Attachment F2: 2021 CHC Facility Interview Questionnaire

Form Approved
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Hello, my name is _____, calling on behalf of the CDC's National Center for Health Statistics regarding their study of health centers, as part of the National Ambulatory Medical Care Survey, or NAMCS. We are in the process of confirming and updating our contact information. Can I ask you a few questions about your center?

Initial Confirmation and Telephone Screen Call

1. Can you please tell me if the following information is correct?
   Health center name: _____
   Health center director: (Mr./Ms./Dr.) _____
   Address: _____
   City, State and ZIP code: _____
   Telephone number: _____
   CONTINUE WITH *Q2*

2. Which of the following best describes your center?
   a. Federally Qualified Health Center (330 grantee) [IF YES ASK THE FOLLOWING]
      Can your center also be classified as a:
      -Migrant Health Center (MHC) or
      -Health Care for the Homeless (HCH) or
      -Public Housing Primary Care (PHPC) grant program
   b. Federally Qualified Health Center Look-Alike
   c. Urban Indian (437) Health Center
   d. Other (Please specify): _____

IF INFORMANT SELECTS "OTHER" THANK THE PERSON FOR HIS/HER TIME AND END THE TELEPHONE INTERVIEW. READ: "At this time, we are only interviewing Federally Qualified Health Centers (FQHCs) and FQHC Look- Alikes. Thank you for your time." END.

OTHERWISE CONTINUE WITH Q3

3. We would like to send some additional information about participation in the National Ambulatory Medical Care Survey (NAMCS) to an official who can agree to participate on behalf of the (insert health center name). This official could be the CEO, Director of Quality Control/Assurance, Health Information Management (HIM) Director, Research Director or someone else. Who would you suggest, and may I have this person's name, title, and contact information?

   Name: (Mr./Ms./Dr.) _____
   Title: _____
   Telephone Number:_____
   E-mail: _____
   C*ONTINUE WITH Q4*

4. Is he/she at this same mailing address?
   - ☐ Yes → *SKIP TO Q5*
   - ☐ No → C*ONTINUE WITH Q4A*

   4a. ASK FOR APPROPRIATE ADDRESS AND RECORD BELOW.
   Address: _____
   City, State and ZIP code: _____
   C*ONTINUE WITH Q5*

5. Can you please confirm if (insert health center name) received an information packet and invitation to participate in NAMCS?
   - ☐ Yes → C*ONTINUE WITH 5A*
   - ☐ No → *SKIP TO Q6*

   5a. Was this given to the Center [Director/CEO/Research Director, etc.]
   - ☐ Yes
   - ☐ No

   C*ONTINUE WITH Q6*

6. Can you please transfer me to [INSERT NAME FROM QUESTION 3]?
   - ☐ Yes → *TRANSFER TO OFFICIAL.*
   - ☐ No → *SCHEDULE A DATE AND TIME TO CALL BACK WITHIN 3 DAYS AND ENTER BELOW → THANK INFORMANT FOR THEIR TIME AND REPEAT THE DATE AND TIME OF THE NEXT SCHEDULED CONTACT.*

   _____/_____/_____
   Day / Month /Year
   Time:_____:_____ _____A.M. _____P.M _____Time Zone

TRANSFER TO OFFICIAL:

Hello, my name is _____, calling on behalf of the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS) regarding the National Ambulatory Medical Care Survey, known as NAMCS.

The NCHS selected (insert health center name) as part of a nationally representative sample to participate in NAMCS. Your participation in the survey is voluntary and will help health care providers and professionals plan for more effective health services, improve medical and health education, and assist the public health community in understanding the patterns of diseases and health conditions. If you choose to participate in NAMCS, the NCHS will offer your health center a set-up fee of up to $10,000 to help transmit patient level electronic health record (EHR) data such as medical records and visits for the calendar year.

6a. As the [title], are you *authorized* to agree to participate on behalf of [insert health center name)?

- ☐ Yes → *SKIP TO Q7*
- ☐ No → C*ONTINUE WITH Q6B*

6b. Who is the best person who can *authorize* participation in the survey?

Name: (Mr./Ms./Dr.) _____

Job title: _____

Telephone Number: _____

E-mail: _____ → *GO BACK TO Q6*

We would like to send this individual some additional information about participation in NAMCS, after which we will follow up with a call to answer any questions. Thank you for your time. END.

