

Frequently Asked Questions on the revised

Family Planning Clinic Forms

8/4/2016

1. Why is the print so small and no place to write in any information about the client's general information (i.e., marital status, age, employment, attending school etc.)?
 - As we all transition into electronic health records (EHR), the issue of having small print and/or limited space for notes will be eliminated. The programs will have free text space to write in general comments and the information on our forms is for content delivery as opposed to use in a hard copy format.
 - In regards to the second part of this question, the client's name, patient #, date of birth, race/ethnicity, gender, county of residence, address and marital status can be found at the top of the Health History form (4060 M&F). The questions related to employment, attending school and some other general information can be found in Section A on the History form. The flow sheet (2814 M&F) has a space for the client's age.
2. Why is there no coding system on the flow sheet for the review of systems and physical exam sections?
 - The coding system an agency decides to use is site specific and thus we did not want to include on this form (nor was it included on the previous versions). The clinic must have a policy on what are approved abbreviations and use these for the completion of the forms.
3. Where is the space for the interpreter to sign?
 - There is a line at the bottom of the Health History form for the interpreter's signature.
 - An agency can decide if they want to add a line to the flow sheet if multiple interpreters are used during a visit.
4. Are we expected to have the client complete the Health History form at each comprehensive visit?
 - It is an agency decision but the intent of this form is to be used and updated at each comprehensive visit (i.e., initial, annual exam). In order for patient information to be populated into your EHR it needs to be entered into the system. We recommend this be entered into the system at the time of the visit so it can be incorporated into this client's chart.
 - The past guidance has been to redo this form (history form) every three years and this is no longer the recommendation. The form would only need to be updated from the time of the last visit and you would not be asking questions that do not change (i.e., age at first menses).

5. Do we have to complete both the health history and the flow sheet with each comprehensive visit?
 - Yes
 - The health history form would only need to be updated with information that has changed *since their last comprehensive visit*.
 - The review of systems (ROS) found on the flow sheet (2814 M&F) is to be asked with the client on the day of the exam as these are questions that ask about their health in the past weeks or past few months, etc.
 - The questions found under Section B (Medical History, Hospitalizations, Medications) are those that have been diagnosed by a healthcare provider for the client and immediate family members.

6. Why are there no Intimate Partner Violence (IPV) questions for males on the history form?
 - Currently there is no evidence to support screening men for IPV per the USPSTF and thus we did not include.
 - The Quality Family Planning (QFP) Services does not list men to be screened for IPV as they have included in their guidance *only* evidence-based interventions.
 - An agency can decide to include these questions on their male visits and would need to include in their clinic policies/procedures.

7. Is the flow sheet (2814 M&F) recommended for a supply visit (i.e., oral contraceptives, patch, ring, Depo)?
 - No
 - We have in the past recommended clinics use a different form (i.e., supply visit form) for these visits since there is limited clinical information required for this visit.
 - Nationally recognized standards of care (i.e., ACOG, QFP, SPR) have recommended providing a year's supply of oral contraceptives, patch and ring to clients who have been on this method and have not had any medical complaints or problems with the method. We have supported this practice and by doing this, it will lessen your clinic burden with supply visits.

8. Why has Hct/Hgb, U/A and rubella titer been removed from the choices in the lab section in #9 on the Flow sheet?
 - The above lab tests are not required in the prescribing of any birth control method per the QFP and the CDC's Selected Practice Recommendations (SPR).
 - If the clinician has a concern and one of these lab tests would be needed to help in the diagnosis of a presenting condition (i.e., dysuria), it is an agency decision and can be performed in these situations. These tests would be used as clinically indicated and not as general screening tests.

9. How do we address the new requirement for adolescents of providing an intervention to prevent tobacco initiation and relationship abuse (i.e., sexual coercion)?
 - An intervention to prevent tobacco initiation is required per the QFP as a direct result of the USPSTF's Grade B recommendation.
 - This is not intended to be a long intervention but rather the interviewing RN and/or clinician only needs to verbally compliment the adolescent for not smoking (per his/her health history) and reinforce that smoking can be very addictive and damaging to one's health.

- The USPSTF found adequate evidence that behavioral counseling interventions, such as face-to-face or phone interaction with a health care provider, print materials, and computer applications, can reduce the risk of smoking initiation in school-aged children and adolescents. Here is the link to this site
<http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/tobacco-use-in-children-and-adolescents-primary-care-interventions#consider>
- In regards to sexual coercion, this is not a new requirement but it is addressed by either the interviewing RN and/or the clinician when reviewing the health history form or during the counseling session of the exam. The intervention is just to ask if the adolescent is sexually active on her/his own account and is not being pressured to have sex.
- If the adolescent confirms he/she is being coerced to have sex, you must have policies/procedures in place as to who this person may be referred to or if the client is in eminent danger, is this a situation that requires reporting?

10. What is required with the new IPV screening during the FP comprehensive visit?

- This sensitive issue may not be revealed in the first clinic visit. Therefore repeated screening may encourage women, over time, to reveal their circumstances.
- ACOG (2012) recommends that all women be screened for IPV by asking simple questions (these are the two questions now included on the female health history form) prefaced by an introductory statement such as :
“Because violence is so common in many women’s lives and because there is help available for women being abused, I now ask every patient about domestic violence”.
- Clinics can encourage disclosure by displaying posters and educational brochures as well as providing hotline numbers and referral numbers available in private spaces such as the exam room or restrooms.
- A Toolkit is available at Before, Between & Beyond Pregnancy at
<http://beforeandbeyond.org/>

11. How do we document the required counseling/education, patient demographics, past history, review of systems, etc. has been reviewed with the client when using electronic health records?

- This is another agency decision. We have added an “attestation statement” on our female and male flow sheets in Sections 11 and 10 respectively to document these areas were all addressed with the client by the interviewing nurse and clinician.
- This process will also need to be in your agency’s policy/procedures manual describing what this attestation statement and/or “check box” on the EHR represents and what components do they include.

12. How do we distinguish between nursing and provider responsibilities on the forms?

- This again is an agency decision. You will need to determine which person is the most logical in your clinic flow as well as scope of practice of the individual (i.e., the clinician may be the best person to provide the STD reduction counseling as he/she would be the one who is ordering the STD testing based on history and/or exam).

13. Per the revised FY14-15 FP AA, it is allowable to use the “Teach Back” method for method counseling vs. using the method specific consent forms; therefore, how do we document the required components of method counseling (found in #13 on the female flow sheet and #12 on the male flow sheet) if we use the Teach Back method?
- Each agency that chooses to use the Teach Back method for method counseling will need to have a policy/procedure that identifies the components of this process and provide a “check box” in your EHR for this requirement.
 - The Teach Back method does not include the results of the physical assessment and labs, if performed (which is a requirement found in this section), so you will need to have this listed on your EHR for the individual who provides this information to the client (most likely your provider). The other areas not required in the Teach Back method (and required on our forms) are “when to return for a follow up (planned return schedule)” and “appropriate referral for additional services as needed”. These would again need a check box on your EHR for your clinic personnel to mark when provided.
14. There are no Spanish Health History forms on the website, what do we use?
- Spanish versions of the form will not be developed as DHHS 4060F and DHHS 4060M are no longer considered a self-history and all agencies, including those on HIS, will be transitioning to electronic health records October 2015.