



SouthEastPrimary
HealthCareNetwork

Registers Recalls Reminders



Australian Government
Department of Health and Ageing

enhancing health together

Registers, Recalls, Reminders

A guide for General Practice

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November 2006
Revised December 2007
Revised May 2010

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Introduction

This guide is designed to help you establish where you are at with your recall systems and extend your systems if necessary to ensure a cost-effective and efficient Practice Register, Recall and Reminder system. This guide can be used to help set up a reminder system for a number of purposes such as preventive care, chronic disease management and immunisation.

Information management and technology are important tools in the use of Registers, Recall and Reminder systems.

Information management describes the means by which an organisation efficiently plans, collects, organises, uses, controls, disseminates and disposes of its information, and through which it ensures that the value of that information is identified so it can be utilised to the fullest extent.

Information technology is a means through which health information can be efficiently and effectively managed and utilised. In General Practice this focuses on the better management of information that can assist in promoting improved clinical, patient and practice outcomes. (1)

1. What are Registers, Recalls and Reminders?

Definitions

Registers: A register is a list of patients in the practice and contains specific information such as date of birth, address details, gender and any conditions that need follow-up.

Recalls: A recall is a proactive follow-up to a preventive or clinical activity. Recall systems are used to recall patients back to the practice for a consultation with the doctor to discuss the results of a test or clinical correspondence, usually in the instance of an abnormal test result or failing to attend a specialist appointment.

Reminders: Reminders can be opportunistic or proactive. A reminder system is used to provide patients with systematic preventive care (eg for diabetes, cervical screening and immunisations). (2)

Types

Registers

Age register

- Patients over 65 years for influenza and pneumococcal vaccination
- Children at appropriate ages for vaccination according to the ASVS
- Patients over 75 years for annual health assessments

Sex Register

- Pap smear

Disease Register

- Diabetes
- Asthma
- Mental Health

Preventive Register

- HMR – medication review
- Indigenous patients for health assessments

At-risk Register

- Abnormal pap smears
- Patients on anti-coagulant therapy

Other

- RACF – residents of aged care facilities – eligible for Comprehensive Medical Assessment on entry to ACF and then annually, RMMR - Residential medication management review.

Recalls and Reminders

- Phone calls
- Letters
- Prompts - designed to alert the GP to a preventive or clinical activity, relevant to the individual patient, during the consultation so that the matter can be raised opportunistically.

Reasons

Immunisation

- Childhood immunisation
- Influenza, pneumococcal
- ADT
- MMR – 18-30 yr old

Chronic Disease Management

- Diabetes
- Asthma
- Cardiovascular disease

Enhanced Primary Care

- Health assessments

Other

- Skin checks
- DepoProvera injections

2. The Benefits of Registers, Recall and Reminder Systems

Why have Registers, Recall and Reminder systems?

Many studies show that recall and reminder systems improve the overall health of patients.

There is evidence that where patient registers are established, there is increased provision of appropriate investigations and preventive care activities.

The various practice registers help you to systematically target all of the patients in a particular group (e.g. patients over 65 years in the case of influenza and pneumococcal vaccinations). (2)

A recall system following review of tests and results is a clinical and legal necessity. It is also a requirement of the RACGP Standards for general practice 3rd edition that GPs have a system to recall patients with clinically significant tests and results.

Reminders are an appropriate and acceptable method for promoting preventive care. Studies have shown that the delivery of preventive care improves with reminder systems. One study found that patient reminder systems were effective in improving immunisation rates in 80% of the studies, irrespective of baseline immunisation rates, patient age, setting or vaccination type. All types of reminders were effective. The study concluded that patient reminder systems in primary care settings were effective in improving immunisation rates. **Primary care physicians should use patient reminders to improve immunisation delivery.** (3)

What can these systems offer?

- Patient confidence that the doctor is monitoring their health by issuing recalls and reminders
- Continuity of care
- An increase in patient involvement in their health
- Better management of chronic conditions therefore leading to reduced acute care and greater preventive care
- Better quality of life for patients
- Increase practice income
- Meet Accreditation standards

Income versus Cost

What income can a reminder system produce?

28 patients attend a consultation over a three month period as a result of a reminder letter - at an average of \$30 per consultation this equals \$840.

