Attachment I1: Approved HC Facility Interview Questionnaire

[VARIABLE NAME] [C=Character or N=Numeric]

Script: 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: [HC_NAME_CHK] [N]
Health center director: (Mr./Ms./Miss/Mrs./Dr.) [HC_DIR_SALUTE] [C]
 [HC_DIR_NAME_CHK] [N]
Email Address: [HC_EMAIL_CHK] [N]
Address: [HC_ADDRESS_CHK] [N]
City: [HC_CITY_CHK] [N]
State: [HC_STATE_CHK] [N]
ZIP code: [HC_ZIP_CHK] [N]
Telephone number: [HC_PHONE_CHK] [N] Extension: [HC_PHONE_EXT_CHK] [N]

CONTINUE WITH *Q2*

2. Which of the following best describes your center? [HCTYPE] [N]
- ▱ Federally Qualified Health Center (330 grantee) → *CONTINUE WITH Q3*
- ☐ Federally Qualified Health Center Look-Alike → *SKIP TO Q5*
- ☐ Urban Indian (437) Health Center → *READ SCRIPT BELOW AND CONCLUDE INTERVIEW*
- ☐ Other (Please Specify) → *SKIP TO Q4*

IF INFORMANT SELECTS "URBAN INDIAN HEALTH CENTER" READ:
Script: At this time, we are only interviewing Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes. Thank you for your time.

END INTERVIEW.

3. **Can your center also be classified as a:** [FQHCTYPE] [N]
   - ☐ Migrant Health Center (MHC)
   - ☐ Health Care for the Homeless (HCH)
   - ☐ Public Housing Primary Care (PHPC) Grant Program
   - ☐ None of the above

SKIP TO Q5

4. **Other – please Specify:** _____ [HCTYPEOTH] [C] → *READ SCRIPT BELOW AND CONCLUDE INTERVIEW*

Script: At this time, we are only interviewing Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes, I need to confirm your health center's eligibility and get back to you. Thank you for your time.

END INTERVIEW.

5. **Are you the official who can agree to participate in NAMCS on behalf of the (INSERT HEALTH CENTER NAME)?** [CONF_HCOFFIC] [N]
   - ☐ Yes → *SKIP TO Q13 AND READ PRIOR INTRODUCTION SCRIPT.*
   - ☐ No → *CONTINUE WITH Q6*

6. **Can you identify an official who can agree to participate in NAMCS 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. May I have this person's name, title, and contact information?**
   Salutation/Name: (Mr./Ms./Miss/Mrs./Dr.) [HC_DIR_SALUTE2] [C]
   [HC_DIR_FIRST2] [C] [HC_DIR_LAST2] [C]
   Title: [HC_DIR_TITLE2] [C]
   Telephone number: [HC_DIR_PHONE2] [C] Extension: [HC_DIR_PHONE_EXT2]
   [C]
   Email Address: [HC_DIR_EMAIL2] [C]
   Address: [HC_DIR_ADDRESS2 [C]
   City: [HC_DIR_CITY2] [C]
   State: [HC_DIR_STATE2] [C]
   ZIP Code: [HC_DIR_ZIP2] [C]

CONTINUE WITH Q7

7. **Can you please confirm if [INSERT HEALTH CENTER NAME] received an information packet and invitation to participate in NAMCS?** [CEN_INFOPAK] [N]
   - ☐ Yes → *CONTINUE WITH Q8*
   - ☐ No → *SKIP TO Q9*

8. **Was this given to the [INSERT TITLE FROM Q6]?** [DIR_INFOPAK] [N]
   - ☐ Yes
   - ☐ No

CONTINUE WITH Q9

9. **Can you please transfer me to [INSERT NAME FROM Q6 or Q12?** [TRANSFER] [N]
   - ☐ Yes → *RECORD TRANSFER DATE/TIME AND SKIP TO Q11*

☐ No → *CONTINUE WITH Q10*

Record transfer date and time:
_____/_____/_____ [TRANSFER_DATE] [<mark>C</mark>]
Day / Month /Year
Time: _____:_____   _____A.M. _____P.M. _____ Time Zone [TRANSFER_TIME]
[<mark>C</mark>]

10. **What is a good time to call back and speak with the [INSERT TITLE FROM Q6 or Q12]?**
    Schedule a date and time to call back within 3 days and enter call back information.
    Thank informant for their time and repeat the date and time of the next scheduled contact.
    _____/_____/_____ [CALLBACK1_DATE] [<mark>C</mark>]
    Day / Month/Year
    Time: _____:_____   _____A.M. _____P.M. _____Time Zone [CALLBACK1_TIME] [<mark>C</mark>]

Conclude interview and call back at specified time.