INTRODUCTION

(FOR THE PREVIOUSLY CONFIRMED AUTHORIZING OFFICIAL.)

Hello, my name is _____, calling on behalf of the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) regarding the National Ambulatory Medical Care Survey, known as NAMCS. We recently sent you an information packet and invitation to participate in NAMCS.

(FOR A NEW AUTHORIZING OFFICIAL.)

IF NEEDED:
The NCHS selected (insert health center name) as part of a nationally representative sample to participate in NAMCS. Your participation in the survey is voluntary and will help health care providers and professionals plan for more effective health services, improve medical and health education, and assist the public health community in understanding the patterns of diseases and health conditions. If you choose to participate in NAMCS, the NCHS will offer your health center a set-up fee of up to $10,000 to help transmit patient level electronic health record (EHR) data such as medical records and visits for the calendar year.

Interview with CHC official

7. Did you receive the NAMCS informational packet?
   - ☐ Yes → *SKIP TO Q8*
   - ☐ No → C*ONTINUE WITH Q7A*
   - ☐ 7a. I apologize and will ensure the information is sent to you right away. → C*ONTINUE WITH Q7B*

7b. OFFER TO READ LETTER TO THEM.
Can I email you the information while you remain on the phone to confirm you receive the information?

☐ Yes → *[CAPTURE EMAIL: _____].*
☐ No → *CONTINUE WITH Q7C*

IF DECLINED, RECORD EMAIL AND MAILING ADDRESS TO BE USED TO SEND A NEW LETTER AND SCHEDULE ANOTHER TIME TO CALL BACK WITHIN A WEEK, IF THE PERSON IS UNABLE OR UNWILLING TO CONTINUE AT THIS TIME.→ SKIP TO Q7D

OTHERWISE ADDRESS QUESTIONS AND PRESENT INFORMATION ON NAMCS AND THEN CONTINUE WITH Q8.

PROGRAMMING NOTE: AUTOFILL CONTACT INFORMATION AND CONFIRM AS NEEDED.

Name: (Mr./Ms./Dr.) _____
Job title: _____
CHC (Center?) name: _____
Address: _____
City, State and ZIP code: _____
Telephone Number:_____
E-mail: _____

7c. Date and time of next scheduled telephone call:

_____/_____/_____
Day / Month /Year
Time: _____:_____ _____A.M. _____P.M _____Time Zone

8. Do you have any questions about the information you received or concerns about what I have discussed so far?
   ☐ Yes→ C*ONTINUE WITH Q8A*
   ☐ No → *SKIP TO Q9*

   8a. *RECORD MAJOR TOPICS BELOW. USE MATERIALS TO TRY TO ADDRESS EACH ONE*.
   1) _____
   2) _____
   3) _____
   4) _____
   5) _____
   C*ONTINUE WITH Q9*

9. Can we count on your health center's participation in the NAMCS?
   ☐ Yes → *SKIP TO Q10.*
   ☐ Need more information
   RECORD MAJOR TOPICS BELOW. USE MATERIALS TO TRY TO ADDRESS EACH ONE.
   ☐ _____
   ☐ _____
   ☐ _____
   ☐ _____

☐ _____
CONTINUE WITH Q9A.

—

Q9a. *SCHEDULE A DATE AND TIME TO CALL BACK WITHIN A WEEK, IF FEASIBLE, AND ENTER BELOW → THANK INTERVIEWEER FOR THEIR TIME AND REPEAT THE DATE AND TIME OF THE NEXT SCHEDULED CONTACT.*

_____ /_____/_____
Day / Month /Year
Time: _____:_____ _____A.M. _____P.M _____Time Zone

☐ No, health center official declines to participate. → C*ONTINUE WITH Q9A.*
9a. Please tell me why your health center does not want to participate.

RECORD RESPONSE TO BE CODED LATER: _____

DO NOT READ THESE RESPONSES OUT LOUD; INSTEAD; CHECK THE OPTION THAT BEST CAPTURES THE OFFICIAL'S REASON FOR REFUSAL.

