MCBS Revision to Current Clearance
Proposed Changes to Community and Facility Interviews and Effect on Burden

Community Interview Additions	Section	Effect on Annual Burden	Question Text	Response Options
Addition: CBD for Pain Management	CPQ: Summer Round	Increase of 0.25 minutes	Since (TODAY'S MONTH AND YEAR - 3 MONTH), did you use any of the following to manage your pain? Please indicate yes or no to each one. CBD (cannabidiol)	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED
Addition: Supplemental Nutrition Assistance Program (SNAP) Participation	IAQ: Summer Round	Increase of 0.22 minutes	In the last 12 months, did [you/you or any member in the household/(SP)/((SP) or any member in (SP)'s household] receive benefits from the Food Stamp Program or SNAP (the Supplemental Nutrition Assistance Program) [,also called (STATE SNAP PROGRAM NAME)]? DO NOT INCLUDE THE WOMEN, INFANTS, AND CHILDREN (WIC) SUPPLEMENTAL NUTRITION PROGRAM, THE SCHOOL LUNCH PROGRAM, OR ANY ASSISTANCE FROM FOOD BANKS OR FOOD PANTRIES.	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED
Addition: Prevalance of Bowel Incontinence	HFQ: Fall Round	Increase of 0.80 minutes	We are now going to ask you some questions about [your/(SP's)] ability to control [your/his/her] bowel movements. Since (LAST HF MONTH YEAR), [have you/has (SP)] had any of the following problems? [IF NEEDED: Was that because [you/(SP)] [were/was] sick?] SELECT 'NO' IF THE RESPONDENT HAD ANY PROBLEMS DUE TO SHORT-TERM DIARRHEAL ILLNESSES SUCH AS THE FLU OR A VIRUS. Leaking gas?	(01) YES (02) NO (-8) Don't Know (-9) Refused
			We are now going to ask you some questions about [your/(SP's)] ability to control [your/his/her] bowel movements. Since (LAST HF MONTH YEAR), have [you/(SP)] had any of the following problems? [IF NEEDED: Was that because [you/(SP)] [were/was] sick?] SELECT 'NO' IF THE RESPONDENT HAD ANY PROBLEMS DUE TO SHORT-TERM DIARRHEAL ILLNESSES SUCH AS THE FLU OR A VIRUS. Leaking a small amount of stool?	(01) YES (02) NO (-8) Don't Know (-9) Refused
			We are now going to ask you some questions about [your/(SP's)] ability to control [your/his/her] bowel movements. Since (LAST HF MONTH YEAR), have [you/(SP)] had any of the following problems? [IF NEEDED: Was that because [you/(SP)] [were/was] sick?] SELECT 'NO' IF THE RESPONDENT HAD ANY PROBLEMS DUE TO SHORT-TERM DIARRHEAL ILLNESSES SUCH AS THE FLU OR A VIRUS. Leaking a moderate amount of stool, requiring a change of underwear?	(01) YES (02) NO (-8) Don't Know (-9) Refused
			We are now going to ask you some questions about [your/(SP's)] ability to control [your/his/her] bowel movements. Since (LAST HF MONTH YEAR), have [you/(SP)] had any of the following problems? [IF NEEDED: Was that because [you/(SP)] [were/was] sick?] SELECT 'NO' IF THE RESPONDENT HAD ANY PROBLEMS DUE TO SHORT-TERM DIARRHEAL ILLNESSES SUCH AS THE FLU OR A VIRUS. Leaking a large amount of liquid stool, requiring a complete change of clothes?	(01) YES (02) NO (-8) Don't Know (-9) Refused
			[Have you/Has (SP)] talked about [your/his/her] problem with stool leakage with [your/his/her] doctor or other health professional? [IF NECESSARY: This is also referred to as bowel or fecal incontinence.]	(01) YES (02) NO (-8) Don't Know (-9) Refused
Addition: Oral Health-Related Quality of Life	HFQ: Fall Round	Increase of 1.90 minutes	SHOW CARD HF4 Since [LAST HF MONTH YEAR], [have you/has (SP)] had painful aching in [your/their] mouth? Would you say:	(01) Never (02) Hardly ever (03) Occasionally (04) Fairly often (05) Very often (-8) DON'T KNOW (-9) REFUSED
