# Approaches and Indicators for Measuring Quality in Region VIII Family Planning Programming

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## TABLE OF CONTENTS

# PART I

## Background

The existing literature on family planning effectiveness covers a broad range of program indicators, including immediate program impact such as the population served or services delivered and ultimate population outcomes such as the number of unintended pregnancies averted and decreases in teen pregnancy. Measuring the more long-term or ultimate outcomes of family planning typically requires population level analyses that allow researchers to control for a variety of factors that might affect these outcomes other than Title X services and activities. In order to assess long-term impact, it is essential to have systems in place that track processes and intermediate program outcomes. This project specifically focused on identifying these intermediate outcomes.

Selecting criteria for evaluating the quality of family planning services is essential, especially now that all government programs, particularly those focused on health, are being asked to document their effectiveness. Although Title X Grantees currently use many appropriate measures, no one set of criteria has been designated to evaluate the quality of care provided at family planning clinics. Consensus by a panel of family planning professionals regarding an appropriate set of quality assessment criteria will ultimately lead to better and more consistent analysis of the effectiveness of Title X Family Planning Programs. It is this consensus that was an important component of this project, and that is presented in Part I of the project report.

## Project Objectives and Design

The three major objectives of this project were: 1) to conduct a review of the literature on performance measures of the quality of family planning services; 2) to develop a set of performance indicators in collaboration with state family planning professionals in Federal Region VIII and 3) to provide guidance and a work plan to collect data for measuring the agreed-upon family planning performance indicators.

The review of the literature on family planning indicators involved a thorough review of the work conducted not only in the United States, but also in developing countries, where the bulk of the research has occurred. An annotated bibliography was developed and is presented in Appendix A. The literature review also included an assessment of various frameworks that have been used to assess quality of family planning and reproductive health services as well as the limited literature to date on the effect of quality of family planning services on outcomes of interest. This latter review is presented in Appendix B. The framework chosen to guide the selection of the performance indicators was the one developed by Judith Bruce, discussed in more detail below. Finally, an inventory was made of the available data sources for measuring performance indicators, the indicators that could be obtained from each source and the advantages and disadvantages of each source. A table summarizing this information is found in Appendix C.

Several steps were undertaken in determining a consensus among the directors of state Title X programs in Region VIII about a common set of performance indicators to be obtained in all six states in the region. These steps involved face-to-face meetings and conference calls between the consultants from the Johns Hopkins University Women's and Children's Health Policy Center (JHU WCHPC) and the Title X professionals to clarify the objectives of the project and to present iterations of recommended performance indicators. In addition, a survey was undertaken with each state to understand their current data capacity for obtaining potential indicators. Finally, the WCHPC team adapted a framework for monitoring and evaluation of Title X programs, as discussed below, that was used to organize the indicators and to assist the family planning program directors in evaluating the usefulness of each indicator.

The final objective, to develop a work plan for the state professionals for obtaining data for the indicators, involved work by the WCHPC team in translating the performance indicators into data collection instruments that could be used by each state for medical records access and client exit surveys. This guidance is provided in Part II of the report.

**Components of Quality**

The Institute of Medicine defines quality as "the extent to which health services for populations increased the likelihood of desired health outcomes and are consistent with current professional knowledge." Three separate but related activities make up much of the work on quality: practice guidelines; quality assessment; and quality improvement.

Practice guidelines have been developed to define appropriate processes of care for diagnosing and managing specific diseases or to outline preventive processes. Title X regulations, in conjunction with standards developed by professional organizations such as the American College of Obstetrics and Gynecology, have resulted in strong clinical practice guidelines for grantees. In addition, there is a body of literature regarding quality standard guidelines for family planning administrative processes that can be integrated into Title X program management.

Quality assessment activities determine the extent to which actual practices are consistent with a particular indicator of quality, such as adherence to a practice guideline. Quality assessment activities are an integral component of Title X grantees' work plans. To assess quality based on guidelines, it is necessary to translate the guideline's elements into quality indicators. Quality assurance activities, such as chart audits and medical or administrative site visits, determine the adherence of an agency to the given standards via evaluation of quality indicators. It is this aspect of quality of care that was addressed in this project.

The final step of the quality cycle is the implementation of quality improvement techniques. The purpose of quality improvement is to learn where there are deficiencies in adherence to the standards, to assess why this has occurred, and to implement changes to bring practices into compliance. This is one purpose for which the indicators

recommended here could be used. Total quality assurance includes implementation of a systematic cycle of: design examination, action, and redesign. The focus is on day-to-day activities, identification of system issues which require in-depth analyses into reasons for performance outcomes, and intervention efforts to improve, modify, or maintain these outcomes.

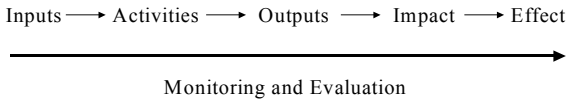
## Quality of Care Frameworks

Frameworks for assessing the quality of family planning services have been heavily influenced by the pioneering work of Avedis Donabedian for assessing the quality of medical care. In this framework, Donabedian identified three major aspects of **quality of care** that can be evaluated: the structure of the care delivery system, the process by which care is delivered, and the outcomes of the care. The structure of the care delivery systems includes community, individual, and provider characteristics associated with the likelihood of providing high quality care. The process of care focuses on the content and method by which health providers deliver services. Most are based on practice guidelines which delineate the components of high quality care. The final aspect is outcomes of the care, which can include clinical status, functional status, and satisfaction with care. Evaluation of this element is more difficult to assess as many factors other than service quality can influence outcomes.

This framework of structure, process and outcome has been adapted in a causal pathway model by Vaughan (1999) for use in family planning programs for program design, monitoring, and evaluation, as shown in Figures 1 and 2.

Figure 1

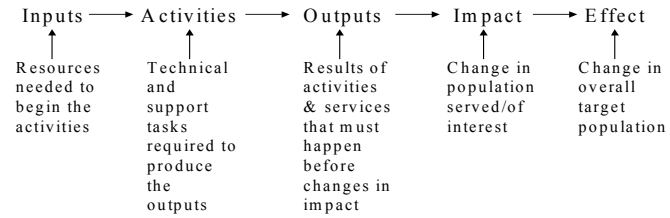
Causal Pathway Map




Source: Dr. Roger Vaughn
Center for Population and Family Health
Joseph L. Mailman School of Public Health of Columbia University

Figure 2

Causal Pathway Map Definitions




Source: Dr. Roger Vaughn
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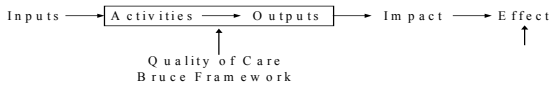
The causal pathway model divides the structure of health care into two components: *inputs* at the program level and *activities* at the clinic level. Process of care involves a set of *outputs* among clients served at the clinic level. Outcomes are divided into intermediate impact, those that occur at the clinic level in terms of the population served, and effects, as measured at the population level.

Donabedian emphasized two main components of quality of care: 1) technical quality of care and 2) the interpersonal relationship. Aided by Donabedian's work, considerable progress had been made in the field of medicine in defining technical standards of care. However, as Donabedian himself recognized, the interpersonal relationship has until recently been largely overlooked, owing to the absence of well-developed standards and the difficulty in measurement. Building upon the work of Donabedian, a decade ago, Judith Bruce developed a framework specifically for assessing the quality of family planning care. Bruce's framework remains highly relevant to service programs today, and has emerged as the central framework from which family planning programs are evaluated. The Bruce framework attempts to incorporate both technical and interpersonal aspects of care in measuring the quality of care provided in family planning programs. The relationship between these two frameworks is depicted in Figure 3.

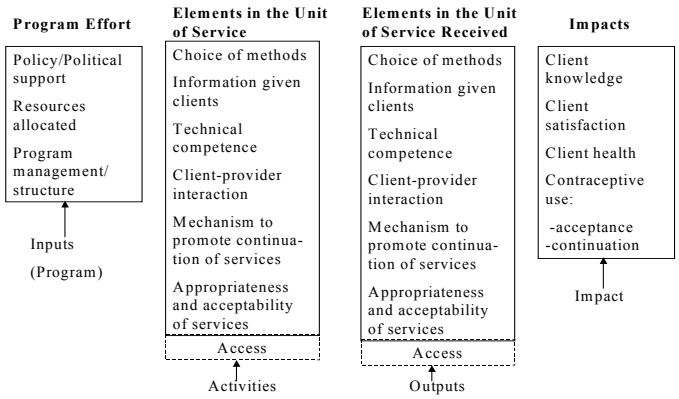
Figure 3
Causal Pathway Map
Concurrent with Bruce Framework




The Bruce quality of care approach is the central framework guiding our work in the present evaluation project. The Bruce framework has at least four main advantages over other efforts to evaluate the quality of family planning care. First, in contrast to other quality of medical care frameworks (e.g., Donabedian and others), Bruce's framework is tailored specifically to family planning. Second, the Bruce framework provides a comprehensive framework for evaluating the interpersonal dimension of quality of care and for developing appropriate indicators, a perspective that has been lacking in most other quality frameworks. Third, the Bruce framework focuses attention on the actual *process* of service provision, as opposed to a primary focus upon service structure (e.g., staffing, equipment) or service outputs (e.g., number of contraceptive users, unintended pregnancy). Finally, the Bruce quality framework takes as a central focus the perspectives and direct experiences of clients themselves with the service process.

