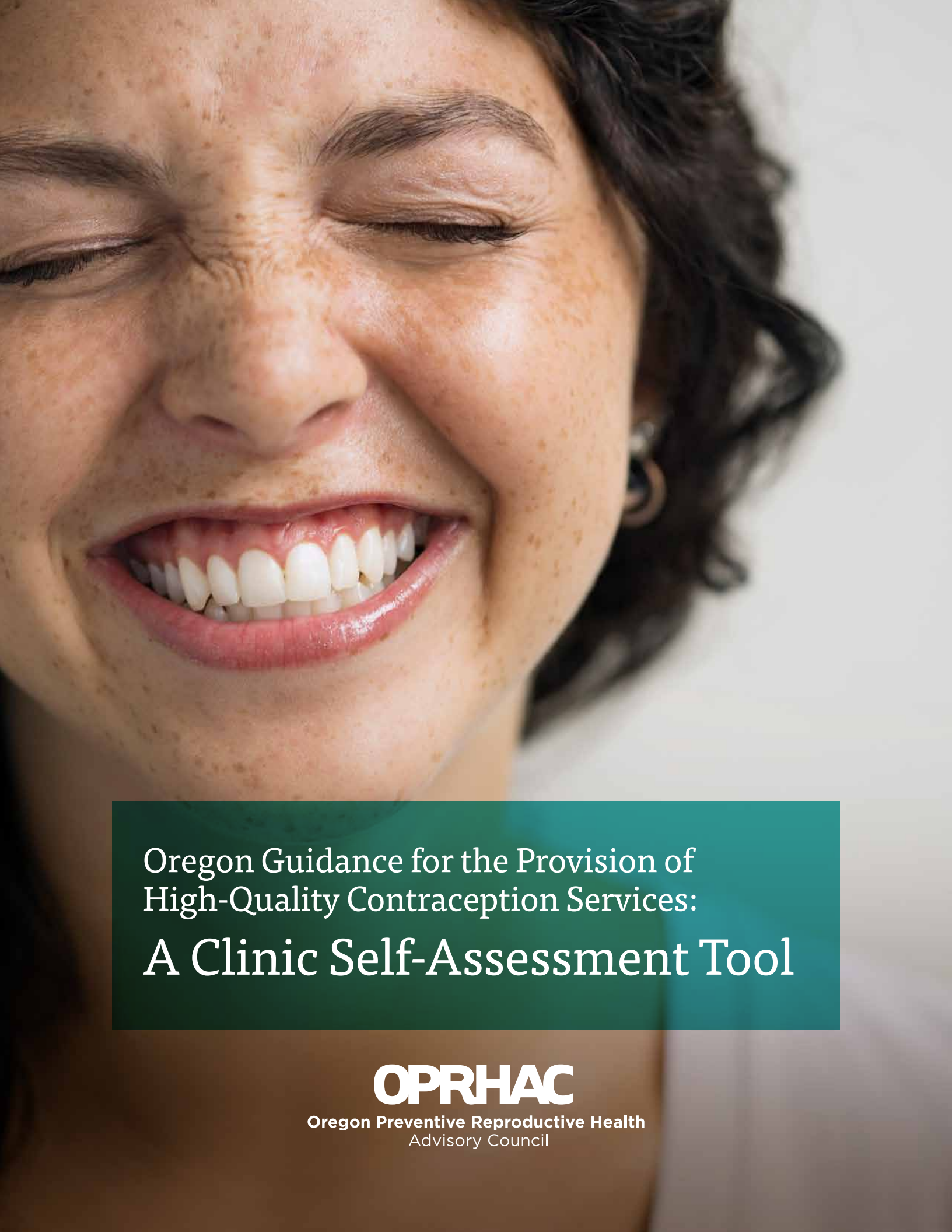


Oregon Guidance for the Provision of High-Quality Contraception Services:

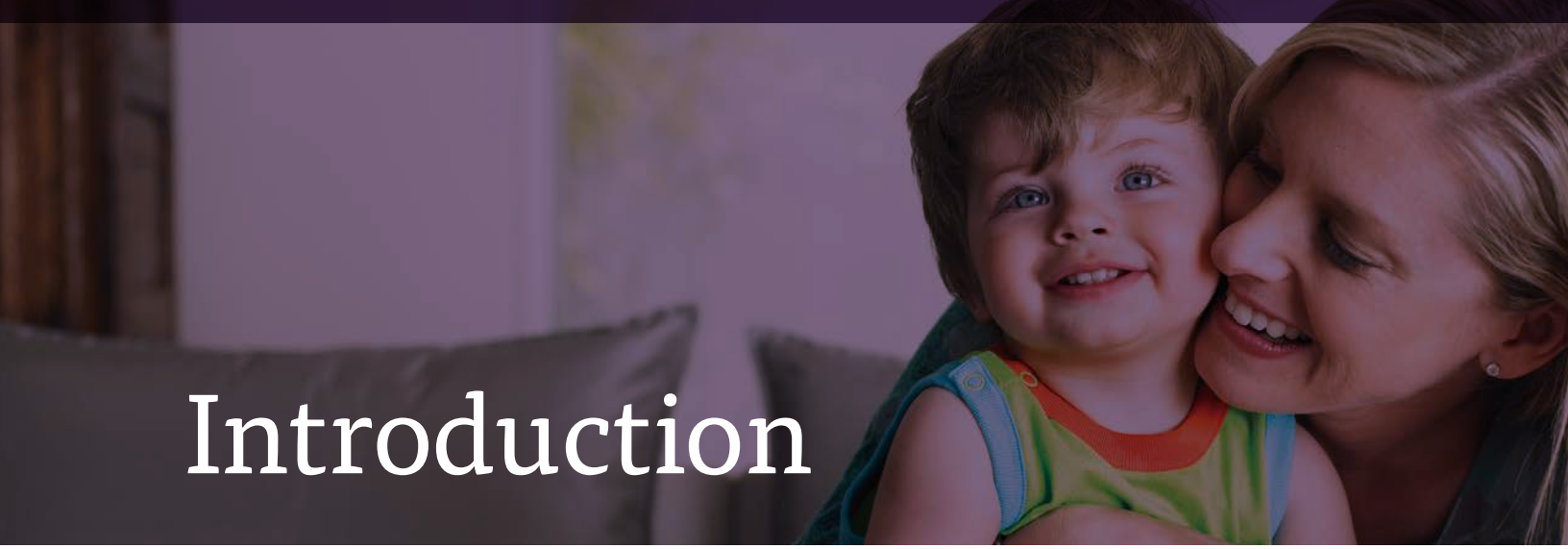
A Clinic Self-Assessment Tool

OPRHAC
Oregon Preventive Reproductive Health
Advisory Council

Using the Bookmarks in this PDF

In Acrobat Reader, the Bookmarks panel should open up along with this .pdf. If you do not see it, navigate to:
View → Show/Hide → Navigation Panes → Bookmarks

Use the Bookmarks panel to move around and between the two main sections: the Self-Assessment Tool and the Strategy and Resource Guide that follows.



Introduction

Purpose and Origins

The purpose of the Oregon Guidance for the Provision of High-Quality Contraception Services: A Clinic Self-Assessment Tool is to define and encourage the adoption of standards for the provision of high-quality contraception services in both **primary care and family planning clinical settings** throughout Oregon.

The Tool is intended for clinics to assess the current state of their contraception services and identify areas for improvement. Clinics that score high enough to be rated as a **quality contraception provider** or **expert contraception provider** are encouraged to communicate that message to their patients, colleagues and communities.

The Tool was based primarily on the CDC MMWR, *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs*. It was developed by the Oregon Preventive Reproductive Health Advisory Council, which is a collaborative effort of state, local, private and public health sectors. Special recognition goes to the significant support provided by the Oregon Health Authority, Oregon Foundation for Reproductive Health and Health Share of Oregon.

Key Assumptions

The Tool makes some key assumptions about the provision of contraception care, which are described on the next page. These three areas are not explicitly scored on the Tool because they are considered essential to the provision of high-quality contraception care. If these key assumptions are not true for your clinic, support and resources are available to address these areas before you begin the assessment process.

1. **EQUITY AND INCLUSION** – Achieving health equity requires valuing every person equally and contributing to ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and intentional efforts to eliminate health disparities. A health-equity perspective on health care delivery allows those providing care to consider how race, ethnicity, economic status and sexual orientation inform a patient's need for and access to preventive reproductive health services. In turn, greater sensitivity to the challenges and concerns of a diverse patient population can be developed, with greater opportunity to strengthen therapeutic relationships and improve outcomes.

2. **COST AND BILLING TRANSPARENCY** – Clinic staff are transparent about all costs and billing policies related to contraception services before services are delivered. These include policies not in the clinic's control, such as the generation of explanation of benefits (EOB) statements by insurance companies. Clinics will make alternate arrangements for any patient who wants to avoid such notifications.

3. **CONFIDENTIALITY** – Patients have a right to privacy and confidentiality during delivery of services. Information obtained by clinic staff about a patient receiving services may not be disclosed without the patient's documented consent, except as required by law or as may be necessary to provide services to the patient, with appropriate safeguards for confidentiality. Clinics have policies and procedures in place to protect patient confidentiality and clearly communicate those policies to patients.

What's Inside

I. OREGON GUIDANCE FOR THE PROVISION OF HIGH-QUALITY CONTRACEPTION SERVICES: A CLINIC SELF-ASSESSMENT TOOL (pg. 8)

The Tool is organized into four quality domains:

1. Access
2. Service Provision
3. Community Collaboration with other Providers
4. Evaluation of the Patient Experience with Contraception Services

Each domain contains components. Each component contains a set of measures that define the component.

Clinics should complete the Tool as a team, review and score

each measure, then calculate their sub-total for each domain. Combine your sub-totals to find your overall total score. Clinics are encouraged to use the Tool to assess how their clinic is performing in relation to specific components of effective contraception services and as a basis for ongoing quality improvement efforts. See below **("How to Complete the Clinic Self-Assessment Tool")** for a step-by-step guide to use with your clinic team.

II. STRATEGY AND RESOURCE GUIDE

A Strategy and Resource Guide is available to help clinic staff understand and meet the measures scored on the Tool. The Guide is provided separately in the print version of these materials. In the PDF version, it appears at the end of the document.

The Strategy and Resource Guide is organized by the same numbering system as the Tool and offers definitions, strategies, resources and additional citations for understanding and meeting the measures. It also serves as an educational and reference resource for clinicians and clinic staff.

How to Complete the Clinic Self-Assessment Tool

It is recommended that the Tool be used and completed by a team of staff members who are involved in the delivery of reproductive health services within the clinic, to ensure all staff roles are represented. Examples include clinicians, medical assistants, administrative and billing staff, reception and appointment schedulers, interpreters, lab and pharmacy staff, medical director, clinic manager, nurse supervisor, etc. Once your team is assembled:

STEP 1: Review Oregon Guidance for the Provision of High-Quality Contraception Services: A Clinic Self-Assessment Tool.

STEP 2: Convene staff members to discuss the process and logistics for completing the Tool as a team. (Alternatively, the team may divide into several pairs or small groups to assess specific domains, followed by a team meeting to share and discuss results.)

STEP 3: Review each measure, discuss with team members and score as follows:

- For each measure, circle the numbered response that best describes your clinic's practice.
- Total the scores of all the measures within each component to arrive at a component score.

- Use the Scoring Worksheet (pg. 25) to add all component scores under each domain for a total Domain Score.
- Finally, add the Domain Scores to arrive at your overall Total Score.

Scoring

- 70 or above: Clinics that score 70 or above are considered *expert* contraception providers. While these clinics would routinely provide care at the highest level, most clinics—even at *expert* level—will have room for improvement.
- 50 to 69: Clinics that score between 50 and 69 are considered *quality* contraception providers.
- These designations are to be considered along a continuum because clinics will have areas of relative strength and weakness. Thus, the designation of *quality* versus *expert* is likely to be fluid over time.

STEP 4: Consider the following guidance when completing the Tool:

- Keep the patients' perspective in mind when scoring each measure.
- Avoid making assumptions about how another clinic staff member may score a measure. Solicit input from the appropriate staff to ensure accuracy.
- Measures with "uncertain" or "do not know" responses may require further team discussion and/or consultation with another clinic staff member.
- Try to score each measure in a way that represents the majority of relevant clinic staff, not the experience or capacity of any one provider within the clinic.

STEP 5: Summarize the findings with your team and determine next steps:

- What are the most important domains and components for your clinic to address?
- Prioritize which components your clinic would like to focus their improvement efforts on.
- Review the Strategy and Resource Guide for resources and recommended strategies.
- Create an action plan for improving your clinic's scores on priority components.
- Consider integrating the priority components into your clinic's quality improvement plan.