- ☐ CONFIDENTIALITY CONCERNS
- ☐ THE HEALTH CENTER'S FINANCIAL SITUATION DOES NOT PERMIT IT TO DEDICATE TIME TO THIS EFFORT
- ☐ THE HEALTH CENTER HAS TOO MANY OTHER PRIORITIES AT THIS TIME
- ☐ OTHER – SPECIFY _____

THANK THE OFFICIAL FOR THEIR TIME AND END INTERVIEW. END

10. I have a few additional questions that I need to ask about your health center. Can you please provide the name, title and contact information for a primary contact, the person who will be responsible for submitting data to the National Ambulatory Medical Care Survey? -
    Name: (Mr./Ms./Dr.) _____
    Job title: _____
    Telephone Number: _____
    E-mail: _____
    END OF NORC SCREENER. BOOZ ALLEN WILL CONTINUE WITH Q11.

Booz Allen:

Hello, my name is _____, calling on behalf of the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) National Ambulatory Medical Care Survey, known as NAMCS. We recently spoke with [FILL IN NAME OF CENTER OFFICIAL], and [HE/SHE] identified you as our primary point of contact for the survey. The Facility Interview Questionnaire will take approximately 15 minutes to complete with me over the phone. Is this a good time?

IF YES, GO TO QUESTION 11. IF NO, SET A CALLBACK APPOINTMENT.

Date and time of next scheduled telephone call:

_____/_____/_____
Day / Month/Year

Time: _____:_____ _____A.M. _____P.M. _____Time Zone

CHC Primary Contact Interview

11. Is this health center a subsidiary of a larger company or network?
    - ☐ Yes → *CONTINUE WITH Q11a*

      11a. What is the name of larger company or network?

      _____

      → *SKIP TO Q12.*
    - ☐ No → *SKIP TO Q12.*
    - ☐ Don't know. → *CONTINUE WITH Q11b.*

11b. Who is the best person to contact for this information?

Name: (Mr./Ms./Dr.) _____
Job title: _____
Telephone Number: _____
E-mail: _____
C*ONTINUE WITH Q12.*

12. Are other health centers covered under your state license?

☐ ☐ Yes → 12a. *What* are the name(s) of the health center(s)? → *SKIP TO Q13*

_____

No → *SKIP TO Q13*

☐ Don't know → *CONTINUE WITH Q12B*

12b. Who is the best person to contact for this information?

Name:_____
Job title: _____
Telephone Number: _____
E-mail: _____
C*ONTINUE WITH Q13*

13. When this health center reports data to the governing bodies is the information solely for this health center or are other health centers included in the data submission?
    - ☐ Solely for this health center? → *SKIP TO Q14*
    - ☐ Combined with one or more other health centers → C*ONTINUE WITH Q13A*

      12a. What are the name(s) of the other health centers?

      _____

      C*ontinue with Q14.*

Part 2. General Questions

14. Was this health center open for the full calendar year 2020?
    - ☐ Yes → C*ONTINUE WITH Q15*
    - ☐ No → Please provide the dates the health center was open in 2020:

      _____ → C*ONTINUE WITH Q*15
    - ☐ Never open in 2020. → C*ontinue with Q15.*
15. Do you anticipate any significant changes in your visit volume in 2021?
    - ☐ Yes → Please explain**:**_____ → C*ONTINUE WITH Q16*
    - ☐ No → C*ONTINUE WITH Q16*

16. During its last normal year, approximately how many office visit encounters did this health center have?
- Only include the visits to the sampled health center.
- *IF PARTICIPANT ASKS FOR CLARIFICATION, SAY: A NORMAL YEAR IS CONSIDERED 2019, PRIOR TO COVID-19.*

☐ Enter visits_____ →*CONTINUE WITH Q17*

17. Approximately how many office visit encounters do you estimate this health center will have in 2021?
- Only include the visits to the sampled health center.

☐ Enter estimated visits_____ →*CONTINUE WITH Q18*

18. Please provide the actual counts or your best estimates for the total number of health center visits during calendar year 2020 for each quarter if possible, and for the year overall.

	Annual	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
All visits made to health center:					

CONTINUE WITH Q19

Electronic Health Records (EHR)

19. Are you able to electronically output patient level data from your electronic health record (EHR) system?

☐ Yes → *CONTINUE WITH Q20*
☐ No → *CONTINUE WITH Q20*
☐ Don't know → *CONTINUE WITH Q20*

20. Will the data you provide include electronic health records from your health center only?

☐ Yes → *SKIP TO Q21*
☐ No → 19a. Is it possible to identify the records from your health center separate from the other health centers that report with you?
- Yes - No - Don't know →*CONTINUE WITH Q21*

☐ Don't know → *Continue with Q21*

Data Transfer

21. Will the data you provide include patients only from your health center?

Yes→ *SKIP TO Q22*
No → *CONTINUE WITH Q21A*

21a. What are the name(s) of the other health centers included?

