

2012-2013 SURVEY FOR ADMINISTRATORS OF PUBLICLY-FUNDED HEALTH CENTERS THAT PROVIDE FAMILY PLANNING

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I. HEALTH CENTER CHARACTERISTICS

1. What type of organization is your health center? (Select all that apply.)

Hospital	<input type="checkbox"/>
Planned Parenthood	<input type="checkbox"/>
Community health center	<input type="checkbox"/>
Private, non-profit organization	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>

2. What best describes your health center's clinical focus?

Family planning/reproductive health	<input type="checkbox"/>
Primary (general health) care	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>

3. What state or territory is your agency located in?

4. Which best describes the area that your health center serves?

Mostly urban/suburban	<input type="checkbox"/>
Mostly rural	<input type="checkbox"/>
Combination of rural & urban	<input type="checkbox"/>

5. Approximately how many clients received any clinical services at your health center in the last year? (fiscal or calendar)

<500	<input type="checkbox"/>
500-999	<input type="checkbox"/>
1,000-4,999	<input type="checkbox"/>
5,000-9,999	<input type="checkbox"/>
10,000-49,999	<input type="checkbox"/>
50,000 +	<input type="checkbox"/>

6. Approximately how many clients received family planning services at your health center in the last year? (fiscal or calendar)

<500	<input type="checkbox"/>
500-999	<input type="checkbox"/>
1,000-4,999	<input type="checkbox"/>
5,000-9,999	<input type="checkbox"/>
10,000 +	<input type="checkbox"/>

7. What is the approximate age and gender breakdown of your health center's family planning clients?

All clients (male and female)	
<20 years old	_____ %
20-29 years old	_____ %
30-44 years old	_____ %
45 years or older	_____ %
Males (all ages)	_____ %

8. Is your health center a part of the following health care networks?

	Yes	No	Don't know
Accountable care organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical home (PCMH or other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid managed care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other managed care network/PPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participating provider in one or more private insurance company networks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

II. CLINICAL SERVICES PROVIDED

9. In the past 3 months, were the following contraceptive methods* provided on site to clients who requested them? Also, please note whether your health center ran out of supplies of that method in the last 3 months.

	Provided on site, last 3 months		Supplies ran out, last 3 months	
	Yes	No	Yes	No
Sterilization (male)	<input type="checkbox"/>	<input type="checkbox"/>		
Sterilization (female)	<input type="checkbox"/>	<input type="checkbox"/>		
LNG-IUD (Mirena®)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cu-IUD (ParaGard®)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Implant (Implanon® or Nexplanon®)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DMPA (Depo-Provera®)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patch (Ortho Evra®)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal ring (NuvaRing®)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Combined Oral Contraceptives (COCs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Progestin-only oral contraceptives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency contraceptive pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Male condom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Female condom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

10. In the past 3 months, about how often did your health center provide the following services?

	Never	Rarely	Occasionally	Frequently
Pregnancy diagnosis & counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contraceptive services for women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contraceptive services for men	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Basic infertility services for women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Basic infertility services for men	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STD screening for women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STD screening for men	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preconception health care for women	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preconception health care for men	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. In the past 3 months, how often did your health center use the following referral practices?

	Never	Rarely	Occasionally	Frequently
Provided a resource listing or directory to the client	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provided a documented referral to the client	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Made an appointment for the client	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contacted the client directly about the referral outcome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contacted the referral source to find out if the client was seen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asked the client about the referral at his or her next visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. The following questions refer to your health center's clinical recommendations for on site, routine screening during initial or follow-up family planning visits. *By screening, we mean the process of routinely asking questions about a client's history or performing a physical exam or laboratory test in average-risk asymptomatic persons to help assess risk factors for, or the presence of, a specific disease or condition.*

	Is this standard of care for female clients?		Is this specified in a written protocol?		Is this standard of care for male clients?		Is this specified in a written protocol?	
	Yes	No	Yes	No	Yes	No	Yes	No
Intimate partner and sexual violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol and drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unhealthy diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Body-mass index (BMI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Cervical cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Testicular cancer					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. The following questions relate to your health center's clinical recommendations for contraceptive counseling.

	Is this standard of care?		Is this specified in a written protocol?	
	Yes	No	Yes	No
Use open-ended questions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assess the client's reproductive life plan (i.e., ask about their intentions regarding the number and timing of pregnancies in the context of their personal values and life goals)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Present information regarding potential contraceptive methods with the most effective methods presented first (tiered approach)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Help the client think about potential barriers to using their selected method correctly and develop a plan to deal with these barriers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use method-specific consent forms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inform adolescents that long-acting reversible contraceptives are safe and effective options	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

III. HEALTH CENTER INFRASTRUCTURE, SYSTEMS, AND COMMUNITY EDUCATION

14. In the past 3 months, about how often did your health center make available the following services or materials to clients?

	Never	Rarely	Occasionally	Frequently
Same-day appointments for clinical services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weekend or evening hours for clinical services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adolescent-only hours or days for clinical services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Educational materials (written or video) specifically designed for adolescents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Educational materials (written or video) in languages that match the needs of your client base	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language translation services that match the needs of your client base	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. In the past 3 months, about how often did your health center do the following, related to adolescent clients?

