Frequently Asked Questions (FAQs) on the Revised Family Planning Clinic Forms

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General FAQs that apply to multiple Family Planning Clinic Forms

1. Why is the print so small, and there is 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. 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.

3. 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.

4. 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.

5. 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).

Female and Male Flowsheets (DHHS 2814F and DHHS 2814M)

6. What do environmental exposures/hazards entail?

    - The guidance from *Providing Quality Family Planning Services* (the QFP) is that environmental exposures/hazards include alcohol, tobacco and/or other drugs in the patient's environment. The Women's Health Branch has added electronic nicotine devices as another environmental exposure to assess for. Your agency may also opt to screen for additional environmental exposures/hazards, such as workplace or home exposure to air pollution, chemical hazards, and/or other toxins. However, screening for environmental alcohol, tobacco, electronic nicotine devices and other drugs is what this form requires.

7. What's the difference between "provide Emergency Contraception counseling" and "Emergency Contraception offered"?

    "Provide Emergency Contraception counseling"

    - This means that the nurse or provider educates a patient about Emergency Contraception (EC). After speaking with the nurse or provider, the patient should know what EC is, what EC is not (i.e. NOT the "abortion pill"), when EC is indicated, EC side effects and how to obtain EC. All patients should be informed

that EC is available over the counter for all ages (levonorgestrel EC) and by prescription (ulipristal acetate EC). Both male and female patients should be educated about EC in the above manner annually, regardless of the patient's method of contraception.

"Emergency Contraception offered"

- This means that the patient has an indication for EC (unprotected intercourse in the past five days), and the nurse or provider offers the patient EC. Emergency Contraception may be dispensed via the agency, or a prescription may be offered to fill at the pharmacy of the patient's choice. We recommend offering a prescription for patients with Medicaid or private insurance. We strongly recommend that agencies purchase at least one brand of EC at 340B pricing, and stock this EC in-house or at their contract pharmacy. Patients may decline when the nurse or provider offers EC. However, the nurse or provider must offer EC as above whenever EC is indicated.

8. Do we have to offer levonorgestrel Emergency Contraception up to five days after unprotected intercourse? The label for Plan B One Step says to use it up to three days after unprotected intercourse?
    - There are two types of Emergency Contraception pills – ulipristal acetate (i.e. ella®) and levonorgestrel (i.e. Plan B One Step®). A third option for Emergency Contraception is the copper IUD, which is the most effective type of EC.

    - The labeling on ulipristal acetate EC indicates that it may be taken up to 120 hours (five days) after unprotected intercourse. The labeling on levonorgestrel EC indicates that it may be taken up to 72 hours (3 days) after unprotected intercourse.

    - Despite levonorgestrel EC's labeling, CDC's guidance in both *Providing Quality Family Planning Services* (2014) and the *U.S. Selected Practice Recommendations for Contraceptive Use* (2016) states that levonorgestrel EC (i.e. Plan B One Step, Next Choice) can be provided safely and effectively until 120 hours (5 days) after unprotected intercourse. While levonorgestrel EC appears to be less effective on day 5 than it is on day 3, the CDC cites evidence suggesting that levonorgestrel EC is still effective enough on day 5 that it is worth offering to patients as a viable option.

      When a patient reports unprotected intercourse within five days of unprotected intercourse, the Women's Health Branch recommends following CDC guidance and offering ulipristal acetate or levonorgestrel Emergency Contraception as

indicated. If a provider is not comfortable prescribing levonorgestrel EC past 72 hours (3 days) of unprotected intercourse, the provider may offer a prescription for ulipristal acetate EC up to 120 hours after unprotected intercourse instead.

9. 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.

10. 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.

11. 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.

12. How do we address the 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: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-children-and-adolescents-primary-care-interventions.
- 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?

13. 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.

    - To document that the Teach Back method was used, the agency must check "Yes" on the "Teach Back Method used" box under Client Method Counseling (#13 on the female flow sheet and #12 on the male flow sheet).

Female and Male Health History Forms (DHHS 4060F and DHHS 4060M)

14. Are agency staff expected to complete the Health History form with the client 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).

15. 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.

16. 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/

17. 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.

Pregnancy Testing Form (DHHS 4140)

18. When are we required to use this form?

    - Agencies are required to use the Pregnancy Testing Form when providing a pregnancy test only visit. This applies to pregnancy test only visits in the Family Planning clinic, as well as in general clinic or other clinics. If a pregnancy test is done as part of a problem visit or preventive exam visit, agencies generally do not need to use this form. However, if a pregnancy test result is positive during an office visit or preventive exam visit, agencies should document the options

counseling and referral components of the Pregnancy Testing Form in their notes. In this case, the agency may use the Pregnancy Testing Form itself, or document all components of the form in progress notes.

19. Why do we have to do Reproductive Life Planning if a patient has a positive pregnancy test?

    - Agencies may opt to ask questions related to Reproductive Life Planning (RLP) either before or after obtaining pregnancy test results. If an agency opts to ask RLP questions after obtaining pregnancy test results, it may make sense to alter the RLP question wording somewhat from the wording on the form. The wording on the form is meant as a guideline, and is not meant to be prescriptive. Pregnancy can be an ideal time to engage patients in RLP, since patients may be more motivated to consider whether they desire future pregnancies after the current pregnancy ends.

20. Why is this form so long/comprehensive?

    - Title X conducted a North Carolina Program Review in the spring of 2016, and required North Carolina to add several items to our Pregnancy Testing Form. A sample Pregnancy Testing form had been available and recommended for use on the Women's Health Branch website since 2012. The current form was revised based on the 2016 NC Program Review.

21. Do we have to offer Quick Start with negative pregnancy tests?

    - Agencies are not required to offer Quick Start with negative pregnancy test results. However, the Women's Health Branch encourages Quick Start as a best practice to reduce unintended pregnancy.

22. I thought we were not allowed to discuss or refer for abortion per Title X. Why does this form have checkboxes for counseling/education and referral for abortion?

    - Title X prohibits agencies funding abortion services with Title X dollars, and from coercing patients to have abortions. However, Title X also requires agencies to offer patients neutral, nondirectional options counseling that includes the pregnancy options they wish to hear about, including abortion. Title X also requires referral upon request related to any pregnancy option patients wish to hear about, including abortion. The Women's Health Branch recommends that

you develop resource/referral handouts that include abortion services in your local area for patients who request that information.

23. Do we have to complete Presumptive Eligibility for all patients with a positive pregnancy test?

    - If your agency has a Maternal Health clinic, and the patient requests services there, you do not need to complete a Presumptive Eligibility application at the pregnancy test only visit. In this case, you need to complete the Presumptive Eligibility application at the initial prenatal visit at the agency's Maternal Health clinic. If your agency does not have a Maternal Health clinic, and/or if the patient voices a preference to attend an alternate clinic for prenatal care, you must complete a Presumptive Eligibility application at the pregnancy test visit.

24. Do patients who already know they are pregnant need a pregnancy confirmation to apply for Medicaid?

    - Patients may self-attest to pregnancy to apply for Medicaid for Pregnant Women. The only instance where pregnancy verification/confirmation is required is when the patient knows she pregnant with multiple fetuses. Otherwise, pregnancy verification/confirmation is not required. Patients also need an estimated due date to apply for Medicaid for Pregnant Women. However, an estimated due date can be calculated with a pregnancy wheel or online app based on the last menstrual period – pregnancy testing is not needed to calculate an estimated due date.