CONTINUE WITH Q11 DURING CALL BACK.

TRANSFER TO OFFICIAL:

*Script: 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. You were identified as someone who could authorize participation in NAMCS. If I could have a few minutes of your time, I'd like to ask you a few questions about your health center.*

11. **As the [INSERT TITLE FROM Q6 or Q12], are you *authorized* to agree to participate on behalf of [INSERT HEALTH CENTER NAME]?** [AUTH_RESPONDENT] [<mark>N</mark>]
    ☐ Yes → *SKIP TO Q13 AND READ PRIOR INTRODUCTION SCRIPT*
    ☐ No → C*ONTINUE WITH Q12*

12. **Who is the best person who can *authorize* participation in the survey?**
    Name: (Mr./Ms./Miss/Mrs./Dr.) [AUTH_SALUTE] [<mark>C</mark>] [AUTH_FIRST] [<mark>C</mark>]
    [AUTH_LAST] [<mark>C</mark>]
    Job title: [AUTH_TITLE] [<mark>C</mark>]
    Telephone Number: [AUTH_PHONE] [<mark>C</mark>] Extension: [AUTH_EXT] [<mark>C</mark>]
    E-mail: [AUTH_EMAIL] [<mark>C</mark>]
    Address: [AUTH_ADDRESS] [<mark>C</mark>]
    City: [AUTH_CITY] [<mark>C</mark>]
    State: [AUTH_STATE] [<mark>C</mark>]
    ZIP code: [AUTH_ZIP] [<mark>C</mark>]

GO BACK TO Q9

INTRODUCTION (FOR A NEW AUTHORIZING OFFICIAL CONFIRMED IN Q5 OR Q11)

*Script: 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 Health Center Official

13. Did you receive the NAMCS information packet? [AUTH_INFOPAK] [N]
- ☐ Yes → *SKIP TO Q18*
- ☐ No → ***Script:*** *I apologize and will ensure the information is sent to you right away.* → C*ONTINUE WITH Q14*

14. Can I email you the information while you remain on the phone to confirm you received it? [AUTH_INFO_LETTER] [N]
- ☐ Yes → *CONTINUE WITH Q15 TO CAPTURE EMAIL AND EMAIL LETTER*
- ☐ No → *SKIP TO Q16 TO CONFIRM MAILING ADDRESS TO BE USED TO SEND A NEW LETTER*

15. *CAPTURE EMAIL:* _____ [AUTH_INFO_EMAIL] [C]

Script: If you'd like, I can read the letter to you over the phone.

CONTINUE WITH Q16

PROGRAMMING NOTE: AUTOFILL CONTACT INFORMATION.

16. Could you please confirm the following contact information? [AUTH_CONFIRM] [N]
Confirm authorized official email from Q6 or Q12 and mailing address to mail new recruitment package.

Name: (Mr./Ms./Miss/Mrs./Dr.) ___(**FILL FROM Q6 OR Q12 OR Q1**)_____
Health Center name: _____(**FILL FROM Q6 OR Q12 OR Q1**)_____
Address: _____(**FILL FROM Q6 OR Q12 OR Q1**)_____
City, State and ZIP code: _____(**FILL FROM Q6 OR Q12 OR Q1**)_____
E-mail: _____(**FILL FROM Q6 OR Q12 OR Q1**)_____

CONTINUE WITH Q17 TO SCHEDULE ANOTHER TIME TO CALL BACK WITHIN A WEEK, IF THE PERSON IS UNABLE OR UNWILLING TO CONTINUE AT THIS TIME.

17. What would be a good time to call back?
Record date and time of next scheduled telephone call:

_____/_____/_____ [CALLBACK2_DATE] [C]
Day / Month /Year
Time: _____:_____   _____A.M. _____P.M. _____Time Zone [CALLBACK2_TIME] [C]

Conclude interview and call back at specified time.

DURING SCHEDULED CALL BACK, GO BACK TO Q13.

OTHERWISE, CONTINUE WITH Q18.

