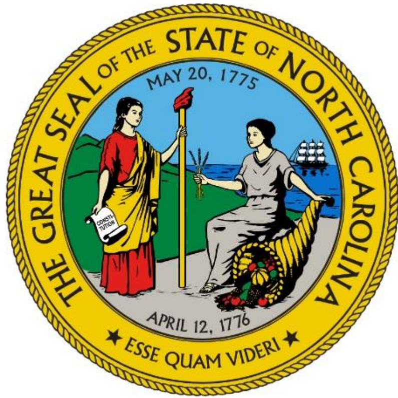


NC Department of Health and Human Services

Division of Public Health

FPAR 2.0 Update

(Family Planning Data)

Marissa Peters

Reproductive Health Data Manager

July 24, 2023

Purpose

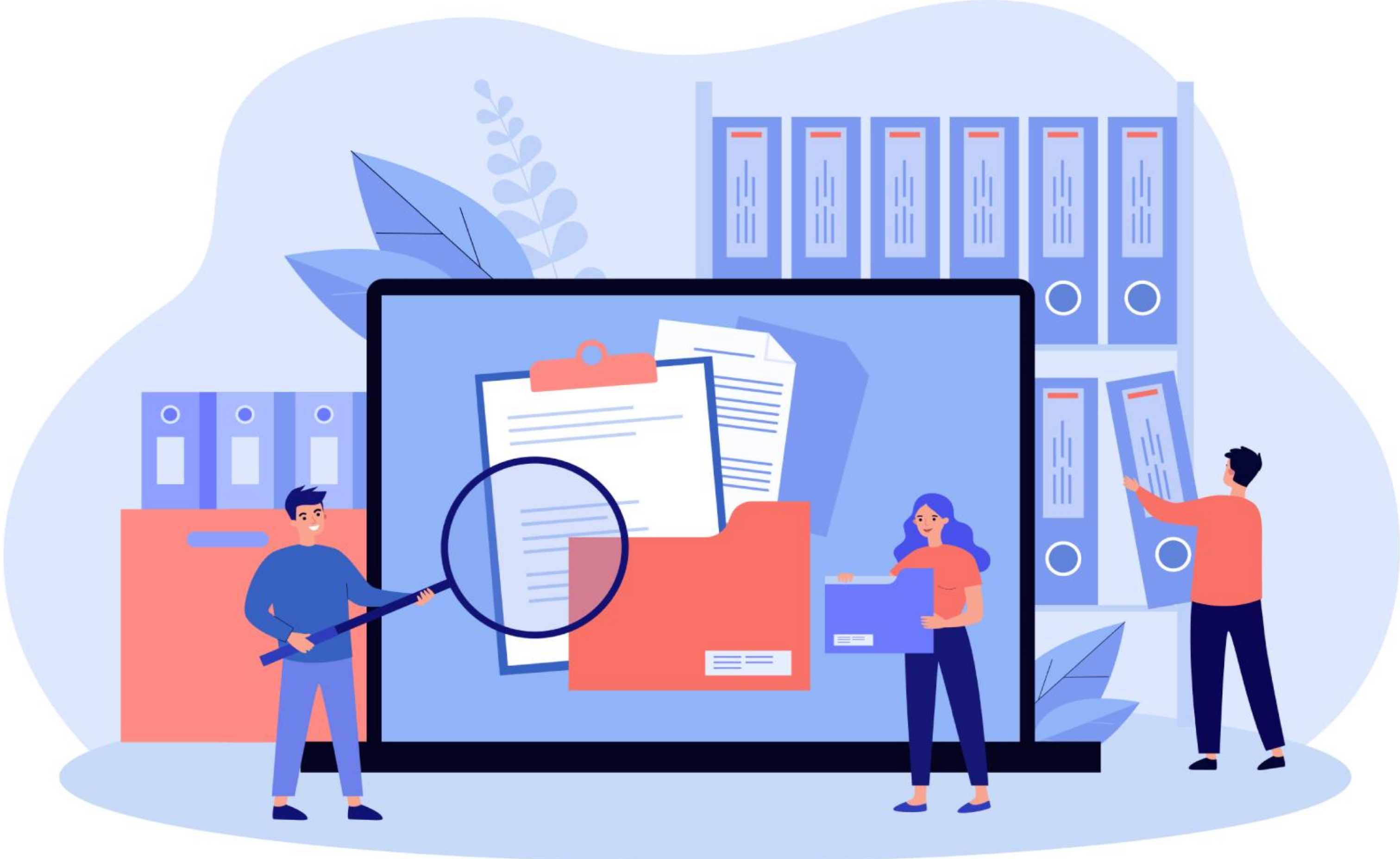
- FPAR 2.0 status Update
- Overview of FPAR required data elements on Fiscal Year (FY) 2023-2024 forms

FPAR 2.0 Status

Testing and Results

- STD (Chlamydia, Gonorrhea, Syphilis, HIV)
  - Plan to use NC EDSS data
- Pap and HPV
  - Continue to track internally at each site and report through STD/PAP Survey Monkey
  - If the majority of your pap tests are reflex-pap tests, please indicate that both Pap and HPV were ordered in the labs section.

