

Health Center Provider Survey

Public reporting of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a current valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (XXXX-XXXX)

Thank you for agreeing to complete this survey. The purpose of the survey is to assess your attitudes and practices related to adolescent sexual and reproductive health. Please answer each of the following questions as they relate to your experiences providing family planning services to your adolescent patients. *Please answer questions thinking only about services you have provided at your current health center.*

Your responses will be kept private and your completed assessment will be stored on a secure, password protected server. Your responses will be combined with those from others at your health center in order to tailor training and technical assistance. Your individual responses will not be shared. Your participation in this survey is voluntary and you can discontinue participation at any time.

PROVIDER AND PATIENT CHARACTERISTICS

1. On average, approximately how many unduplicated **female patients ages 15-19** do you see per week?
 _____(provide a whole number)

2. Approximately what percent of your **female patients ages 15-19** do you provide sexual and reproductive health services?

0-24%	<input type="checkbox"/>
25-49%	<input type="checkbox"/>
50-74%	<input type="checkbox"/>
75% or more	<input type="checkbox"/>

TRAINING

3. Have you been formally trained in the insertion and removal of the following contraceptive methods?

	Yes	No
Copper Intrauterine Device (Cu-IUD or ParaGard®)?	<input type="checkbox"/>	<input type="checkbox"/>
Levonorgestrel-releasing Intrauterine Device (LNG-IUD LILETTA™, Skyla® or Mirena®)?	<input type="checkbox"/>	<input type="checkbox"/>
Contraceptive implant (Implanon®)?	<input type="checkbox"/>	<input type="checkbox"/>

ATTITUDES AND PRACTICES

4. How comfortable are you recommending IUDs for the following groups of adolescents (ages 15 to 19 years old)?

	Not at all comfortable	Slightly comfortable	Somewhat comfortable	Moderately comfortable	Very comfortable
Nulliparous adolescents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Postpartum adolescents (10 minutes after delivery of placenta to less than 4 weeks postpartum)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obese adolescents (BMI ≥30 kg/m²)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. In the past year, have you referred, prescribed or provided IUDs to nulliparous adolescents?

- Yes No

If no, please indicate why (Select all that apply):

- My practice/health center does not provide IUDs.
- I do not have nulliparous adolescents as patients.
- I am concerned about recommending IUDs for adolescents.
- I am concerned about the effects on future fertility.
- I am concerned about difficult insertion.
- I am not trained in IUD insertion.
- My nulliparous adolescent patients generally prefer a different method.
- Adolescents are more likely to have it removed within a year of insertion, compared to adults
- My practice/health center protocol does not allow it.
- There are financial-related issues with billing, coding, and reimbursement processes that make the process very difficult.
- Providing adolescents with IUDs makes them less likely to use a condom
- I do not feel comfortable inserting IUDs.
- I do not generally provide IUDs to adolescents for other reasons (please specify):

6. In the past year, have you referred, prescribed or provided hormonal implants to nulliparous adolescents?

- Yes No

If no, please indicate why (select all that apply):

- My practice does not provide implants.
- I rarely have nulliparous adolescents as patients.
- I am concerned about recommending implants for adolescents.
- I am concerned about the effects on future fertility.
- I am concerned about difficult insertion.
- I am not trained in implant insertion.
- My nulliparous adolescent patients generally prefer a different method.
- Adolescents are more likely to have it removed within a year of insertion, compared to adults
- Providing adolescents with hormonal implants makes them less likely to use a condom
- My practice/health center protocol does not allow it.
- There are financial-related issues with billing, coding, and reimbursement processes that make the process very difficult.
- I do not feel comfortable inserting implants.
- I do not generally provide implants to adolescents for other reasons (please specify):

7. Before providing the following contraceptive methods, please indicate if you perform any of the following exams and tests for an otherwise healthy female adolescent.

Contraceptive Method	Blood pressure	Clinical breast exam	Bimanual exam and cervical inspection	Cervical cytology	Chlamydia/ gonorrhea screening	Do not provide this method
COCs/patch/ring	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>
Progestin-only pills (POPs)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>
DMPA (Depo-Provera®)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>
Contraceptive implant (Implanon®)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>
Copper Intrauterine Device (Cu-IUD or ParaGard®)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>
LEVONORGESTREL-RELEASING INTRAUTERINE DEVICE (LNG-IUD LILETTA™, SKYLA® OR MIRENA®)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/>

8. In the past year, how frequently have you provided the following services for adolescent females?

	Never	Rarely	Sometimes	Often	Always
Provided or prescribed the pill, patch, ring or Depo Provera on the day of her visit regardless of the timing of her menses (Quick Start)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provided a hormonal implant on the day of her visit regardless of the timing of her menses (Quick Start) if you were reasonably certain she was not pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provided an IUD on the day of her visit regardless of the timing of her menses (Quick Start) if you were reasonably certain she was not pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provided or prescribed a contraceptive method at the same time you provided EC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provided contraceptive services to an adolescent that came in for a pregnancy test that was negative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provided a Cu-IUD as EC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provided another method of birth control if selected method not available on day of visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dispensed a year's supply of pills at one visit for adolescent females	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Addressed contraceptive needs on the day of service regardless of chief complaint rather than scheduling a follow-up visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. In the past month, when counseling your typical female patient ages 15 to 19 years old on family planning, how frequently did you (or your clinical team) do the following?

	Never	Rarely	Sometimes	Often	Always
Assessed the patient's reproductive life plan (i.e., asked 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"/>	<input type="checkbox"/>
Worked with the client interactively to select the most effective method that meets the client's needs and preferences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Presented 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"/>	<input type="checkbox"/>
Helped the patient 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"/>	<input type="checkbox"/>
Used a method-specific informed consent form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Informed adolescents that long-acting reversible contraceptives are safe and effective options	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
Encouraged male/partner involvement in contraceptive and reproductive health services, if appropriate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SERVICES TO ADOLESCENTS NOT INITIALLY SEEKING SEXUAL OR REPRODUCTIVE HEALTH CARE

The following items are about services provided to your adolescent patients who were seeking health care for a purpose other than sexual or reproductive health care (e.g., sick visit).

Check here if you only see family planning clients. You have completed the survey. Thank you.

10. In the past month, when your **female** adolescent patients (ages 15 to 19 years old) were seeking health care for a purpose other than sexual or reproductive health care (e.g., sick visit), how frequently did you or your clinical team do the following?

	Never	Rarely	Sometimes	Often	Always
Provide time alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Screen to determine if in need of contraceptive services (i.e., sexually active, not desiring pregnancy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. In the past month, when your **male** adolescent patients (ages 15 to 19 years old) were seeking health care for a purpose other than sexual or reproductive health care (e.g., sick visit), how frequently did you or your clinical team do the following?

	Never	Rarely	Sometimes	Often	Always
Provide time alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Screen to determine if in need of counseling around preventing pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Thank you.