NEW YORK STATE OF OPPORTUNITY. Department of Health

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New York Home and Community Based Services(HCBS) Adult Day Health Center Provider Initial Survey

Directions: Providers will also be required to submit site surveys to the State **within 5 businessdays *after* completing the attestation** and quarterly beginning January 1, 2024, to retain theirawards and maintain eligibility for future New York Home and Community Based Services enhanced Federal Medical Assistance Percentage (FMAP) funding opportunities.

1. Additionally, sites that fail to expend funds, or expend funds on non-approved uses, will be ineligible for future awards and/or subject to recoupment of their awardThe survey includes a combination of multiple choice, short answer, and descriptive narrative questions.

2. All questions must be completed online. A link will be provided once **Attestation** and **Spending Plan** is approved. Follow up questions may appear depending on the information you provide. The PDF version contains all questions, so it may include questions your program site does not need to answer.

3. You will have the option to move forward and backward between pages using the Back and Next buttons on the bottom of the page.

4. You must submit your responses within 5 business days after submitting your **Attestation** and **Spending Plan**. A reminder notice will be sent to the email address on file. Surveys will not be accepted after ***February 26, 2024***.

5. Failure to submit the survey by the deadline will result in exclusion from payment. Please keep in mind, if you don't have the all the information right now, please start tracking this information. In the online form you will have the option to select if you're not currently tracking the information. The purpose of the survey is to collect baseline information. The same survey will be sent out to all sites March 2025 where sites will be required to respond to all questions.

6. Please make sure that all information is answered completely and matches what is on file with Medicaid and eMedNY where applicable.

7. Documentation will be requested to accompany future quarterly survey based on the selected funding strategies. Documentation will not be required for the initial survey.

8. Please answer the following questions as accurately as possible.

Section 1: General Intake

Please provide the following information:

1. Full Name: _____
2. Site Name: _____

Section 2: Activities and Budget:

Please select the programs and/or strategies that your program site will develop from the list below. Additional detail on these strategies is available in the Adult Day Health Center and AIDS Adult Day Health Center Guidance for Providers document. Please select at least one.

3. **Workforce:**

☐ Workforce retention strategies

☐ Development, implementation, and promotion of training programs for staff

☐ Recruit and retain a racially, ethnically diverse and culturally competent workforce.

☐ We are **NOT** using funds for this investment category.

4. **Service Support:**

☐ Supplement Community Integration activities

☐ Transportation subsidy fund

☐ We are **NOT** using funds for this investment category.

5. **Emergency Preparedness:**

☐ Emergency preparedness efforts such as personal protective equipment (PPE)

☐ We are **NOT** using funds for this investment category.

Section 3: Member Information

Please provide the following information:

6. Is your site contracted with Managed Care Organization(s). If yes, please indicate which:
7. Number of members with Managed Care:
8. Yes/No. Does your site serve individuals with Fee for Service:
9. Number of members with Fee for Service:
10. Yes/No. Does your site serve individuals with Private Pay:
11. Number of members with Private Pay:

Section 4: Workforce Information

12. Please enter the number of employees working **full-time** at your program site (full-time does not refer to full-time equivalents):

13. Please enter the number of employees working **part-time** at your program site.

14. Please list the average and range of hourly wages your program site provides to its staff: **Average ($/hour) for Straight Time Employee**

15. Please list the average and range of hourly wages your program site provides to its staff:
Minimum ($/hour) for Straight Time Employee

16. Please list the average and range of hourly wages your program site provides to its staff:
Maximum ($/hour) for Straight Time Employee

17. Please list the average and range of hourly wages your program site provides to its staff:
Average ($/hour) for Overtime Employee

18. Please list the average and range of hourly wages your program site provides to its staff:
Minimum ($/hour) for Overtime Employee

19. Please list the average and range of hourly wages your program site provides to its staff.
Maximum($/hour) for Overtime Employee:

20. What is your current direct care staff to Adult Day Health member ratio?
Example: 1 Direct Care Staff: 5 Adult Day Health members

21. With your most recently hired an employee, please share the following information:
    a. Job Title
    b. Date of job posting
    c. Date of hire

22. With your most recently hired an employee, how long did it take (in weeks) between posting the position and hiring the first individual?

Section 5: Workforce Benefits

Does your program site offer benefit programs to employees? Select the from the option below:

	Yes	No
Full-Time	☐	☐
Part-Time	☐	☐

23. Please select the **benefits** that you provide from the following list:

☐ Paid Time Off

☐ Health Insurance

☐ Vision and/or dental insurance

☐ Disability Insurance

☐ None of the above

24. Please select the **transportation benefits** that you provide from the following list:

- ☐ Commuting costs
- ☐ Gas
- ☐ Mileage
- ☐ Parking
- ☐ Public Transportation
- ☐ Ride Share
- ☐ Rental Cars
- ☐ Childcare
- ☐ Continuing Education Assistance
- ☐ None of the above
- ☐ Other: _____

25. Did your program site have to turn down or delay requests for past year (2023)?
26. If you selected 'Yes', please select the months in which your program site had to turn down requests.