_____ → *CONTINUE WITH Q21B*

21b. Is it possible to identify the records from your health center as opposed to records from the other center(s) that report with you?

☐ Yes→ *CONTINUE WITH Q21C*
21c. How can we make that distinction? _____→ *CONTINUE WITH Q22*
☐ No → *CONTINUE WITH Q22*

22. Who is the IT/data contact for submitting your health center's claims data and what is their contact information?

Name: (Mr./Ms./Dr.) _____

Job title: _____
Telephone Number: _____
E-mail: _____
CONTINUE WITH Q23

COVID Information

Now I would like to ask you a few questions about the coronavirus disease (COVID-19) and the impact it had on operations in your Center and on your staff.

23. During the past THREE months, how often did your center experience shortages of any of the following personal protective equipment due to the onset of the coronavirus disease (COVID-19) pandemic?
    - Check only one box per piece of equipment.

    a. N95 respirators or other approved facemasks
    - ☐ Never → *CONTINUE WITH Q23B*
    - ☐ Some of the time → *CONTINUE WITH Q23B*
    - ☐ Most of the time → *CONTINUE WITH Q23B*
    - ☐ All of the time → *CONTINUE WITH Q23B*
    - ☐ Don't know → *CONTINUE WITH Q23B*

    b. Eye protection, isolation gowns, or gloves
    - ☐ Never → *CONTINUE WITH Q24*
    - ☐ Some of the time → *CONTINUE WITH Q24*
    - ☐ Most of the time → *CONTINUE WITH Q24*
    - ☐ All of the time → *CONTINUE WITH Q24*
    - ☐ Don't know → *CONTINUE WITH Q24*

24. During the past THREE months, did your center have the ability to test patients for coronavirus disease (COVID-19) infection?
    - Check only one box.

    ☐ Yes → *CONTINUE WITH Q24A.*

    a. During the past THREE months, how often did your center experience shortages of coronavirus disease (COVID-19) tests for any patients who needed testing?)
        - Check only one box.
        - ☐ Never → *CONTINUE WITH Q25*
        - ☐ Some of the time → *CONTINUE WITH Q25*
        - ☐ Most of the time → *CONTINUE WITH Q25*
        - ☐ All of the time → *Continue with Q25*
        - ☐ Don't know → *Continue with Q25.*

    ☐ No → *CONTINUE WITH Q24B*

    ☐ Not applicable – did not need to do any COVID-19 testing → *SKIP TO Q25*

    ☐ Don't know → *CONTINUE WITH Q24B*

    b. During the past THREE months how often did your center have a location where patients could be referred to for coronavirus disease (COVID-19) testing?
        - Check only one box.
        - ☐ Never → *CONTINUE WITH Q26*
        - ☐ Some of the time → *CONTINUE WITH Q26*
        - ☐ Most of the time → *CONTINUE WITH Q26*
        - ☐ All of the time → *CONTINUE WITH Q26*
        - ☐ Don't know → *CONTINUE WITH Q26*

25. During the past THREE months, did your center need to turn away or refer elsewhere any patients with confirmed or presumptive positive coronavirus disease (COVID-19) infection?

- Check only one box.
  - ☐ No, COVID-19 patients were not turned away or referred elsewhere → *CONTINUE WITH Q26*
  - ☐ Yes, some COVID-19 patients were turned away or referred elsewhere → *CONTINUE WITH Q26*
  - ☐ Yes, most COVID-19 patients were turned away or referred elsewhere → *CONTINUE WITH Q26*
  - ☐ Yes, all COVID-19 patients were turned away or referred elsewhere → *CONTINUE WITH Q26*
  - ☐ Not applicable – the center did not have any COVID-19 patients → *CONTINUE WITH Q26*
  - ☐ Don't know → *CONTINUE WITH Q26*

26. During the past THREE months, did any of the following clinical care providers in your center test positive for coronavirus disease (COVID-19) infection?
    - Check only one box per provider.