Costs in generating this income –

GP time (overview)	1.5 hrs at \$100 per hour	\$150
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Mail		\$ 25
Junior staff time	1.5 hrs at \$16 per hour	<u>\$ 24</u>
Total costs		\$199

TOTAL INCOME GENERATED - \$641 for a 3 month period. (4)

Practice income can be generated by the use of registers and recall systems through -

Chronic Disease Management

- Contribution to Care Plans
- Review of GP management plan
- Review of Team Care Arrangement

Health Assessments

- 45 Year Old Health Check
- Aboriginal and Torres Strait Islander health checks for children, adults and older persons (55 years+)
- Comprehensive Medical Assessment for Patients of Aged Care Homes
- Health Assessments for Older Persons (75+)
- Intellectual Disability Health Assessment
- Health Assessment for Refugees and other Humanitarian Entrants
- Healthy Kids Check
- Type 2 Diabetes Risk Evaluation

PIP/SIP payments as shown by the following table-

- Diabetes
- Cervical screening
- Asthma
- Indigenous Health

PIP/SIP Payments

Incentives	Aspect or activity	Payment amount
Diabetes Incentive	<i>Sign-On Payment:</i> one-off payment for notifying the Australian Government that the practice uses a diabetes register and recall/reminder system.	\$1 per SWPE.
	<i>Outcomes Payment:</i> payment to practices that complete an annual cycle of care for a target proportion of their patients with diabetes.	\$20 per HbA1c SWPE annually.
	<i>Service Incentive Payment:</i> payment for each annual cycle of care for a patient with diabetes, payable once per year per patient.	\$40 per patient per annum.
Cervical Screening Incentive	<i>Sign-on Payment:</i> one-off payment to practices that engage with the state/territory cervical screening registers.	\$0.25 per SWPE.
	<i>Outcomes Payment:</i> payment to practices where a specified proportion of women aged between 20 and 69 years have been screened in the last 30 months.	\$3 per female WPE†† aged between 20 and 69.
	<i>Services Incentive Payment:</i> payment to practitioners for screening women between 20 and 69 years who have not had a cervical smear within the last four years.	\$35 per patient per annum.
Asthma Incentive	<i>Sign-on Payment:</i> one-off payment to practices that implement a cycle of care for patients with moderate to severe asthma.	\$0.25 per SWPE.
	<i>Service Incentive Payment:</i> payment to practitioners who complete an asthma cycle of care for patients with moderate to severe asthma, payable once per year per patient.	\$100 per patient per annum
Indigenous Health Incentive	<i>Sign-on Payment:</i> one-off payment to practices that agree to undertake specified activities to improve the provision of care to their Aboriginal and/or Torres Strait Islander patients with a chronic disease.	\$1000 per practice
	<i>Patient Registration Payment:</i> A payment to practices for each Aboriginal and/or Torres Strait Islander patient aged 15 years and over, registered with the practice for chronic disease management.	\$250 per eligible patient per calendar year
	<i>Outcomes Payment Tier 1:</i> Payment to practices for each registered patient for whom a target level of care is provided by the practice in a calendar year.	Tier 1: \$100 per eligible patient per calendar year
	<i>Outcomes Payment Tier 2:</i> Payment to practices for providing the majority of care for a registered patient in a calendar year.	Tier 2: \$150 per eligible patient per calendar year

The average FTE GP sees 1,000 SWPEs annually (Standardised Whole Patient Equivalent)

More information regarding these incentive payments can be found on the Internet at <http://www.medicareaustralia.gov.au/provider/incentives/pip/payment-formula/index.shtml>

General Practice Immunisation Incentive (GPII)

The GPII provides financial incentive to general practices that monitor, promote and provide immunisation services to children under the age of seven.

The overall aim of the GPII is to encourage at least 90 per cent of practices to achieve 90 per cent proportions of full immunisation.

The GPII is made up of an outcomes payment administered by Medicare Australia and paid to practices that achieve 90 per cent or greater proportions of full immunisation, providing the practice attains 10 Whole Patient Equivalents (WPE).

More information regarding the GPII is available at the following web address <http://www.medicareaustralia.gov.au/provider/incentives/gpii/index.shtml>

3. Medico-legal Issues

Reviewing the results of ordered tests is a fundamental part of clinical practice. At a time when doctors are being presented with ever-increasing quantities of information, having a comprehensive system for results review is both a clinical and legal necessity. Recent high profile cases have shown that the courts do not tolerate missed results. A system that enforces review is the safest way to improve clinical outcomes for patients and reduces the risk of litigation. ⁽⁶⁾

The RACGP commissioned a legal opinion on the issue of follow-up of tests and results before releasing the 3rd edition Standards for general practices.