The Bruce framework consists of six main elements, which are assessed in the causal pathway model as activities and outputs as shown in Figure 4:

Figure 4: Causal Pathway and Bruce Framework




*1) Choice of methods*: number of contraceptive methods offered on a reliable basis; methods offered to serve needs of major subgroups (age, gender, breast-feeding women); satisfactory choices for couples wishing to space/limit births; no unnecessary restrictions upon methods

2) *Information to clients:* information provided to clients during service interactions which allows clients to choose and use contraception with competence and satisfaction. This includes information about method contraindications, method advantages and disadvantages, how to use selected method, potential side effects, and continuing care from service providers.

3) *Technical competence*: providers' clinical techniques; observance of protocols; and asepsis in clinical conditions

4) *Interpersonal relations*: the degree of empathy; trust/ rapport, confidentiality/ privacy; and sensitivity by provider to the client's needs.

5) *Mechanisms for encouraging continuity and follow up*: encouraging continuity of use through well-informed users/formal program mechanisms. Mechanisms could include both mass media and client-based follow-up mechanisms (return appointments, home visits to clients)

6) *Appropriate constellation of services*: the extent to which family planning services are situated to be convenient and acceptable to clients. This includes their accessibility (distance, timing, cost) and the degree of integration with other services (vertical, integrated with maternal and child health services, comprehensive reproductive health services).

The causal pathway model was used in this project to provide an overview of the context in which decisions about performance indicators were made using the Bruce framework. As noted above, the two components of the causal model that were addressed using the Bruce framework were activities and outputs. Included under activities was a measure of access to services which has not been a central domain

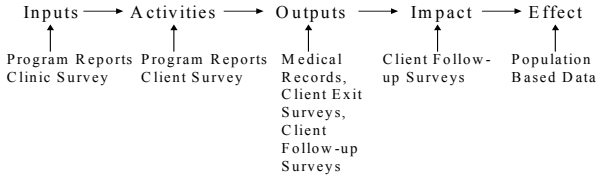
measured in the Bruce framework. In addition, a limited number of indicators were selected that represented the impact of the activities and outputs on the clients served, such as clients' continued use of contraceptive methods and unintended pregnancy. In this report, the appropriate constellation of service components terminology in the Bruce framework was also changed to the appropriateness and acceptability of services.

## Measurement of Quality

Information used to evaluate the quality of care is usually gathered through administrative data, medical records, and client surveys. In order to facilitate the process of selecting indicators for assessing the quality of family planning services, the six components of the Bruce framework were organized by data source so that state professionals could understand the usefulness of each source. The sources of data that were emphasized included clinic surveys, medical records data, client exit surveys and client follow-up surveys. Figure 5 shows where the data sources are used along stages of the causal pathway model.

Figure 5

Causal Pathway Map
Data Sources




Within each source of data, the domain in the Bruce framework and specific performance indicator measuring the domain was listed, although not all domains could be measured for each source. This approach enabled the state family planning program directors to assess priorities for data collection, potential costs of obtaining the data, and the timing of feasibility of obtaining data on the indicator for all six states in the region. A set of recommended indicators were presented to the state directors and from this set, the directors discussed and decided on which indicator(s) to use for each domain for each data source.

## Family Planning Performance Indicators

The complete list of performance indicators determined by the WCHPC team at Johns Hopkins University and the Region VIII state family planning program directors is

presented in Table 1. In this table, the potential data sources for each indicator and the capacity of each state with regard to the data source and indicator is shown. Tables 2, 3, 4 and 5 separate the indicators by the sources of data: clinic survey (Table 2), medical records (Table 3), client exit surveys (Table 4) and client follow-up surveys (Table 5), respectively. In these tables, comments are included about the potential questions or approach to measuring each indicator, along with the current capacity of each state to obtain the indicator.

### *Clinic Surveys*

For the ease of understanding the specific indicators recommended within the Bruce framework domains, they are presented in the figures by source of data. Figure 6 shows the domains in the Bruce framework related to activities that can be measured using data from program reports and clinic surveys. Domains for inputs are also available from these sources of data but were not included as part of the project as they are not specifically measures of performance. The four domains of the Bruce framework that can be measured, in part, using clinic surveys are: choice of methods, information given to clients, technical competence of providers and mechanisms to promote continuation of services. Access, not specifically included in the framework, can also be measured using clinic surveys. Figure 6 also shows that outputs and impact are not measured using data from clinic surveys.

Figure 6: Source of Data: **Program Reports & Clinic Survey**

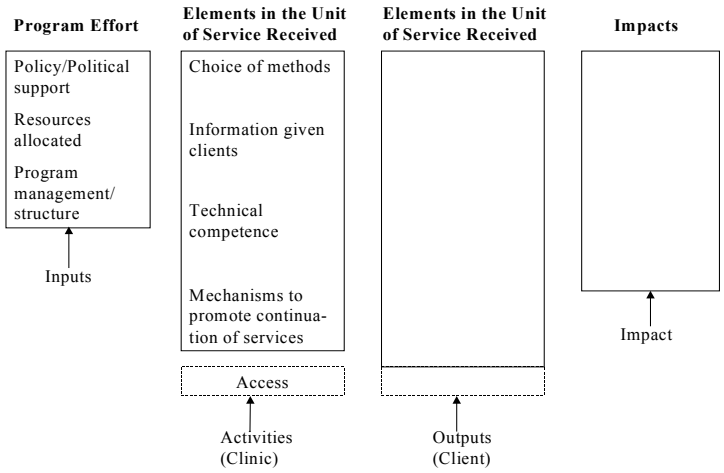
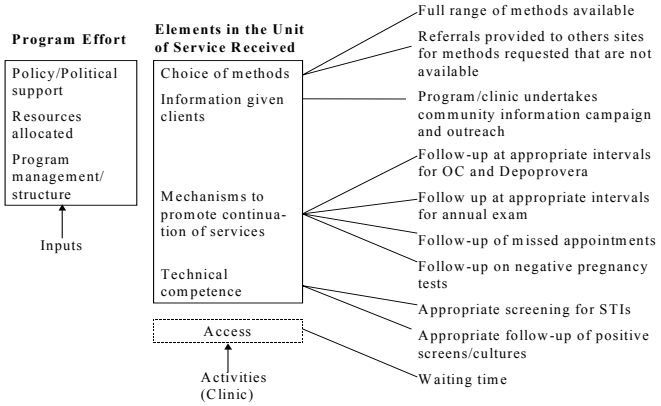



Figure 7 shows the specific indicators recommended for the five domains that can measured using clinic surveys. The choice of methods includes an indicator of whether the full range of methods are available at each clinical site and whether or not referrals to other sites are made for methods requested but not available at the site. The information given to clients focused on a clinic level measure, whether or not the clinic undertakes community information and outreach campaigns. Under the mechanisms to promote

continuation of services, two indicators were recommended related to appropriate follow-up procedures for oral contraceptives and injectables and annual exams, and two others related to follow-up on missed appointments and negative pregnancy tests. Technical competence indicators from clinic surveys include whether or not screening procedures for sexually transmitted infections (STIs) were appropriate and whether or not follow-up on positive screenings or cultures for STIs was appropriate. The final indicator, related to access, is waiting time for an appointment.

Figure 7: Source of Data: **Program Reports & Clinic Survey**




## *Medical Records*

Figure 8 presents the output domains of the Bruce framework that can be measured through data obtained from medical records. Three domains of the framework - choice of methods, mechanisms to promote continuity of services and appropriateness and acceptability of services - along with access can be measured through medical or client visit records at clinical sites.

Figure 8: Source of Data: **Medical Records**

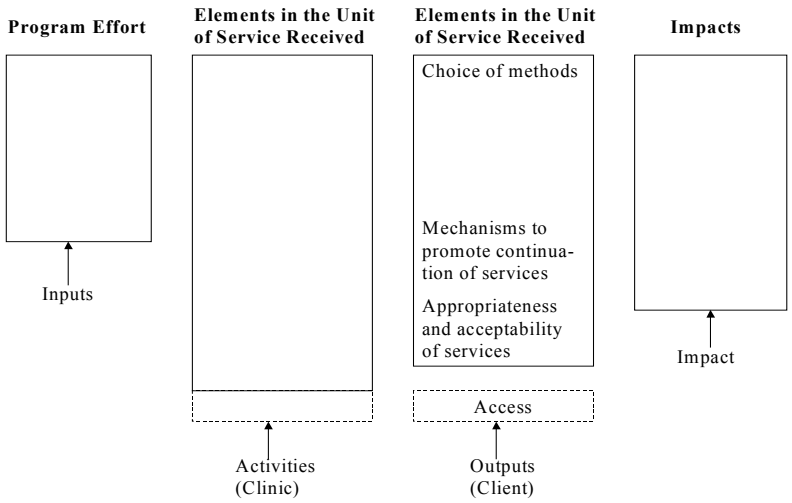
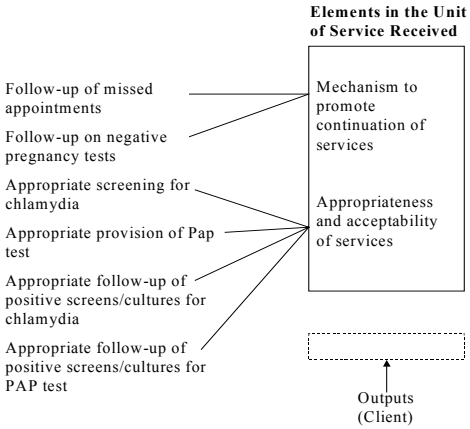