			SHOW CARD HF4 Since [LAST HF MONTH YEAR], [have you/has(SP)] had difficulty chewing any foods because of problems, if any, with [your/their] teeth, mouth, dentures, or jaw? Would you say:	(01) Never (02) Hardly ever (03) Occasionally (04) Fairly often (05) Very often (-8) DON'T KNOW (-9) REFUSED

Community Interview Additions	Section	Effect on Annual Burden	Question Text	Response Options
			SHOW CARD HF4 Since [LAST HF MONTH YEAR], [have you/has (SP)] felt uncomfortable about the appearance of [your/their] teeth, mouth, dentures, or jaws? Would you say:[IF NEEDED: “Uncomfortable” can include a wide spectrum of emotions (embarrassment, anxiety, anger, sadness, etc.).]	(01) Never (02) Hardly ever (03) Occasionally (04) Fairly often (05) Very often (-8) DON'T KNOW (-9) REFUSED
			SHOW CARD HF4 Since [LAST HF MONTH YEAR], [have you/has (SP)] had difficulty doing [your/their] usual activities because of problems, if any, with [your/their] teeth, mouth, dentures, or jaws? Would you say:[IF NEEDED: “Activities” may include going to a job, doing housework such as light cleaning, shopping, or running errands, preparing meals, etc.]	(01) Never (02) Hardly ever (03) Occasionally (04) Fairly often (05) Very often (-8) DON'T KNOW (-9) REFUSED
			SHOW CARD HF4 Since [LAST HF MONTH YEAR], [have you/has (SP)] felt that there has been less flavor in [your/their] food because of problems, if any, with [your/their] teeth, mouth, dentures, or jaws? Would you say:	(01) Never (02) Hardly ever (03) Occasionally (04) Fairly often (05) Very often (-8) DON'T KNOW (-9) REFUSED
Addition: VA Health Care Enrollment and Utilization	HIQ: Fall Round	Net increase of 0.10 minutes	Since (TODAY'S DATE - 12 MONTHS, MONTH AND YEAR), did [you/(SP)] receive any care at a Veteran's Health Administration facility or receive any other health care paid for by the VA? [IF NEEDED: Veteran's Health Administration facilities include VA hospitals, VA medical centers, VA outpatient clinics, and VA nursing homes.] INCLUDE PRESCRIBED MEDICINES THROUCH THE DEPARTMENT OF VETERANS AFFAIRS OR VA.	(01) YES (02) NO (-8) Don't Know (-9) Refused
			Since (TODAY'S DATE - 12 MONTHS, MONTH AND YEAR), [have you been/has (SP) been/was (SP)] enrolled in VA health care?	(01) YES (02) NO (-8) Don't Know (-9) Refused

Community Interview Revisions	Section	Effect on Annual Burden	Question Text	Response Options
Revision to Existing Items: COVID-19	CVQ	Decrease of 0.50 minutes	The next questions are about coronavirus or COVID-19 vaccination. Have you had at least one dose of a COVID-19 vaccination?	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED
			How many COVID-19 vaccinations have you received in total? IF NEEDED: Please include booster shots and any additional doses. IF NEEDED: This question is asking for the total number of COVID-19 vaccine doses that [you have/(SP) has] received since the vaccine first became available in December 2020.	(01) 1 VACCINATION (02) 2 VACCINATIONS (03) 3 VACCINATIONS (04) 4 OR MORE VACCINATIONS (-8) DON'T KNOW (-9) REFUSED
			In [PREVIOUS YEAR], did you receive at least one dose of the COVID-19 vaccine?	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED
			[Have you/Has (SP)] ever tested positive for COVID-19 or been told by a doctor or other health care provider that [you have/(SP) has] or had COVID-19? [IF NEEDED: Some COVID-19 tests are done by swabbing the nose or mouth to test for COVID-19 infection at the time of the test. Other tests look for COVID-19 antibodies by looking at someone's blood to see if they have ever been infected with COVID-19. COVID-19 tests can be done at home by yourself or by someone else, and some tests are done by a health professional.] INCLUDE ANTIBODY TESTS, WHICH TEST WHETHER SOMEONE HAS EVER BEEN INFECTED WITH COVID-19.	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED
			In [PREVIOUS YEAR], [were you/was (SP)] tested at least one time to see whether [you were/(SP) was] infected with COVID-19? [IF NEEDED: For example, the test can be done by swabbing the nose or mouth. Some tests can be done by yourself or by someone else at home, and some tests are done by a health professional.] INCLUDE ANTIBODY TESTS, WHICH TEST WHETHER SOMEONE HAS EVER BEEN INFECTED WITH COVID-19.	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED
			What kind of test(s) did [you/(SP)] take? A nasal or throat swab or saliva test that was collected or read by a health care professional, an at-home test that was read by yourself or a non-health care professional, or a blood test to look for COVID-19 antibodies? SELECT ALL THAT APPLY	(01) NASAL OR THROAT SWAB OR SALIVA TEST THAT WAS COLLECTED OR READ BY A HEALTH CARE PROFESSIONAL (02) AT-HOME TEST THAT WAS READ BY YOURSELF OR A NON-HEALTH CARE PROFESSIONAL (03) BLOOD TEST TO LOOK FOR COVID-19 ANTIBODIES (-8) DON'T KNOW (-9) REFUSED
			In [PREVIOUS YEAR], how often did [you/(SP)] wear a facemask when out in public? Would you say none of the time, some of the time, most of the time, or all of the time?	(01) NONE OF THE TIME (02) SOME OF THE TIME (03) MOST OF THE TIME (04) ALL OF THE TIME (05) NOT APPLICABLE- R DOES NOT GET OUT(-8) DON'T KNOW (-9) REFUSED

Community Interview Revisions	Section	Effect on Annual Burden	Question Text	Response Options
Deletion: COVID-19	CVQ	Decrease of 4.00 minutes	[Have you/Has (SP)] ever suspected that [you have/he has/she has] had the coronavirus or COVID-19?	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED
			Since [REFERENCE DATE], [have you/has (SP)] suspected that [you have/he has/she has] had the coronavirus or COVID-19?	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED
			What symptoms did [you/(SP)] have that made [you/(SP)] suspect [you/he/she] had the coronavirus? INTERVIEWER CODE BASED ON VERBATIM RESPONSE FROM RESPONDENT.	(01) FEVER (02) ONGOING DRY COUGH (03) RUNNY NOSE (04) SNEEZING (05) SHORTNESS OF BREATH (06) HEADACHE (07) SORE THROAT (08) NAUSEA (09) VOMITING (10) EXTREME FATIGUE (11) CHILLS/REPEATED SHAKING WITH CHILLS (12) MUSCLE PAIN (13) NEW LOSS OF TASTE OR SMELL (14) LOSS OF APPETITE (15) DIARRHEA (91) OTHER (-8) DON'T KNOW (-7) REFUSED
			Has a doctor or other health professional ever told [you/(SP)] that [you have/he has/she has] or likely had coronavirus or COVID-19? [IF NEEDED: A doctor or other health professional might make this diagnosis based on a test for COVID-19 or based on symptoms [you have/(SP)] has].	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED
			Since [REFERENCE DATE], has a doctor or other health professional told [you/(SP)] that [you have/he has/she has] or likely had coronavirus or COVID-19? [IF NEEDED: A doctor or other health professional might make this diagnosis based on a test for COVID-19 or based on symptoms [you have/(SP)] has].	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED
			[Have you/has(SP)] ever been tested to see whether [you were/he was/she was] infected with coronavirus or COVID-19 at the time of the test? [IF NEEDED: For example, the test can be done by swabbing [your/his/her] nose or mouth. Some tests can be done by yourself or by someone else at home, and some tests are done by a health professional.] DO NOT INCLUDE ANTIBODY TESTS, WHICH TEST WHETHER SOMEONE HAS EVER BEEN INFECTED WITH CORONAVIRUS.	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED
			Since [REFERENCE PERIOD], [have you/has(SP)] been tested to see whether [you were/he was/she was] infected with coronavirus or COVID-19 at the time of the test? [IF NEEDED: For example, the test can be done by swabbing [your/his/her] nose or mouth. Some tests can be done by yourself or by someone else at home, and some tests are done by a health professional.] DO NOT INCLUDE ANTIBODY TESTS, WHICH TEST WHETHER SOMEONE HAS EVER BEEN INFECTED WITH CORONAVIRUS.	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED

Community Interview Revisions	Section	Effect on Annual Burden	Question Text	Response Options
			How long did it take to get [your/(SP)'s] test results? Did [you/he/she] get the results the same day, the next day, within 2-3 days, within 4-6 days, or after 7 days or more? [IF NEEDED: If [you have/(SP) has] had more than one test to see whether [you were/he was/she was] infected with coronavirus or COVID-19 at the time of the test, think about [your/his/her] most recent test.] DO NOT INCLUDE ANTIBODY TESTS, WHICH TEST WHETHER SOMEONE HAS EVER BEEN INFECTED WITH CORONAVIRUS.	(01) SAME DAY (02) NEXT DAY (03) 2-3 DAYS (04) 4-6 DAYS (05) 7 DAYS OR MORE (-8) DON'T KNOW (-7) REFUSED
			How much did [you/(SP)] pay out of pocket for the test: none of the cost, part of the cost, or all of the cost? [IF NEEDED: Please answer to the best of your knowledge.] [IF NEEDED: If [you have/(SP) has] had more than one test to see whether [you were/he was/she was] infected with coronavirus or COVID-19 at the time of the test, think about [your/his/her] most recent test.] DO NOT INCLUDE ANTIBODY TESTS, WHICH TEST WHETHER SOMEONE HAS EVER BEEN INFECTED WITH CORONAVIRUS.	(01) NONE OF THE COST (02) PART OF THE COST (03) ALL OF THE COST (-8) DON'T KNOW (-7) REFUSED
			Why did [you/(SP)] not seek medical care? READ EACH ITEM AND RECORD YES/NO RESPONSE:Was it too expensive?	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED
			Was it not available?	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED
			Were [your/(SP)'s] symptoms not severe enough?	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED
			Was there some other reason?	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED
			[You/(SP) previously reported the following COVID-19 vaccines.] [Have you/Has (SP)] received any [additional] doses of a COVID-19 vaccine?	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED
			When did [you/(SP)] receive this dose of the COVID-19 vaccine? IF NEEDED: [You/(SP)] may have been given a "COVID-19 Vaccination Record Card" with this information on it. It could be helpful to refer to that card if it is available. PLEASE ENTER COVID-19 VACCINE DOSES IN THE ORDER THEY WERE RECEIVED, STARTING FROM THE EARLIEST DOSE RECEIVED TO THE MOST RECENT DOSE RECEIVED.	MONTH YEAR
			Which COVID-19 vaccine did (you/(SP)) get? IF NEEDED: Examples include Pfizer-BioNTech/Comirnaty, Moderna/Spikevax, and Johnson & Johnson/Janssen, and Novavax. IF NEEDED: [You/(SP)] may have been given a "COVID-19 Vaccination Record Card" with this information on it. It could be helpful to refer to that card if it is available. ONLY USE THE 'OTHER' CATEGORY TO ADD VACCINE MANUFACTURERS APPROVED IN AN FI MEMO	(01) PFIZER-BIONTECH/COMIRNATY (02) MODERNA/SPIKEVAX (03) JOHNSON & JOHNSON/JANSSEN (04) NOVAVAX (91) OTHER (-8) DON'T KNOW (-9) REFUSED
