This survey is a tool that can be used to develop a Project Connect Provider Referral Guide. It was developed by the Project Connect Detroit site and does not meet CDC's Office of Management and Budget (OMB) or Institutional Review Board (IRB) standards. This survey is provided as an example to aid communities in adapting Project Connect. CDC's Project Connect team recommends that this tool be adapted to meet the needs of the local area.

Throughout this document, text in *italics* represents script for the person conducting the interview.

Interviewer:_____ **Date:** _____

Contact Information	
Clinic name:	
Address:	
Main phone number:	
Website:	
Contact name:	
Position:	
Contact phone:	
Fax number:	
Email:	

If leaving a message:
Hi, my name is [NAME] *and I am calling from Project Connect at the Michigan Public Health Institute. We are working with the Centers for Disease Control and Prevention and the Detroit Public School system to learn more about sexual and reproductive health-related services available for adolescents. We are identifying various resources in the area to see what options are available for adolescents seeking care. I was directed to you as someone who may be able to speak about this as it relates to your organization. I would appreciate a bit of your time to discuss about the range of services available to adolescents. I can be reached at* XXX-XXX-XXXX. *Again, my name is* [NAME] *and I am calling from Project Connect. You can reach me at* XXX-XXX-XXXX.

Date	**History of Contact and Interviewer Notes**

Opening

Hi, my name is [NAME] *and I am calling from Project Connect at the Michigan Public Health Institute. We are working with the Centers for Disease Control and Prevention and the Detroit Public Schools to learn about sexual and reproductive health-related services available for adolescents. Part of this work is identifying various resources in the area to see what services are available. I would like to speak with someone who can tell me about your organization's services. Is there someone available that I can speak to?*

☐ Primary contact can answer

Name:_____

Title:_____

☐ Yes, refer to someone else

Name:_____

Title:_____

☐ Don't Know or Refused

Introduction

Thanks so much for agreeing to speak with me about your facility. I am going to ask you questions about three general areas: the types of services provided, office practices (such as hours and insurances accepted), and collaboration with other community organizations. This information will be included in a guide to help connect adolescents to services. If you think there are things that are related or may be important, please share them so I can get a better picture of reproductive health care services for youth in the area.

Part I: Services Provided

This first section is about services provided by your organization to adolescents.

1. *Please verify the following general clinic information:*

   Clinics Address and Cross Street_____

   Appointment Phone Number(s)_____

2. *Would your clinic see an adolescent patient for reproductive health care services (STD testing, pregnancy testing) without a parent?*

   ☐ Yes

   ☐ No → End interview and thank respondent for their time

   ☐ Don't know/decline to answer → End interview and thank respondent for their time

3. *Are you currently accepting new adolescent patients?*
   - ☐ Yes
   - ☐ No → End interview and thank respondent for their time
   - ☐ Don't know/ decline to answer → End interview and thank respondent for their time

4. *Do you provide services to both males and females?*
   - ☐ Males only
   - ☐ Females only
   - ☐ Both males and females
   - ☐ Don't know/ decline to answer

5. *How many of the following health care providers are in your practice?*
   - ☐ MD/DO _____
   - ☐ PA.NP/CNM _____
   - ☐ MSW/case worker _____
   - ☐ MA
   - ☐ Non-clinical _____

6. *What are your clinic's weekday hours?*

7. *What are your clinic's weekend hours?*

To be filled out by interviewer: Are after-school appointments (between 3pm and 5pm) available?
- ☐ Yes
- ☐ No
- ☐ Don't know/refused

To be filled out by interviewer: Are evening appointments (after 5pm) available?
- ☐ Yes
- ☐ No
- ☐ Don't know/refused

To be filled out by interviewer: Are weekend appointments (Saturday and/or Sunday) available?
- ☐ Yes
- ☐ No
- ☐ Don't know/refused

8. *Do you have open scheduling options (same day appointments for acute care)?*
   - ☐ Yes
   - ☐ No
   - ☐ Don't know/refused

9. *Do you accept walk-in appointments?*
   - ☐ Yes
   - ☐ No
   - ☐ Don't know/refused

10. *Do you have designated adolescent space for waiting and/or check in?*
    - ☐ Yes
    - ☐ No
    - ☐ Don't know/refused

11. *Does your clinic provide services at a satellite location?*
    - ☐ Yes
    - ☐ No
    - ☐ Don't know/refused

    If yes, ask: *What is the address of the satellite location?* _____

12. *Does your clinic offer general health services, such as:*

    12a. Immunizations
    - ☐ Yes
    - ☐ No
    - ☐ Don't know/refused

    12b. Illness/injury care
    - ☐ Yes
    - ☐ No
    - ☐ Don't know/refused

    12c. Physicals
    - ☐ Yes
    - ☐ No
    - ☐ Don't know/refused

13. *How does your clinic screen adolescents for STDs? In your practice, do you…*
    - ☐ Screen all adolescent patients
    - ☐ Screen patients based upon personal history (i.e. sexual activity, risk)
    - ☐ Don't know/refused

14. *Does your clinic screen adolescents for the following STDs?*

14a. HIV

- ☐ Yes
- ☐ No
- ☐ Don't know/refused

14b. Chlamydia

- ☐ Yes
- ☐ No
- ☐ Don't know/refused

If yes, ask: Is the test done by culture or urine-based?