Figure 9 shows the indicators for two of the four domains: mechanisms to promote continuity of care and appropriateness and acceptability of services. It was our view that method choice was better assessed through client surveys than using medical records data. Follow-up of missed appointments and of negative pregnancy tests are recommended to be tracked from medical records. A study of procedures surrounding chlamydia screening is being conducted in the region, accounting for its prominence in the recommended indicators. The appropriateness and acceptability of services indicators include appropriate screening procedures for chlamydia, appropriate provision of PAP tests, appropriate follow-up on positive screens or cultures of chlamydia and for positive

Figure 9: Source of Data: **Medical Records**

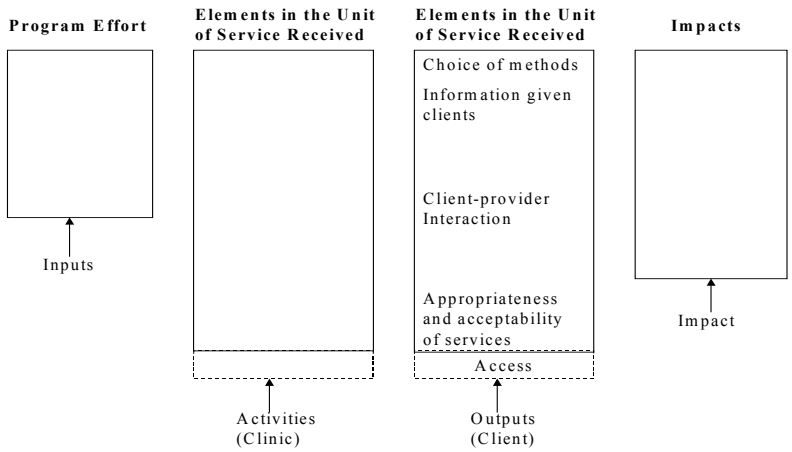



PAP tests.

## *Client Exit Surveys*

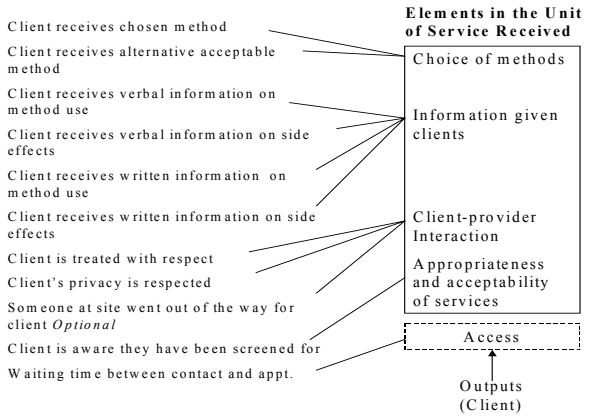
Figure 10 shows the four Bruce framework output domains: choice of methods, information given to clients, client-provider interaction, and appropriateness and acceptability of services, that are recommended for measurement using client exit surveys.

Figure 10: Source of Data: **Client Exit Interviews**



Access can also be assessed through these exit surveys. The aspects of choice of methods, as shown in Figure 11 and assessed by indicators from client exit surveys, are whether or not the client received her chosen method; if not, whether or not the alternative was acceptable. Indicators related to information given to clients include both verbal and written information about how to use their chosen method and about side effects. Client-provider interaction indicators include aspects of care related to treating the client with respect, and offering privacy. An optional indicator assessed whether someone at the clinic went out of the way for the client.

Figure 11: Source of Data: **Client Exit Interviews**

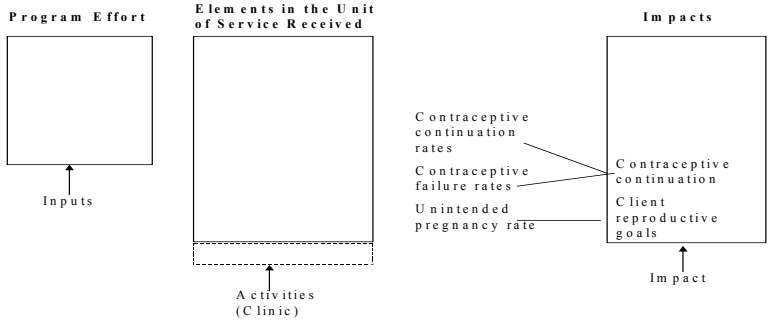



Appropriateness of service indicators involve whether or not the client was examined, whether or not the exam or procedures were described to her during the visit, and whether or not she was told the results for the exam or procedures. The access indicator includes the waiting time of the client from contact with the clinic and their scheduled appointment.

### *Client Follow-up Surveys*

The final data source, client follow-up surveys, was viewed by the family planning program directors as an important data source primarily because it provides measures of the impact of the services received by clients. Most measures related to the outputs of care, however, can be assessed using exit surveys. Figure 12 shows that the indicators selected by the family planning program directors involved measures of contraceptive continuation and failure rates, and rates of unintended pregnancy, all requiring subsequent follow-up surveys.

Figure 12
Source of Data: **Client Follow-up Surveys**



# PART II

Part II of this report addresses the third objective of the project - to provide a work plan to collect data for measuring the agreed-upon family planning performance indicators. It focuses on the information recommended to be obtained from three sources of data to measure the indicators described in Part I; these sources are clinic surveys, medical records, and client exit interviews. For each data source, the specific questions to be asked or data elements to be obtained are provided, along with a description of the approach to be taken for obtaining the data, particularly sampling methods and data collection procedures.

## Clinic Surveys

### *Sampling*

The unit of analysis for sampling differs for the clinic survey, medical records and client exit interviews. For the clinic survey, clinics are the obvious unit of analysis.

The choice of the sample for the estimation of each indicator depends on the data source, how often it is feasible to obtain data, and the availability of data in a given state. For the clinic surveys, it is preferable to obtain data about all clinical sites during a specified time period, most commonly a fiscal or calendar year. If this is not possible, then a sample of clinics can be selected. If possible, this sample should be representative of all clinics in a state with regard to geographic location, volume of patients, and any other factors that may influence the services provided and policies at a site. If the sample is known to not be representative, then the ways in which it departs from the general characteristics of sites in the state needs to be acknowledged.

### *Data collection*

There are several formats for obtaining clinic survey data, including: by telephone, through a self-administered mailed survey, and through in-person interviews. Obtaining data from mailed surveys or by telephone is the least costly approach, unless the clinic survey can be incorporated into ongoing activities such as quality assurance visits. Although mailed surveys often have low response rates, incentives to obtain data from sites can be used; for example, the completion of the survey could be a contingency for approval of the operating budget for the coming year. Another limitation of data from mailed surveys is that there is little opportunity to validate the data; alternatives to mailed surveys, therefore, may be preferable in this regard.

In-person interviews may provide more valid data than telephone or mailed questionnaires as it is possible to also observe the clinic and its operations during visits to the site to conduct the interviews. They also provide the opportunity to clarify questions and probe for answers. There may, however, be some bias introduced from in-person interviews because of the increased likelihood of socially desirable responses by the

respondent. Moreover, because the visit to conduct interviews usually needs to be prescheduled in order to assure a good response rate, clinic staff and operations may be more favorably presented than they would be if the visit were not known beforehand.

A combination of methods may be used to improve response rates and to validate data from clinic surveys. For example, mailed surveys could be used as a first approach with follow-up by telephone or in-person interviews at sites where surveys were not returned or where there are missing or suspect data. This approach also is less costly than conducting on-site interviews and may make it feasible to collect data from all clinics in a year, rather than relying solely on quality assurance visits to conduct in-person interviews. The survey format could vary yearly by site to ensure that data are collected through in-person interviews at all sites periodically. Regardless of the format, the data from the clinic survey should be obtained to reflect a uniform time period.

Attachment 1 includes the content of questions that can be used to obtain data for the performance indicators described in Part I from the clinic survey. They cover four domains from the Bruce framework: choice of method; approaches to support continuation of care; technical aspects of care, as measured by appropriate follow-up procedures; and access. The specific questions can be linked to the family planning indicators from clinic survey data using the information provided in Table 2 in Part I of this report. Moreover, Appendix C contains a list of the advantages and disadvantages of the sources of data described here.

The clinic survey does not include questions about the performance indicators related to the guidelines for follow-up of sexually transmitted infections (STIs). They were not included because of their variability across states and because of the lack of information about the guidelines used in some of the states. Accordingly, it is recommended that either 1) each state develop its own questions for clinics about the guidelines or 2) the six states in Region VIII negotiate the specific guidelines that they think should be assessed at each clinic. The questionnaire also does not include the number of outreach activities that each clinic undertook as this information should be available from reports from the clinics about their activities in the past year.

The questionnaire is designed so that the respondent or interviewer can check the box indicating the appropriate response to a question. It does not include a specific numeric code for the responses to the questions as state staff may have particular coding conventions that they prefer; for example, some states may prefer to code no/yes response categories as 0,1, respectively, while others may prefer to code them as 1,2. This approach is used for data collection from all three sources.