- ☐ January
- ☐ February
- ☐ March
- ☐ April
- ☐ May
- ☐ June
- ☐ July
- ☐ August
- ☐ September
- ☐ October
- ☐ November
- ☐ December

27. If applicable, for instance of delays, please provide the typical length of time (in days) between service request and service fulfillment.
    Example answer: 3 days

Section 6: Recruit and Retain an ethnically diverse and competent workforce.

28. Please list the number of staff your program site employ's race/ethnicity.

29. Please list the number of staff your program site employs by race / ethnicity.

Race	Full-Time Staff	Part-Time Staff
Asian		
Black or African American		
Hispanic or Latino		
Native American or Alaskan Native		
Hawaiian or Other Pacific Islander		
White or Caucasian		
Other		
Data Not Available		

30. Please list the number of staff your program site employs by gender identity.

Gender Identity	Full-Time Staff	Part-Time Staff
Female (including Transgender Female)		
Male (including Transgender Male)		
Non-Binary		
Other/Not Available		

31. Does your program site have recruitment strategies that help build a diverse workforce that reflects its client population? ☐ Yes ☐ No
    a. Please list the strategies your program site employs that help build a diverse workforce that reflects its client populations. _____

32. Please list the number of staff your program site employs and/or is seeking staff by language spoken.

Primary Language Spoken	Full-Time Staff	Part-Time Staff	Are You Actively Recruiting Staff Who Speak this Language?
English			
Spanish			
Mandarin			
Russian			
Yiddish			
Bengali			
Korean			
Haitian Creole			
Italian			
Arabic			
Polish			
Other			

Section 7: Development, implementation, and promotion of training programs for staff

33. Does your program site require staff to complete any trainings beyond those required by New York State that aim to enhance their skills and improve quality of care?

    ☐ Yes ☐ No

    a. If your program site requires staff to complete any trainings beyond those required by New York State, how many hours of additional training does your program site require staff to complete? _____hours

34. Please find the two categories of trainings below (required by your program site and voluntary). Please list the trainings that your staff completes under the relevant categories below.

Program site Required	Additional Voluntary
a. *Example: CPR required for some staff.*	a. *Example: CPR also offered as voluntary for staff where certification is not required.*
b.	b.
c.	c.

35. How many staff members complete at least one voluntary training per year?

    Number: ____

36. How many staff members complete more than one voluntary training per year?

    Number: ____

37. How does your staff access trainings?

    ☐ Directly through the program site

    ☐ Via partnerships with other organizations such as Workforce Investment Organization, community colleges, other higher education organizations

    ☐ Through other agencies

    ☐ Other: _____

38. Please describe your program site's partnerships with other organizations, including how they facilitate trainings. _____

39. Does your program site incentivize training for staff? ☐ Yes ☐ No

a. Please select all the strategies your program site uses to incentivize trainings.

☐ Compensation for training hours

☐ Childcare or other caregiver coverage during training

☐ Bonuses for training completion or certification

☐ Wage increases for training completions or certifications

☐ Career advancement or mobility within the program site

☐ Other: _____

Section 8: Service Support for Patients

40. How does your program offer opportunities to increase independence and engagement in the community, such as cooking or other activities related to Activities of Daily Living/Instrumental Activities of Daily Living; community habilitation such as social networking, communication skills; and other person-centered interests or hobbies like gardening, sports, etc.? Note that this should reflect opportunities that are either off-site or not offered through the program. Depending on the population served these may vary.

☐ Habilitation Services

____Monthly

____Weekly

____Daily

☐ Self-Directed Service Delivery

____Monthly

____Weekly

____Daily

☐ Peer Support Services

____Monthly

____Weekly

____Daily

☐ Community Partnerships

____Monthly

____Weekly

____Daily

☐ Community Workshops

____Monthly

____Weekly

____Daily

☐ Other: _____

____Monthly

____Weekly

____Daily

41. How does your program offer opportunities to engage in social contact outside of the program site or with individuals who are not program staff? Note that this funding cannot be used to buy equipment for social contact.

☐ In Person One on One (off or on site)

☐ In Person Social Events (off site)

☐ Internet (e.g. social media, forums, etc.)

☐ Video (e.g. Zoom)

☐ Phone (e.g. Text or Calls)

☐ None of the above

☐ Other: _____

Section 9: Transportation Subsidy Fund

42. Do your program participants use public transportation, or any other form of paid transportation?

☐ Yes

☐ No

☐ N/A

43. Does your program have access to adequate transportation for participants to arrive and leave the site?

☐ Yes

☐ No

☐ N/A

44. Does your program have access to adequate transportation for participants to attend community activities?

☐ Yes

☐ No

☐ N/A

Section 10: Emergency Preparedness

45. In the past month, has a lack of PPE limited your program site's ability to accept new clients?

☐ Yes ☐ No ☐ N/A

46. Does your program have sufficient PPE to deliver care in the next three months?

☐ Yes ☐ No ☐ N/A

47. How challenging is it for your program site to source PPE? Please select the level of difficulty from a scale of 1 to 5, where 1 is comparable to ease of access before the COVID-19 emergency and 5 is almost impossible.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5