			OTHER (SPECIFY)	(01) CONTINUOUS ANSWER

Community Interview Revisions	Section	Effect on Annual Burden	Question Text	Response Options
			Where did [you/(SP)] go for this dose of the COVID-19 vaccine? A MASS VACCINATION SITE IS A LOCATION THAT WAS SET UP ESPECIALLY TO ADMINISTER COVID-19 VACCINES, OFTEN ORGANIZED BY A LOCAL, STATE, OR FEDERAL AGENCY. MASS VACCINATION SITES MAY BE LOCATED AT A SHOPPING CENTER, CONVENTION CENTER, SPORTING FACILITY, CHURCH, LIBRARY, HOSPITAL OR OTHER COMMUNITY LOCATION.	(01) FACILITY ONLY- FACILITY NAME (DO NOT DISPLAY) (02) PHARMACY/DRUG STORE (03) DOCTORS OFFICE OR GROUP PRACTICE (04) MASS VACCINATION SITE (05) MANAGED CARE PLAN CENTER/HMO (06) NEIGHBORHOOD/FAMILY HEALTH CENTER/MEDICAL CLINIC (07) COMPANY CLINIC/WORKPLACE (08) WALK-IN URGENT CENTER (09) HOSPITAL (10) VA FACILITY (11) HEALTH DEPARTMENT OFFICE (12) AT HOME (91) OTHER, SPECIFY (-8) DON’T KNOW (-9) REFUSED
			OTHER (SPECIFY)	(01) CONTINUOUS ANSWER
			[Have you/Has (SP)] had any other COVID-19 vaccine doses? PLEASE ENTER COVID-19 VACCINE DOSES IN THE ORDER THEY WERE RECEIVED, STARTING FROM THE EARLIEST DOSE RECEIVED TO THE MOST RECENT DOSE RECEIVED.	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED
			Now that a vaccine to prevent COVID-19 is available to most adults in the United States, will [you/(SP)] get it? Definitely, probably, probably not, definitely not, or are you not sure?	(01) DEFINITELY (02) PROBABLY (03) PROBABLY NOT (04) DEFINITELY NOT (05) NOT SURE (-9) REFUSED
			Since April 1, 2021, [have you/has (SP)] worn a facemask when out in public in response to the coronavirus or COVID-19? IF THE RESPONDENT HAS WORN A FACEMASK IN SOME SETTINGS BUT NOT OTHERS (FOR EXAMPLE, INSIDE BUT NOT OUTSIDE), SELECT "YES."	(01) YES (02) NO (03) NOT APPLICABLE (-8) DON'T KNOW (-9) REFUSED
Deletion: VA Health Care Enrollment and Utilization	HIQ	N/A	[We recorded that [you/(SP)] served in the Armed Forces of the United States.] Since (REFERENCE DATE), [have you/has (SP) received/did (SP) receive] health care or health services or prescribed medicines through the Department of Veterans Affairs or V.A.?	(01) YES (02) NO (-8) DON'T KNOW (-9) REFUSED

Facility Interview Revisions	Section	Effect on Annual Burden	Question Text	Response Options
Revision to Existing Items: COVID-19	CV	Decrease of 0.42 minutes	Has (SP) received any COVID-19 vaccines? [IF NEEDED: Please include booster shots and any additional doses.] [IF NEEDED: This question is asking for the total number of COVID-19 vaccine doses that (SP) has received since the vaccine first became available in December 2020.]	(00) NO (01) YES (-8) DON'T KNOW (-9) REFUSED
			How many COVID-19 vaccines has (SP) received in total? [IF NEEDED: Please include booster shots and any additional doses.] [IF NEEDED: This question is asking for the total number of COVID-19 vaccine doses that (SP) has received since the vaccine first became available in December 2020.]	(01) ONE VACCINE (02) TWO VACCINES (03) THREE VACCINES (04) FOUR OR MORE VACCINES (-8) DON'T KNOW (-9) REFUSED
			In (PREVIOUS YEAR), has (SP) received at least one dose of the COVID-19 vaccine? [IF NEEDED: Please include booster shots and any additional doses.] [IF NEEDED: This question is asking for the total number of COVID-19 vaccine doses that (SP) has received since the vaccine first became available in December 2020.]	