- Identify and highlight the strengths of your clinic in the provision of contraception services and consider how your clinic might build on those strengths.
- Determine how your clinic can communicate the Tool results to relevant audiences and develop a plan to do so.

If you have any questions, concerns or feedback about the Clinic Self-Assessment Tool, please contact the Oregon Reproductive Health Program at: rh.program@state.or.us.

Contributors

Helen Bellanca, MD, MPH, Health Share of Oregon
Helene Rimberg, PsyD, Oregon Health Authority, Adolescent, Genetics & Reproductive Health Programs
Emily Elman, MPH, Oregon Health Authority, Reproductive Health Program
Michele Stranger Hunter, (Former) Executive Director, Oregon Foundation for Reproductive Health
Elizabeth Gharst, MScPHDC , Oregon Health Authority, Reproductive Health Program
Lesli Leone Uebel, MPH, CHES, Oregon Health Authority, Reproductive Health Program
Jillian T. Henderson, PhD, MPH, Kaiser Permanente, Center for Health Research
Michael Policar, MD, MPH, Bixby Center for Global Reproductive Health, University of California, San Francisco
Karol Almroth, Oregon Health Authority, Reproductive Health Program
Lesa A. Dixon-Gray, MSW, MPH, Oregon Health Authority, Maternal and Child Health Program
Connie Clark, NP, Hood River County Public Health
Dana Smothers, MS, RN, CNL (Formerly) Yamhill County Public Health
Shelagh Johnson, Oregon Health Authority, Adolescent and School Health Program
Rachael Linz, MPH, Oregon Health Authority, Reproductive Health Program
Maria Rodriguez, MD, MPH, Dept. of Obstetrics and Gynecology, Oregon Health & Science University
Merry-K. Moos, RN, FNP, MPH, University of North Carolina at Chapel Hill
Anna Stiefvater, RN, MPH, Oregon Health Authority, Maternal and Child Health Program
Laurie Francis, RN, MPH, Oregon Primary Care Association
Julie McFarlane, MPH, Oregon Health Authority, Maternal and Child Health Program

OREGON GUIDANCE FOR THE PROVISION OF HIGH-QUALITY CONTRACEPTION SERVICES

The Clinic Self-Assessment At-a-Glance

DOMAIN 1: Access	
1.1	Timeliness of Care
1.2	Affordability/Cost
1.3	Special Populations/Diversity
1.4	Language/Health Literacy/Communication
DOMAIN 2: Service Provision	
2.1	Assess for Pregnancy Intentions
2.2	Counseling and Education
2.3	Condoms and Vasectomy Services
2.4	Services for Youth
2.5	Services for Postpartum and/or Breastfeeding Women
2.6	Contraceptive Supplies
2.7	Contraceptive Procedures: LARC Insertion/Removal and Diaphragm Fitting
2.8	Patient Support for Contraception Management
DOMAIN 3: Community Collaborations with Other Providers	
3.1	Linkages to Contraception Services
3.2	Linkages to Social and Behavioral Services, Including Domestic Violence/Mental Health/ Substance Abuse
3.3	Linkages to Primary Care and/or Chronic Disease Care Management Services
DOMAIN 4: Evaluation of Patient Experience with Contraception Services	
4.1	Evaluation of Patient Experience

Self-Assessment Tool

Start here to complete the Self-Assessment Tool for your clinic. When you've completed the Tool, use the scoring worksheet at the end to calculate your clinic score and determine the current state of your contraception services.

1.1 Timeliness of Care

Learn more about 1.1

Measure	Which option describes your clinic?	Circle # for your answer
a. Clinicians provide contraception, including single-day LARC insertions, without requiring routine pelvic exams, cervical cancer screenings and STI results before offering contraception.	Clinicians do not provide contraception without requiring routine pelvic exams, cervical cancer screenings and STI results before offering contraception.	0
	All clinicians provide contraception without requiring routine pelvic exams, cervical cancer screenings, and STI results some of the time OR some of the clinicians provide contraception without requiring routine pelvic exams, cervical cancer screenings, and STI results all of the time.	1
	All clinicians routinely provide contraception without requiring routine pelvic exams, cervical cancer screenings and STI results before offering contraception.	2
b. Clinicians follow "quick start" protocols for initiation of hormonal contraception.	Clinicians do not follow "quick start" protocols for initiation of hormonal contraception.	0
	All clinicians follow "quick start" protocols some of the time OR some of the clinicians follow "quick start" protocols all of the time.	1
	All clinicians routinely follow "quick start" protocols for initiation of hormonal contraception.	2
c. Clinic scheduling staff assess for urgency of need regarding contraception visits.	Scheduling staff do not assess for urgency of need.	0
	All scheduling staff assess for urgency of need some of the time OR some scheduling staff assess for urgency of need all of the time.	1
	All scheduling staff routinely assess for urgency of need regarding contraception visits.	2

Measure	Which option describes your clinic?	Circle # for your answer
d. Third next available appointment is available within two business days (specialty care standard) for routine visits.	Third next available appointment within two business days is never available.	0
	Third next available appointment within two business days is sometimes available.	1
	Third next available appointment within two business days is routinely available.	2
e. Clinic offers urgent care for contraception concerns.	Clinic has limited or no capacity to address same-day needs for contraception concerns.	0
	Clinic is sometimes able to address contraception concerns, same-day.	1
	Clinic is routinely able to address urgent contraception concerns, same-day.	2
	Component 1.1: **TOTAL SCORE**	

1.2 Affordability/Cost

Learn more about 1.2

Measure	Which option describes your clinic?	Circle # for your answer
a. Clinic accepts Medicaid.	Clinic does not accept Medicaid.	0
	Less than 30% of clinic's payer mix is Medicaid.	1
	More than 30% of clinic's payer mix is Medicaid.	2
b. Clinic accepts uninsured patients and accepts payment plans.	Clinic does not accept uninsured patients OR does not accept payment plans.	0
	Clinic accepts uninsured patients AND accepts payment plans from all patients.	1
	Clinic has protocol to waive unpaid balances, regardless of patient's insurance status.	2

Measure	Which option describes your clinic?	Circle # for your answer
c. Clinic offers sliding fee for contraception services.	Clinic does not have sliding fee scale.	**0**
	Clinic has sliding fee scale that slides to a nominal fee.	**1**
	Clinic has sliding fee scale that slides to zero.	**2**
d. Clinic accepts broad range of commercial insurance with in-house billing capacity.	Clinic does not accept commercial insurance plans AND has no in-house billing capacity.	**0**
	Clinic accepts limited number of commercial insurance plans OR has in-house billing capacity.	**1**
	Clinic accepts broad range of commercial insurance AND has in-house billing capacity.	**2**
e. Clinic helps with applications for patient assistance programs.	Clinic is unable to help patients with patient assistance programs.	**0**
	Clinic is sometimes able to help with patient assistance plans for contraceptive supplies, including IUDs, for patients who qualify.	**1**
	Clinic is routinely able to help with a broad array of patient assistance plans for contraceptive supplies, including IUDs, for patients who qualify.	**2**
f. Access to contraception services never denied based on inability to pay.	Clinic always requires some payment at the time of visit.	**0**
	Clinic is sometimes able to offer services to those unable to pay.	**1**
	Clinic never denies access based on inability to pay.	**2**
	Component 1.2: **TOTAL SCORE**	

1.3 Special Populations/Diversity

Learn more about 1.3

Measure	Which option describes your clinic?	Circle # for your answer
a. Accommodations are made to ensure quality contraception services for people with disabilities.	Clinic is accessible to people with disabilities (Title II and III of the ADA).	0
	Clinic is fully accessible, including exam room and medical equipment.	1
	Clinic has fully accessible and inclusive services and conducts outreach and education welcoming people with disabilities.	2
b. Clinic offers welcoming and inclusive environment. Clinic layout and written information, signage and staff are reflective of patients (including but not limited to communities of color, teens, sexual minorities and people with disabilities).	Clinic does not make efforts to have materials, signage and staff (including recruiting and retaining policies) that are reflective of patient populations.	0
	Clinic sometimes, or in some ways, makes efforts to create a welcoming and inclusive environment in which clinic layout and written information, signage and staff (including recruiting and retaining policies) are reflective of patients.	1
	Clinic routinely makes efforts to create a welcoming and inclusive environment in which clinic layout and written information, signage and staff (including policies for recruiting and retaining staff) are reflective of patients.	2
c. Clinic provides contraception care to transgender patients that is sensitive, respectful, and affirming and that recognizes and honors the patient's self-description or self-identification.	Clinic is not aware of the specific contraceptive needs of female-to-male transgender or non-binary individuals.	0
	Clinic is somewhat aware of the specific contraceptive needs of female-to-male transgender or non-binary individuals.	1
	Clinic is recognized in its community as expert in transgender reproductive health care.	2

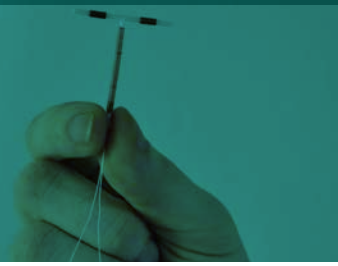
Measure	Which option describes your clinic?	Circle # for your answer
d. Clinic collects patient demographic data to inform and improve the provision of culturally appropriate services.	Clinic collects minimal patient demographic data.	**0**
	Clinic collects robust patient demographic data OR uses patient demographic data to inform and improve provision of culturally appropriate contraception services.	**1**
	Clinic collects robust patient demographic data AND uses data to inform and improve provision of culturally appropriate contraception services.	**2**
e. Clinic conducts community assessment and engagement activities to inform and improve the provision of culturally appropriate services.	Clinic does not conduct community assessment, OR if assessment is conducted, it does not address contraception needs.	**0**
	Clinic periodically conducts community assessment and engagement activities that address contraception needs.	**1**
	Clinic uses community assessment and engagement data to inform and improve provision of quality contraception services.	**2**
f. Clinic has patient advisory panel or other structured means for patients to provide input on contraception services.	Clinic does not have a patient advisory panel OR patient advisory panel does not address contraception.	**0**
	Clinic has patient advisory panel but it is not active and does not meet regularly.	**1**
	Clinic has patient advisory panel that addresses contraception services AND meets regularly to provide input.	**2**
	Component 1.3: **TOTAL SCORE**	

1.4 Language/Health Literacy/Communication

Learn more about 1.4

Measure	Which option describes your clinic?	Circle # for your answer
a. Clinic has patient interpretation services available.	Patient interpretation services are not available.	0
	Clinic notifies patients of available language interpretation services (in person when feasible) at no cost to patient.	1
	Clinic employs bilingual staff based on patient demographics and/or makes in-person interpreters available (when feasible).	2
b. Clinic has patient education materials related to contraception available at 6th grade reading level.	No patient education materials related to contraception are available at 6th grade reading level.	0
	Some patient education materials related to contraception are available at 6th grade reading level.	1
	All patient education materials related to contraception are available at 6th grade reading level.	2
c. Clinic has materials/ documents and important health information related to contraception available in non-English language(s) and non-written formats.	Materials/documents are available in English language only.	0
	Vital materials/documents, such as enrollment forms, consent forms and key signage, are available in most prevalent non-English language(s).	1
	All materials/documents are available in most prevalent non-English language(s) AND important health information is conveyed in a non-written (e.g. graphic or verbal) format.	2
d. Clinic provides all staff with training and tools to facilitate courteous and helpful communication between patients and staff.	Clinic does not provide staff with training or tools to facilitate patient-staff communication.	0
	Clinic routinely provides *some* staff with training and tools to facilitate patient-staff communication.	1
	Clinic provides *all* staff with training and tools to facilitate patient-staff communication.	2
	Component 1.4: **TOTAL SCORE**	

DOMAIN 2 Service Provision



2.1 Assess for Pregnancy Intentions

Learn more about 2.1

Measure	Which option describes your clinic?	Circle # for your answer
a. Clinicians/staff conduct patient assessment of pregnancy intentions.	Clinicians/staff do not routinely assess for and discuss pregnancy intentions with patients.	0
	Pregnancy intentions are discussed with patients of reproductive capacity some of the time OR by some clinicians/staff.	1
	All clinicians/staff routinely assess for and discuss pregnancy intentions with patients of reproductive capacity.	2
	Component 2.1: **TOTAL SCORE**	

2.2 Counseling and Education

Learn more about 2.2

Measure	Which option describes your clinic?	Circle # for your answer
a. Clinic supports staff training and/or professional development related to contraception counseling strategies and methods.	Clinic never offers staff training or professional development related to contraception counseling strategies and methods.	0
	Clinic sometimes offers hard-copy and electronic resources with up-to-date information about contraception counseling strategies and methods to all staff providing contraception services.	1
	Clinic routinely offers hard-copy and electronic resources and in-person/live trainings with up-to-date information about contraception counseling strategies and methods to all staff providing contraception services.	2