## Medical Records

### *Unit of Analysis*

The unit of analysis for the performance indicators from medical records data should theoretically be the client since the care provided to each client is of primary interest. Nevertheless, it is not always possible to follow each client from visit to visit using the available data sources. For example, client visits are often compiled for a site during a given time period through computerized client visit records. While client visit records have the advantage of providing data on all visits for a given time period, it is often not possible to link these records by a unique identifier for each client unless the data collection system was developed to do so. If the records cannot be linked, then the unit of analysis is the visit rather than the client.

The second approach to compiling data from medical records is through abstracting data from the clinic records of individual clients. Here, the unit of analysis is the client; medical record abstraction has the advantage over clinic visit records without unique client identifiers in that the data can be collected and organized by visit for each individual client. It also provides the opportunity to obtain data that might not be included in computerized client visit records (CVR); the information that is included on the form used for input to the CVR database may not include information to measure the performance indicator. Use of medical records to obtain information about services received by clients has the disadvantage of requiring that a careful sampling process be undertaken to obtain the records to be abstracted.

***Sampling***

Sampling approaches differ for each format of data collection about visits by clients; that is, these approaches vary by whether or not there is a computerized CVR with no unique client identifier, whether there is a CVR with a unique identifier or if medical records are to be abstracted. If a computerized CVR is available without a unique client identifier, then the sampling unit during a given time period, most likely a year, should be based on the type of visit; the specific performance indicators are generally tied to the type of visit. For example, the indicator related to the performance of PAP tests refers to first visits or annual visits. Similarly, screening measures should be captured for all visits except those that are indicated to be a follow-up visit.

When there is a CVR system with unique client identifiers, then the sample for assessment of the indicators should be all women who made a specific type of visit to a Title X site during a given year, as consistent with the specific indicator. The type of visit can be searched for each woman and used to form the denominator for the specific indicator. Follow-up can be directly assessed by the linkage of a visit in which an abnormal PAP or a positive chlamydia screen was noted with follow-up visits to determine the percentage of women with appropriate follow-up for each respective problem.

The sample for the indicators from medical records where there is no computerized CVR requires a sampling strategy that minimizes costs while maximizing validity. Sampling is conducted in two stages. First, it is optimal to obtain a sample of women who received care from *all Title X sites* during a given time period. Where this is

not possible, then the *sampling strategy for selecting sites* should be similar to the one for the clinic survey; that is, the sites should be *representative* of all sites, as much as possible, on geographic location, volume of services and other important factors. To reduce the costs associated with this approach, the data could be abstracted at the time of quality assurance (QA) visits to clinics that are done periodically in all states in Region VIII.

Second, it is necessary to *sample women within sites for medical record abstraction*. The approach here is not straightforward, and involves determining an adequate sample size, the women who should be sampled, and the information needed to draw a sample. With regard to sample size, the objective of the sampling should be to obtain at least 20 women represented for each performance indicator at small sites and 40 at large sites during a given time period. Given the variation in the ability of the states in Region VIII to achieve a sample of women for the indicators, these numbers are recommended as a pragmatic approach to obtaining the data. It is also recommended that data be aggregated over a three year period as, at least in one state, QA visits are only made to about one-third of sites yearly. In states were data are available annually, the above numbers should be adequate. In states in which data cannot be obtained from all sites yearly, it might be prudent to increase the sample to 30-40 for small sites and 60-80 for larger ones to increase the stability of the performance indicator estimates.

Sampling of medical records is complicated by the fact that each performance indicator is targeted to a particular kind of visit, but medical records are seldom organized in this manner. The most frequent information available for sampling comes from visit logs or administrative or billing records. Because these records generally are organized by whether or not a visit was made, over-sampling of all women with a visit during a given time period may be needed to achieve the targeted sample size for a given indicator. For example, performance of a PAP test at annual or initial visits must include women with these types of visit. In this case, a sample could be identified from visit logs or other administrative information at the site which included women with any visit, with over-sampling (based on the ratio of all visits to first or annual visits at the site) to assure adequate numbers of women with first or annual visits. The medical records of all sampled women with a visit would need to be inspected, but only women with annual or initial visits would be included in the final sample for the indicator.

Sampling for the indicators evaluating follow-up of abnormal or positive tests would be more efficiently conducted using information from other sources. For example, for abnormal PAP tests, the sample would likely be identified through laboratory results, while the sample for positive cultures for chlamydia would be identified through the on-going chlamydia study in the region. In each case, it would be best to obtain at least 20 women for each indicator, although it may not be feasible for these indicators at small sites.

A final issue in the selection of the sample involves who is responsible for and determines the manner by which the sample is identified and drawn at each site. Although it is important to be flexible in addressing variations across Title X sites in the

ease by which a sample can be identified and selected, it should not be determined by the site. Criteria should be established based on information available about clients either through visits logs, billing records or any other administrative sources related to clients that would minimize introduction of selection bias into the sample. For example, a time period could be identified during which clients making a visit to the site were identified and a sample drawn starting at the beginning of the time period. A list of eligible women would then be generated for accessing and abstracting medical records data.

The next step is to determine how the sample will actually be drawn. If the numbers are adequate, then a proportional sample could be selected; for example, a one in two sample for sites where there are at least twice as many clients seen as needed in the sample for the time period. Data for the women in the sample would be abstracted until the desired sample size were achieved. While it is optimal to have individuals other than staff at the site enumerate the sample, it may not be possible to do this. If it is not, it is still important for the data abstractors to verify that the sampling process is a valid one.

***Data Collection***

The data collection form for abstraction of medical records is shown in Attachment B. It includes data on visit type, screening for chlamydia, provision of a PAP test and whether or not a pregnancy test was performed and the results. These data are first obtained on a separate visit abstraction form for the visit in which the test or screen was conducted. Any follow-up visits or contacts made about the results of the screens are then collected separately for follow-up visits using the same data collection form. The forms for each visit are linked to an individual client through a unique identification number assigned to the client's record at the time of data abstraction. The data on chlamydia include whether or not a woman was treated presumptively or whether or not she was contacted by visit or telephone following a positive screen. The data for negative pregnancy tests are optional for each state, and include data collected at the visit in which the test was performed and found to be negative, and a follow-up visit for contraception.

In the case of a CVR with a client identifier, it is possible to obtain data for the performance indicators for the initial or annual visit first and, then, to evaluate the results of PAP tests and screen following the initial visit to create the specific technical competence indicators. The performance indicators that may be difficult to assess from a CVR with no client identifier are those related to follow-up of an abnormal PAP or positive screen for chlamydia, as records cannot be linked by client. These indicators must be assessed indirectly from the available data. It is possible to count the number of women who, for example, had a positive culture for chlamydia as the denominator for the latter indicator and to count the number of follow-up visits from the CVR for chlamydia as the numerator. A similar approach can be used for PAP tests.

**Client Exit Surveys**

### *Sampling*

By definition, client exit surveys refer to surveys conducted on clients as they exit the clinic from a visit; the unit of analysis is the client. A sampling strategy is needed to define which clients are eligible for the exit surveys during a specified time period. For clinics with a large volume of clients, it would be best to take a sample of women seen at the clinic on any given day, even if the survey is self-administered. This would eliminate the influence of day-to-day variability in the provision of care at the clinic. It is also important to identify women appropriate for the sample, as the performance indicators to be obtained from exit interviews draw heavily on method choice, procedures performed, and information provided to the client about methods and procedures. Here, the clients of interest are primarily women who attend the clinic for contraception, with the focus largely on new clients and clients returning for an annual visit or a contraception follow-up.

As with medical records, a sample size estimate is needed for each site. Again, a minimum of 20 women at small site and 40 at larger sites is recommended. Unlike medical records data, however, these surveys are not recommended to be completed every year, but rather every 3-4 years. The ultimate sample size at each site is dependent on resources available in both money and personnel to conduct the survey and the feasibility of obtaining data through self-administered questionnaires. In the case where is it is feasible to conduct self-administered questionnaires, a larger sample size could be obtained to increase the stability of the performance indicators at each site, perhaps 30-40 at small sites and 70-80 at larger ones.

### *Data Collection*

Client exit surveys can be completed in two different formats; a face-to-face interview and a self-administered form. The face-to-face interview has the advantage that the interviewer reads the question to the respondent, so that the level of literacy of the respondent does not interfere with obtaining the data. Where literacy is not a major problem, the self-administered form can be used. In the face-to-face interview, the interviewer can assure, to the extent the respondent is willing to answer questions, that the questionnaire is completed; this is only possible with self-administered forms if the forms are inspected after the client completes the questionnaire and before she leaves the clinic, or if a telephone follow-up is made to complete unanswered questions. This latter approach is much less costly, and provides the opportunity, because of the lower cost, to obtain data on more clients.

Attachment C shows the questions to be included on a client exit questionnaire and Table 4 in Part I links the questions to the performance indicators. In addition to the questions about method choice, procedures and information given to the client about them during the visit, the questionnaire also asks the client about how she was treated by clinic staff and whether or not her privacy was respected during examinations and consultation with the provider. Access items are included and cover not only waiting time for an appointment and while at the clinic but also the convenience of the clinic

hours and travel time to the clinic. A few satisfaction questions are included as optional, as there are no specific performance indicators associated with them.

