Sample VFC Provider Feedback Survey

We’d love to hear what you think about the Vaccines for Children program. Please take a minute to complete the following survey. Your answers will help us improve the program to serve both you and our children better.

Provider/Clinic Name: __________________________________ Type of Practice: □ Private Solo Practice □ Private Group Practice
□ Federally Qualified Health Center/Rural Health Center
□ Health Department Clinic □ Other: ____________________

Practice Specialty Type: □ Pediatrics □ Family practice □ Internal Medicine □ Multispecialty □ Health Department Clinic □ Other: ____________________

Address:

Street       City    County   Zip Code

Telephone Number: ___________________________ E-Mail: ___________________________

Person Completing the Survey: ___________________________ Title: ___________________________

WE WANT TO KNOW WHAT YOU THINK ABOUT THE VFC PROGRAM. PLEASE RATE YOUR EXPERIENCE FOR QUESTIONS 1 - 9 USING THE SCALE FROM 1 TO 5.

1. The support, information and materials provided by state/local VFC program staff. 1 2 3 4 5 NA

2. The ease of screening patients for VFC-eligibility. 1 2 3 4 5 NA

3. The ease of VFC record keeping. 1 2 3 4 5 NA

4. The ease of using the VFC vaccine ordering system. 1 2 3 4 5 NA

5. The timeliness of VFC supplied vaccine delivery. 1 2 3 4 5 NA

6. The condition of VFC supplied vaccine at delivery. 1 2 3 4 5 NA

7. The decreased need to refer children to public clinics for immunizations. 1 2 3 4 5 NA

8. The merit of the VFC vaccine accountability system (reporting the number of doses administered, benchmarking, etc.) 1 2 3 4 5 NA

9. Overall satisfaction with the VFC program 1 2 3 4 5 NA
10. The range of vaccine brand choice available for VFC vaccines

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11. Which vaccines are routinely recommended in this practice/clinic? (Please check all that apply)

- DTaP
- MMR
- Hepatitis A
- Pneumococcal
- Hepatitis B
- Polio
- Hib
- Varicella
- HPV
- Influenza
- Hib
- Meningococcal
- Rotavirus
- Others: ______________________

12a. Does this practice/clinic have a systematic way to identify and recall children in need of vaccinations?  

- Yes
- No

12b. If yes, what kinds of system do you use?

- recall system, computerized
- recall system, tickler file
- registry
- periodic chart reviews
- other: ______________________

13a. Have immunization coverage levels been assessed in your practice within the last year?  

- Yes
- No

13b. If yes, by whom?

- Own practice/clinic staff
- State health department staff
- Local health department staff
- MCO staff

13c. If yes to 13a., what assessment tool was used?

- CoCASA
- Other: ________
- Do not know

13d. If yes to 13a., what age & series was assessed?

- ______________

13e. If yes to 13a., what was the coverage level ________%

14. Does this practice/clinic participate in a state/local immunization registry?  

- Yes
- No

15. What recommendations do you have for improving the VFC program in (specify state)?

_______________________________________________________________________________________________________________
Please fax or mail your completed form to: Your Health Department's Name
Attn: VFC Program
Street Address
City, State, Zip
Telephone: (   ) ________________________ Fax: (   ) ________________________