18. Do you have any questions about the information you received or concerns about what we have discussed so far? [AUTH_QUES] [N]
- ☐ Yes → C*ONTINUE WITH Q19*

☐ No → *SKIP TO Q20*

19. Record major topics below. Use materials to try to address each one.
  _____ [AUTHTOPIC_1] [C]
  _____ [AUTHTOPIC_2] [C]
  _____ [AUTHTOPIC_3] [C]
  _____ [AUTHTOPIC_4] [C]
  _____ [AUTHTOPIC_5] [C]

CONTINUE WITH Q20

20. Can we count on your health center's participation in NAMCS? [HCPART] [N]
 ☐ Yes → *SKIP TO Q26*
 ☐ Need more information → *CONTINUE WITH Q21*
 ☐ No, health center official declines to participate. → *SKIP TO Q23*

21. Record major topics below. Use materials to try to address each one.
  _____ [HCTOPIC_1] [C]
  _____ [HCTOPIC_2] [C]
  _____ [HCTOPIC_3] [C]
  _____ [HCTOPIC_4] [C]
  _____ [HCTOPIC_5] [C]

CONTINUE WITH Q22

22. Do you need more information or time to decide on your health center's participation in NAMCS? [MORETIME] [N]
 ☐ *Yes → DOCUMENT CALL BACK DATE/TIME*
 ☐ *No → GO BACK TO Q20*

Record date and time to call back.
  _____/_____/_____ [CALLBACK3_DATE] [C]
  Day / Month/Year
  Time: _____:_____ _____A.M. _____P.M. _____Time Zone [CALLBACK3_TIME] [C]

Script: We will reach back out on [repeat date and time of scheduled call back]. Thank you for your time.
CONCLUDE INTERVIEW.

DURING CALL BACK, GO BACK TO Q20

23. Please tell me why your health center does not want to participate.

  RECORD RESPONSE TO BE CODED LATER: _____ [REFUSE_REPONSE] C]

Thank the official for their time and end interview.

CONTINUE WITH Q24

24. DO NOT READ THESE RESPONSES OUT LOUD; Instead; check the option that best captures the official's reason for refusal. [WHY_REF] [N]
 ☐ 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 → *CONTINUE WITH Q25*

25. Other – please specify: _____ [REFUSE_OTH] [C]

CONCLUDE interview.

26. 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 <u>primary contact</u>, the <u>person who will be responsible for transmitting data</u> to the National Ambulatory Medical Care Survey? -
Name: (Mr./Ms./Miss/Mrs./Dr.) [TRANSMIT_C_SALUTE] [C] [TRANSMIT_C_FIRST] [C] [TRANSMIT_C_LAST] [C]
Job title: [TRANSMIT_C_TITLE] [C]
Telephone Number: [TRANSMIT_C_PHONE] [C] Extension: [TRANSMIT_C_EXT] [C]
E-mail: [TRANSMIT_C_EMAIL] [C]

CONTINUE WITH Q27

27. Is this a good time to complete the Facility Interview; if not what would be a good time to call back?
CONTINUE WITH Q28 if the participant agrees. If it is not a good time schedule a date and time to call back within a week, if feasible, to complete the facility interview and enter below. Thank interviewee for their time and repeat the date and time of the next scheduled contact.
_____ /_____/_____ [CALLBACK4_DATE] [C]
Day / Month /Year
Time: _____:_____   _____A.M. _____P.M. _____Time Zone
[CALLBACK4_TIME] [C]

END SCREENER. CONTINUE WITH Q28 DURING THE FOLLOW-UP CALL.

Script: 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.

28. The Facility Interview Questionnaire will take approximately 45 minutes to complete with me over the phone. Is this a good time? [BEGIN_FACINT] [N]
☐ Yes → *SKIP TO Q30*
☐ No → *CONTINUE WITH Q29 TO SET CALLBACK APPOINTMENT*

29. What would be a good date/time to call back?
Record date and time of next scheduled telephone call:
_____/_____/_____ [TRANSMIT_C_DATE] [C]
Day / Month/Year
Time: _____:_____   _____A.M. _____P.M. _____Time Zone [TRANSMIT_C_TIME] [C]

RETURN TO Q28 DURING CALL BACK.