Measure	Which option describes your clinic?	Circle # for your answer
b. Clinicians use established guidelines for medical decision-making during contraception counseling.	Clinicians don't use established guidelines for medical decision-making during contraception counseling.	0
	Recommendations of the U.S. Medical Eligibility Criteria and U.S. Selected Practice Recommendations for Contraceptive Use are used in contraception counseling by some clinicians OR some of the time.	1
	All clinicians routinely use recommendations of the U.S. Medical Eligibility Criteria and U.S. Selected Practice Recommendations for Contraceptive Use in contraception counseling.	2
c. Clinicians/ staff provide patient-centered contraceptive counseling and decision-making techniques that take into account patients' cultural, religious, and personal values and preferences.	Clinicians/staff consider only medical criteria when recommending methods to their patients and do not provide patient-centered counseling and decision-making techniques that are responsive to patients' cultural, religious, and personal values and preferences.	0
	Clinicians/staff have some skills in providing patient-centered contraceptive counseling and decision-making techniques that are responsive to patients' cultural, religious, and personal values and preferences.	1
	Clinicians/staff routinely and skillfully provide patient-centered contraceptive counseling and decision-making techniques that are responsive to patients' cultural, religious, and personal values and preferences.	2

Measure	Which option describes your clinic?	Circle # for your answer
d. Personal and professional development is available to ensure that contraception counseling is conducted with sensitivity to cultural and historical context and awareness of the potential role of implicit bias and stereotyping.	Clinicians/staff are unaware of their need for personal/professional development to ensure that contraception counseling is conducted with sensitivity to cultural and historical context and awareness of the potential role of implicit bias and stereotyping.	**0**
	Some clinicians/staff actively seek personal/professional development opportunities, including materials, experiences (e.g., community cultural events) or trainings, to ensure that contraception counseling is conducted with sensitivity to cultural and historical context and awareness of the potential role of implicit bias and stereotyping.	**1**
	All or most clinicians/staff seek personal/professional development opportunities, including materials, experiences (e.g., community cultural events) or trainings, to ensure that contraception counseling is conducted with sensitivity to cultural and historical context and awareness of the potential role of implicit bias and stereotyping.	**2**
	Component 2.2: **TOTAL SCORE**	

2.3 Condoms and Vasectomy Services

Learn more about 2.3

Measure	Which option describes your clinic?	Circle # for your answer
a. Contraception services are available to patients assigned male at birth.	Neither condoms nor vasectomy services are provided.	**0**
	Condoms are dispensed onsite.	**1**
	Condoms are dispensed on-site and clinic has established referral relationship in place for the provision of vasectomies OR vasectomies are provided on-site.	**2**
	Component 2.3: **TOTAL SCORE**	

2.4 Services for Youth

Learn more about 2.4

Measure	Which option describes your clinic?	Circle # for your answer
a. Clinic has policies in place related to mandatory reporting requirements and minors' rights.	Clinic has no policies in place related to mandatory reporting requirements OR minors' rights to consent for contraception care.	0
	Clinic has policies in place related to mandatory reporting requirements AND minors' rights to consent for contraception care.	1
	Clinic staff are adequately and routinely trained on clinic policies related to mandatory reporting requirements AND minors' rights to consent for contraception care.	2
b. Clinic has youth-friendly practices in place.	Clinic provides contraception services in the same manner to all patients regardless of their age.	0
	Clinic makes some efforts to ensure that youth-friendly contraception services are provided, including but not limited to visual and auditory privacy in waiting/exam rooms, separate waiting area and/or special clinic hours for youth.	1
	Clinic seeks youth input on contraception services, including but not limited to youth membership on clinic advisory board and active and continuous youth involvement in design of services.	2
c. Clinic takes into account patient confidentiality concerns in billing procedures.	Clinic has no *alternative* billing procedures in place for patients with confidentiality concerns.	0
	Clinic staff advise patients about potential breaches in confidentiality associated with billing communications.	1
	Clinic staff provide *alternative* billing options (e.g. self-pay on sliding fee scale) for patients with confidentiality concerns.	2
	Component 2.4: **TOTAL SCORE**	

2.5 Services for Postpartum and/or Breastfeeding Women

Learn more about 2.5

Measure	Which option describes your clinic?	Circle # for your answer
a. Clinicians provide contraception to postpartum and/or breastfeeding women.	Clinicians do not routinely provide contraception to postpartum and/or breastfeeding women.	0
	Some clinicians offer contraception to postpartum and/or breastfeeding women in accordance with U.S. Medical Eligibility Criteria and U.S. Selected Practice Recommendations for Contraceptive Use.	1
	All clinicians provide contraception to postpartum and/or breastfeeding women in accordance with U.S. Medical Eligibility Criteria and U.S. Selected Practice Recommendations for Contraceptive Use.	2
b. Clinicians provide a range of contraceptive methods to postpartum and/or breastfeeding women.	Clinic provides limited range of methods to postpartum and/or breastfeeding women.	0
	Clinic provides full range of methods, including LARCs (early insertion), hormonal methods, and lactational amenorrhea method (LAM) to postpartum and/or breastfeeding women.	1
	Women are offered immediate postpartum LARC insertion.	2
c. Clinicians/staff provide counseling on inter-conception birth spacing for postpartum and/or breastfeeding women.	Clinicians/staff do not provide counseling on optimal inter-conception birth spacing to postpartum and/or breastfeeding women.	0
	Clinicians/staff sometimes provide counseling on optimal inter-conception birth spacing to postpartum and/or breastfeeding women.	1
	Clinicians/staff routinely provide counseling on optimal inter-conception birth spacing to postpartum and/or breastfeeding women.	2
	Component 2.5: **TOTAL SCORE**	

2.6 Contraceptive Supplies

Learn more about 2.6

Measure	Which option describes your clinic?	Circle # for your answer
a. Clinic provides access to emergency contraception (EC) on-site.	EC is not available on-site.	0
	Clinic can administer oral EC, including Plan B and ella®, for immediate use on-site (according to efficacy guidelines for weight and BMI) OR can insert Paragard® IUD within five days of unprotected intercourse.	1
	Clinic can administer oral EC, including Plan B and ella®, for immediate use on-site (according to efficacy guidelines for weight and BMI) AND can insert Paragard® IUD within five days of unprotected intercourse.	2
b. Clinic provides access to broad range of contraceptive methods on-site.	No contraceptive methods are available on-site.	0
	Clinic dispenses broad range of FDA-approved methods on-site.	1
	When clinically indicated, clinic dispenses up to one-year supply of broad range of FDA-approved methods onsite AND LARCs continuously stocked on-site for easy and timely access.	2
	Component 2.6: **TOTAL SCORE**	

2.7 Contraceptive Procedures: LARC Insertion/Removal and Diaphragm Fitting

Learn more about 2.7

Measure	Which option describes your clinic?	Circle # for your answer
a. Clinic offers IUD insertions/removals.	IUD insertions/removals are not offered on-site.	0
	Clinic offers on-site, routine IUD insertions/removals, including for women who are nulliparous, adolescents, or who have yet to engage in sexual activity.	1
	Clinic is able to manage both routine and complicated IUD insertions and removals on-site.	2
b. Clinic offers implant insertions/removals.	Implant insertions/removals are not offered on-site.	0
	Clinic offers on-site, routine implant insertions/removals.	1
	Clinic is able to manage both routine and complicated implant insertions and removals on-site.	2
c. Clinic offers timely access to LARCs.	Clinic access to LARCs is limited (e.g., clinician available only one to two days per month).	0
	Clinic is able to accommodate single-visit provision of LARCs within a reasonable appointment window (e.g., two weeks).	1
d. Clinic offers diaphragm fittings.	Clinic does not offer diaphragm fittings on-site.	0
	Clinic offers diaphragm fittings on-site.	1
	Component 2.7: **TOTAL SCORE**	

2.8 Patient Support for Contraception Management

Learn more about 2.8

Measure	Which option describes your clinic?	Circle # for your answer
a. Clinicians provide patient support for contraceptive method adherence/ management of side effects.	Clinicians are unable to provide patient support for method adherence and to guide them through routine side effects.	0
	Clinicians are able to provide patient support for method adherence and to guide them through routine side effects.	1
b. Clinicians provide patient support for contraceptive method switch.	Clinicians are unable to support patients with method switch when there is strong patient preference or medical necessity.	0
	Clinicians are able to support patients with method switch when there is strong patient preference or medical necessity.	1
c. Clinicians provide patient support for routine side effects versus serious complications related to contraception.	Clinicians are unable to distinguish between routine side effects and serious complications (e.g., deep vein thrombosis, uterine perforation).	0
	Clinicians are able to distinguish between routine side effects and serious complications (e.g., deep vein thrombosis, uterine perforation).	1
d. Clinic provides patients information about who to contact, how to contact them, and when to make contact about ongoing contraception needs.	Clinic provides limited or no information to patients about contacting the clinic/clinicians about ongoing contraception needs.	0
	Clinic offers some information to patients about contacting the clinic/clinicians about ongoing contraception needs.	1
	Clinic always offers information to patients about contacting the clinic/clinicians about ongoing contraception needs.	2
	Component 2.8: **TOTAL SCORE**	

DOMAIN 3

Community Collaborations with Other Providers

3.1 Linkages to Contraception Services

Learn more about 3.1

Measure	Which option describes your clinic?	Circle # for your answer
a. Clinic makes referrals to other providers for contraception services not provided on-site (e.g., tubal ligations, vasectomies, etc.).	Patient referrals are not made to other providers for contraception services not provided on-site.	0
	Patient referrals are made to other providers for contraception services not provided on-site. System in place to document referral and to request and track follow up for referrals, including requesting information back from referral agencies for services rendered, when clinically relevant and legally appropriate.	1
	Clinic has established relationships with other providers to refer patients for contraception services not provided on-site, including formal agreements with referral agencies.	2
b. Clinic receives referrals and telephone consultations from other providers for contraception services.	Clinic accepts referrals and telephone consultations from other providers to provide routine contraception services.	0
	Clinic accepts referrals and telephone consultations from other providers for patients with contraception complications or difficult management issues.	1
	Clinic actively seeks formal arrangements with other providers to provide contraception services to their patients, particularly providers with high priority patient populations.	2
	Component 3.1: **TOTAL SCORE**	

3.2 Linkages to Social and Behavioral Services, Including Domestic Violence/ Mental Health/Substance Abuse

Learn more about 3.2

Measure	Which option describes your clinic?	Circle # for your answer
a. Clinic makes referrals to other providers for social and behavioral services, including domestic violence/ mental health/ substance abuse.	Patient referrals are made to other providers for social and behavioral services not provided on-site.	0
	Systems are in place to document referrals and to request and track follow up for referrals, including requesting information back from referral agencies for services rendered, when clinically relevant and legally appropriate.	1
	Clinic provides integrated social and behavioral services on-site and doesn't require patients to schedule separate encounters for these services.	2
	Component 3.2: **TOTAL SCORE**	

3.3 Linkages to Primary Care and/or Chronic Disease Care Management Services

Learn more about 3.3

Measure	Which option describes your clinic?	Circle # for your answer
a. Clinic makes referrals to other providers for primary care and/ or chronic disease care management services.	Patient referrals are made to other providers for primary care and/or chronic disease care management services not provided on-site.	0
	Systems are in place to document referral and to request and track follow up for referrals, including requesting information back from referral agencies for services rendered, when clinically relevant and legally appropriate.	1
	Clinic provides primary care and/or chronic disease care management services on-site and doesn't require patients to schedule separate encounters for these services.	2
	Component 3.3: **TOTAL SCORE**	