While GPs are not expected to follow up every test ordered, there might be considerable risk in not following up clinically significant tests and results.

Milstein & Associates found in their legal review that -

- The duty to follow-up tests and results is to exercise a level of care that is “reasonable in all circumstances” rather than to deliver perfect care; and
- If an effective, efficient and cost-effective follow-up system is available and is not used then “reasonable care” has not been taken. ⁽⁷⁾

Overall the following factors are important in determining if something is clinically significant and therefore requires follow up –

- The probability that the patient will be harmed if adequate follow up does not occur;
- The likely seriousness of the harm; and
- The burden of taking steps to avoid the risk of harm.

Clinically significant results do not necessarily only mean “abnormal” results. For example, a normal mammogram in a woman with a breast lump or a normal ECG in a patient with chest pain does not preclude the need for further consultation, investigation and management.

Effective information management is essential in the modern clinical environment. A comprehensive results review system produces better clinical outcomes for patients and reduces litigation risk. ⁽⁶⁾

The practice needs a system aimed to ensure that –

- All received test results and clinical correspondence relating to a patient’s clinical care are reviewed;
- Clinically significant tests and results are followed up.

The practice needs to have in place some process or system for following up so that when there is concern about the significance of the test or result, a reminder occurs.

Review and action on results and reports needs to be completed in a timely manner. The speed with which results/reports are acted on, and the degree of effort taken to contact the patient to discuss the results will depend on the GP’s judgement of the clinical significance of the result and the context, duration and longevity of the clinical relationship. If the practice needs to initiate follow up contact with a patient it needs to do so in a reasonable manner.

RACGP Guidelines

Informed patient consent must be obtained from patients for them to participate in Practice, National and State register, recall and reminder systems

- Patient consent
- Give clear reasons why recalling is important
- Link to clinical condition
- Explain patient's responsibility
- Indicate method and frequency of contact
- Provide pamphlet or information sheet
- Indicate practice policy "opt in" or "opt out"
- Refusal must be informed ⁽⁸⁾

Patient Consent

Do you need explicit consent from patients to allow practice staff to generate recall letters and phone patients for recall?

No. Implied consent is adequate. GPs and practice staff are bound by the same code of ethics and privacy legislation.

Implicit or explicit consent?

If the use of an individual's information for recall was one of the primary purposes of collection, or an expected directly related secondary purpose, the individual's consent will not be required.

The Privacy Act does not require that medical staff/medical support staff sign a confidentiality agreement specific to each of the tasks that they perform. ⁽⁹⁾

4. Implementing Systems

Most medical software includes a register, recall and reminder system so it is important to become familiar with the systems within your particular clinical software. If no clinical software programme is used then a reliable manual register, recall and reminder system needs to be set up. The GP will usually identify the patient and the report, test or result and either place it directly onto the register, recall, and reminder system themselves or delegate it to the appropriate person. Each practice must develop their own fail-safe system of recalling patients.

Risk Management Strategy

Educate your front line staff to ask every patient when they arrive at the practice:

- Has your address changed?
- Have we got your current mobile phone number?
- Have you changed any of your personal contact details?
- Has your Medicare number changed?

Registers

Medical computer software that has the ability to compile a register allows for ease of use of registers.

For practices that use software that does not have the facility to compile a register, or for a non-computerised practice, the setup of a patient register can be a time consuming job. For these practices patient registers can be obtained from third parties such as pathology companies (eg pap smear, diabetes, anti-coagulant therapy).

SETTING UP A REGISTER

1. Instigate a series of searches of your patient population for each required register by
 - Diagnoses recorded
 - Medication prescribed
 - Pathology tests performed – pathology providers can provide a list of patients who have had for example – HbA1c or GTT for diabetes, INR for anticoagulant therapy, pap smears in the past two years.
2. Develop systems to maintain the registers
 - Decide who will maintain and manage the registers
 - Who will identify new cases? Who will record the information on the register – Doctor or receptionist?

PROCEDURE FOR SETTING UP COMPUTERISED REGISTERS

Disease Registers are generated from coded diagnosis. Codes for diseases should be decided on by all GPs in the practice to ensure accurate registers. (eg Diabetes – Type 1, Diabetes – Type 2, Asthma).