Health Center Primary Contact Interview

30. Is this health center a subsidiary of a larger company or network? [HC_NETWORK] [N]
☐ Yes → *CONTINUE WITH Q31*

☐ No → *SKIP TO Q33*
☐ Don't know → *SKIP TO Q32*

31. What is the name of the larger company or network? [NETWORK_NAME] [C]

_____

SKIP TO Q33

32. Who is the best person to contact for this information?
       Name: (Mr./Ms./Miss/Mrs./Dr.) [NETWORK_SALUTE] [C] [NETWORK_FIRST] [C]
       [NETWORK_LAST] [C]
       Job title: [NETWORK_TITLE] [C]
       Telephone Number: [NETWORK_ PHONE] [C] Extension: [NETWORK_EXT] [C]
       E-mail: [NETWORK_EMAIL] [C]

CONTINUE WITH Q33

33. Are other health centers covered under your state license? [HC_LICENSE] [N]
    ▱ Yes → *CONTINUE WITH Q34*
    ☐ No → *SKIP TO Q36*
    ☐ Don't know → *SKIP TO Q35*

34. *What* are the name(s) of the health center(s)?
    [HC_LICENSENAM1] [C] _____
    [HC_LICENSENAM2] [C] _____
    [HC_LICENSENAM3] [C] _____

SKIP TO Q36

35. Who is the best person to contact for this information?
       Name: (Mr./Ms./Miss/Mrs./Dr.) [LIC_SALUTE] [C] [LIC_FIRST] [C] [LIC_LAST] [C]
       Job title: [LIC_TITLE] [C]
       Telephone Number: [LIC_PHONE] [C] Extension: [LIC_EXT] [C]
       E-mail: [LIC_EMAIL] [C]

CONTINUE WITH Q36

36. 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 transmission? [REPDATOTH] [N]
    ☐ Solely for this health center → *SKIP TO Q38*
    ▱ Combined with one or more other health centers → CONTINUE WITH Q37

37. What are the name(s) of the other health centers?
    _____ [REPDATOTH_NAM1] [C]
    _____ [REPDATOTH_NAM2] [C]
    _____ [REPDATOTH_NAM3] [C]

CONTINUE WITH Q38

Part 2. General Questions

38. **Was this health center open for the full calendar year (FILL PREVIOUS CALENDAR YEAR)?** [HCOPEN_PREV] [N]
- ☐ Yes → *SKIP TO Q40*
- ☐ No → *CONTINUE WITH Q39*
- ☐ Never open in **(FILL PREVIOUS CALENDAR YEAR)**→ *SKIP TO Q40*

39. **Please provide the dates the health center was closed in (FILL PREVIOUS CALENDAR YEAR):**

_____

PERIOD 1: [STARTMTH1] [STARTDAY1] [ENDMTH1] [ENDDAY1] [N]
PERIOD 2: [STARTMTH2] [STARTDAY2] [ENDMTH2] [ENDDAY2] [N]
PERIOD 3: [STARTMTH3] [STARTDAY3] [ENDMTH3] [ENDDAY3] [N]

CONTINUE WITH Q40

40. **Do you anticipate any significant changes in your visit volume in (FILL CURRENT CALENDAR YEAR)?** [VISCHG_CURR] [N]
- ☐ Yes → C*ONTINUE WITH Q41*
- ☐ No → *SKIP TO Q42*

41. **Please explain: _____** [WHY_VISCHG_CURR] [C]

C*ONTINUE WITH Q42*

42. **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.
Note: if participant asks for clarification, say: an example of a normal year is 2019, prior to COVID-19.
- ☐ Enter number of visits: _____ [AVG_TOTVIS] [N]

CONTINUE WITH Q43

43. **Approximately how many office visit encounters do you estimate this health center will have in (FILL CURRENT CALENDAR YEAR)?**
◆ Only include the visits to the sampled health center.
- ☐ Enter estimated visits: _____ [EST_TOTVIS_CURR] [N]

CONTINUE WITH Q44

44. **Please provide the actual counts or your best estimates for the total number of health center visits during calendar year (FILL PREVIOUS CALENDAR YEAR) 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:	[TOTVIS] [C]	[TOTVISQ1] [C]	[TOTVISQ2] [C]	[TOTVISQ3] [C]	[TOTVISQ4] [C]

CONTINUE WITH Q45

Electronic Health Records (EHR)
45. **Are you able to electronically output patient level data from your electronic health record (EHR)**

system? [EHR_OUPUT] [N]