    a. Physicians
    - ☐ Yes → *CONTINUE WITH Q26B*
    - ☐ No → *CONTINUE WITH Q26B*
    - ☐ Not applicable – did not have such provider type onsite → *CONTINUE WITH Q26B*
    - ☐ Don't know → *CONTINUE WITH Q26B*

    b. Physician assistants
    - ☐ Yes → *CONTINUE WITH Q26C*
    - ☐ No → *CONTINUE WITH Q26C*
    - ☐ Not applicable – did not have such provider type onsite → *CONTINUE WITH Q26C*
    - ☐ Don't know → *CONTINUE WITH Q26C*

    c. Nurse practitioners
    - ☐ Yes → *CONTINUE WITH Q26D*
    - ☐ No → *CONTINUE WITH Q26D*
    - ☐ Not applicable – did not have such provider type onsite → *CONTINUE WITH Q26D*
    - ☐ Don't know → *CONTINUE WITH Q26D*

    d. Certified nurse-midwives
    - ☐ Yes → *CONTINUE WITH Q26E*
    - ☐ No → *CONTINUE WITH Q26E*
    - ☐ Not applicable – did not have such provider type onsite → *CONTINUE WITH Q26E*
    - ☐ Don't know → *CONTINUE WITH Q26E*

    e. Registered nurses/licensed practical nurses
    - ☐ Yes → *CONTINUE WITH Q26F*
    - ☐ No → *CONTINUE WITH Q26F*
    - ☐ Not applicable – did not have such provider type onsite → *CONTINUE WITH Q26F*
    - ☐ Don't know → *CONTINUE WITH Q26F*

    f. Other clinical care providers
    - ☐ Yes (please specify: _____) → *CONTINUE WITH Q27*
    - ☐ No → *CONTINUE WITH Q27*
    - ☐ Not applicable – did not have such provider type onsite → *CONTINUE WITH Q27*
    - ☐ Don't know → *CONTINUE WITH Q27*

27. During **January and February 2020**, was your center using telemedicine or telehealth technologies (for example, audio with video, web videoconference) to assess, diagnose, monitor, or treat patients?
    - ☐ Yes → *CONTINUE WITH Q27A*
      a. **After February 2020**, did your center's use of telemedicine or telehealth technologies to conduct patient visits increase?
         - Yes → *CONTINUE WITH Q27a.i*
           i. After February 2020, how much has your center's use of telemedicine or telehealth technologies to conduct patient visits increased?

- Less than 25% → *CONTINUE WITH Q28*
- 25% to 49% → *CONTINUE WITH Q28*
- 50% to 74% → *CONTINUE WITH Q28*
- 75% or more → *CONTINUE WITH Q28*
- Don't know → *CONTINUE WITH Q28*

- No → *SKIP TO Q28*
- Don't know → *SKIP TO Q28*

☐ No → CONTINUE WITH *Q27b*

b. After February 2020, has your center started using telemedicine or telehealth technologies? (**TELEMED_START**)

- Yes → *SKIP TO Q27a.ii*

ii. Since your center started using these technologies, how many of your patient visits have been conducted using telemedicine or telehealth technologies?

- Less than 25% → *CONTINUE WITH Q28*
- 25% to 49% → *CONTINUE WITH Q28*
- 50% to 74% → *CONTINUE WITH Q28*
- 75% or more → *CONTINUE WITH Q28*
- Don't know → *CONTINUE WITH Q28*

- No → *CONTINUE WITH Q28*
- Don't know → *CONTINUE WITH Q28*

☐ Don't know → *CONTINUE WITH Q28*

Payment Information

This next question relates to reimbursement to your health center for participating in the survey. Your health center will receive a onetime set-up fee of up to $10,000 for the electronic data transmission required by NAMCS participants.

28. Can you tell me to whom the checks should be sent?

Yes → *Enter information and then thank official for their time and end interview.*

Payee: (Mr./Ms./Dr.) _____
Job title: _____
Attn: _____
Address: _____
Mail Stop: _____
City/State/ZIP Code: _____
Telephone Number: (____) _____
E-mail: _____

No → Is there someone else that I should speak with about getting this information?

Name: (Mr./Ms./Dr.) _____
Job title: _____
Telephone Number: _____
E-mail: _____

Thank you for your time and your contribution to the National Ambulatory Medical Care Survey.
END.