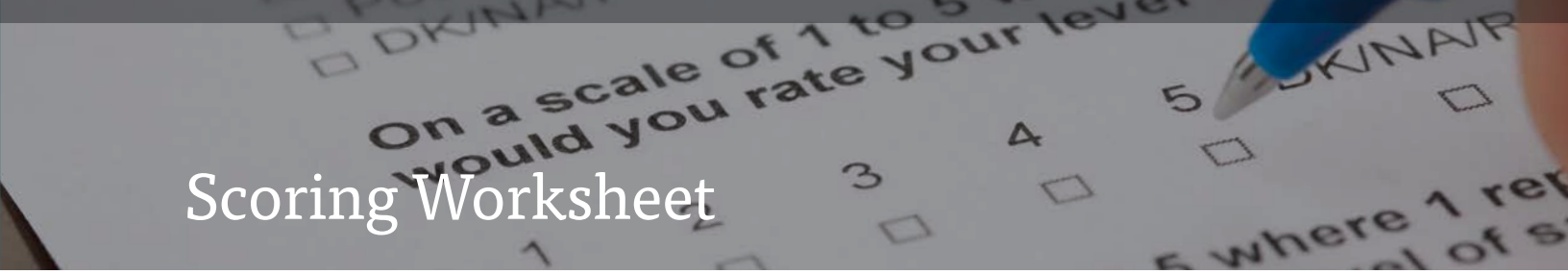
DOMAIN 4

Evaluation of Patient Experience with Contraception Services

4.1 Evaluation of Patient Experience

Learn more about 4.1

Measure	Which option describes your clinic?	Circle # for your answer
a. Clinic solicits patient feedback regarding the contraception services they receive.	Clinic has no process to solicit patient feedback regarding contraception services.	**0**
	Clinic has informal process (e.g., patient comment box) to solicit patient feedback regarding contraception services.	**1**
	Clinic has formal process (e.g., advisory group, routine patient survey) for soliciting patient feedback regarding contraception services.	**2**
b. Clinic uses patient feedback and other patient experience evaluation findings to improve/ enhance patients' experience with contraception services.	Clinic never uses patient feedback and other evaluation findings to improve patients' experience with contraception services.	**0**
	Clinic sometimes uses patient feedback and other evaluation findings to improve patients' experience with contraception services.	**1**
	Clinic routinely uses patient feedback and other evaluation findings to improve patients' experience with contraception services.	**2**
	Component 4.1: **TOTAL SCORE**	



Scoring Worksheet

DOMAIN 1:
Access

1.1:	
1.2:	
1.3:	
1.4:	
SCORE:	

DOMAIN 2:
Service Provision

2.1:	
2.2:	
2.3:	
2.4:	
2.5:	
2.6:	
2.7:	
2.8:	
SCORE:	

DOMAIN 3:
Community Collaborations with Other Providers

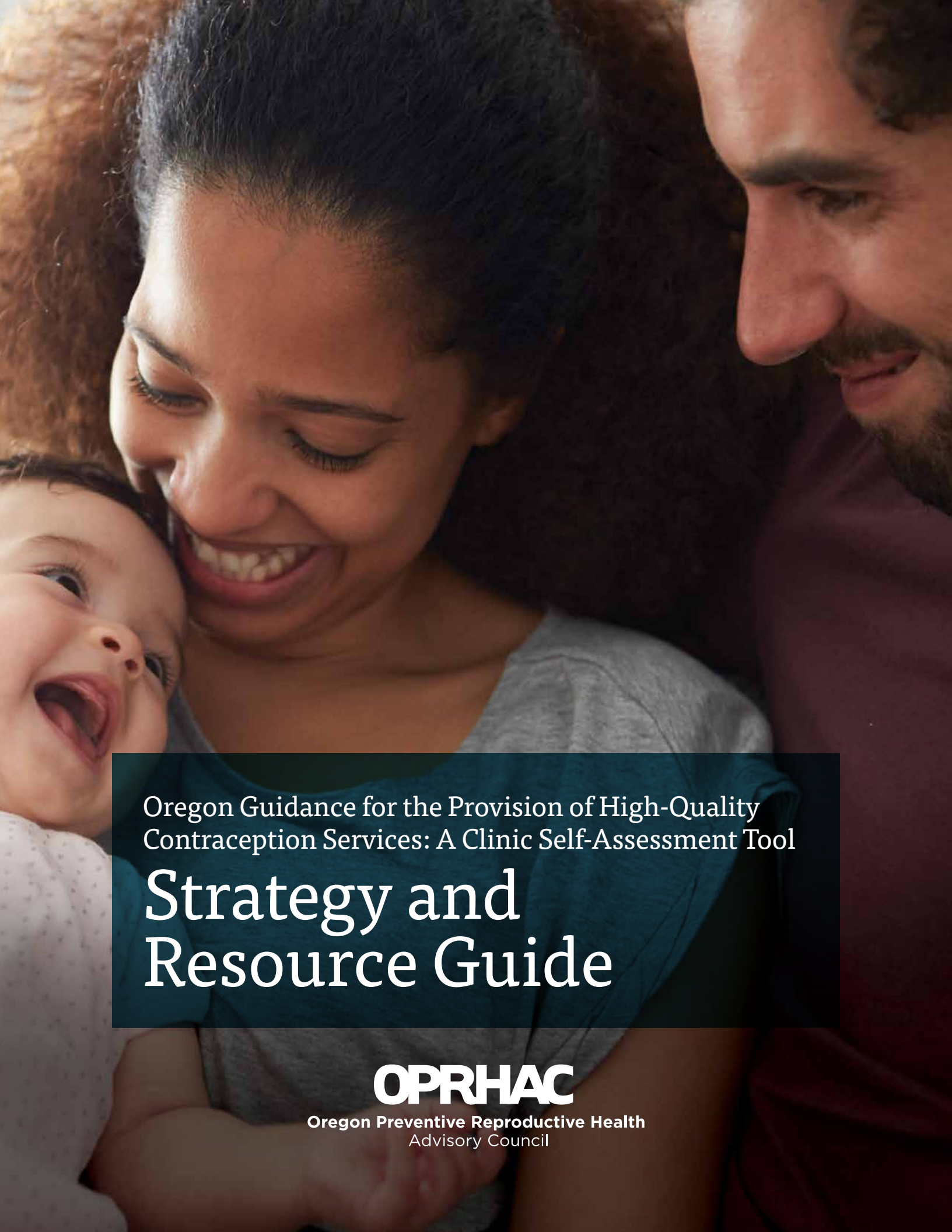
3.1:	
3.2:	
3.3:	
SCORE:	

DOMAIN 4:
Evaluation of Patient Experience with Contraception Services

4.1:	
SCORE:	

= **MY CLINIC SCORE:**

SCORE OF:
50-69 = QUALITY CONTRACEPTION PROVIDER
70+ = EXPERT CONTRACEPTION PROVIDER



Oregon Guidance for the Provision of High-Quality Contraception Services: A Clinic Self-Assessment Tool

Strategy and Resource Guide

OPRHAC
Oregon Preventive Reproductive Health
Advisory Council

Welcome to the Strategy and Resource Guide.

This resource is a companion guide meant to be used together with the *Oregon Guidance for the Provision of High-Quality Contraception Services: A Clinic Self-Assessment Tool.*

DOMAIN 1

Access

Rationale

The Institute of Medicine (IOM) defines access to health care as “the timely use of personal health services to achieve the best health outcomes.” However, these components go further to include not only timeliness, but affordability and the ability of providers to meet the needs of diverse populations, culturally and linguistically.

Back to Self-Assessment Tool

COMPONENT 1.1

Timeliness of Care

Definitions

Quick start protocols for contraception initiation:
refers to the initiation of contraception on the day of the visit.

Third next available appointment:
refers to the average length of time in days between the day a patient makes a request for an appointment and the third next available appointment. The third next available appointment is used rather than the next available appointment because it is a more sensitive reflection of true appointment availability.

Strategies

- Reduce unnecessary barriers and facilitate same-day access to and successful use of contraceptives.
  - For example, do not require a negative chlamydia test result prior to inserting an IUD or a Pap test/pelvic exam in asymptomatic women wanting oral contraceptives.
  - Follow the Centers for Disease Control and Prevention's (CDC) *U.S. Selected Practice Recommendations (US SPR) for Contraceptive Use* to determine the appropriate initiation and use of specific contraceptive methods.[1]
  - Use the "quick start" method to provide patients with protection from unplanned pregnancy faster and more reliably.[2]

- Develop written policies that include directions for phone staff to ask patients if they need a same-day appointment.
  - Establish a process to schedule these appointments as requested.
  - Ensure clinic workflows accommodate appointments for patients with urgent needs, including double booking as needed.

- Consider maintaining at least 10% of the average number of daily appointments unfilled at the start of the business day based on an audit of a representative sample.[3, 4]

- Assess and understand the patterns of both demand (i.e., daily number of patient requests for appointments) and supply (i.e., clinical resources/members of care team available to the clinic) in clinical practice.
  - Adjust supply based on fluctuations in demand.
  - Use team members to expand access by having them provide all intake and education. Use medical providers only as needed for top-of-license work.
  - The Institute for Healthcare Improvement (IHI) measures access to care as the average length of time in days between the day a patient makes a request for an appointment and the actual appointment.[5]

- See Domain 2. Service Provision: Component 2.6: Contraceptive Supplies, for information on stocking birth control methods on-site.

Resources

1. U.S. Selected Practice Recommendations (SPR) for Contraceptive Use, 2013: http://www.cdc.gov/reproductivehealth/unintendedpregnancy/usspr.htm
2. Association of Reproductive Health Professionals, Quick Reference Guide for Clinicians, Choosing a Birth Control Method: https://www.arhp.org/Publications-and-Resources/Quick-Reference-Guide-for-Clinicians/choosing/Initiation-Hormonal-Contraceptives
3. Providing Quality Family Planning Services (QFP), Recommendations of CDC and U.S. Office of Population Affairs, 2014, page 26: http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf
4. Oregon's Patient-Centered Primary Care Home Program, 2014 Recognition Criteria; Technical Specifications and Reporting Guide, page 26: http://www.oregon.gov/oha/pcpch/Documents/TA-Guide.pdf
5. Institute for Healthcare Improvement (IHI): http://www.ihi.org/resources/Pages/Measures/ThirdNextAvailableAppointment.aspx

Back to Self-Assessment Tool

COMPONENT 1.2

Affordability/Cost

Strategies

- Consider using non-financial techniques to maximize fee collection and minimize barriers to patients.
  - Examples include focusing staff efforts on properly assigning patients for a sliding fee and other reimbursement programs, designing procedures to collect at the time of the service, and forgoing use of mailed statements and collection agencies for sliding fee patients.

- Contract with local Coordinated Care Organizations (CCOs) to maximize Medicaid billing and reimbursement capabilities.

- Request that uninsured patients make some payment on day of visit, but do not deny access to care.

- If located along state borders, consider enrolling in the other state's Medicaid program.[1]
  - For Medicaid beneficiaries in underserved areas of the state, this increases patient access to providers.[1]

- Develop a policy and system to identify and enroll patients who are eligible for a sliding fee scale discount.
  - To appropriately apply the discount, perform a cost analysis/assessment to determine the cost of providing services.

- Hire dedicated outreach and enrollment assistance staff to seek out and engage uninsured individuals and assist them with enrolling in health care coverage.[2]

- Consider finding outside grants and resources or internal mechanisms to ensure all women get the contraceptives they need at each visit.[3]

Resources

1. Families USA Policy Brief: Interstate Medicaid Billing Problems: Helping Medicaid Beneficiaries Who Get Care Out of State: http://familiesusa.org/product/interstate-medicaid-billing-problems-helping-medicaid-beneficiaries-who-get-care-out-state
2. Enroll America, Best Practices in Outreach and Enrollment for Health Centers: https://www.enrollamerica.org/research-maps/publications/best-practices-in-outreach-and-enrollment-for-health-centers
3. Patient-assistance program for purchasing Skyla and Mirena IUDs, ARCH Foundation: http://www.archpatientassistance.com

Back to Self-Assessment Tool

COMPONENT 1.3

Special Populations/Diversity

Definitions

Special populations:
in this document, refers to those who are vulnerable, experience unequal access to health care and/or who experience the burden or risk of health disparities due in part to race, ethnicity, culture, socioeconomic status, geography, gender, age, disability status, risk status related to sex and gender, and other factors. (The CDC, Office of Minority Health and Health Equity: http://www.cdc.gov/minorityhealth/populations/atrisk.html.)

Transgender or Trans:
umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with the sex they were assigned at birth. (Note: Transgender is correctly used as an adjective, not a noun, thus "transgender people" is appropriate but "transgenders" is often viewed as disrespectful.)

Non-binary:
term used by some individuals who identify as neither entirely male nor entirely female. Also termed gender-queer.

Strategies

The impact of culture on access to and quality of care is particularly important to address in health care. As Oregon's population of diverse racial and ethnic communities and linguistic groups continues to increase, patients and providers bring with them individual, learned patterns of language and culture. All of these patterns affect the health care experience.