☐ Yes
☐ No
☐ Don't know

CONTINUE WITH Q46

46. **Is your health center's EHR system compatible with the Health Level 7 (HL7) Clinical Document Architecture (CDA®) R2 Implementation Guide (IG): National Health Care Surveys (NHCS) Release 1, Draft Standard for Trial Use (DSTU) 1.2 – U.S. Realm?** [EHR_COMPAT] [N]

☐ Yes → *SKIP TO Q48*
☐ No → *CONTINUE WITH Q47*
☐ Don't know → *CONTINUE WITH Q47*

47. **Do you need assistance setting up your EHR system to ensure that it is compatible with the 1.2 version of the HL7 CDA® R2 IG: NHCS Release 1, DSTU 1.2 – U.S. Realm?** [EHR_SETUP] [N]

☐ Yes
☐ No
☐ Don't know

CONTINUE WITH Q48

48. **Will the data you provide include electronic health records from your health center only?** [EHR_HCONLY] [N]

☐ Yes → *SKIP TO Q52*
☐ No → *CONTINUE WITH Q49*
☐ Don't know → *SKIP TO Q52*

49. **Is it possible to identify the records from your health center separate from the other health centers that report with you?** [EHR_HCID] [N]

☐ Yes
☐ No
☐ Don't know

CONTINUE WITH Q50

Data Transfer

50. **What are the name(s) of the other health centers included?**

_____

[EHR_OTHNAM1] [C]
[EHR_OTHNAM2] [C]
[EHR_OTHNAM3] [C]

CONTINUE WITH Q51

51. **How can we make that distinction?** _____ [EHR_DIST] [C]

CONTINUE WITH Q52

52. **Who is the <u>IT/data contact</u> for <u>transmitting your health center's data</u> and what is their contact information?**
Name: (Mr./Ms./Miss/Mrs./Dr.) [IT _SALUTE] [C] [IT _FIRST] [C] [IT _LAST] [C]
Job title: [IT _TITLE] [C]

Telephone Number: [IT _PHONE] [C] Extension: [IT _EXT] [C]
E-mail: [IT _EMAIL] [C]

CONTINUE WITH Q53

COVID-19 Information

Script: 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.

For questions 53 and 54: 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.

53. N95 respirators or other approved facemasks [COVID_N95_RESP] [N]
  ☐ Never
  ☐ Some of the time
  ☐ Most of the time
  ☐ All of the time
  ☐ Don't know

CONTINUE WITH Q54

54. Eye protection, isolation gowns, or gloves [COVID_EYE] [N]
  ☐ Never
  ☐ Some of the time
  ☐ Most of the time
  ☐ All of the time
  ☐ Don't know

CONTINUE WITH Q55

55. During the past THREE months, did your center have the ability to test patients for coronavirus disease (COVID-19) infection? [COVID_TEST] [N]
  ◆ Check only one box.
    ☐ Yes → *CONTINUE WITH Q56*
    ☐ No → *SKIP TO Q57*
    ☐ Not applicable – did not need to do any COVID-19 testing → *SKIP TO Q58*
    ☐ Don't know → *SKIP TO Q57*

56. During the past THREE months, how often did your center experience shortages of coronavirus disease (COVID-19) tests for any patients who needed testing? [COVID_SHORT] [N]
  ◆ Check only one box.
    ☐ Never
    ☐ Some of the time
    ☐ Most of the time
    ☐ All of the time
    ☐ Don't know

SKIP TO Q58

57. **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?** [COVID_REFER] [N]
   ◆ Check only one box.
   - ☐ Never
   - ☐ Some of the time
   - ☐ Most of the time
   - ☐ All of the time
   - ☐ Don't know

CONTINUE WITH Q58

58. **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?** [COVID_AWAY] [N]
   ◆ Check only one box.
   - ☐ No, COVID-19 patients were not turned away or referred elsewhere
   - ☐ Yes, some COVID-19 patients were turned away or referred elsewhere
   - ☐ Yes, most COVID-19 patients were turned away or referred elsewhere
   - ☐ Yes, all COVID-19 patients were turned away or referred elsewhere
   - ☐ Not applicable – the center did not have any COVID-19 patients
   - ☐ Don't know

CONTINUE WITH Q59

For questions 59 – 64: 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.