**Table 1: PERFORMANCE INDICATORS FOR FAMILY PLANNING PROGRAMS**

| INDICATOR AGREED UPON | POTENTIAL DATA SOURCES | STATE CAPABILITY |
|---|---|---|
| **Choice of Method** | | |
| Full range of methods available | Clinics required to report on this – Policy and Procedures | Assume all states do or will conduct clinic survey |
| Referrals provided to other sites | Clinic survey - Policy and Procedures | Assume all states do or will conduct clinic survey |
| Client receives chosen method | Client exit interviews | SD-not on current survey<br>ND-not on current survey<br>UT- no<br>CO- no- satisfaction survey only<br>MT- survey not at state level<br>WY-yes? need survey |
| Client receives method acceptable to her | Client exit interviews | SD-not on current survey<br>ND-not on current survey<br>UT- no<br>CO- no- satisfaction survey only<br>MT- survey not at state level<br>WY-yes? need survey |
| **Information Given to Clients** | | |
| Program or clinic undertakes community information campaign and outreach | Clinic survey - Policy and Procedures | Assume all states do or will conduct clinic survey |
| Client was given verbal information on method use | Client exit interview | SD- yes<br>ND- yes<br>UT- no<br>CO- no- satisfaction survey only<br>MT- survey not at state level<br>WY- yes? need survey |
| Client was given verbal information on side effects of method | Client exit interview | SD- yes but not specific<br>ND- yes but not specific<br>UT- no<br>CO- no- satisfaction survey only<br>MT- survey not at state level<br>WY- yes? need survey |

| INDICATOR AGREED UPON | POTENTIAL DATA SOURCES | STATE CAPABILITY |
|---|---|---|
| Client was given written information on method use | Client exit interview | SD- not clear from survey<br>ND-not clear from survey<br>UT- no<br>CO- no- satisfaction survey only<br>MT- survey not at state level<br>WY- ? need survey |
| Client was given written information on side effects on side effects | Client exit interview | SD- no specific question<br>ND- no specific question<br>UT- no<br>CO- no- satisfaction survey only<br>MT- survey not at state level<br>WY- ? need survey |
| **Technical Competence** | | |
| Appropriate screening procedures for STIs | Clinic survey - Policy and Procedures | Assume all states do or will conduct clinic survey |
| Appropriate follow up on positive screens and cultures | Clinic survey - Policy and Procedures | Assume all states do or will conduct clinic survey |
| **Client Provider Interaction** | | |
| Client was treated with respect and courtesy | Client exit interview | SD- yes<br>ND- yes<br>UT- no<br>CO- yes? Need survey<br>MT- survey not at state level<br>WY- yes? Need survey |
| Client's privacy was respected | Client exit interview | SD- yes<br>ND- yes<br>UT- yes? need survey<br>CO- yes? need survey<br>MT- survey not at state level<br>WY-yes? need survey |

| INDICATOR AGREED UPON | POTENTIAL DATA SOURCES | STATE CAPABILITY |
|---|---|---|
| **Mechanism to Promote Continuation of Services** | | |
| Follow up at appropriate intervals for annual exam | Clinic survey - Policy and Procedures | Assume all states do or will conduct clinic survey |
| Follow up at appropriate intervals for oral contraceptives | Clinic survey - Policy and Procedures | Assume all states do or will conduct clinic survey |
| Follow up on missed appointments | Clinic survey - Policy and Procedures | Assume all states do or will conduct clinic survey |
| Follow up on negative pregnancy test | Medical records and/or Clinic survey - Policy and Procedures | Assume all states do or will conduct clinic survey |
| **Appropriateness and Acceptability of Services** | | |
| Appropriate screening for Chlamydia | Medical records, Special Chlamydia Project | SD- does audit on 1/3 of clinics/yr<br>ND- CVR ok<br>UT- need to see CVR<br>CO- medical chart audits<br>MT- not covered on current CVR--are they changing CVR?<br>WY- need to see CVR |
| Appropriate provision of Pap test (timing at initial and annual exam) | Medical records | SD<br>ND-has CVR computerized<br>UT- has CVR computerized<br>CO<br>MT- has CVR computerized<br>WY- has CVR computerized |
| Appropriate follow up on positive screens and cultures for Chlamydia | Medical records | SD<br>ND- has CVR computerized<br>UT- has CVR computerized<br>CO<br>MT- has CVR computerized<br>WY- has CVR computerized |
| Appropriate follow up on positive screens and cultures for Pap test | Medical records | SD<br>ND- has CVR computerized<br>UT- has CVR computerized<br>CO<br>MT- specific form-- Is it useful?<br>WY- has CVR computerized |

| INDICATOR AGREED UPON | POTENTIAL DATA SOURCES | STATE CAPABILITY |
|---|---|---|
| Client knows they have been screened | Client exit interview | SD- not specific<br>ND- not specific<br>UT- ? need survey<br>CO- ? need survey<br>MT- survey not at state level<br>WY ? need survey |
| **Access** | | |
| Waiting time between client's contact and date of appointment | Clinic survey – Policy and Procedures<br>Client exit interview | Assume all states do or will conduct clinic survey<br>SD- yes?<br>ND- yes<br>UT- yes? need survey<br>CO- yes? need survey<br>MT- survey not at state level<br>WY- no |
| **Outcome Measures** | | |
| Contraceptive continuation rates | Client follow up survey<br><br>BRFSS | No states currently conduct follow-up surveys<br><br>SD- BRFSS results summarized for program (disproportionate stratified sampling, >18 years)<br>ND- BRFSS select data analyzed by program<br>UT- BRFSS not conducted in FP<br>CO- BRFSS results summarized for program (random digit dial >18years)<br>MT- BRFSS results summarized for program, uses FP module developed by CDC<br>WY- BRFSS select data analyzed by state health dept. |

| INDICATOR AGREED UPON | POTENTIAL DATA SOURCES | STATE CAPABILITY |
|---|---|---|
| Contraceptive failure rates | Client follow up survey<br><br>BRFSS | No states currently conduct follow-up surveys<br><br>SD- BRFSS results summarized for program (disproportionate stratified sampling, >18 years)<br>ND- BRFSS select data analyzed by program<br>UT- BRFSS not conducted in FP<br>CO- BRFSS results summarized for program (random digit dial >18years)<br>MT- BRFSS results summarized for program, uses FP module developed by CDC<br>WY- BRFSS select data analyzed by state health dept. |
| Unintended pregnancy rates | Client follow up survey<br><br>BRFSS<br><br><br><br><br><br>PRAMS | No states currently conduct follow-up surveys<br><br>SD- BRFSS results summarized for program (disproportionate stratified sampling, >18 years)<br>ND- BRFSS select data analyzed by program<br>UT- BRFSS not conducted in FP<br>CO- BRFSS results summarized for program (random digit dial >18years)<br>MT- BRFSS results summarized for program, uses FP module developed by CDC<br>WY- BRFSS select data analyzed by state health dept.<br><br>SD has survey similar to PRAMS<br>CO-PRAMS, stratified random sample of births during specified time period (rural, urban, LBW, adequate PNC) |

**Table 2: PERFORMANCE INDICATORS FOR FAMILY PLANNING PROGRAMS CLINIC SURVEY – POLICY AND PROCEDURES**

| INDICATOR | DATA BY STATE | INFORMATION NEEDED |
|---|---|---|
| **Choice of Method** | | |
| Full range of methods available | Assume all states do or will conduct clinic survey | List all methods and indicate if available at clinic |
| Referrals provided to other sites | Assume all states do or will conduct clinic survey | Categories: (1) on site, (2) off site/referral-paid, (3) off site/referral-unpaid |
| **Information Given to Clients** | | |
| Program or clinic undertakes community information campaign and outreach | Assume all states do or will conduct clinic survey | How many community education sessions conducted? Where are sessions conducted? Topics? How many attendees? Age/gender of attendees? |
| **Technical Competence** | | |
| Appropriate screening for STIs | Assume all states do or will conduct clinic survey | **Are you following established screening protocols for STIs? Y/N (M.K. recommends removing)**<br>A series of questions can be developed based on state protocols |
| Appropriate follow up on positive screens and cultures | Assume all states do or will conduct clinic survey | Are state guidelines for follow-up followed at clinic? |
| **Mechanism to Promote Continuation of Services** | | |
| Follow up at appropriate intervals for annual exam | Assume all states do or will conduct clinic survey | What do you do to assure appropriate, timely follow-up? Annual follow-up contact/ annual exam card? |
| Follow up at appropriate intervals for OC prescriptions | Assume all states do or will conduct clinic survey | What do you do to ensure that women continue to get back to clinic for OC? |
| Follow up at appropriate intervals for Depo. | Assume all states do or will conduct clinic survey | What do you do to ensure that women continue to get back to clinic for Depo? |
| Follow up on missed appointments | Assume all states do or will conduct clinic survey | Are there procedures in place to follow-up on missed appointments? |
| Follow up on negative pregnancy test | Assume all states do or will conduct clinic survey | |

| INDICATOR | DATA BY STATE | INFORMATION NEEDED |
|---|---|---|
| **Access** | | |
| Waiting time between client's contact and date of appointment | Assume all states do or will conduct clinic survey | **Series of questions:** If a first time client calls today, how long would she have to wait for her appointment?<br>Are there particular times of the year during which her wait would be longer? Shorter?<br>Does your clinic accept walk-ins?<br>What are clinics business hours?<br>Can a client pick up supplies anytime?<br>What type of triage is used to ascertain the time-sensitivity of a client's need for an appointment? |

Issues raised in review of Clinic Survey:

1. Technical Competence - When asking a clinic if appropriate screening was done based on established protocols, the answer will invariably be "Yes." A better way to ask would be to develop a series of questions based on individual state protocols.