- Develop a plan to implement the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care.[1]

- Provide ADA training for all clinic staff; assess clinic facility and services for ADA compliance; ensure physical access to medical care for people with mobility disabilities, and ensure effective communication for people who are deaf or have hearing loss.[2]

- Use images, written materials and signs that can be easily understood by the diversity of patients served by the clinic and are reflective of the patient population.[1]

- Provide ongoing in-service training on ways to meet the unique needs of the populations served.[3]

- Ensure that all clinicians are aware that individuals with same-sex partners may not identify as gay/lesbian, particularly teenagers and young adults. Avoid making assumptions based on identity.[5]

- Training on transgender health issues and availability of clinical resources should be provided to all clinic staff and providers, including front desk staff, and should be integrated into the standard hiring and on-boarding process for all employees.[6-9]

- Ensure intake forms include a way to document patient's preferred name and gender pronoun.
    - Institute procedures to ensure that patients preferred name is used by all clinic staff at every visit, regardless of whether the patient's preferred name is identical to the patient's name as listed in the electronic health record system.[6, 9]

- Assess the limitations of the clinic's electronic health record system in providing trans care and ensure the patient is advised in advance of potential obstacles. Examples include:
    - Challenges that may arise with any gendered forms of care (such as Pap smears, mammograms, prostate exams, Plan B, etc.)
    - Rejection of coding if the gender associated with the service is incongruent with the gender on record.

- Policies should either define all bathrooms as gender-neutral or specifically state that patients may choose the women's or men's rooms according to their own preference.[6,9]

- Prioritize the recruitment of staff who reflect the patient population and possess skills to effectively interact with diverse patients.
    - Specify key characteristics such as training in cultural competency, experience providing services to diverse and underserved populations, and demographics similar to patients served.[3]

- Hire individuals for entry-level positions (community health workers, medical assistants) with backgrounds closely matching those of patients, close community ties, firsthand knowledge of cultural practices relevant to sexual health, and the ability to speak more than one language.[3]

- Conduct a community needs assessment or partner with the local Public Health Authority and/or CCO to do so. Gather input from an advisory board, including CCO Community Advisory Committee. Create and/or strengthen relationships with the community, patients and their families.[3] Create new partnerships and programming as needed in response to these findings.

- Conduct outreach activities to underserved communities such as holding town hall meetings and community health fairs, and establishing community advisory panels.

- Use a system to collect distinct racial categories in demographic data, such as REAL+D race, ethnicity and language (REAL) and disability (+D).[4]

Resources

1. The National Standards for Culturally and Linguistic Appropriate Services (CLAS) in Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice issued by the HHS Office of Minority Health: https://www.thinkculturalhealth.hhs.gov
2. Information and Technical Assistance on the Americans with Disabilities Act: http://www.ada.gov/ada_intro.htm
3. Assuring Healthcare Equity, A Healthcare Equity Blueprint: http://www.ihi.org/resources/Pages/Tools/HealthcareEquityBlueprint.aspx
4. Oregon Health Authority, Office of Equity and Inclusion, Division 70, Race, Ethnicity, Language, and Disability Demographic Data Collection Standards: http://www.oregon.gov/oha/oei/policy-procedures/Race%20Ethnicity%20Language%20Disability%20Data%20Collection%20Standards.pdf
5. Reproductive Health Access Project: Contraceptive Care for LGBT Patients: http://www.reproductiveaccess.org/resource/contraceptive-pearl-contraceptive-care-for-lgbt-patients
6. Center of Excellence for Transgender Health: http://www.transhealth.ucsf.edu
7. OHSU Transgender Health Program: http://www.ohsu.edu/xd/health/services/transgender-health
8. Gay, Lesbian, Bisexual, and Transgender Health Access Project, Community Standards of Practice for Provision of Quality Health Care Services for Gay, Lesbian, Bisexual and Transgendered Clients: http://www.glbthealth.org/documents/SOP.pdf
9. Gay and Lesbian Medical Association, Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients: http://www.glma.org/_data/n_0001/resources/live/Welcoming%20Environment.pdf

Back to Self-Assessment Tool

COMPONENT 1.4

Language/Health Literacy/ Communication

Definitions

Limited English proficiency (LEP):
refers to individuals who are unable to communicate effectively in English because their primary language is not English.

Health literacy:
defined by the HHS National Institutes of Health as the degree to which individuals have the capacity to obtain, process and understand basic health information and services they need to make appropriate health decisions.

Patients with limited English proficiency (LEP) and/or limited health literacy are less able to access health care services, understand health-related information and follow health care instructions. Limited English proficiency and poor health literacy are associated with poor health outcomes and higher health care costs. Clinicians and patients need to be able to understand each other. If patients with limited English proficiency lack access to language assistance services, they will have a difficult time understanding the care they receive and will be less satisfied with services.

Universal precautions for health literacy:
steps that practices take when they assume that all patients may have difficulty comprehending health information and accessing health services. Health literacy universal precautions are aimed at:

- Simplifying communication with all patients and making sure they understand information, to minimize the risk of miscommunication.
- Making the office environment and health care system easier to navigate.
- Supporting patients' efforts to improve their health.[4]

Non-written formats:
verbal formats and graphic formats such as visual brochures, videos, infographics, and graphic demonstrations.

Strategies

- Use the Ten Attributes of a Health Literate Organization to guide thinking/implementation.[1]

- Offer language assistance to patients who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.[2]

- Use "I Speak" cards with patients who do not speak enough English to respond to questions about language preference, to identify the language they speak.[3]

- Display interpretive services posters in waiting and reception areas to make patients aware that free interpreter services are available.[2]

- Ask all new patients what language they *prefer* to speak and read, and if they would like an interpreter. Record patients' language assistance needs in the medical record.[3,4]

- Practice universal precautions for health literacy.[3,4]

- Assess whether patient materials are easy to read and understand.[3,4,5]

- Assess and meet the direct language needs of patients during visits by using clinicians who speak the same language, providing in-person interpretation by trained language interpreters and using visual aids.[2]

Resources

1. Institute of Medicine's Ten Attributes of Health Literate Health Care Organizations: http://www.ahealthyunderstanding.org/Portals/0/Documents1/IOM_Ten_Attributes_HL_Paper.pdf
2. Oregon Office of Equity and Inclusion: http://www.oregon.gov/oha/oei/Pages/hci-resources.aspx
3. Providing Quality Family Planning Services (QFP), Recommendations of CDC and U.S. Office of Population Affairs, 2014, page 48: http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf
4. Agency for Health and Research Quality (AHRQ) Health Literacy Universal Precautions Toolkit, Second Edition, January 2015: http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit
5. CMS Toolkit for Making Written Material Clear and Effective: https://www.cms.gov/Outreach-and-Education/Outreach/WrittenMaterialsToolkit/index.html

DOMAIN 2

Service Provision

Rationale

The delivery of quality, comprehensive contraception health services is essential for preventing unintended pregnancy and improving reproductive health outcomes. These services should be based on national standards of care and align, where appropriate, with the recommendations of the Centers for Disease Control and Prevention (CDC) and Office of Population Affairs (OPA) for the provision of quality family planning services.

Back to Self-Assessment Tool

COMPONENT 2.1

Assess for Pregnancy Intentions

Strategies

Pregnancy intention screening may take different forms depending on the patient's needs and the relationship between the patient and her/his clinician. Regardless of the format, pregnancy intention screening should be patient-centered.

- Screen for pregnancy intention as part of initial and continuing health assessments. Pregnancy intention screening/counseling should assess the patient's current desire to become pregnant. [1-4]

- Routinely ask patients about satisfaction with their current method and extent to which current method aligns with pregnancy intention. Method satisfaction is a key factor associated with continuation/discontinuation.[2-4]

- Recognize that pregnancy intentions are often complex and multi-dimensional.
  - Many patients experience ambivalence regarding pregnancy and parenting desires.
  - Facets of pregnancy intention may include the strength of patient's motivations in avoiding pregnancy, their expected emotional reaction if s/he were to become or cause their partner to become pregnant, and the perceived support of the partner.[1-4]

- Provide preconception and/or contraception services, based on the patient's pregnancy intention, during the current visit, in subsequent visit(s), or through coordinated referral.[1-6]

- Some populations, such as males, adolescents, and LGBT patients, may be less likely to receive pregnancy and parenting intention screening in a typical clinic setting.

- Research on the effectiveness of existing pregnancy intention screening tools and methods among special populations is ongoing but limited. Some adaptation may be necessary to ensure that screening is culturally appropriate and patient-centered.

Resources

Several pregnancy intention screening tools are used in different clinical and non-clinical settings. Numbers one and two below are the most commonly-recommended tools.

1. One Key Question®, developed by the Oregon Foundation for Reproductive Health and strongly supported by the Oregon Health Authority: http://www.onekeyquestion.org
2. Reproductive life plan resources, Centers for Disease Control and Prevention, Preconception Health and Health Care: http://www.cdc.gov/preconception/reproductiveplan.html
3. Motivational Interviewing (MI) can be applied to contraception counseling. https://www.arhp.org/uploaddocs/Client%20Centered%20Contraception%20Counseling%20.pdf and http://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co423.pdf?dmc=1&ts=20170407T2144229678
4. Providing Quality Family Planning Services (QFP), Recommendations of CDC and U.S. Office of Population Affairs, 2014, pages 5-7: http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf
5. Before, Between and Beyond Pregnancy, The National Preconception Curriculum and Resources Guide for Clinicians: http://beforeandbeyond.org/toolkit
6. Preconception health and health care, resources from the Centers for Disease Control and Prevention: http://www.cdc.gov/preconception/index.html

Back to Self-Assessment Tool

COMPONENT 2.2

Counseling and Education

Definitions

Patient-centered counseling:
counseling that is respectful of, and responsive to, individual patient preferences, needs and values. This approach saves time and encourages patient decision-making and responsibility.

Effective contraceptive counseling and education is a two-way process. By asking questions and listening to what patients say, we experience bi-directional learning. Patient-centered counseling benefits patients because it addresses their concerns, focuses on their needs and results in positive health outcomes. It benefits clinicians by saving time, decreasing stress and frustration, and increasing effectiveness and professional engagement.

A range of factors can influence a patient's choice of a contraceptive method. Personal preferences, relationship characteristics, social influences, pregnancy intentions, and cultural considerations may affect the decision-making process. The contraception care provider has an important role in assisting patients with their decisions. First, by listening to the patient—eliciting concerns, interests and goals related to pregnancy prevention. Then, by providing clear and accurate information about the full range of contraceptive options, emphasizing those most aligned with patient-expressed desires.

Strategies

- Ensure clinician proficiency with one or more evidence-based or nationally endorsed patient-centered counseling techniques and approaches. Examples include:
  - The Five Principles for Providing Quality Counseling, as laid out by the Center for Disease Control and the Office of Population Affairs in Providing Quality Family Planning Services.[1]
  - Teach-Back Method: a practice based on the health literacy principles of plain language that confirms patient understanding and improves patient outcome. This method is also effective in ensuring the clinician can explain back to the patient what the clinician heard regarding the patient's preferences.[2]
  - O.A.R.S.: a skills-based model of interactive techniques adapted from a patient-centered approach, using motivational interviewing principles.[3]
  - PC2 You Decide: a five-step approach to guide clinicians in helping patients choose a new contraceptive method, understand cardiovascular risks associated with combined hormonal methods, and address patient concerns.[4]

- Offer annual training and resources that maintain clinician knowledge and understanding of all FDA-approved contraceptive methods. Ensure contraceptive counseling reflects current practice standards.[5,6,7]
  - Ensure clinicians have access to the most current versions (print and/or electronic) of the U.S. Medical Eligibility Criteria for Contraceptive Use, 2010 and the U.S. Selected Practice Recommendations for Contraceptive Use, 2013 for all contraceptive counseling and education providers.[5,6]
  - Consider training on the tiered approach to counseling. In this approach, the most effective, reversible long-acting methods are presented before less effective methods, and include methods that may not be available on-site. Tiered counseling should start at the patient's experience level and be based on their stated preferences and goals. It is particularly important to be mindful of historic experiences of coercion and forced sterilization among communities of color and other vulnerable populations.

- As a result of counseling and education training and resources offered, clinicians should be able to demonstrate the following skills[8]:
  - Establish rapport: The ability to establish rapport and gain insight into the patient's personal circumstances and challenges can help the clinician to individualize information and guidance.
  - Engage patients as partners in their own care: The ability to engage the patient in developing a plan that includes setting goals, discussing possible difficulties and challenging situations, and considering backup plans and follow-up (see Component 2.8: Patient Support for Contraceptive Management).
  - Use education and decision aids: Appropriate use of decision aids (paper or computer-based) during the counseling visit to help patients self-assess, learn about methods, and develop questions for the clinician.
  - Build trust: Competent interpersonal skills that build trust allow for greater insight into the patient's cultural and personal context.
  - Interpersonal communication skills: Nonjudgmental listening and empathy can be especially important in sexual health discussions.

- Offer training in Implicit Bias in addition to Cultural Competency. Consider innovative approaches to understanding implicit biases of clinicians, such as videotaping encounters to analyze for patterns[9] and examining relevant data (e.g., examining contraceptive methods used by patients of different racial and ethnic backgrounds across individual clinicians to see whether there are differences in method provision).