Deletion: COVID-19	CV	Decrease of 5.24 minutes	Since (PREVIOUS INTERVIEW DATE/ADMISSION DATE) has (SP) been tested to see whether (he/she) was infected with coronavirus or COVID-19 at the time of the test? [IF NEEDED: For example, the test can be done by swabbing someone's nose.] DO NOT INCLUDE ANTIBODY TESTS, WHICH TEST WHETHER SOMEONE HAS EVER BEEN INFECTED WITH CORONAVIRUS.	(00) NO (01) YES (-8) DON'T KNOW (-9) REFUSED
			Did the test find that (SP) had Coronavirus or COVID-19? [IF NEEDED: If (SP) had more than one test since (PREVIOUS INTERVIEW DATE/ADMISSION DATE) to see whether (he/she) was infected with coronavirus or COVID-19, answer yes if any of them were positive.] DO NOT INCLUDE ANTIBODY TESTS, WHICH TEST WHETHER SOMEONE HAS EVER BEEN INFECTED WITH CORONAVIRUS .	(01) YES, THE TEST SHOWED R HAD COVID-19 (02) NO, THE TEST SHOWED R DID NOT HAVE COVID-19 (03) NO RESULTS YET (-8) DON'T KNOW (-9) REFUSED
			Since (PREVIOUS INTERVIEW DATE/ADMISSION DATE) has (SP) received medical care (either inside or outside this (facility/home)) for the coronavirus or COVID-19? [IF NEEDED: Please include services provided by all health care personnel.]	(00) NO (01) YES (-8) DON'T KNOW (-9) REFUSED

Facility Interview Revisions	Section	Effect on Annual Burden	Question Text	Response Options
			What kind of provider did (he/she) receive care from for the coronavirus or COVID-19? SELECT ALL THAT APPLY. CODE BASED ON THE RESPONSE FACILITY RESPONDENT GIVES.	(01) EMERGENCY MEDICAL SERVICE PERSONNEL (02) NURSES (03) NURSING ASSISTANTS (04) PHARMACISTS (05) PHLEBOTOMISTS (06) PHYSICIANS (07) TECHNICIANS (08) THERAPISTS (91) OTHER (-8) DON'T KNOW (-9) REFUSED
			OTHER (SPECIFY)	(01) CONTINUOUS
			[It was previously reported that (SP) received the following COVID-19 vaccines.] DOSE 1: [MONTH] [YEAR] [MANUFACTURER] DOSE 2: [MONTH] [YEAR] [MANUFACTURER] ... DOSE 10: [MONTH] [YEAR] [MANUFACTURER] Has (SP) received any [additional] COVID-19 vaccines?	(00) NO (01) YES (-8) DON'T KNOW (-9) REFUSED
			When did (SP) receive this dose of the COVID-19 vaccine? MONTH PLEASE ENTER COVID-19 VACCINE DOSES IN THE ORDER THEY WERE RECEIVED, STARTING FROM THE EARLIEST DOSE RECEIVED TO THE MOST RECENT DOSE RECEIVED. IT WAS PREVIOUSLY REPORTED THAT (SP) RECEIVED THE FOLLOWING COVID-19 VACCINES. DOSE 1: [MONTH] [YEAR] [MANUFACTURER] DOSE 2: [MONTH] [YEAR] [MANUFACTURER] ... DOSE 10: [MONTH] [YEAR] [MANUFACTURER]	(01) CONTINUOUS
			When did (SP) receive this dose of the COVID-19 vaccine? YEAR PLEASE ENTER COVID-19 VACCINE DOSES IN THE ORDER THEY WERE RECEIVED, STARTING FROM THE EARLIEST DOSE RECEIVED TO THE MOST RECENT DOSE RECEIVED. IT WAS PREVIOUSLY REPORTED THAT (SP) RECEIVED THE FOLLOWING COVID-19 VACCINES. DOSE 1: [MONTH] [YEAR] [MANUFACTURER] DOSE 2: [MONTH] [YEAR] [MANUFACTURER] ... DOSE 10: [MONTH] [YEAR] [MANUFACTURER]	(01) CONTINUOUS
			Which COVID-19 vaccine did (SP) get? [IF NEEDED: Examples include Pfizer-BioNTech/Comirnaty, Moderna/Spikevax, Johnson & Johnson/Janssen, and Novavax.] ONLY USE THE 'OTHER' CATEGORY TO ADD VACCINE MANUFACTURERS APPROVED IN AN FI MEMO	(01) PFIZER-BIONTECH/COMIRNATY (02) MODERNA/SPIKEVAX (03) JOHNSON & JOHNSON/JANSSEN (04) NOVAVAX (91) OTHER (-8) DON'T KNOW (-9) REFUSED
			OTHER (SPECIFY)	(01) CONTINUOUS

Facility Interview Revisions	Section	Effect on Annual Burden	Question Text	Response Options