2. Access – Measures of access should include more than just waiting time. Add question about clinic hours.

3. Information Given to Clients – Should include more than community outreach.

## Table 3: PERFORMANCE INDICATORS FOR FAMILY PLANNING PROGRAMS
**MEDICAL RECORDS**

| INDICATOR | DATA BY STATE | INFORMATION NEEDED |
|---|---|---|
| **Choice of Method** | | |
| Full range of methods available | Assume all states do or will conduct clinic survey | List all methods and indicate if available at clinic |
| Referrals provided to other sites | Assume all states do or will conduct clinic survey | Categories: (1) on site, (2) off site/referral-paid, (3) off site/referral-unpaid |
| **Information Given to Clients** | | |
| Program or clinic undertakes community information campaign and outreach | Assume all states do or will conduct clinic survey | How many community education sessions conducted? Where are sessions conducted? Topics? How many attendees? Age/gender of attendees? |
| **Technical Competence** | | |
| Appropriate screening for STIs | Assume all states do or will conduct clinic survey | **Are you following established screening protocols for STIs? Y/N (M.K. recommends removing)**<br>A series of questions can be developed based on state protocols |
| Appropriate follow up on positive screens and cultures | Assume all states do or will conduct clinic survey | Are state guidelines for follow-up followed at clinic? |
| **Mechanism to Promote Continuation of Services** | | |
| Follow up at appropriate intervals for annual exam | Assume all states do or will conduct clinic survey | What do you do to assure appropriate, timely follow-up? Annual follow-up contact/ annual exam card? |
| Follow up at appropriate intervals for OC prescriptions | Assume all states do or will conduct clinic survey | What do you do to ensure that women continue to get back to clinic for OC? |
| Follow up at appropriate intervals for Depo. | Assume all states do or will conduct clinic survey | What do you do to ensure that women continue to get back to clinic for Depo? |
| Follow up on missed appointments | Assume all states do or will conduct clinic survey | Are there procedures in place to follow-up on missed appointments? |
| Follow up on negative pregnancy test | Assume all states do or will conduct clinic survey | |

| INDICATOR | DATA BY STATE | INFORMATION NEEDED |
|---|---|---|
| **Access** | | |
| Waiting time between client's contact and date of appointment | Assume all states do or will conduct clinic survey | **Series of questions:** If a first time client calls today, how long would she have to wait for her appointment?<br>Are there particular times of the year during which her wait would be longer? Shorter?<br>Does your clinic accept walk-ins?<br>What are clinics business hours?<br>Can a client pick up supplies anytime?<br>What type of triage is used to ascertain the time-sensitivity of a client's need for an appointment? |

Issues raised in review of Clinic Survey:

1. Technical Competence - When asking a clinic if appropriate screening was done based on established protocols, the answer will invariably be "Yes." A better way to ask would be to develop a series of questions based on individual state protocols.

2. Access – Measures of access should include more than just waiting time. Add question about clinic hours.

3. Information Given to Clients – Should include more than community outreach.

## Table 4: PERFORMANCE INDICATORS FOR FAMILY PLANNING PROGRAMS
### CLIENT EXIT INTERVIEWS

| INDICATOR | DATA BY STATE | INFORMATION NEEDED |
|---|---|---|
| **Choice of Method** | | |
| Client receives chosen method | SD-not on current survey<br>ND-not on current survey<br>UT- no<br>CO- no- satisfaction survey only<br>MT- survey not at state level<br>WY-yes? need survey | Did you receive the method you wanted? |
| Client receives method acceptable to her | SD-not on current survey<br>ND-not on current survey<br>UT- no<br>CO- no- Satisfaction survey only<br>MT- survey not at state level<br>WY-yes? need survey | If method received is not chosen method, is the method you received acceptable to you? If not, why is it unacceptable?<br><br>*Or: Did you receive a method that is acceptable to you? If not, why is it unacceptable? (M.K. recommends removing)* |
| **Information Given to Clients** | | |
| Client was given verbal information on method use | SD- yes<br>ND- yes<br>UT- no<br>CO- no. Satisfaction survey only<br>MT- survey not at state level<br>WY- yes? need survey | Were you told how to use the method? |
| Client was given verbal information on side effects of method | SD- yes but not specific<br>ND- yes but not specific<br>UT- no<br>CO- no. Satisfaction survey only<br>MT- survey not at state level<br>WY- yes? need survey | Were you told what the side effects are? |
| Client was given written information on method use | SD- not clear from survey<br>ND-not clear from survey<br>UT- no<br>CO- no. Satisfaction survey only<br>MT- survey not at state level<br>WY- ? need survey | Were you given written materials about the method use and side effects? |

| INDICATOR | DATA BY STATE | INFORMATION NEEDED |
|---|---|---|
| Client was given written information on side effects | SD- no specific question<br>ND- no specific question<br>UT- no<br>CO- no. Satisfaction survey only<br>MT- survey not at state level<br>WY- ? need survey | See above |
| **Client Provider Interaction** | | |
| Client was treated with respect and courtesy | SD- yes<br>ND- yes<br>UT- no<br>CO- yes? Need survey<br>MT- survey not at state level<br>WY- yes? Need survey | Specific questions can be asked about front desk, exam room etc. Add questions relating to courtesy and respect at time of appointment, at reception, from nurse, and from phsycian |
| Client's privacy was respected | SD- yes<br>ND- yes<br>UT- yes? need survey<br>CO- yes? need survey<br>MT- survey not at state level<br>WY-yes? need survey | When you were asked to share sensitive information, did you feel your privacy was respected?<br><br>And/or: Were you comfortable during consultation that information was not overheard? |
| Someone went out of his or her way for client at the clinic | OPTIONAL | Did someone at the clinic go out of her/his way for you? Who was this person? |
| **Appropriateness and Acceptability of Services** | | |
| Client knows they have been screened | SD- not specific<br>ND- not specific<br>UT- ? need survey<br>CO- ? need survey<br>MT- survey not at state level<br>WY ? need survey | Was a health exam conducted?<br>Were procedures explained to you before/during?<br>Were any results of the exam explained afterward?<br>Did you have any questions?<br>Were you given an opportunity to ask your questions?<br>Were your questions answered to your satisfaction? |

| INDICATOR | DATA BY STATE | INFORMATION NEEDED |
|---|---|---|
| **Access** | | |
| Waiting time between client's contact and date of appointment | SD- yes?<br>ND- yes<br>UT- yes? need survey<br>CO- yes? need survey<br>MT- survey not at state level<br>WY- no | How long from the time you called for an appointment was the appointment made? Was this waiting time acceptable? |

Issues raised in review of Client Exit Interview

1. Method choice. Make simpler and clearer by asking "Did you receive the method you wanted? If not, was the method received acceptable? If not, why not?"

2. Expand Client was treated with respect and courtesy to gather information at the time of making the appointment, at the reception desk, by the nurse, and by the physician.

3. Tighten up the wording for "Client's privacy was respected." Suggestion: "When you were asked to share sensitive information were you given adequate privacy?"

4. Access. More than just waiting time. Clinic hours? Convenience? Transportation?

5. Client exit interviews offer the opportunity to get information on client satisfaction. Questions should be added to assess satisfaction and impact. For instance, a question could be asked whether the client would recommend the clinic to others.

## Table 5: PERFORMANCE INDICATORS FOR FAMILY PLANNING PROGRAMS
### CLIENT FOLLOW-UP SURVEY

| INDICATOR | DATA BY STATE | INFORMATION NEEDED |
|---|---|---|
| **Outcome Measures** | | |
| Contraceptive continuation rates | No states conduct follow up surveys | |
| Contraceptive failure rates | | |
| Unintended pregnancy rates | SD has survey similar to PRAMS | |

Issues raised in review

1. Information needed is not easily available. We will need to provide a model or references. CDC has good model. L. Zabin may have good model as well.

2. Unintended pregnancy rates. Retrospective or prospective measurement?

**Data Sources, Possible Data Elements, Advantages, Disadvantages, Indicators and Current Use**
**For Data Sources Routinely Available at the Clinic and Population Level**

| Data Source | Possible Data Elements | Advantages | Disadvantages | Important Indicators | Current Use |
|---|---|---|---|---|---|
| ----------Clinic Level---------- | | | | | |
| Medical Records | -Client's demographic characteristics<br>-Type of visit/reason for visit<br>-Exams, tests, procedures<br>-Compliance with standards of care<br>-Methods given/prescribed<br>-Problems/diagnoses noted<br>-Pregnancy test<br>-STI screening<br>-Problem resolution<br>-Follow-up recommendation<br>-Counseling about:<br>--side effects<br>--how to use method<br>-Counseling following a negative pregnancy test<br>-Compliance with visits<br>-Method changes over visits | -Routinely available already a source of data for Title X reporting requirements<br><br>-Provides detailed clinical information<br><br>-Can be used to follow clients longitudinally from visit to visit:<br>--compliance with visits<br>--resolution of problems<br>--method changes<br>--method continuation | -Only available for clients who make visits<br><br>-Quality of record keeping varies across sites<br><br>-Cannot access quality of Provider-client interaction<br><br>-Does not assess client's perspective | -Percentage of women with negative pregnancy test who received counseling<br>-Percentage of women with contraceptive visit who leave with a method<br>-Percentage of women with contraceptive visit who leave with a prescription for a method<br>-Percentage of women who return for a follow-up visit<br>-Percentage of women who are screened for STIs<br>-Percentage of women who receive a PAP smear<br>-Percentage of women who receive counseling about:<br>--side effects<br>--how to use method | -Source of data for Title X reporting requirements<br><br>-Source of data quality assurance audits |
| Encounter Forms | -Same as for medical records | -Can be used to obtain uniform information at each visit<br><br>-Quality control-can direct reporting of information/ procedures, directing content of care | -Require capturing most important information: prioritizing data<br><br>-Another paper form to complete<br><br>-May be complex to analyze if computerized | -Same as medical record | -?Unknown |