- Competencies 1.3 Special Populations/Diversity and 1.4 Language/Health Literacy/Communication include strategies and resources related to the provision of culturally and linguistically appropriate counseling and education services.

Resources

1. Providing Quality Family Planning Services (QFP), Recommendations of CDC and U.S. Office of Population Affairs, 2014, Appendix C – Five Principles for Providing Quality Counseling and Appendix E – Strategies for Providing Information to Clients: www.cdc.gov/mmwr/pdf/rr/rr6304.pdf
2. Teach-Back Method: http://www.teachbacktraining.org
3. The OARS Model, Essential Communication Skills, Center for Health Training, 2010: https://public.health.oregon.gov/HealthyPeopleFamilies/ReproductiveSexualHealth/Documents/edmat/OARSEssentialCommunicationTechniques.pdf
4. PC2 You Decide: A Five-Step Approach to the personal choice interview, risk assessment, and patient education with regards to cardiovascular risks associated with hormonal contraception: http://www.knowwhatuwant.org/uploads/pdf/ARHPs_5-step_Provider_Counseling_Guide.pdf
5. Centers for Disease Control and Prevention, Reproductive Health, US Selected Practice Recommendations (US SPR) for Contraceptive Use, 2013: http://www.cdc.gov/reproductivehealth/unintendedpregnancy/usspr.htm
6. Centers for Disease Control and Prevention, Reproductive Health, US Medical Eligibility Criteria (US MEC) for Contraceptive Use, 2010: http://www.cdc.gov/reproductivehealth/unintendedpregnancy/usmec.htm
7. Dehlendorf C, Krajewski C, Borrero S. Contraceptive counseling: best practices to ensure quality communication and enable effective contraceptive use. Clin Obstet Gynecol 2014 Dec; 57(4):659-73.
8. Oregon Health Authority, Public Health Division, Reproductive Health Program, Client-Centered Counseling Models and Resources, 2013: https://public.health.oregon.gov/HealthyPeopleFamilies/ReproductiveSexualHealth/Documents/edmat/Client-CenterCounselingModelsandResources.pdf
9. Rachel L. Johnson, Debra Roter, Neil R. Powe, Lisa A. Cooper. Patient Race/Ethnicity and Quality of Patient–Physician Communication During Medical Visits. Am J Public Health. 2004 December; 94(12): 2084–2090.

Back to Self-Assessment Tool

COMPONENT 2.3

Condoms and Vasectomy Services

Definitions

Males:
in this context, refers to patients assigned male at birth who are having sex with women.

Strategies

Males are increasingly recognized as a key part of preventing unintended pregnancies, as well as planning and supporting healthy pregnancies. Several strategies can be used to increase their involvement in the spacing and timing of pregnancies.

- Order condoms in bulk to receive price discounts.
- Make condoms available in restrooms and at the front desk. This allows patients access at no cost to them and without an appointment or use of clinic staff.
- Offer condoms to males and females at a variety of visit types.
- Make available various types of condoms (latex and non-latex; lubricated and non-lubricated; different sizes).
- Demonstrate to patients the best techniques for applying and removing condoms using a penile model.
- Discuss dual protection of methods (condoms provide excellent back-up to other contraceptive methods and are the only contraceptive method that also protects against the transmission of STIs).

Strategies specific to Vasectomy Services

- Obtain a memorandum of understanding (MOU) or formal contract with a partner organization to accept referrals for vasectomy.

- Ensure the MOU/contract addresses the provision of services across payer sources. Ensure the MOU/contract addresses who will perform the pre-procedure counseling; post-procedure semen analysis; and deal with any complications/emergencies.

- Provide patient with counseling on vasectomy, including the permanent nature of the method, to ensure appropriate referral is made.

- To prevent delays, obtain patient consent for sterilization using the federal sterilization consent form.
  - Fax or email the signed consent form and relevant medical information to the referred clinician.
  - At the time the patient requests the service, offer to call and schedule an appointment with the referred clinician.

- Follow-up on referral as described in Component 3.3: Linkages to Primary Care and/or Chronic Disease Care Management Services.

- Accept referrals for vasectomies from outside agencies and across payer sources.

- Ensure that patient instructions after the procedure include direction for after hours' emergencies, interim contraception and post-procedure semen analysis.

- Have a system in place to obtain and follow up as needed on post-procedure semen analysis.

- Follow nationally-recognized recommendations for all aspects of the procedure.

- Ensure that referrals received are tracked. As appropriate, share information with the referring provider.

Resources

1. Providing Quality Family Planning Services (QFP), Recommendations of CDC and U.S. Office of Population Affairs, 2014, pages 15 and 23: http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf
2. American Urology Association (AUA) vasectomy guidelines: http://www.auanet.org/education/guidelines/vasectomy.cfm

Back to Self-Assessment Tool

COMPONENT 2.4

Services for Youth

Definitions

Adolescent:
a person in a period of human growth and development that occurs after childhood and before adulthood, from ages 10 to 19.

Minor:
a person under the age of 18.

Youth:
a person under the age of 24.

Strategies

- When serving adolescents, special considerations are essential for high quality services.
  - Confidentiality
    - Ensure all clinic staff are familiar with minor rights to access and consent to health care.[1]
    - Schedule slightly longer visits with adolescents so they have time to ask questions and get answers to their questions.[2]
    - Create counseling areas that provide visual and auditory privacy.
    - Ensure examination areas provide visual and auditory privacy.

Ensure that all patients, particularly youth, are aware of the Oregon Confidential Communication Request law. This law gives patients enrolled in a private health insurance policy the right to request that protected health information is sent directly to them instead of the person who pays for health insurance.[3]

- Mandatory Reporting
  - Encourage youth to communicate with parents or other trusted family members as appropriate. If the adolescent has not talked with her/his parent(s) about sexual health, be sure that the adolescent lives in a safe environment before counseling her/him to do so.[2,4]
  - Provide staff training and support on mandatory reporting.
- Cost and Billing Transparency
  - Use billing procedures to maintain patient confidentiality. If this is not possible, advise the patient about the potential breach of confidentiality. Provide alternative billing options such as self-pay on a sliding fee scale.[5]

▶ Quality adolescent services are patient-centered, respectful and developmentally appropriate.

- Youth-friendly Services
  - Ensure all clinic staff receives training in adolescent development and treating youth respectfully. Involve the adolescent in her/his own health management.[2]
  - Seek youth input on clinic services, such as having youth members on a clinic advisory board and/or active youth involvement in design of and feedback about programming.
  - Consider adding trained peer counselors/mentors/instructors to team.
  - Consider offering a "teen clinic" or clinic hours that accommodate teen schedules.
  - Ensure services are "youth-friendly": accessible, equitable, acceptable, appropriate, comprehensive, effective and efficient for youth, as recommended by the World Health Organization. Examples include youth-friendly/specific materials, effective communication skills, etc.
- Parent/Guardian Involvement[6]
  - Communicate with each patient that they may have their examination and counseling without parents or guardians present, and that their privacy is respected.

- Inform parents and guardians of the health center's standard procedure for the provider to spend time alone with patients to discuss their comprehensive health and wellness.
- Give clear information to parents and guardians on the patient's right to confidentiality, privacy and informed consent.

Resources

1. Minor Rights: Access and Consent to Health Care, developed by the Oregon Health Authority Adolescent Health Program: https://public.health.oregon.gov/HealthyPeopleFamilies/Youth/Documents/minor-rights.pdf
2. Advocates for Youth, Best Practices for Youth Friendly Clinical Services: http://www.advocatesforyouth.org/publications/publications-a-z/1347--best-practices-for-youth-friendly-clinical-services
3. Information regarding the Oregon Confidential Communication Request law: https://public.health.oregon.gov/HealthyPeopleFamilies/ReproductiveSexualHealth/Pages/Reproductive-Health-Data-and-Reports.aspx. Insurance Division webpage on the law: www.patientprivacy.oregon.gov
4. Providing Quality Family Planning Services (QFP), Recommendations of CDC and U.S. Office of Population Affairs, 2014, page 13: http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf
5. CDC: A Teen Friendly Reproductive Health Visit: http://www.cdc.gov/teenpregnancy/pdf/teenfriendlyclinic_8.5x11.pdf
6. Advocates for Youth Parents Sex Ed Center: http://www.advocatesforyouth.org/parents-sex-ed-center-home

Back to Self-Assessment Tool

COMPONENT 2.5

Services for Postpartum and/or Breastfeeding Women

Strategies

- Ensure the clinic is breastfeeding-friendly for patients and staff. Breastfeeding and postpartum women will feel more comfortable seeking services in an environment that is receptive to their needs.[1]

- Encourage and support access to contraception services prior to resuming sexual activity, which often may occur before the routine six-week postpartum visit. Encourage contraceptive use prior to resuming sexual activity.[2,3]

- Offer a broad range of methods and ensure staff can counsel and support the use of each available contraceptive method, including Lactational Amenorrhea Method (LAM).[2,3]

- Discuss the spacing of pregnancies and the patient's reproductive life plan during pregnancy and in the postpartum period. Offer contraception that supports patient's plan.[2,3]

- Obstetric providers should counsel pregnant women about all forms of postpartum contraception in a context that allows informed decision-making. Immediate postpartum LARC should be offered as an effective option for postpartum contraception.[4,5]

Resources

1. Breastfeeding-friendly physician's office: optimizing care for infants and children, 2013: http://www.guideline.gov/content.aspx?id=46908
2. Association of Reproductive Health Professionals 2013, https://www.arhp.org/publications-and-resources/quick-reference-guide-for-clinicians/postpartum-counseling/contraception
3. US MEC revisions for postpartum contraception, 2011: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6026a3.htm
4. The American College of Obstetricians and Gynecologists. Committee Opinion on Immediate Postpartum Long-Acting Reversible Contraception, 2016: https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co670.pdf?dmc=1&ts=20160826T1311208590
5. Health Evidence Review Commission (HERC) Coverage Guidance: Timing of Long-Acting Reversible Contraceptive (LARC) Placement, 2016: http://www.oregon.gov/oha/herc/Coverage-Guidances/LARC-CG.pdf

Back to Self-Assessment Tool

COMPONENT 2.6

Contraceptive Supplies

Definitions

Broad range of FDA approved methods:
includes a choice of combination oral contraceptives (phasic and monophasic), at least one non-oral combination contraceptive (ring or patch), a progestin-only pill and injectable, IUD and IUS, sub-dermal implant, latex and non-latex male condoms, female condoms, two types of spermicide, diaphragm or cervical cap, Fertility Awareness Method (FAM), emergency contraception pills (ECP) for immediate use, information about abstinence and withdrawal, and information and referral for sterilization.

On-site:
on the premises, such as in the clinic, in the building or on the campus, so that a patient does not have to travel to another location such as a separate retail pharmacy.

Strategies

Contraceptive choice is an important aspect of quality care as patients may be more likely to select a method that fits her/his unique circumstances.[1]

- Provide a broad range of FDA-approved methods available on-site or by referral.[2]

- Administer EC for immediate use on-site according to proven efficacy guidelines for appropriate weight and body mass index (BMI).[3,4]

- Dispense up to a one-year supply of FDA-approved methods on-site. Dispensing a one-year supply of pills is associated with a 30% reduction in the odds of conceiving an unplanned pregnancy, compared with dispensing just one or three packs.[5]

Resources

1. Providing Quality Family Planning Services (QFP), Recommendations of CDC and U.S. Office of Population Affairs, 2014, page 13: http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf
2. Broad range of FDA approved contraceptive methods as defined in the Oregon Health Authority Reproductive Health Program Manual, Section A.6: http://public.health.oregon.gov/HealthyPeopleFamilies/ReproductiveSexualHealth/Resources/Documents/FP_Program_Manual/sectiona.pdf
3. Association of Reproductive Health Professionals. 2011. Update on Emergency Contraception: http://www.arhp.org/Publications-and-Resources/Clinical-Proceedings/EC/Methods
4. EC: Challenges and Choices. Algorithm for Dispensing Emergency Contraceptives Rapkin, R.B., Creinin, M. OBG Management 2011; 23(8): slides 16-24: http://www.ctcfp.org/wp-content/uploads/EC-Challenges-Choices1.pdf
5. Number of Oral Contraceptive Pill Packages Dispensed and Subsequent Unintended Pregnancies Foster, Diana Greene PhD; Hulett, Denis; Bradsberry, Mary; Darney, Philip MD, MSc; Policar, Michael MD, MPH Obstetrics & Gynecology: http://journals.lww.com/greenjournal/Fulltext/2011/03000/Number_of_Oral_Contraceptive_Pill_Packages.8.aspx#

Back to Self-Assessment Tool

COMPONENT 2.7

Contraceptive Procedures: LARC Insertion/Removal and Diaphragm Fitting

Strategies

- Remove barriers/delays to receiving LARCs. For example, do not require Pap test or negative STI results for asymptomatic patients prior to inserting LARCs.[1]
- Train staff on insertion/removal procedures for all LARCs (including assistive staff). Offer annual LARC update training.[1]
- Arrange mentorship programs for clinic staff and provide mentoring for outside clinicians.[1]
- Encourage single-day insertion appointments.[1,2]
- Maintain an adequate supply of LARCs to ensure same-day availability and use of Paragard® as EC.[1,2]
- Train staff on diaphragm fitting. Offer Caya® as an alternative diaphragm that doesn't require fitting.
- Stock and dispense spermicidal formulation appropriate for use with a diaphragm.