1. Search database for coded disease (eg diabetes, asthma)
2. Search database for uncoded disease by
 - prescribed medication in the computer records
 - lists requested from pathology company – HbA1c for diabetics
3. From these lists, go into patient notes and check to see if patient does have disease and if so code diagnosis by adding diagnosis to past history section
4. Tidy up your register – check register now to remove patients who no longer attend the practice (mark inactive if appropriate) or are deceased (mark as deceased)
5. Staff and GPs decide on a policy and procedure to keep the registers up to date

Recalls and Reminders

The practice should attempt to contact the patient via the following methods:

- three phone calls at different times of the day
- If the patient has not responded – a letter sent asking the patient to contact the practice - via registered post for recalls

If the patient has not responded to these communication attempts, the GP must be notified. All communication attempts must be documented in the patient health record.

Important factors to remember when recalling a patient

- Make sure the patient attends the surgery for the recall – **the recall is never completed until the doctor discusses that specific matter with the patient.**
- Every attempt must be made at contacting the patient and these must be documented in the patients' record.
- Try telephoning at different times of the day/night and on different days.
- Registered mail is also advisable to use if you have not been able to get a response. At least you will be able to prove that the patient received a letter.
- Any recall appointment should be marked as a “recall appointment” so that you will be able to check to see if the patient attended for the consultation.
- The only way to assess if the patient attended for the recall is to check the patients' records – never use the appointment book as a check, as the patient might not have kept the appointment or may have attended with another issue.

An effective recall/reminder system comprises the following components:

- **Recalls** – occurs when it is vital for a patient to attend the practice, usually in the instance of an abnormal test result or failing to attend a specialist appointment.
- **Reminders** – an offer to provide patients with systematic preventive care (eg for diabetes, cervical screening and immunisations).
- **Tracking** – a system to track diagnostic test requests and referrals leaving the surgery, register results of tests and referrals that arrive at the surgery and to ensure that the patient has been notified. A tracking system generally targets “at risk” patients. It is an essential component of an effective recall and reminder system.

Paper based systems

Recall systems

A book/record is kept for recalling patients with worrying or high-risk cases, tests, results, correspondence or referrals. Each time the GP indicates a need for recalling a patient, the patient details should be recorded, including:

- Patient's name, date of birth, chart number and contact details including phone numbers
- Reason for recall
- Date of recall and how it was done (eg letter / phone call)
- Follow up recall if necessary
- Date patient attended the consultation for the recall
- Any other system used if unable to contact patient (eg registered mail)

Reminder systems

Paper based reminder systems work just as well but require time in setting them up and keeping them up to date. A simple card file system with each month on it can be used for each different type of reminder.

Example: A patient comes in for the flu vaccination in April. Ask them if they would like a reminder for next year. If so write their name on the card for April next year. Come April next year, you will have a list of patients to send reminders to and as they come in for their vaccination you can cross them off and continue the process for the next year.

Computer based systems

The following procedures could apply to the **Recall system**:

- A recall list can be generated with a computerised system. Decide how often this will be done – daily for “urgent” recalls, weekly for “discuss”
- When the GP returns the results, follow the instructions provided by the GP – this may entail contacting the patient to make an appointment or transferring the call to the GP
- Before contacting the patient, cross-reference the patient’s health record to ensure they have not already been contacted
- If contacting the patient to make an appointment to see the GP, make three phone calls at three different times of the day
- Document in the patient’s health record all attempts to phone them and the times of the day called
- If the patient does not respond, send a letter via registered post asking the patient to contact the practice
- Document in the patient’s health record the date that the letter was sent
- Include a copy of the letter in the patient’s health record
- If the patient does not attend, advise the GP and repeat the above procedures
- Once the patient has attended their appointment and the GP has actioned the results and initialled accordingly, remove the recall flag, and if paper-based, file the report
- If the patient fails to attend the appointment they must be contacted immediately to reschedule the appointment. Notify the GP to advise that they did not attend and document all contact attempts in the patient health record and the reason for failing to attend the appointment

The following procedures could apply to the **Reminder system**:

- On a weekly or monthly basis, generate the reminder to the patient
- Document in the patient’s health record the date that a reminder was forwarded to the patient
- Before contacting the patient, cross-reference with the patient’s health record to ensure that they have not already been forwarded a reminder
- If the patient does not contact the practice after the reminder, send a second letter the next month
- Document all contact attempts in the patient’s health record
- If the patient does not attend, notify the GP for further advice
- Once the patient has their appointment, remove the reminder flag

Tracking System

There are many different ways to track recalled patients and some practices use a combination of systems to accommodate the needs of different patients and to ensure that the system is watertight.

