Policy Statement

To improve patient safety and quality of care and to minimize delayed or missed diagnoses, each MFHS clinical service site will establish and utilize a reliable tracking and reminder “tickler” system for patient visits requiring follow up care. Accompanying documentation of all actions taken related to follow-up must be recorded in the medical record.

Standards

1. Providers will review routine services (exams, testing, and referrals) with the patient at the initial visit and will explain the established process for contact and follow up on normal and abnormal results. If a patient requests "no contact" status, an alternative process must be established. The discussion and contact method must be documented in the patient’s medical record.

2. All printed results (e.g. PAP tests, mammograms, consults, pathology reports, etc.) must be reviewed, initialed and dated by a health care provider who has been designated to perform this function. A notation of what follow-up testing or procedures are recommended must also be included on the report prior to results being permanently filed in the patient chart.

3. Health care providers have an obligation to their patients to encourage them to complete studies believed essential for patient care within an acceptable time frame; by providing clear information and instruction to help facilitate patient participation in their ongoing care and an understanding of the importance of follow-up.

4. Patients are responsible for following through on a provider’s recommendations; the health care professional is responsible for contacting patients about laboratory, imaging, or consultation results.

5. Each clinic should prioritize items according to their individual practice and importance for tracking. Common trackable events for GYN / Family Planning clinics include:
   - Pap test results and follow-up, need for colposcopy, etc.
   - Mammography results and necessary follow-up
   - Laboratory tests, radiologic studies and pathology reports
   - Referrals to consultants, patient visit confirmation and consult report
   - After hours emergencies follow up on interim care

6. Suggested characteristics of the tracking / reminder system include:
   - defining time frames for when to expect various types of results and dealing with delayed or missing reports;
   - documentation of dates for receipt of information and specifying timelines for notifying the patient should be included;
   - addressing how to contact the patient in compliance with HIPPA regulations (e.g. postcard reminders are not compliant; e-mail is not compliant unless both office and patient systems are
secure, limiting information disclosed on an answering machine, or to an individual who may answer the call without prior consent, it may be preferable to leave a name and telephone number, asking the patient to call the office.) The result of the attempt for client contact, must be documented in the patient’s chart;

- centrally locating the system in the office (not to be kept in individual patient charts) so that reminders are accessible to the entire staff;
- cross training the office staff (the tracking system should not be the responsibility of a single individual, though person(s) responsible for regular review of open items according to the office’s established procedures should be identified);
- implementing the system as part of a culture of safety in the office and encouraging staff to report problems or mistakes and explore the causes of errors to improve the system and improve outcomes.

7. An appropriate tracking system (manual or electronic) requires correct and prompt data entry. Once information is entered, it should be retrieved and reviewed regularly with accompanying documentation of any actions taken or discussions with the patient. Information on each patient should be reviewed through the entire process from data input through resolution. The tracking form should include key follow-up elements such as:
   a. date ordered
   b. patient name
   c. identifying number
   d. test, procedure, consult, or referral
   e. date of results
   f. follow up required
   g. evaluation completed and patient notified

8. Whenever a patient does not appear for a scheduled follow-up appointment, that fact should be recorded in the medical record. An attempt should be made to contact the client about the missed visit and to assist in rescheduling the appointment. Follow the office procedure for patients who do not appear for an appointment after several appointments have been made.

**Procedure**

1. At the initial visit, discuss patient confidentiality and the office policy for notification of test results. If the patient requests that confidentiality be maintained, establish and document an alternate method of contact, but inform the patient that confidentiality may be broken if they cannot be contacted when a life threatening condition is suspected/detected.

2. After clinician review of abnormal results and notation of follow up care recommendations, begin the process of patient notification and counseling by contacting the patient by the agreed upon method. Patients should be instructed to contact office for test results if they are not received in a timely manner. Document the date, time, and results of the patient notification attempt in the medical record (see attachments: abnormal PAP and abnormal CBE follow up forms). Initiate the tracking system and file the abnormal result report in the patient’s chart.

3. If the client responds to the initial contact, provide results information / explanation and counsel regarding management options and process, recommended follow up, and possible consequences of not receiving additional follow up.
   - Schedule the in clinic follow up care appointment or
   - Assist with scheduling a referral appointment with another provider and obtain consent to release information to the referral source as indicated.
   Document all related activity.

4. An initial contact via telephone, or the agreed upon method of contact, must be made and documented in the client’s chart. If initial contact is unsuccessful, additional steps to contact client will include:
Follow up on Abnormal Exam or Test Results

• Contact #2 form letter mailed to client’s last known address; or a repeat attempt to contact client using the agreed upon method of contact.
  If no response
• Contact #3 form letter mailed to client’s last known address; or a repeat attempt to contact client using the agreed upon method of contact.

Document all attempts at contact in the client’s chart. Include a copy of any form letter sent.

5. When a patient refuses to obtain follow up as recommended or fails scheduled follow up care appointment(s), the patient must sign a release form (see attachment: Release When Test/Service/Consultation Will Not Be Obtained As Recommended). Clinician will review these cases before further clinical services can be provided.

6. When a patient is determined to be lost to follow up, a special notation should be placed in the tracking system and medical record to alert all clinic personnel to take appropriate action with any future contact from the patient.

References:

• “Agencies must have written policies/procedures for follow up on referrals that are made as a result of abnormal physical or laboratory findings”, Program Guidelines…for Family Planning Services, OPA, 2001.
• “The Quality Assurance System should include…a tracking system to identify clients in need of follow-up and/or continuing care”, Program Guidelines…for Family Planning Services, OPA, 2001.
• “Informed Refusal”, ACOG Committee Opinion #306, Obstet Gynecol 2004;104:1465-6

Document History

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