Resources

1. LARC First: http://www.larcfirst.com
2. UCSF LARC Program: http://larcprogram.ucsf.edu

Back to Self-Assessment Tool

COMPONENT 2.8

Patient Support for Contraception Management

Strategies

Many of the strategies and resources recommended in Component 2.2: Counseling and Education are relevant to this Component. The strategies below are also recommended to support patients and their use of contraception.

- Provide education for contraceptive methods that are based on the patient's stated needs and priorities.
  - Include medical contraindications as appropriate, prior to initiation and throughout reproductive health care, as patient lifestyle, reproductive goals, medications/ contraindications and side effects will change.[1,2,3,6]

- Use decision aids and a tiered counseling approach for nonjudgmental, accessible patient problem-solving. This will increase effective adoption, change, and maintenance of contraception of choice.[1,2,3,4,6]

- Co-create a patient-centered plan for contraceptive choice using the highest degree of consistent correct use of method.[1,2,3]

- Confirm the patient's understanding of their method of choice.
  - Address safety concerns and how to contact the clinic when they have questions or concerns.
  - Ensure that all clinics have a 24-hour call-back policy for patient telephone calls about contraceptive concerns. Communicate this to the patient.[1,2,3,5]

- Create a follow-up plan to sustain the method (follow-up visit in three months, IUD check appointment in six weeks, etc.).
    - Encourage immediate contact with the clinic about concerns, uncertainty about maintaining methods as planned, adjustments, and emergency contraception as needed.[1,2,3,4,7]

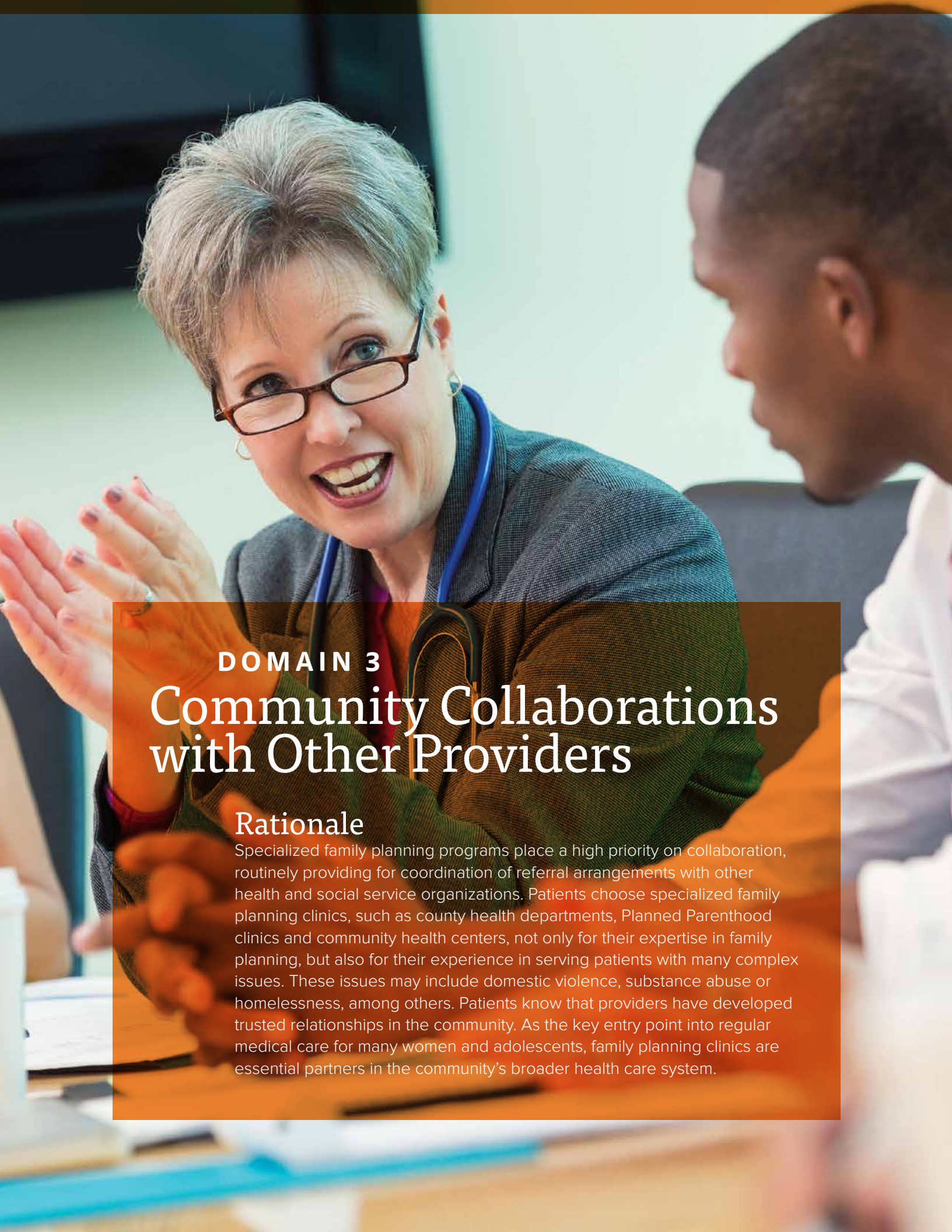
- Use effective reminders such as text messages or reminder cards for Depo shots or refills.[1,7]

- Train staff as to how they will route triage calls from patients with contraceptive questions, or who need emergent care or to make a follow-up appointment.[1,6]
    - For example, will staff send calls to one person or is everyone trained?

- Maintain staff supports for providing quality contraceptive care: updated evidence-based training on methods, standing orders for RNs to dispense methods, updated clinic reference resources (e.g. QFP, Contraceptive Technology, etc.).[1,2,3,6]

Resources

1. Providing Quality Family Planning Services (QFP), Recommendations of CDC and U.S. Office of Population Affairs, 2014, pages 7-13: http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf
2. Association of Reproductive Health Professionals – contraceptive decision-making tool: http://www.arhp.org/methodmatch
3. World Health Organization – evidence-based contraceptive decision-making tool: http://www.who.int/reproductivehealth/publications/family_planning/9241593229index/en
4. National Campaign to Prevent Teen Pregnancy - clinician tool with tips to improve contraceptive use: http://thenationalcampaign.org/resource/careful-current-and-consistent
5. Center for Evidence Based Practice-Case Western Reserve University – introduction to motivational interviewing: https://www.centerforebp.case.edu/practices/mi
6. References for understanding and problem-solving issues (e.g. irregular bleeding) related to specific methods:
    - U.S. Selected Practice Recommendations for Contraceptive Use, 2013: adapted from the World Health Organization selected practice recommendations for contraceptive use, 2nd edition. Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion. MMWR Recomm Rep 2013;62:1–60. [PubMed] [Full Text]
    - Hatcher, R.A., et al., (20th ed.) (2011). Contraceptive Technology. Ardent Media, Inc.
    - Dickey, Richard, P., (15th ed.) 2014. Managing Contraceptive Pill Patients. Fort Collins, CO: Emis Medical Publishers
    - U S. Medical Eligibility Criteria for Contraceptive Use, 2010. Centers for Disease Control and Prevention (CDC). MMWR Recomm Rep 2010;59(RR-4):1–86. [PubMed] [Full Text]
    - Understanding and using the U.S. Medical Eligibility Criteria For Contraceptive Use, 2010. Committee Opinion No. 505. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011;118:754–60. [PubMed] [Obstetrics & Gynecology]
7. Bedsider – method finder tool and appointment reminder services: www.bedsider.org



DOMAIN 3

Community Collaborations with Other Providers

Rationale

Specialized family planning programs place a high priority on collaboration, routinely providing for coordination of referral arrangements with other health and social service organizations. Patients choose specialized family planning clinics, such as county health departments, Planned Parenthood clinics and community health centers, not only for their expertise in family planning, but also for their experience in serving patients with many complex issues. These issues may include domestic violence, substance abuse or homelessness, among others. Patients know that providers have developed trusted relationships in the community. As the key entry point into regular medical care for many women and adolescents, family planning clinics are essential partners in the community's broader health care system.

Back to Self-Assessment Tool

COMPONENT 3.1

Linkages to Contraception Services

Strategies

- Conduct an organizational assessment to identify which clinicians can offer the full range of contraception options, including procedure-based methods such as sterilization, IUDs, implants and diaphragm fittings.
  - Determine which ones are only comfortable with prescription-based methods.
  - Ensure good communication regarding which clinicians offer which services so that patients can be referred internally first.[1,2]

- For any contraceptive methods not available within the clinic, identify clinicians in the community who are willing to serve as a referral resource. Communicate with them about how to optimize referrals for those services.[1,2]

- Ensure that counseling documentation reflects the fact that all methods were offered to the patient. If the patient chooses a method not available, document the clinic to which the patient was referred.

- If as a result of this self-assessment your clinic scores as an “expert-level” provider, then draft a letter to the practice managers of local provider offices that: introduces your practice as an expert-level contraception practice; reviews the contraceptive methods your practice offers; and explains your availability as a resource to provide telephone consultation or patient referrals with contraceptive complications or difficult contraceptive management issues (e.g. ultrasound on-site).

Resources

1. Geiger Gibson /RCHN Community Health Foundation Research Collaborative, Policy Research Brief # 26A; Natural Fit: Collaborations Between Community Health Centers and Family Planning Clinics; George Washington University, October 9, 2011: http://www.rchnfoundation.org/?page_id=1563

2. OHA, Effective Contraceptive Use Among Women at Risk of Unintended Pregnancy: A Guidance Document, page 28: http://www.oregon.gov/oha/analytics/CCOData/Effective%20Contraceptive%20Use%20Guidance%20Document.pdf

Back to Self-Assessment Tool

COMPONENT 3.2

Linkages to Social and Behavioral Services, Including Domestic Violence/ Mental Health/Substance Abuse

Strategies

- Consider screening all patients for domestic violence and distribute Safety Cards routinely (available from Futures Without Violence).[1]
- Consider screening all patients for depression using the Patient Health Questionnaire (PHQ-2).[2]
- Consider screening all patients for Substance Use Disorders using the SBIRT tool.[3]
- If patients express difficulty in meeting basic needs such as food, housing, transportation or child care, refer them to 211 Info. Or help patients, if willing, to call 211 Info from the clinic.[4]
- Identify key mental health, domestic violence and substance use treatment providers in the community.
  - Maintain an up-to-date list of their contact information.
  - 211 Info can also be used for this purpose—clinicians can call to find out where to send patients in their community.[4]
- When a social or behavioral health concern arises as part of the patient's visit, document any referrals made or phone numbers/ contact information given to the patient.

- Mental health, substance use treatment and domestic violence providers are usually restricted from communicating back with referring clinicians, to protect the privacy of the patient. Documenting that the referral was made is usually sufficient, although it is good practice to check back with the patient to make sure they received needed services.