FPAR 2.0 Form Alignment



Record Audit Forms

FP Program Female Medical Record Audit Tool
FY 2023-24

CODE
✓ = Present
0 = Absent

KEY
(R) Required to offer/recommend
(I) As indicated by history, physical, method, or previous lab test
(*) Data reported in FPAR
(Rec) Recommended

NA = Not Applicable

	Patient Identifier									

1. History (can be found on history or flowsheet)	1	2	3	4	5	6	7	8	9	10
Significant illnesses (i.e., hospitalizations, surgery, blood transfusion or exposure, chronic/ acute medical conditions) **R**										
Allergies **R**										
Documentation regarding Primary Care Provider **R**										
Current use of prescription/OTC meds **R**										
*Use of/exposure to tobacco, electronic nicotine devices, alcohol, and other drugs – patient and/or environment **R**										
Review of systems **R**										
Pertinent history of immediate family members **R**										
Partner history (i.e., injectable drug use, multiple partners, risk history for STDs and HIV, bisexuality, etc.) **R**										
Contraceptive use past/~~present~~ (including adverse effects) **R**										
*Contraceptive Method at Intake **R**										
*Reproductive Life Planning (pregnancy intention) **R**										
Unprotected intercourse in past 5 days **R**										
Menstrual History **R**										

Pregnancy Test Form

12. NEGATIVE RESULTS: Education/Counseling

- ❑ Preconception Counseling Done (Base on Vital Signs and Current History sections above) ❑ N/A
- ❑ *Client centered contraceptive counseling/education provided ❑ N/A
- ❑ Emergency Contraception Offered If Unprotected Intercourse in Past 5 Days ❑ N/A
- ❑ *Provide Achieving Pregnancy Counseling ❑ N/A
- ❑ Infertility Services Offered ❑ N/A
- ❑ Folic Acid Supplement Recommended ❑ N/A
- ❑ Other ______________________________

*Contraceptive Method at Exit:
(see List of methods provided on page 3)

*If no method at exit, why?
▫Abstinence ▫Same sex partner ▫ Other ▫ Sterile for non-contrac reasons ▫Seeking Pregnancy

*How was method dispensed? (If method provided)
▫Provided on site ▫Referral ▫Prescription ▫Pregnant

16. Appointment Referrals: (Check All That Apply)

- ❑ Family Planning Clinic at Local Health Department

Family Planning Appointment Date: ______________

- ❑ Maternal Health Clinic at Local Health Department

First Maternal Health Appointment Date: ______________

- ❑ Clinic/Facility Outside of Local Health Department

Clinic/Facility Name: ______________________

- ❑ Referred to Emergency Department
- ❑ Department of Social Services
- ❑ Domestic Violence Support
- ❑ WIC
- ❑ Behavioral Health
- ❑ Pregnancy Care Management
- ❑ Transportation
- ❑ Other: ______________________

Flowsheets

5. Reproductive Life Planning (pregnancy intention)

*Do you want to have (more) children in the next 12 months? ◻ Yes ◻ No
◻ Unsure ◻I'm ok either way

How important is it to you to prevent pregnancy (until then)?______________

Date of last pregnancy______________________
◻ IF POSTPARTUM advised to delay future pregnancy
for 18 mos.- 5 years

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6. *Contraceptive Method at Intake: ________________________________
(see List of methods provided on page 4)

*If no method at intake, why?
◻Abstinence ◻Same sex partner ◻ Other ◻ Sterile for non-contraceptive reasons ◻Seeking Pregnancy ◻Pregnant

Satisfied? ◻ Yes ◻ No

Desired method changed? ◻ Yes ◻ No

Unprotected Intercourse in Past Five Days: ◻ Yes ◻ No

Template Intake Form

Last Name_______________________________First Name__________________________Middle Initial_____________

Age ______ *Date of Birth ________/________/_________ month day year

Physical address____City________________ State_________

Zip__________ Mailing address ____City________________

State_________ Zip _________ Phone (home) _________________________ Phone (cell) ________________________

Phone (work) ___________________________ County where you live ____________________________________

Safe CONFIDENTIAL number we can call you with results?____

***Sex assigned at birth (check one)** ☐ Male ☐ Female

***How do you describe yourself? (check one)**

☐ Male ☐ Female ☐ Female-to-Male/Transgender Male ☐ Male-to-Female/Transgender Female
☐ Genderqueer/neither Male nor Female/Non-binary ☐ Other ☐ Declined to Answer

***Race (check at least one)**

☐ White

☐ Black or African American

☐ American Indian or Alaska Native

☐ Asian

☐ Native Hawaiian or Other Pacific Islander

***Ethnicity (check one)**

☐ Hispanic ☐ Not Hispanic

***Primary Language**

☐ English ☐ Spanish ☐ Other _________________

*Monthly household gross income $_____________________(include all sources of income)

*Household size___________ (number of people living in household, including patient)

*Insurance ____

Other Documents

- No Changes to the Patient History Forms
- FPAR 2.0 FAQ document will be updated