- ☐ Culture
- ☐ Urine-based
- ☐ Don't know/refused

14c. Gonorrhea

- ☐ Yes
- ☐ No
- ☐ Don't know/refused

14d. Syphilis

- ☐ Yes
- ☐ No
- ☐ Don't know/refused

15. *Does your clinic offer the following services to adolescents?*

15a. Pap tests

- ☐ Yes
- ☐ No
- ☐ Don't know/refused

15b. Pregnancy testing

- ☐ Yes
- ☐ No
- ☐ Don't know/refused

15c. Emergency contraception

- ☐ Yes
- ☐ No
- ☐ Don't know/refused

15d. Hepatitis B vaccination

- ☐ Yes
- ☐ No
- ☐ Don't know/refused

15e. Pregnancy-related services (such as prenatal care)

- ☐ Yes
- ☐ No
- ☐ Don't know/refused

16. *What sexual and reproductive health services are provided to adolescents by your facility?*

16a. Male condoms

- ☐ Yes
- ☐ No
- ☐ Don't know/refused

16b. Female condoms

- ☐ Yes
- ☐ No
- ☐ Don't know/refused

16c. Dental dams

- ☐ Yes
- ☐ No
- ☐ Don't know/refused

16d. Hormonal contraception

- ☐ Yes
- ☐ No
- ☐ Don't know/refused

16e. Depo-Provera

- ☐ Yes
- ☐ No
- ☐ Don't know/refused

16f. Intrauterine device

- ☐ Yes
- ☐ No
- ☐ Don't know/refused

16g. Implant

- ☐ Yes
- ☐ No
- ☐ Don't know/refused

16h. Sexual-health related materials or education

- ☐ Yes
- ☐ No
- ☐ Don't know/refused

16i. Mental health-related services or referrals

- ☐ Yes
- ☐ No
- ☐ Don't know/refused

17. *Are there any other reproductive health services provided by your clinic to adolescents?*

Part II: Service Delivery and Related Processes

These next questions are about the particular processes involved in the provision of services/care for adolescents by your facility.

18. *Which of the following insurance and payment options are offered by your clinic?*
    - ☐ Private insurance
    - ☐ MiChild/Medicaid/ county-level health plans
    - ☐ Free care options
    - ☐ Reduced or sliding fee scale options
    - ☐ Payment plans
    - ☐ Fee for service
    - ☐ Other (please specify): _____

19. *Does your clinic provide opportunities for client feedback (anonymous or not) designed for adolescents?*
    - ☐ Yes
    - ☐ No
    - ☐ Don't know/refused

20. *Before we move on, are there things that make it hard to provide sexual and reproductive health care to adolescents?*
    - ☐ Yes
    - ☐ No
    - ☐ Don't know/refused

    If yes, ask: *Could you please share an example?*

Part III: Project Connect Referral Guide

21. *Project Connect will provide local high school nursing and/or counseling staff with a provider guide that they can use when making referrals to adolescents for reproductive health care. May we include your clinic in our referral guide?*
    - ☐ Yes
    - ☐ No → Skip to Part IV
    - ☐ Don't know/refused → Skip to Part IV

22. *Does your office track the source of incoming referrals?*
    - ☐ Yes
    - ☐ No → Skip to Part IV
    - ☐ Don't know/refused → Skip to Part IV

23. *Would your office be willing to track and report referrals coming from the local school to Project Connect?*
    - ☐ Yes
    - ☐ No
    - ☐ Don't know/refused

24. *Do you ask which school adolescent patients attend?*
    - ☐ Yes
    - ☐ No
    - ☐ Don't know/refused

Part IV: Electronic Health Records

25. *What kind of medical record system does your clinic use?*

    25a. *Is it electronic?*
    - ☐ Yes
    - ☐ No
    - ☐ Don't know/refused

26. *If we were able to get all of the permissions from the adolescent, your clinic and the Institutional Review Board at the Michigan Public Health Institute (MPHI), how easy would it be for us to retrieve STD test results, pregnancy test results, etc.?*

Part V: Surrounding Community Information

We are almost done. Now that I have a sense of your facility's services, I am going to ask you about other services in the community that you might have worked with.

27. *How much interaction does your clinic have with the local public schools and their personnel?*

    Probes:
    - Describe relationships or collaboration with local schools.
    - Which schools?
    - What personnel/role?

28. *What types of things would you want high school nurses to know about the services you provide?*

29. *What types of things would you want to know from high school nurses?*

30. *Does your facility collaborate with other agencies to provide adolescent health care?*
    - ☐ Yes
    - ☐ No
    - ☐ Don't know/refused

    30a. If yes, ask: *What types of agencies does your facility typically work with?*
    (Check all that are mentioned and note type of relationship)
    - ☐ Community-based groups (specify): _____
    - ☐ Department of Human Services
    - ☐ Counseling centers (specify):_____
    - ☐ Detroit Department of Health and Wellness
    - ☐ Other (specify):_____
    - ☐ Don't know/refused

31. *What barriers do adolescents face in getting sexual and reproductive health care in your area of the city?*
    - ☐ Yes
    - ☐ No
    - ☐ Don't know/refused

    31a. *If yes, please explain.*

32. *Is there anything else you think is important for me to know about community services and resources in your area?*

Part VI: Additional Feedback

33. *Do you have any additional comments to share?*

Closing

That completes the interview. Thanks so much for answering these questions; I really appreciate your time. If there is any additional information you would like to share, you can reach me at XXX.XXX.XXXX*.*

If contact agreed to be included in the guide: *We will be sending the providers in the Project Connect referral guide copies of the guide as soon as it is updated. Should I send them to your attention?*

Post Interview - Interviewer Feedback

Complete the following questions after ending the interview:

Did the interview yield the necessary information for a complete description of the facility?

- ☐ Yes
- ☐ No
- ☐ Unsure

If no, what information is missing?