To track recalled patients, our practice's recall and reminder system includes:

Tracking log – every GP maintains a log to enter patient details and key information including follow-up dates and progress. The log can be maintained on computer, in an exercise book or printed sheets in a folder. At every stage of the process, the patient file and log must be updated.

Clinical software – utilises recall prompts on clinical software to track patients. For example, when a test or referral is requested add a prompt such as “Test/s Requested” or “Referral Sent” and add a follow-up date. These prompts are best added as a code for consistency purposes. At every stage of the process, the patient file and recall prompt must be updated.

Card file – as with to the tracking log, every GP records patient details and key information including follow-up dates and progress, but on a card which is then added to a central card system which is filed by month according to the date of follow-up. At every stage of the process, the patient file, recall card and prompt must be updated.

A system is in place whereby a staff member is allocated the task of checking due recalls on a daily, weekly and/or monthly basis and then following-up patients. ⁽¹⁰⁾

5. Resources and Information

RACGP www.racgp.org.au

AGPAL www.agpal.com.au

MEDICARE AUSTRALIA www.medicareaustralia.gov.au

GENERAL PRACTICE

COMPUTING GROUP www.gpcg.org.au

“How to” manuals for computerised Register, Recall and Reminder systems can be found at the following websites

DIVISIONS OF GENERAL PRACTICE www.monashdivision.com.au

www.nevdgp.org.au

6. Appendix

Appendix 1 - Sample Policies

1.1. Follow up of Tests, Results and Referrals Policy (Item 7.5)

All test results- including pathology results, diagnostic imaging and investigation reports- and clinical correspondence is reviewed, initialled and, if clinically significant, followed up by the patient's doctor or delegated authority in a timely manner.

The report/result/correspondence, including a record of review and any follow up required, is incorporated into the patient health record.

Clinically significant tests and results are followed up according to the procedure outlined in 7.5.1.

The nature and extent of responsibility for following up test results, diagnostic imaging and investigation reports, and clinical correspondence depends on:

- The probability that the patient will be harmed if adequate follow up does not occur
- The likely seriousness of the harm
- The burden of taking steps to avoid the risk of harm

Staff are aware of the need for confidentiality and discretion, with regard to diagnostic tests and the results.

Procedure

Doctors maintain a record of significant diagnostic tests, referrals and pathology specimens sent or ordered by them and returned results or reports are checked against this list.

Correct demographics and legible handwriting when ordering diagnostic tests will assist with ensuring the results from any test ordered are matched with the correct patient.

Patients contact details are verified prior to ordering the diagnostic test.

Patients should be advised:

- If the doctor or practice will notify them of the results or if further follow up is required; or
- whether it is their own responsibility to seek the results of their tests.

Patients telephoning or presenting to the reception for results should be correctly identified before giving out any results or being referred to the doctor.

Following up reports, results and clinical correspondence that are expected but have not been received:

The patient is contacted, either by phone or letter, if a significant test result or confirmation of attendance at a referred service is not received within a reasonable time after the Doctor completed the request. The outcome of this contact is documented and either;

- More time is given for the patient to attend for the test or appointment
- The diagnostic laboratory is contacted if the patient indicated the tests have been undertaken
- The patient is managed in accordance with the procedure for a patient refusing treatment or advice (Refer 7.10)

Review of Results, reports and clinical correspondence received:

Hardcopies for review:

- Reception/nursing staff
 - ⇒ Check for the doctor's name on the report and record on it the date received before placing it in the correct doctor's IN tray; or
 - ⇒ Scan the hard copy into the computer for checking by the doctor concerned or allocated;
 - ⇒ Results received for a doctor not on duty that day are allocated to another doctor for review.
- Doctor will review the results, initial report and take action as required or clearly communicate in writing with reception/nursing staff any action delegated.
- Once the doctor has reviewed the results, the original report is initialled, and action required is noted on the report prior to it being filed/scanned into the medical record.

Electronic or scanned hardcopies for electronic review:

- Doctors (or the doctor allocated if the doctor that ordered the test is not on duty);
 - ⇒ Review the results, select the appropriate action box on the computer and take action as required or clearly communicate in writing with reception/nursing staff any action delegated.