59. **Physicians** [COVID_PROV1] [N]
   - ☐ Yes
   - ☐ No
   - ☐ Not applicable – did not have such provider type onsite
   - ☐ Don't know

CONTINUE WITH Q60

60. **Physician assistants** [COVID_PROV2] [N]
   - ☐ Yes
   - ☐ No
   - ☐ Not applicable – did not have such provider type onsite
   - ☐ Don't know

CONTINUE WITH Q61

61. **Nurse practitioners** [COVID_PROV3] [N]
   - ☐ Yes
   - ☐ No
   - ☐ Not applicable – did not have such provider type onsite
   - ☐ Don't know

CONTINUE WITH Q62

62. **Certified nurse-midwives** [COVID_PROV4] [N]

☐ Yes
☐ No
☐ Not applicable – did not have such provider type onsite
☐ Don't know

CONTINUE WITH Q63

63. Registered nurses/licensed practical nurses [COVID_PROV5] [N]
☐ Yes
☐ No
☐ Not applicable – did not have such provider type onsite
☐ Don't know

CONTINUE WITH Q64

64. Other clinical care providers [COVID_PROV6] [N]
☐ Yes → *CONTINUE WITH Q65*
☐ No → *SKIP TO Q66*
☐ Not applicable – did not have such provider type onsite → *SKIP TO Q66*
☐ Don't know → *SKIP TO Q66*

65. Please specify the other clinical care providers in your center that tested positive for coronavirus disease (COVID-19) infection: _____
[COVID_PROV_OTH1] [C]
[COVID_PROV_OTH2] [C]
[COVID_PROV_OTH3] [C]

CONTINUE WITH Q66

66. During <u>January and February 2020</u>, was your center using telemedicine or telehealth technologies (for example, audio with video, web videoconference) to assess, diagnose, monitor, or treat patients? [TELEMED] [N]
☐ Yes → *CONTINUE WITH Q67*
☐ No → *SKIP TO Q69*
☐ Don't know → *SKIP TO Q71*

67. <u>After February 2020</u>, did your center's use of telemedicine or telehealth technologies to conduct patient visits increase? [TELEMED_INC] [N]
☐ Yes → *CONTINUE WITH Q68*
☐ No → *SKIP TO Q71*
☐ Don't know → *SKIP TO Q71*

68. <u>After February 2020</u>, how much has your center's use of telemedicine or telehealth technologies to conduct patient visits increased? [TELEMED_INC_PER] [N]
◆ Check only one box.
☐ Less than 25%
☐ 25% to 49%
☐ 50% to 74%
☐ 75% or more
☐ Don't know

SKIP TO Q71

69. **After February 2020, has your center started using telemedicine or telehealth technologies?**
   [TELEMED_START] [N]
   - ☐ Yes → *CONTINUE WITH Q70*
   - ☐ No → *SKIP TO Q71*
   - ☐ Don't know → *SKIP TO Q71*

70. **Since your center started using these technologies, how many of your patient visits have been conducted using telemedicine or telehealth technologies?** [TELEMED_START_PER] [N]
   ◆ Check only one box.
   - ☐ Less than 25%
   - ☐ 25% to 49%
   - ☐ 50% to 74%
   - ☐ 75% or more
   - ☐ Don't know

CONTINUE WITH Q71

Payment Information

Script: 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.

71. **Can you tell me to whom the checks should be sent?** [PAYINFO_SEND] [N]
   - ☐ Yes → *CONTINUE WITH Q72*
   - ☐ No → *SKIP TO Q73*

72. **Enter information and then thank official for their time and end interview.**
   Payee: (Mr./Ms./Miss/Mrs./Dr.) [PAY1_SALUTE] [C] [PAY1_FIRST] [C] [PAY1_LAST] [C]
   Attn: [PAY1_ATTN] [C]
   Job Title: [PAY1_TITLE] [C]
   Address: [PAY1_STREET] [C]
   City/State/ZIP Code: [PAY1_CITY] [C] / [PAY1_STATE] [C] / [PAY1_ZIP] [C]
   Telephone Number: [PAY1_PHONE] [C] Extension: [PAY1_EXT] [C]
   E-mail: [PAY1_EMAIL] [C]

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

73. **Is there someone else that I should speak with about getting this information?**
   Name: (Mr./Ms./Miss/Mrs./Dr.) [PAYINFO_SALUTE] [C] [PAYINFO_FIRST] [C]
   [PAYINFO_LAST] [C]
   Job title: [PAYINFO_TITLE] [C]
   Telephone Number: [PAYINFO_PHONE] [C] Extension: [PAYINFO_EXT] [C]
   E-mail: [PAYINFO_EMAIL] [C]

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