| Data Source | Possible Data Elements | Advantages | Disadvantages | Important Indicators | Current Use |
|---|---|---|---|---|---|
| ----------Clinic Level---------- | | | | | |
| Tracking Logs/ Appointment Logs | -Client compliance with visits | -Can be used as a means to follow-up on clients<br><br>-Very efficient when computerized | -Another process/form to complete | -Percentage of women who return for follow-up visit | -?Unknown |
| ----------Population Level---------- | | | | | |
| Abortion Surveillance | -Number of abortions by characteristics of women | -Provides a crude estimate of pregnancies when combined with birth and fetal death certificates<br><br>-Population based | -Variable quality of data<br>-Limited characteristics of women<br>-Not available in all states<br>-Not available specifically for client population | -Abortion ratio (when combined with birth and fetal death certificates) | -Three states in Region VIII |
| Birth and Fetal Death Certificates | -Fertility rates by characteristics of women | -Covers entire birth population in a given year<br><br>-Can target fertility rates for specific population groups | -Only relates to live births and fetal deaths, not all pregnancies<br><br>-Not available specifically for client population | -Teenage birth rates | -All states |

**Data Sources, Possible Data Elements, Advantages, Disadvantages, Indicators and Current Use For Periodically Collected Data at the Clinic and Population Level**

| Data Source | Possible Data Elements | Advantages | Disadvantages | Important Indicators | Current Use |
|---|---|---|---|---|---|
| **Clinic Level** | | | | | |
| Client Exit Interviews | -Satisfaction with care:<br>--treated with respect<br>--privacy/confidentiality respected<br>--question answered/ listens<br>-Congruence of method desired with method received<br>-Counseling provided:<br>--side effects of method<br>--how to use method<br>-Knowledge of:<br>--side effects of method<br>--how to use method<br>-Return/follow-up encouraged<br>--follow-up visit scheduled<br>-Waiting time to get appointment<br>-Waiting time to see provider<br>-Total time at appointment<br>-Perception of available methods<br>-Previous use of contraceptives | -Obtain information about process of care from clients' perspective<br><br>-Efficient data collection strategy<br><br>-Relatively inexpensive to collect data | -Requires separation of data collection from provision of care<br><br>-Requires additional resources<br><br>-Does not assess the technical aspects of care<br><br>-Does not assess compliance or retention<br><br>-May be difficult to analyze if interviews are long<br><br>-Subject to client courtesy bias<br><br>-Includes select group of only those seeking or continuing services | -Percentage of clients satisfied with method given<br><br>-Percentage of clients satisfied with care<br><br>-Percentage of clients who know side effects of method given<br><br>-Percentage of clients who know how to use method given | -?Unknown |

**Data Sources, Possible Data Elements, Advantages, Disadvantages, Indicators and Current Use For Periodically Collected Data at the Clinic and Population Level (Cont'd)**

| Data Source | Possible Data Elements | Advantages | Disadvantages | Important Indicators | Current Use |
|---|---|---|---|---|---|
| **Clinic Level** | | | | | |
| Client Follow-up Interviews | -Contraceptive use/ continuation<br>-Satisfaction with care at clinic<br>-Plans to return to clinic<br>-Use of other family planning sources<br>-Occurrence of pregnancy-induced abortions | -Short of a population survey, only way to get information about women who don't return to clinic or between visits there<br>-Can assess important measures like continuation rates, pregnancy rates<br>-can be less expensive if use telephone survey | -Requires additional resources to obtain/ follow hard to reach clients (important group to follow)<br>-Needs to be conducted by independent interviewers<br>-Need to draw upon standard instruments for interview<br>-May be cumbersome to analyze | -Contraceptive continuation rates<br>-Contraceptive failure rates<br>-Pregnancy rates<br>-Abortion rates | -?Unknown |
| Observations of Client Provider Interaction | -Content of visit<br>-Compliance with standards of care<br>-Provider bias about methods<br>-Provider behavior:<br>--treats client with respect<br>--describes side effects of method<br>--describes how to use the method<br>--respects client's privacy/ confidentiality<br>--confirms with client about understanding of side effects/ method use | -Independent assessment of interaction, free of provider or client bias<br><br>-Excellent supplement to client or provider surveys | -Costly in time and resources<br><br>-Cumbersome data analysis<br><br>-Inefficient mechanisms for assessing quality of care<br><br>-'Hawthorn' effect- presents an overly positive picture of provider quality | -Percentage of visits meeting standards of care<br><br>-Percentage of visits in which client is treated appropriately<br><br>-Percentage of visits in which method side effects are described to client<br><br>-Percentage of visits in which client is explained how to use method | -?Unknown |

**Data Sources, Possible Data Elements, Advantages, Disadvantages, Indicators and Current Use For Periodically Collected Data at the Clinic and Population Level (Cont'd)**

| Data Source | Possible Data Elements | Advantages | Disadvantages | Important Indicators | Current Use |
|---|---|---|---|---|---|
| ----------Clinic Level---------- | | | | | |
| Provider Surveys | -Attitudes about specific methods<br>-Practices at visits:<br>--PAP smears<br>--screening for STIs<br>--referrals<br>--follow-up of clients<br>--counseling about side effects<br>--counseling to women with negative pregnancy tests<br>--counseling about method use<br>-Knowledge of methods side effects<br>-Attitudes about barriers to contraception continuation | -Evaluates the provider side of client-provider interaction<br><br>-Relatively low cost and efficient<br><br>-When combined with medical records data, can estimate congruence of what providers say they do with what they do in practice<br><br>-Gives information on key service barriers to providing better quality care | -Low response rates without incentives<br><br>-What providers say they do may not be what they actually do | -Percentage of providers with accurate knowledge of side effects/contra-indications<br><br>-Percentage of providers who:<br>--screen for STIs at all visits<br>--counsel women with negative pregnancy tests<br>--counsel women about side effects of methods | -?Unknown |

**Data Sources, Possible Data Elements, Advantages, Disadvantages, Indicators and Current Use For Periodically Collected Data at the Clinic and Population Level (Cont'd)**

| Data Source | Possible Data Elements | Advantages | Disadvantages | Important Indicators | Current Use |
|---|---|---|---|---|---|
| ----------Population Level---------- | | | | | |
| Behavioral Risk Factor Surveillance System (BRFSS) | -Sexual behavior<br>-Condom use<br>-Unintended pregnancy<br>-Current use of contraception<br>-Source of care for female health concerns<br>-Use of family planning clinics<br>-Reasons for not using contraception/condoms<br>-Risk factors for HIV | -Data collected as part of a larger survey, reducing costs<br><br>-Available on a population basis<br><br>-Use of family planning clinics included | -Limited number of questions<br><br>-Cannot link population to specific clinic/services<br><br>-Rely on completion of data collection from other division/agency | -Unintended pregnancy rate<br><br>-Rates of current use of contraception-by method<br><br>-Condom use by high risk individuals<br><br>-Ever use of family planning clinics | -?Unknown, some states in Region VIII |
| Youth Behavior Risk Survey (YBRS) | -Sexual behavior<br>-Alcohol or drug use at last intercourse<br>-Condom use<br>-Use of other contraceptive methods<br>-Occurrence of pregnancy | -Data collected as part of a larger survey, reducing costs<br><br>-Available on a population basis | -Very limited number of questions<br><br>-If conducted in schools, missing high risk population, like school drop out | -Pregnancy rates among sexually active teens<br><br>-Use of contraception among sexually active teens | -?Unknown: some states in Region VIII |
| Pregnancy Risk Assessment Monitoring System (PRAMS) | -Unintended pregnancy<br>-Use of contraception at time she became pregnant<br>-Reason for not using contraception when she became pregnant | -Data collected as part of a larger survey, reducing costs<br>-Available on a population basis<br>-Can add additional questions to core interview | -Very limited questions<br><br>-Limited to women delivering a live born infant<br><br>-Not possible to link to use of family planning clinics | -Unintended pregnancy rate among live births | -?Unknown: some states in Region VIII |

**Data Sources, Possible Data Elements, Advantages, Disadvantages, Indicators and Current Use For Periodically Collected Data at the Clinic and Population Level (Cont'd)**

| Data Source | Possible Data Elements | Advantages | Disadvantages | Important Indicators | Current Use |
|---|---|---|---|---|---|
| ----------Population Level---------- | | | | | |
| National Survey of Family Growth (NSFG) | -Ever use of contraception<br>-Receipt of family planning services<br>-First use of contraception<br>-Regular source of care<br>-Current source of care<br>-Sterilization of woman or partner | -Detailed questions about family planning use and sterilization<br>-Data can be obtained from most recent National Survey for Western Region<br>-Survey questions can be used in BRFSS interview to obtain more accurate information | -Not available for individual states<br><br>-Some modules require complex question patterns, making them difficult to use in periodic surveys | -Use of contraception at first intercourse<br>-Percentage of couples in which one partner had a sterilization operation<br>-Percentage of couples currently using condoms<br>-Percentage of couples currently using other contraceptive methods | -Not used by state<br>-?Region Unknown |

**Attachment A**

**Clinic Survey**

Does clinic provide the following contraception and sterilization methods on site? If no, are referrals made for them? Are these referrals paid for by the clinic? Check the appropriate box.

| METHOD | Available on Site | | Off Site Referrals | | |
|---|---|---|---|---|---|
| | YES | NO | Yes, Paid | Yes, Not Paid | NO |
| Oral contraceptive, combined | | | | | |
| Oral contraceptive, Progestin only | | | | | |
| IUD | | | | | |
| Injectable | | | | | |
| NORPLANT | | | | | |
| Condom | | | | | |
| Diaphragm | | | | | |
| Spermicide | | | | | |
| Emergency contraception | | | | | |
| Female Sterilization | | | | | |
| Vasectomy | | | | | |
| Natural Family Planning Counseling | | | | | |
| Dual Methods Counseling | | | | | |
| Other | | | | | |

Do you use any of the following to remind clients of up-coming visits?