			Where did (SP) go for their COVID-19 vaccine in (VACDATMM) (VACDATYY)?	(01) (FACILITY) (02) PHARMACY/DRUG STORE (03) DOCTORS OFFICE OR GROUP PRACTICE (04) MASS VACCINATION SITE (05) MANAGED CARE PLAN CENTER/HMO (06) NEIGHBORHOOD/FAMILY HEALTH CENTER/MEDICAL CLINIC (07) COMPANY CLINIC/WORKPLACE (08) WALK-IN URGENT CENTER (09) HOSPITAL (10) VA FACILITY (11) HEALTH DEPARTMENT OFFICE (12) AT HOME (91) OTHER (-8) DON'T KNOW (-9) REFUSED
			OTHER (SPECIFY)	(01) CONTINUOUS
			Has (SP) had any other COVID-19 vaccine doses? PLEASE ENTER COVID-19 VACCINE DOSES IN THE ORDER THEY WERE RECEIVED, STARTING FROM THE EARLIEST DOSE RECEIVED TO THE MOST RECENT DOSE RECEIVED. DOSE 1: [MONTH] [YEAR] [MANUFACTURER] DOSE 2: [MONTH] [YEAR] [MANUFACTURER] DOSE 3: [MONTH] [YEAR] [MANUFACTURER] ... DOSE 10: [MONTH] [YEAR] [MANUFACTURER]	(00) NO (01) YES (-8) DON'T KNOW (-9) REFUSED
Deletion: COVID-19	FC	Decrease of 3 minutes	I am now going to ask you some information about (FACILITY)'s experiences during the coronavirus pandemic, also known as COVID-19 or SARS-CoV-2. Given the impact the coronavirus pandemic has had on facilities, the next questions aim to capture the experiences and challenges facilities such as your own have faced due to the pandemic.	(01) Continue
			The next questions ask about telehealth services this facility is currently providing. As of today, are any services provided through telehealth by (FACILITY)? [IF NEEDED: Telehealth visits include visits by telephone or video.]	(00) NO (01) YES (-8) DON'T KNOW (-9) REFUSED
			[As of today] are doctor or other health professional visits outside this facility currently offered through telehealth? Please include outside visits for both primary and specialty care. VISITS SHOULD INCLUDE BOTH PRIMARY AND SPECIALTY CARE. IF SERVICES ARE OFFERED THROUGH TELEHEALTH FOR EITHER PRIMARY OR SPECIALTY CARE OUTSIDE THE FACILITY ANSWER "YES". [IF NEEDED: "Outside" refers to telehealth visits with off-site primary and specialty care doctors or other health professionals.]	(00) NO (01) YES (02) NOT APPLICABLE (-8) DON'T KNOW (-9) REFUSED
			[As of today] are doctor or other health professional visits inside this facility currently offered through telehealth? Please include inside visits for both primary and specialty care. VISITS SHOULD INCLUDE BOTH PRIMARY AND SPECIALTY CARE. IF SERVICES ARE OFFERED THROUGH TELEHEALTH FOR EITHER PRIMARY OR SPECIALTY CARE INSIDE THE FACILITY ANSWER "YES". [IF NEEDED: "Inside" refers to telehealth visits with primary and specialty care doctors or other health professionals from this facility.]	(00) NO (01) YES (02) NOT APPLICABLE (-8) DON'T KNOW (-9) REFUSED

Facility Interview Revisions	Section	Effect on Annual Burden	Question Text	Response Options
			[As of today] which of the following services, both inside and outside this facility, are currently offered through telehealth? a. Dental visits	(00) NO (01) YES (02) NOT APPLICABLE (-8) DON'T KNOW (-9) REFUSED
			b. Psychiatrist or other mental health professional visits	(00) NO (01) YES (02) NOT APPLICABLE (-8) DON'T KNOW (-9) REFUSED
			c. Podiatrist visits	(00) NO (01) YES (02) NOT APPLICABLE (-8) DON'T KNOW (-9) REFUSED
			d. Educational or habilitational services	(00) NO (01) YES (02) NOT APPLICABLE (-8) DON'T KNOW (-9) REFUSED
			e. Any other types of services [IF NEEDED: Other types of services inside or outside the facility may include dieticians, nurse practitioners, physician's assistants, registered nurses, or social workers.]	(00) NO (01) YES (02) NOT APPLICABLE (-8) DON'T KNOW (-9) REFUSED
			OTHER (SPECIFY)	(01) [Continuous answer.]