If further action is required for clinically significant results, patients are informed according to the procedure outlined in Section 7.5.1.

RACGP 2nd Ed Std., 4.2.4 / RACGP 3rd Ed Std 1.5.4(A,B,C&D) & 1.7.3(A) & 4.2.2

1.2. Recall of Patients with Clinically Significant Results Policy (Item 7.5.1)

The clinical significance of a test result, including pathology results, diagnostic imaging and investigation reports, and clinical correspondence needs to be considered in the overall context of the patients history and presenting problem. Clinically significant results do not necessarily only mean abnormal results.

There is a system to enable the practice to determine that:

- Ordered tests were actually performed;
- Results have been received by the practice;
- Results were seen by a general practitioner, dated and signed (or the equivalent if in an electronic patient health record);
- Results have been acted upon, where appropriate;
- Results have been filed in the patient's record; and
- Results have been reported to the patient (or where this did not occur, that attempts were made to do so).

Procedure

- The patient's doctor (or the doctor allocated, if the doctor that ordered the test is not on duty) reviews the results and determines that something is clinically important for that particular patient in the context of that patient's health care.
- Clinically significant results and test reports require that the patient be contacted and the doctor informs the patient of the result and any subsequent consultation or other action that is indicated.
- The doctor will hold records of patients or add such cases to their computer task list that have been recalled in a defined location until the follow up has occurred (or the equivalent if an electronic patient record).
- The doctor will advise reception of patients who need to be recalled for an appointment to discuss a clinically significant test or result.
- The name, date of recall and reason should be recorded in the RECALL diary under the date due. Urgent recalls should be further identified and actioned promptly.
- Reception staff may be asked to ring the patient to arrange to either speak with or visit the doctor.
- Document actions undertaken to ensure adequate attempts are made to contact the patient to attend the appointment. Refer to procedure 5.2 for actions to follow.

It is important that patients are notified. Persist in telephoning the patient over a few days at different times and, should the patient not respond then send a letter asking that the patient ring the practice. (See sample letter below). If no response from the patient to the first letter then send it again using registered mail.

- Recall appointments, when made, are noted and it is recorded if the patient fails to attend so a subsequent appointment can be scheduled.

- Document date of the follow up appointment attended in the RECALL diary.
- Weekly checks of the RECALL diary or computer task list are made by reception staff or doctors.
- The recall diary is retained and stored in the same manner as any other medical record
- Subsequent significant medical interventions, diagnostic tests or referrals indicated are followed up by the patient's doctor (Refer 7.5).

RACGP 2nd Ed Std 4.2.5/ RACGP 3rd Ed Std 1.5.4(E, F & G)

1.3. Reminder Systems for Preventative Care (Item 7.6)

Policy

We have been providing health care services to our local community for a number of years. For the continuing management of our patient's health we promote a systematic approach to preventative care and early detection of disease, using the best available evidence.

Depending on individual circumstances, provision of information about health promotion and illness prevention for patients (and carers) is encouraged.

Procedure

Patient presentations at the practice are used as an opportunity to provide additional health promotion and illness prevention.

- Pamphlets and brochures from a variety of sources are available for patients to self select or to be provided by staff to reinforce health promotion messages from a consultation.
- Patients are encouraged to self identify information that is recorded on the health summary to assist with early identification of the patients main health issues or risk factors.

Preventative care and early detection of disease activities undertaken by doctors, practice nurses and allied health workers are recorded in the patient medical records.

Targeting of preventative activities and early detection of disease

1. Routinely collected information

Information that is collected and transferred to national registers can be used to improve preventative care by assisting to identify areas or specific patients for the practice to target. (eg ACIR, Overdue Pap testing)

2. Known patient risk factors.

Searching the practice clinical software may provide information about specific patients with risk factors such as ethnicity or positive family history of disease, or general risk factors within the practice patient demographics can be identified. This information provides areas to target (eg Aboriginal or Torres Strait Islander, smoking, weight management).

Preventative activities and early detection of disease includes:

1. Systematic flagging of patient health records.

An identifying marker or flag is used on the patient's record to remind practitioners to undertake additional preventative activities or screening for disease prevention when the patient presents at the practice.

2. Preventative care reminder list

Patients with a specified medical problem or risk factor are placed on a recall list and, subject to patient consent, reminders are issued or appointments made for patients to attend for a check up or routine follow up. This is used in addition to state based reminder systems/registers.