Mailed reminder ( ) Yes ( ) No
Telephone reminder ( ) Yes ( ) No
Other ( ) Yes ( ) No
Specify _____

What procedures do you use to follow-up on annual visits?

Mail exam scheduling reminders ( ) Yes ( ) No
Telephone exam scheduling reminders ( ) Yes ( ) No
Other ( ) Yes ( ) No
Specify _____

What procedures do you use to follow up on missed appointments?

Telephone follow up ( ) Yes ( ) No
Mail follow up ( ) Yes ( ) No
Other ( ) Yes ( ) No

Specify _____

Do you use any of the following to remind clients of the need to refill oral contraceptives?

| | | |
|---|---|---|
| Mailed reminder | ( ) Yes | ( ) No |
| Telephone reminder | ( ) Yes | ( ) No |
| Other | ( ) Yes | ( ) No |

Specify _____

What do you do to insure that women come back to the clinic for oral contraceptives?

_____
_____
_____
_____
_____

Do you use any of the following to remind clients to come to the clinic for depoprovera?

| | | |
|---|---|---|
| Mailed reminder | ( ) Yes | ( ) No |
| Telephone reminder | ( ) Yes | ( ) No |
| Other | ( ) Yes | ( ) No |

Specify _____

**What do you do to insure that women come back to the clinic for depoprovera?**

_____
_____
_____
_____
_____

Do you use any of the follow to follow-up on negative pregnancy test?

**Mailed card to schedule an appointment. ( ) Yes ( ) No**

| | | |
|---|---|---|
| Telephone call to schedule an appointment | ( ) Yes | ( ) No |
| Other | ( ) Yes | ( ) No |

Specify _____

List the hours of operation each day the clinic is open and provides family planning or reproductive healthcare.

| | OPEN | CLOSE |
|---|---|---|
| Monday | _____ | _____ |
| Tuesday | _____ | _____ |

| | | |
|---|---|---|
| Wednesday | _____ | _____ |
| Thursday | _____ | _____ |
| Friday | _____ | _____ |
| Saturday | _____ | _____ |
| Sunday | _____ | _____ |

How long is the current waiting time from when a client calls until an appointment for:

**First time clients** _____

For Annual visits _____
For contraceptive follow – up visits _____
For follow-up visits on STI's _____
For follow-up visits on abnormal PAPs _____

**Do these waiting times vary throughout the year? ( ) Yes ( ) No**

When are they longer? _____
When are the shorter? _____

Is there a triage system for determining a client's need for an appointment?

( ) Yes ( ) No

If yes, what is this system?

_____

Does the clinic accept walk-in clients? ( ) Yes ( ) No

Can clients pick up contraceptive supplies at any time? ( ) Yes ( ) No

**Attachment B**

**Medical Record Abstraction**

Date of Visit _ _/ _ _/ _ _

**Patient Visit Information** (to be used to determine appropriate timing of Pap test)

Basic Visit Type (check one):

| | |
|---|---|
| Initial visit | [ ] |
| Annual visit | [ ] |
| Other revisit, specify | [ ] |
| Not on record | [ ] |
| Follow-up visit | [ ] |

Appropriate Screening for Chlamydia

Reason for exam (check one):

Patient was symptomatic; [ ]
Patient was experiencing no symptoms—Routine Exam; [ ]
Not on record. [ ]

| | | |
|---|---|---|
| Patient was exposed to chlamydia/NGU | [ ] yes | [ ] no |
| Patient was exposed to gonorrhea | [ ] yes | [ ] no |
| Patient was exposed to other STD | [ ] yes | [ ] no |
| Not on record | [ ] yes | [ ] no |

Clinical signs

| | |
|---|---|
| Cervical friability | [ ] |
| PID | [ ] |
| Mucopus | [ ] |
| Urethritis | [ ] |
| None | [ ] |
| Not on record | [ ] |

Risk history

Patient has had >1 partner in past 90 days [ ]
Patient has had new partner in past 90 days [ ]
Patient has had tested positive for chlamydia in past year [ ]
Not on record [ ]

Was client treated presumptively for chlamydia? ( ) yes ( ) no

Was a follow-up visit scheduled ( ) yes ( ) no

Medical services provided ( ) yes ( ) no

Pap smear taken ( ) yes ( ) no

If Yes, were results of Pap smear recorded? ( ) yes ( ) no

If Yes, what were results of Pap test? (check one)

Dysplasia ( )
Other Abnormal ( )
Normal ( )
Not in record ( )

Was follow up conducted?

Yes ( ) By a visit? ( ) By telephone? ( )
No ( )
Not on record ( )

Was a pregnancy test performed? ( ) Yes ( ) No

If yes, what were the results?

( ) Positive
( ) Negative
( ) Not in Record

Was follow up done of women with negative test?

( ) Yes
( ) No

## Attachment C

**Client Exit Interview**

***The first set of questions ask about your choice of contraceptive method:***

What method did you request?

Did you receive the method you wanted? ( )Yes ( )No
If not, why did you not receive this method?

What method did you receive?

If not, is the method received acceptable to you? ( )Yes ( )No
If not, why is it unacceptable?

Were you told how to use the method? ( )Yes ( )No

Were you told about the method's side effects? ( )Yes ( )No
*Optional wording: Were you told what the side effects are?*

Were you given written materials about how to use the method? ( )Yes ( )No

Were you given written materials about side effects? ( )Yes ( )No

Did the provider tell you to call him/her or return to the clinic if you have problems with the method? ( )Yes ( )No

***The next set of questions ask about your interactions with the provider:***

Did you feel you were treated with respect and courtesy at the time of making the appointment? ( )Yes ( )No

When you arrived at the clinic, were you treated with respect and courtesy at the reception desk? ( )Yes ( )No

Were you treated with respect and courtesy during interactions with the nurse? ( )Yes ( )No

Were you treated with respect and courtesy during interactions with the physician? ( )Yes ( )No

When you were asked to share sensitive information, did you feel your privacy was respected? ( )Yes ( )No

Were you comfortable during consultation that information was not overheard? ( )Yes ( )No

Did you have enough privacy during exams and

procedures with the service provider? ( )Yes ( )No

Did someone at the clinic go out of his/her way for you? ( )Yes ( )No
If yes, who was this person (no name, but title or role at the clinic).

***The next set of questions ask about the care you received from your provider during your visit***

*** Original wording from Situation Analysis Book**

During this visit, did the provider conduct any health examinations or procedures? ( )Yes ( )No

(if Yes) Did the provider explain the examinations or procedures before they were performed?

Did the provider explain the results of the health examinations or procedures? ( )Yes ( )No

During this visit, did you have any questions you wanted to ask? ( )Yes ( )No

(if Yes) Did the provider let you ask the questions? ( )Yes ( )No

(if Yes) Did the provider respond to your questions to your satisfaction? ( )Yes ( )No

How long from the time you called for an appointment was the appointment made? **Access**

Was this waiting time acceptable? ( )Yes ( )No
If unacceptable, why?

***Optional questions about Access***

Are the hours this clinic is open convenient for you? ( )Yes ( )No
If no, what time would be most convenient to you?

[ ] Earlier in the morning
[ ] Over lunch hour
[ ] Afternoon
[ ] Evening/night
[ ] Weekends/holidays
[ ] Other
[ ] Don't know

Did the hours of the clinic delay you from getting in for a visit?

About how long did you have to wait between the time you first arrived at the clinic and the time you began receiving the services that you came for?_____
Do you feel this wait time was reasonable or too long?_____
_____reasonable _____too long _____Don't know

How long did it take you to get here today?_____ minutes _____Don't know

What was the main means of transportation that you used to get here?

[ ] Walked
[ ] Bus
[ ] Subway/train
[ ] Personal car
[ ] Taxi
[ ] Bicycle
[ ] Other

***Optional questions about client satisfaction***

Overall, would you say you were satisfied with your visit here today or were you dissatisfied?

[ ] Satisfied
[ ] Dissatisfied
[ ] Other

If dissatisfied, why?

How strongly would you recommend this clinic to a friend who was seeking the same services that you came in for today?

[ ] Highly/Strongly recommend
[ ] Moderately recommend
[ ] Would not recommend/Advise to go elsewhere
[ ] Don't know/Indifferent