	Never	Rarely	Occasionally	Frequently
Offered time alone with a provider for adolescents who came with a parent or guardian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Required parental consent, for adolescents seeking contraceptive services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Actively encouraged communication between adolescents and parents/guardians about sex and reproductive health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Actively promoted the availability of confidential services to adolescents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. Does your health center use the following technologies?

	No	Yes: Limited use	Yes: Routinely
Electronic health records	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Electronic system for billing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Email, phone, or text messages to clients for appointment reminders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Email, phone, or text messages to clients for test results (e.g., STD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Website that allows clients to make appointments online	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. In the past 12 months, did your health center use any of the following methods for community education?

	Yes	No
TV	<input type="checkbox"/>	<input type="checkbox"/>
Radio	<input type="checkbox"/>	<input type="checkbox"/>
Websites or social media (e.g., Facebook)	<input type="checkbox"/>	<input type="checkbox"/>
Billboards	<input type="checkbox"/>	<input type="checkbox"/>
Newspapers or magazines	<input type="checkbox"/>	<input type="checkbox"/>
Community events	<input type="checkbox"/>	<input type="checkbox"/>
Small group education (1 session)	<input type="checkbox"/>	<input type="checkbox"/>
Small group education (2+ sessions with same group)	<input type="checkbox"/>	<input type="checkbox"/>

18. In the past 12 months, did your health center conduct community education in the following places or groups?

	Yes	No
Schools	<input type="checkbox"/>	<input type="checkbox"/>
Colleges or universities	<input type="checkbox"/>	<input type="checkbox"/>
Other youth-serving groups	<input type="checkbox"/>	<input type="checkbox"/>
Parent groups	<input type="checkbox"/>	<input type="checkbox"/>
Faith-based organizations	<input type="checkbox"/>	<input type="checkbox"/>
Other health care services	<input type="checkbox"/>	<input type="checkbox"/>
Community health fairs	<input type="checkbox"/>	<input type="checkbox"/>
Other social service organizations	<input type="checkbox"/>	<input type="checkbox"/>

IV. QUALITY IMPROVEMENT

19. How often does your health center formally review the following aspects of service delivery to monitor the quality of family planning services?

(They could be measured in various ways.)

	Monthly or Quarterly	Annually	Every 2-3 years	As needed	Other frequency	Never/not currently reviewed
Availability of contraceptive methods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Access to services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinic efficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Client satisfaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cultural competency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Referrals and/or care coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contraceptive use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cost of providing services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unintended pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birth spacing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. In the past 12 months, has your health center modified any clinical practices or other aspects of the health center, in response to a review of quality improvement data? Please note this question does not relate to any modification, but only those implemented in response to your center's review of quality improvement data.

Yes No

If yes, please briefly describe what aspect of service delivery was changed:

V. REFERRAL ARRANGEMENTS AND STAFF TRAINING

21. What kinds of partnerships does your health center have with providers who offer the following contraceptive methods and other services? (In each row, select all that apply.)

	We offer this on site	Co-located with those who do, or our parent organization provides this	Contract, or other written agreement	Informal relationships with provider(s) who do this	Referral only
Female sterilization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Male sterilization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IUD insertion/removal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Implant insertion/removal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Natural family planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prenatal care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Primary care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infertility treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22. Please indicate whether all, some, or none of the health center's staff have received training in the following areas:

	All staff	Some staff	No staff
Trained in past 2 years: All relevant staff			
Contraceptive counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Serving male clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ever trained: Clinical staff only			
Inserting and removing copper IUD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inserting and removing hormonal IUD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inserting and removing contraceptive implants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VI. QUESTIONS ABOUT SURVEY COMPLETION AND AWARENESS OF GUIDELINES

23. Which of the following best describes the primary role of the person or persons who completed this survey? (Select all that apply.)
- | | |
|----------------------------------|--------------------------|
| Administrator | <input type="checkbox"/> |
| Medical director | <input type="checkbox"/> |
| Nurse/nurse practitioner manager | <input type="checkbox"/> |
| Other (please specify) _____ | <input type="checkbox"/> |
24. If your health center is a part of a multi-site agency, did you consult your parent agency to complete this survey? (Select one.)
- | | |
|--|--------------------------|
| Yes, parent completed entire survey | <input type="checkbox"/> |
| Yes, parent completed or checked parts of the survey | <input type="checkbox"/> |
| No, parent did not help complete or check the survey | <input type="checkbox"/> |
| No, we are not part of a multi-site agency | <input type="checkbox"/> |
| No, we are the parent agency | <input type="checkbox"/> |

25. How did you learn about the 2013 Guidance for Providing Quality Family Planning Services? (select all that apply)

I did not know about the guidelines before participation in this survey.	<input type="checkbox"/>
Conference attendance	<input type="checkbox"/>
Journals	<input type="checkbox"/>
Online resources	<input type="checkbox"/>
Parent agency	<input type="checkbox"/>
Professional organization publications or notifications	<input type="checkbox"/>
Other (please specify) _____	<input type="checkbox"/>

Please share any additional comments that you may have in the space below.

Thank you for completing this survey!
Please return using the enclosed postage paid envelope.