Resources

1. Futures Without Violence: http://www.futureswithoutviolence.org
   To order Safety Cards: https://secure3.convio.net/fvpf/site/Ecommerce/567623699?FOLDER=1133&store_id=1241
2. Patient Health Questionnaire for depression screening: http://www.cqaimh.org/pdf/tool_phq2.pdf
3. SBIRT tool and support for substance use screening: http://www.sbirtoregon.org
4. 211 Info Family Resource line: http://211info.org

Back to Self-Assessment Tool

COMPONENT 3.3

Linkages to Primary Care and/or Chronic Disease Care Management Services

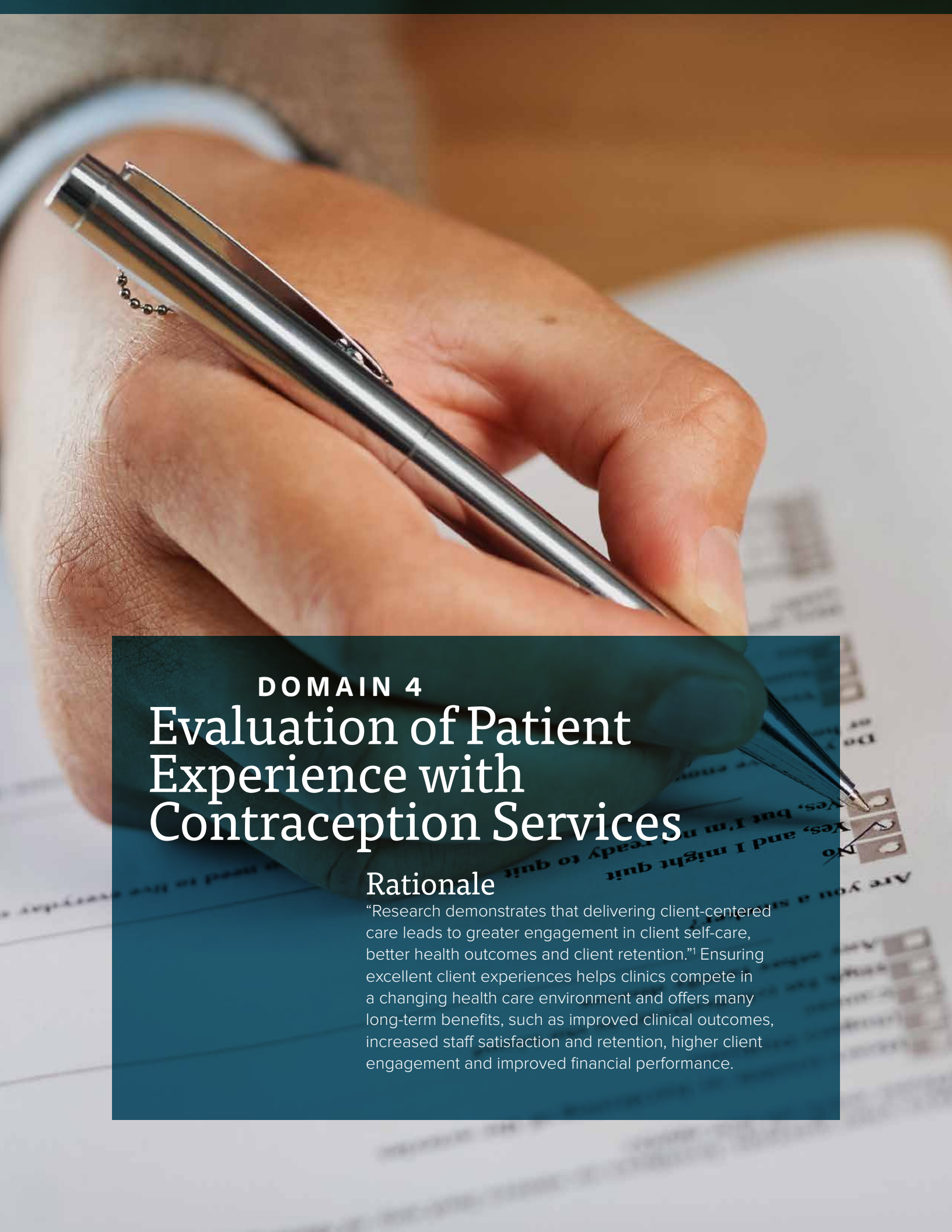
Strategies

- If your clinic is a specialty family planning provider, identify primary care providers in the community who are accepting new patients, including Medicaid and uninsured patients. Communicate with them about the best ways to refer patients in need of primary care and/or chronic disease management.[1,2]

- Primary care providers and specialty family planning providers should consider developing cross-referral agreements or contractual collaborations when they serve the same community.
  - Cross-referral agreements allow for primary care to refer contraceptive patients to family planning for services they do not provide, and for family planning to refer patients to primary care for services they do not provide. In this type of agreement, it is important to understand the parameters for appropriate referrals for each organization to avoid frustrating the patients.
  - Sharing space or co-locating with the family planning center, allows primary care to provide family planning services to its patients. More detail on these arrangements can be found at the Guttmacher Institute link below.[1]

Resources

1. Guttmacher Institute Policy Review Fall 2011: *Strengthening the Safety Net: Pathways for Collaboration Between Community Health Centers and Family Planning Programs:* https://www.guttmacher.org/pubs/gpr/14/4/gpr140414.html
2. Rosenbaum S, et al: *Health Centers and Family Planning Update: Implications of the 2014 Quality Family Planning Services Guidelines* Issued by the CDC and the Office of Population Affairs July 2014: https://publichealth.gwu.edu/pdf/hp/health-centers-family-planning-update.pdf



DOMAIN 4

Evaluation of Patient Experience with Contraception Services

Rationale

"Research demonstrates that delivering client-centered care leads to greater engagement in client self-care, better health outcomes and client retention."[1] Ensuring excellent client experiences helps clinics compete in a changing health care environment and offers many long-term benefits, such as improved clinical outcomes, increased staff satisfaction and retention, higher client engagement and improved financial performance.

Back to Self-Assessment Tool

COMPONENT 4.1

Evaluation of Patient Experience

Definition

Patient experience:

defined by The Beryl Institute as "the sum of all interactions, shaped by an organization's culture, that influence client perceptions across the continuum of care." (The Beryl Institute, http://www.theberylinstitute.org/?page=definingpatientexp)

Strategies

- Place a comment box, clinic journal or bulletin board in the clinic for patients to provide feedback and comments about their care.[1]
  - Such passive assessments will give a highly selective perspective from a small subsection of motivated patients. Some complaints may be very situational and not necessarily useful for motivating clinic changes.
  - In a family planning setting, privacy concerns must be carefully protected. Thus, the handling of comments should be clearly posted (e.g., who will have access to them and how they will be discarded).

- Conduct active evaluation activities such as a patient satisfaction survey (paper or online), exit interviews, telephone audit, mobile survey and focus groups.[1,2]
  - Validated patient surveys designed to evaluate patient's primary health care experiences and interactions with their clinicians are available. Identify survey questions that are relevant to contraceptive care and for evaluating patient perceptions of cultural competency, information delivery, patient-centered communication and interpersonal care from these sources and use them to develop a brief instrument.[2,3,4]

- Include an open field for patient comments to obtain feedback not captured by the survey items.
- The survey can be administered to all patients for a set period (e.g., two days, one week). This can be done twice a year or less frequently, depending on available resources. Alternatively, the survey can be available at all times to all patients (see passive assessments above).

- Use survey findings and resulting actions to:
  1. congratulate staff on their efforts,
  2. communicate to patients that the clinic staff care about their needs and preferences by posting information in waiting areas about current improvement efforts, and
  3. share with board members, funders, Coordinated Care Organizations and/or accreditation organizations.[1]

- Establish procedures for ongoing quality improvement based on the information collected. After conducting the evaluation (active or passive), involve clinic staff in reflection on the results without assigning blame. Encourage a culture of problem solving to improve care.[1,2,4,5,6,7]
  - Involve staff who are being assessed in all stages of the evaluation process: data development, collection and analysis.
  - The Plan, Do, Study, Act model (see Institute for Health Care Improvement resource below) for systematically improving quality of care involves staff in developing a plan, pilot testing, evaluating and permanent implementation.[8]
  - Teach leadership how to evaluate services and share data in positive, productive, systems-focused communication styles.

Resources

1. The National Family Planning Training Center, The Patient Experience Improvement Toolkit: http://fpntc.org/training-and-resources/patient-experience-improvement-toolkit
2. Patient Experience of Care: Inventory of Improvement Resources, Aligning Forces for Quality, RWJF, July 2014: http://forces4quality.org/patient-experience-care-inventory-improvement-resources-0
3. Primary Care Satisfaction Survey for Women: http://www.wakehealth.edu/Research/WHQA/Downloads.htm
4. Agency for Healthcare Research and Quality, CAHPS – Surveys and Tools to Advance Patient-Centered Care: https://cahps.ahrq.gov/surveys-guidance/cg/instructions/visitsurveyinst.html
5. QFP pages 21-24: http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf
6. Becker D, Koenig MA, Kim YM, Cardona K, Sonenstein FL. The quality of family planning services in the United States: findings from a literature review. Perspect Sex Reprod Health 2007; 39:206–15.
7. Becker D, Tsui AO. Reproductive health service preferences and perceptions of quality among low-income women: racial, ethnic and language group differences. Perspect Sex Reprod Health 2008; 40:202–11.
8. Institute for Health Care Improvement. How to improve. Cambridge, MA: Institute for Health Care Improvement; 2014. http://www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx

Additional Resources and Citations

DOMAIN 1: Access

Component 1.3: Special Populations & Diversity

For resources specific to adolescents, see Component 2.4: Adolescent Services

Component 1.4: Language/Health Literacy

For additional resources, see Component 1.3: Special Populations & Diversity

DOMAIN 2: Service Provision

Component 2.1: Assess for Pregnancy Intentions

Santelli JS et al., An exploration of the dimensions of pregnancy intentions among women choosing to terminate pregnancy or to initiate prenatal care in New Orleans, Louisiana. Am J Public Health 2006 November; 96(11): 2009-2015. Retrieved on June 30, 2015 from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1751822

Component 2.2: Counseling and Education

Harper CC, Henderson JT, Raine TR, Goodman S, Darney PD, Thompson KM, Dehlendorf C, Speidel JJ. Evidence-based IUD practice: family physicians and obstetrician-gynecologists. Fam Med. 2012 Oct; 44(9):637-45.

Cultural Component Concepts:
http://nurse-practitioners-and-physician-assistants.advanceweb.com/Features/Articles/Cultural-Competence-in-Contraception-Counseling.aspx

Health Literacy: Hidden Barriers and Practical Strategies:
http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/tool3a/index.html

Agency for Health and Research Quality (AHRQ) Health Literacy Universal Precautions Toolkit, Second Edition, January 2015: http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit

Component 2.8: Patient Support for Contraceptive Management

Oregon Health & Science University resources for consultations and referrals: http://www.ohsu.edu/xd/health/for-healthcare-professionals/consults-referrals/index.cfm

Teach-Back Method – tool to ensure patient understanding: www.nchealthliteracy.org/toolkit/tool5.pdf

Center for Evidence Based Practice-Case Western Reserve University – evidence-based trauma-informed care resources: http://www.centerforebp.case.edu/resources/tools/tic

Motivational Interviewing: http://www.motivationalinterviewing.org

DOMAIN 4: Evaluation of Patient Experience with Contraception Services

Component 4.1: Evaluation of the Patient Experience

Wolf, Jason A. PhD; Niederhauser, Victoria DrPH, RN; Marshburn, Dianne PhD, RN, NE-BC; and LaVela, Sherri L. PhD, MPH, MBA (2014) "Defining Patient Experience," Patient Experience Journal: Vol. 1: Issue 1, Article 3.

Street, R.L., Jr., Makoul, G., Arora, N.K., & Epstein, R.M. (2009). How does communication heal? Pathways linking clinician-patient communication to health outcomes. Patient Education and Counseling, 74 (3), 295-301.

Stewart, M., Brown, J.B., Donner, A., McWhinney, I.R., Oates, J., Weston, W.W., & Jordan, J. (2000). The impact of patient-centered care on outcomes. Journal of Family Practice, 49, 796-804.

Safran, D.G., Montgomery, J>E., Chang, H., Murphy, J., & Rogers, W.H. (2001). Switching doctors: Predictors of voluntary disenrollment from a primary physician's practice. Journal of Family Practice, 50 (2), 130-136.

Levy K, Minnis AM, Lahiff M, Schmittdiel J, Dehlendorf C. Bringing patients' social context into the examination room: an investigation of the discussion of social influence during contraceptive counseling. Womens Health Issues. 2015 Jan-Feb;25(1):13-21.

Dehlendorf C, Bellanca H, Policar M Performance measures for contraceptive care: what are we actually trying to measure? Contraception. 2015 Jun;91(6):433-7.

Schwarz JL, Witte R, Sellers SL, Luzadis RA, Weiner JL, Domingo-Snyder E, Page JE Jr. Development and psychometric assessment of the healthcare provider cultural competence instrument. 4. Inquiry. 2015 Apr 24;52.

Rodriguez MI, Darney BG, Elman E, Linz R, Caughey AB, McConnell KJ. Examining quality of contraceptive services for adolescents in Oregon's family planning program. Contraception. 2015 Apr;91(4):328-35.

Oregon Health Authority

OPRHAC
Oregon Preventive Reproductive Health
Advisory Council

May 1, 2017 | Edition 1

A publication of the Oregon Preventive Reproductive Health Advisory Council (OPRHAC).
Funded by the Oregon Health Authority Public Health Division.