☐

If you answered "No" to 6a, 6b, and 6c, skip to question 34 on page 8.

7. Does this residential care community offer…

MARK YES OR NO IN EACH ROW

	Yes	No
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?	☐	☐

If you answered "No" to 7a and 7b, skip to question 34 on page 8.

2018 NSLTCP Screener Questions

The 2018 NSLTCP eligibility screener questions for RCCs were similar to the 2016 survey's screener questions. However, the mode of administration differed: Internet and mail were used for the 2016 wave, while computer-assisted telephone interview was used for the 2018 survey wave.

1. Is this residential care community currently licensed, registered, certified, or otherwise regulated by the State?

Yes

No

If you answered "No," skip to question 34 on page 8.

2. 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. *If none, enter "0."*

_____Number of beds

If you answered fewer than 4 beds, skip to question 34 on page 8.

3. Does this residential care community only serve adults with…

MARK YES OR NO IN EACH ROW

a. an intellectual or developmental disability? YES NO

b. severe mental illness, such as schizophrenia and psychosis? YES NO

Do not include Alzheimer's disease or other dementias.

If you answered "Yes" to <u>either</u> 3a or 3b, skip to question 34 on page 8.

4. Does this residential care community offer at least two meals a day to residents?

Yes

No

If you answered "No," skip to question 34 on page 8.

5. What is the total number of residents currently living at this residential care community? Please include residents for whom a bed is being held while in the hospital. If you have respite care residents, please include them. *If none, enter "0."*

_____Number of residents

If you answered "0," skip to question 34 on page 8.

6. 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.

MARK A RESPONSE IN EACH ROW

a. Personal care aide or staff caregiver	Yes	On an as-needed basis	No
b. Registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN)	Yes	On an as-needed basis	No
c. Director, assistant director, administrator, or operator (if they provide personal care or nursing services to residents)	Yes	On an as-needed basis	No

If you answered "No" to 6a, 6b, and 6c, skip to question 34 on page 8.

7. Does this residential care community offer…

MARK YES OR NO IN EACH ROW

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

If you answered "No" to 7a and 7b, skip to question 34 on page 8.

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Reports present new statistical methodology including experimental tests of new survey methods, studies of vital and health statistics collection methods, new analytical techniques, objective evaluations of reliability of collected data, and contributions to statistical theory. Reports also include comparison of U.S. methodology with those of other countries.

Series 3. **Analytical and Epidemiological Studies**
Reports present data analyses, epidemiological studies, and descriptive statistics based on national surveys and data systems. As of 2015, Series 3 includes reports that would have previously been published in Series 5, 10–15, and 20–23.

Discontinued Series

Series 4. **Documents and Committee Reports**
Reports contain findings of major committees concerned with vital and health statistics and documents. The last Series 4 report was published in 2002; these are now included in Series 2 or another appropriate series.

Series 5. **International Vital and Health Statistics Reports**
Reports present analytical and descriptive comparisons of U.S. vital and health statistics with those of other countries. The last Series 5 report was published in 2003; these are now included in Series 3 or another appropriate series.

Series 6. **Cognition and Survey Measurement**
Reports use methods of cognitive science to design, evaluate, and test survey instruments. The last Series 6 report was published in 1999; these are now included in Series 2.

Series 10. **Data From the National Health Interview Survey**
Reports present statistics on illness; accidental injuries; disability; use of hospital, medical, dental, and other services; and other health-related topics. As of 2015, these are included in Series 3.

Series 11. **Data From the National Health Examination Survey, the National Health and Nutrition Examination Surveys, and the Hispanic Health and Nutrition Examination Survey**
Reports present 1) estimates of the medically defined prevalence of specific diseases in the United States and the distribution of the population with respect to physical, physiological, and psychological characteristics and 2) analysis of relationships among the various measurements. As of 2015, these are included in Series 3.

Series 12. **Data From the Institutionalized Population Surveys**
The last Series 12 report was published in 1974; these reports were included in Series 13, and as of 2015 are in Series 3.

Series 13. **Data From the National Health Care Survey**
Reports present statistics on health resources and use of health care resources based on data collected from health care providers and provider records. As of 2015, these reports are included in Series 3.

Series 14. **Data on Health Resources: Manpower and Facilities**
The last Series 14 report was published in 1989; these reports were included in Series 13, and are now included in Series 3.

Series 15. **Data From Special Surveys**
Reports contain statistics on health and health-related topics from surveys that are not a part of the continuing data systems of the National Center for Health Statistics. The last Series 15 report was published in 2002; these reports are now included in Series 3.

Series 16. **Compilations of Advance Data From Vital and Health Statistics**
The last Series 16 report was published in 1996. All reports are available online; compilations are no longer needed.

Series 20. **Data on Mortality**
Reports include analyses by cause of death and demographic variables, and geographic and trend analyses. The last Series 20 report was published in 2007; these reports are now included in Series 3.

Series 21. **Data on Natality, Marriage, and Divorce**
Reports include analyses by health and demographic variables, and geographic and trend analyses. The last Series 21 report was published in 2006; these reports are now included in Series 3.

Series 22. **Data From the National Mortality and Natality Surveys**
The last Series 22 report was published in 1973. Reports from sample surveys of vital records were included in Series 20 or 21, and are now included in Series 3.

Series 23. **Data From the National Survey of Family Growth**
Reports contain statistics on factors that affect birth rates, factors affecting the formation and dissolution of families, and behavior related to the risk of HIV and other sexually transmitted diseases. The last Series 23 report was published in 2011; these reports are now included in Series 3.

Series 24. **Compilations of Data on Natality, Mortality, Marriage, and Divorce**
The last Series 24 report was published in 1996. All reports are available online; compilations are no longer needed.

For answers to questions about this report or for a list of reports published in these series, contact:

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