BULLHOOK
Community Health Center

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POLICY

FOLLOW-UP/ INTERNAL AND EXTERNAL TRACKING/ REFERRALS 3025

Appropriate follow-up measures should be taken to ensure continuity of care for:

1. Patients who have abnormal test results
2. Patients who have been referred to other providers
3. Patients who have missed return appointments
4. Patients who transfer to the health center from another health care provider must be screened by the health center protocols and minimal standards of care must be met as outlined in the policy and procedures. (The health center may accept documented normal results of screening tests done within the periodicity according to the specific program guidelines).
5. Patients who are pregnant and request services other than prenatal care must be asked if they have a designated prenatal care provider and if prenatal care has been initiated. This information must be documented in the medical record. If the patient does not have a designated prenatal care provider, the health center staff must assist the patient in accessing prenatal care. These efforts must also be documented in the medical record.

Documentation of all return appointments and contacts made or attempted must be in patient's medical records.

"No Show" should be documented in the medical record when a patient is noncompliant in keeping appointments.

Telephone calls made to or from the patient or the physician regarding the patient's care should be documented in the patient's medical record.
This documentation should include:

1. The reason for the call
2. Any problems discussed by the patient/physician
3. Any action taken and advice or instructions given
4. An electronic timestamp- which includes the date, time, and staff member's name that is documenting the occurrence.

The specific time frames utilized when providing follow-up will be determined by the professional who initiated the referral, unless further defined by federal or state guidelines or services protocols, and as indicated by the urgency of the situation. (Specific guidelines for abnormal laboratory/radiology follow-up are found at the end of this section).

INTERNAL TRACKING

To ensure appropriate follow-up, all laboratory tests, diagnostic imaging and screenings, i.e., mammograms and Pap tests, that are sent outside the agency for interpretation shall be scanned into the patient's chart and assigned to the primary care provider under the Documents tab in the electronic health record to be reviewed and timestamped.

Internal Tracking systems are in place to ensure that emergency, urgent and essential referrals, appointments and return appointments to the health center are made and kept. This system may either be electronic or hard copy. A tracking system will help to keep the timeline for the patient's condition and achievement of expected outcomes. It will satisfy patient management and needs by avoiding letting patients "slip through the cracks" or stopping short of completing the patient care cycle.

The system will make sure that problems and care are documented and resolved. Mechanisms for follow-up must be sensitive to a patient's concern for confidentiality and privacy and must be discussed with the patient. An agreed-on method for reaching the patient must be determined and noted in the medical record.

GUIDELINES FOR LABORATORY/RADIOLOGY FOLLOW-UP

Follow-up on all abnormal laboratory or radiology results are expected. **Patients should be notified within 10 working days** from the health center receiving report of the abnormal result.

Staff shall make a minimum of three attempts to notify patients of abnormal laboratory or radiology tests as follows:

1. Initial contact may be made by telephone if the number is available and patient has permitted home contact. At least 2 phone attempts are made on two separate days to try to reach the patient.

2. The second contact should be a regular mailed letter with directions for the patient to contact the health center for follow-up. A letter is sent after at least 2 phone attempts with no correspondence back from the patient.

3. If the patient cannot be contacted by the above measures, law enforcement will be used for a welfare check if it is determined that there is reason to think the patient may be unsafe.

4. If after three attempts are made with no response or three appointments are made and not kept by the patient, the health center provider should document in the chart that the patient is lost to follow-up care.

5. When the patient is referred to an outside medical provider, the nurse will follow-up with the private provider to assure the results are conveyed to the patient. Exception to this will be the Cancer Program's follow-up guidelines. See the Cancer Screening/Follow-up Section for specific requirements.

Note: For particular conditions such as abnormal Pap tests, mammograms, newborn screening, and communicable diseases, i.e., TB, HIV, and Hepatitis B, see section program guidelines for required follow-up.

HOSPITALIZATION TRACKING

The Bullhook Community Health Center provides quality and continuity of care for its patients by ensuring that information on hospitalizations, including visits to the Emergency Department, is obtained and reviewed in a timely manner. Bullhook will maintain an agreement with Northern Montana Hospital for referrals. Records will be scanned into patient medical records.

Patients may at times require to be sent to the Emergency Department (ED) for acute evaluation, acute illness or for hospitalization or may decide on their own to report to the Emergency Room.

REFERRALS

Referrals are made to assist patients in obtaining services not available on-site. The health center may not coerce patients to undergo any consultation or procedure unwillingly. Referrals may be recommended, arranged for, facilitated and/or paid for by the health center. When the provider or policy and procedures indicates that a referral is recommended, the obligation of the health center is to recommend that the patient seek care beyond the capability of the health center. Documentation in the medical record should reflect a recommendation that the patient seeks further care. Referrals are recommended for further assessment of clinical problems, or problems that are outside the scope of the clinic providers. Internal referrals are made as the situation or diagnosis dictates. Internal referrals, or 'warm hand-offs' will be made to dental, behavioral or mental health. It is always appropriate to assist the patient in finding a provider and payment source.

Written documentation of the outcome and follow-up of an emergency, urgent or essential referral must be obtained. If the patient refuses this level of referral, documentation in the patient's record is essential. Documentation of the patient's history regarding follow-up with discretionary or nonessential referrals is essential.

Patients who are participants in managed care payer systems, such as Health Maintenance Organizations (HMOs) or Medicaid Managed Care may be restricted to certain providers or limitations when needing specialist care. An individual should not be referred to a specialist without knowing whether the primary provider's authorization is required.

Kyndra Hall — Date: 12/14/2020
CHIEF EXECUTIVE OFFICER

Della K Rhines — Date: 12/14/2020
CHAIR, BOARD OF DIRECTORS

Date first adopted	06/29/2011
Date Revised/QI Board approval	06/22/2011, 04/27/2016, 03/29/2017
New date adopted/Board of Directors approval	06/29/2011, 05/09/2016, 04/10/2017, 12/14/2020