Family PACT
Planning • Access • Care • Treatment
OFFICE OF FAMILY PLANNING
CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

Tips for Chart Documentation in Your Family PACT Practice

Medical documentation is an important aspect of your Family PACT practice. Medical documentation records the medical history as well as the patient's life style. The law requires that a medical record contain detailed information on the care and services a client receives. Thorough documentation is important for continuity of patient care, as a communication tool between staff, and to support reimbursement claims.

General Documentation Tips

1. Record client's name and ID number on each page of the medical record.
2. Record date of the visit. Hospital based clinics must also include the time the client was seen.
3. The medical record should be legible to someone other than the writer.
4. All entries into the medical record require an author's signature. Provide a signature that is recognizable and understood.

   Four Signature Options:

   a. Legible signature
   b. Illegible signature + print your name
   c. Illegible signature + stamp with printed name
   d. Illegible signature + signature on file at the clinic site
5. Document the client's pregnancy intentions and reproductive life plan on the medical history form.
6. It is recommended that a client receive a good sexual history once every 2 years.
7. It is acceptable to use pre-printed forms to document client information. Sample medical history forms and exam forms in English and Spanish are available on the Family PACT website[1].
8. Consider documentation for limited English proficient (LEP) clients, such as flagging charts with the language the client prefers to speak so that you can plan ahead. Document the use of language lines or non-staff interpreters and when the visit is conducted in a language other than English. Additional resources to help assess cultural competency in your clinic are available on the Family PACT website [2].

Common Family PACT Scenarios:

Scenario 1: Documenting the client who has a primary care concern…

When a client presents with a primary health concern, you must:

a. Identify the client's usual source of care, that is, the client's primary care provider (PCP). The client's usual source of care must be noted, whether it is your practice or another provider.
b. State how the primary care condition is being managed.
   i. If follow-up appointments in your office are scheduled or if the patient is referred to another provider, this must be noted.
   ii. Make referrals to outside providers or to other clinicians in your office/facility in writing. Include name of the referral provider, indicate if it is for a transfer of care or a consultation, indicate if it is urgent or routine, explain the purpose of the referral, and the type of services the client will be receiving.
   iii. Keep a copy of the written referral in the patient's medical record.
c. Separate your notes for Family PACT services and non-Family PACT services.
   i. Create individual notes for Family PACT services and for non-covered services. Use separate pieces of paper for each note.
   ii. Track face-to-face time separately on each note.
d. Resources for referrals are available on the Family PACT website [3].

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Scenario 2: Documenting Pregnancy Testing Visits…

To assure optimal recording of a client's pregnancy test visit, you must document:

a. Date of the last menstrual period
b. Type of contraceptive method used by the client
c. Client's intent to become pregnant (pregnancy intention), in the short and long term
d. Type of contraceptive the client would like to use in the future
e. Reason for the pregnancy test; it is important to record why the pregnancy test was performed (was it medically indicated?)
f. Lab test(s) and indicate type of test(s)
g. Results of pregnancy test
h. If follow-up care is indicated and/or if the client received a referral
i. Describe the type of counseling received, provide details on the content of the session and record the number of minutes spent counseling
j. Preconception care counseling provided

Scenario 3: Documenting Intrauterine Contraceptive (IUC) Insertions and Removal Visits…

For IUC insertions and removals[5] document:

a. Date of pre-insertion pelvic exam
b. IUC type, lot number and expiration date
c. How long the IUC was used (duration of use)
d. Screening for contraindications (absolute and relative)[6]
e. Reason for removal
f. Client's pregnancy intention and/or contraceptive choice
g. STI risk assessment
h. Describe the type of counseling received, provide details on the content of the session and record the number of minutes spent counseling
i. Preconception care counseling provided (for the client whose IUC is removed in order to become pregnant)[4].

Remember…If it is not on the chart then it did not happen!!!

Complete information on official program policies, administrative practices, and client services can be found in the Policies, Procedures, and Billing Instructions (PPBI) Manual located on the Family PACT website at www.familypact.org.

***Note**: Information provided here is taken from the 2007 Family PACT Medical Record Review[7]. Access the webcast presentation "Improving the Quality of Chart Documentation: Findings from the 2007 Medical Record Review" on the Family PACT website at www.familypact.org.

Resources:

The following resources and information can be found on the Family PACT website at www.familypact.org:

1. Family PACT Medical Exam and History Forms
2. Family PACT Cultural Competency Toolkit
3. Family PACT Referral Resources
4. December 2008 Clinical Practice Alert-Preconception Care and Family Planning Services
5. October 2006 Clinical Practice Alert-Intrauterine Contraceptives (IUCs)
6. IUC Procedure Screening Notes
7. Thiel de Bocanegra, H., Rostovtseva, D., Menz, M., Karl, J., and Darney, P. The 2007 Family PACT Medical Record Review: Assessing the Quality of Services. Sacramento, CA: Bixby Center for Global Health. University of California, San Francisco. 2008

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