			Now I would like to ask you about vaccine policies this facility may have to prevent the spread of the flu and COVID-19.	(01) CONTINUE
			What is (FACILITY)'s policy about the flu shot for health care personnel? READ RESPONSE OPTIONS ALOUD: • Flu shot is required • Flu shot is recommended • Neither	(01) VACCINE IS REQUIRED (02) VACCINE IS RECOMMENDED (03) NEITHER (-8) DON'T KNOW (-9) REFUSED
			What (is/will be) (FACILITY)'s policy about the COVID-19 vaccine for health care personnel? READ RESPONSE OPTIONS ALOUD: • Vaccine (is/will be) required • Vaccine (is/will be) recommended • Neither • Don't know	(01) VACCINE (IS/WILL BE) REQUIRED (02) VACCINE (IS/WILL BE) RECOMMENDED (03) NEITHER (-8) DON'T KNOW (-9) REFUSED
			What is (FACILITY)'s policy about the flu shot for residents? READ RESPONSE OPTIONS ALOUD: • Flu shot is required • Flu shot is recommended • Neither	(01) VACCINE IS REQUIRED (02) VACCINE IS RECOMMENDED (03) NEITHER (-8) DON'T KNOW (-9) REFUSED
			What (is/will be) (FACILITY)'s policy about the COVID-19 vaccine for residents? READ RESPONSE OPTIONS ALOUD: • Vaccine (is/will be) required • Vaccine (is/will be) recommended • Neither • Don't know	(01) VACCINE (IS/WILL BE) REQUIRED (02) VACCINE (IS/WILL BE) RECOMMENDED (03) NEITHER (-8) DON'T KNOW (-9) REFUSED
			The next questions are about mental health services.	(01) CONTINUE
			Does this facility offer… a. Individual Therapy Sessions FOR EACH ITEM INCLUDE SERVICES OFFERED BY THE FACILITY AND/OR COORDINATED BY THE FACILITY.	(00) NO (01) YES (-8) DON'T KNOW (-9) REFUSED

Facility Interview Revisions	Section	Effect on Annual Burden	Question Text	Response Options
			b. Group Therapy Sessions	(00) NO (01) YES (-8) DON'T KNOW (-9) REFUSED
			c. Support Groups	(00) NO (01) YES (-8) DON'T KNOW (-9) REFUSED
			d. Art Therapy	(00) NO (01) YES (-8) DON'T KNOW (-9) REFUSED
			e. Any Other Types of Mental Health Services	(00) NO (01) YES (-8) DON'T KNOW (-9) REFUSED
			The next questions are about social and recreational activities.	(01) CONTINUE
			Does this facility provide social and recreational activities within the facility?	(00) NO (01) YES (-8) DON'T KNOW (-9) REFUSED
			Does this facility provide social and recreational activities outside the facility? "OUTSIDE THE FACILITY" REFERS TO ACTIVITIES THAT OCCUR OFF THE FACILITY PREMISES.	(00) NO (01) YES (-8) DON'T KNOW (-9) REFUSED
			YOU HAVE COMPLETED THE COVID-19 FACILITY-LEVEL SECTION. PRESS "1" TO RETURN TO NAVIGATION SCREEN.	(01) CONTINUE