Such conditions may include immunisation, Pap smear, cancer follow-up, blood test for certain conditions, annual medical check for over 75s and as advised by a doctor for other defined situations.

Doctors seek the patient's consent before placing their details on a formal reminder system for preventative care recalls or operate under an opt-out policy outlined in the practice information brochure or notice board. This consent is documented in the patient's medical record. Reminders may be generated electronically or recorded in the recall diary under the date due.

The patient's privacy and confidentiality is protected and patients are notified in writing when reminder systems, which they participated in, are discontinued.

Resources

Further information regarding preventative activities in general practice is available in the:

- RACGP Red book, "Guidelines for preventative activities in general practice" (Current Edition)
- RACGP Green Book, "Putting prevention into practice -Guidelines for the implementation of prevention in the general practice setting" (Current Edition)
- Australian Government Department of Health and Ageing publication, "Smoking, Nutrition, Alcohol and Physical Activity (SNAP) Framework for General Practice" (2001)
- National Institute of Clinical studies Evidence-Practice Gaps report. www.nicsl.com.au
- Lifescrpts Initiative. Contact you local division to find out more about this Lifescrpts Initiative and to access the Lifescrpts resources DDDGP ph 9706 7311.

1.4. Recalls And Reminders

[SAMPLE]

Name & Address of Practice

This practice uses a “Recall and Reminder” system to provide preventive care for its patients.

This will assist in ensuring that important health checks are not forgotten and are performed on time. You will be reminded when it is time to visit your doctor for a check-up or as a follow-up to health risks that have previously been found. The reminder system will include checks to help in the prevention or early detection of certain conditions such as diabetes, high blood pressure, high cholesterol and forms of cancer – particularly cervical and prostate cancer, and immunisation follow-up.

In some cases, the reminders can also be sent from other places, e.g. the government pap smear register (for the detection of cervical cancer).

We will use information from your health record to tell us the check-ups for which you are due and when you should visit your doctor to discuss the tests that are needed.

Our doctors follow the guidelines for preventive care as outlined in the Royal Australian College of General Practitioners’ Guidelines for Preventive Activities in General Practice. The guidelines are in line with the recommendations of organisations such as the National Health and Medical Research Council, the National Heart Foundation and others.

The new privacy laws require that we obtain your consent to send you these reminders. Your doctor will discuss with you the checks that may be necessary and will make a note on your record if you consent to be included in the recall and reminder system.

By allowing us to send you these reminders, you will help us to detect serious conditions early and to monitor known conditions. This can significantly improve the long-term outcome for you.

When you have had your test your doctor will tell you how you can get the results – e.g. by phone, or by a visit to the doctor a few days after the test.

Even when you agree to be included in the Recall and Reminder system, you should remember when you should be tested for certain conditions and should always contact your doctor to get the results of a test that has been performed. We may not always be able to reach you, especially if you have moved and the contact information on your record has not been updated.

Please discuss with your doctor any concerns you have or if you wish your doctor to make clear anything to do with the Recall and Reminder system. ⁽¹²⁾

Appendix 2 - Sample Letters

2.1. Sample Recall Letter

Patient Unable To Be Contacted Via Telephone

Dear _____,

(Date)

Results of your recent test (Insert test name) have been received by your doctor. We have been unable to contact you by telephone in the past few days to inform you, hence this letter.

Please ring the clinic on Tel: _____ to make an appointment time with the doctor/speak with the doctor.

Thank you.

Yours faithfully,

(11)

2.2. Sample Reminder Letter

Dear _____, (Date)

A reminder that your repeat/annual/monthly _____ check is now due.

Please ring us at the clinic on tel: _____ between 8.30 am and 7 pm
Monday to Friday to arrange an appointment with your doctor.

If you have had this test/check at another clinic, please let us know so we may keep your
medical records updated.

Should you have any queries or concerns don't hesitate to contact us at the clinic.

Yours faithfully,

(11)

2.3. Sample Patient Consent To Participate In Register, Recall And Reminder Systems

Consent to participate in Register, Recall and Reminder Systems

I _____ give my consent to participate in Practice, State and National Register, Recall and Reminder programs.

I understand that this practice will contact me by _____
_____ to advise me of results and preventive care activities.

I understand that I can have my name removed from this register at any time.

Signed _____

Print Name _____

Appendix 3

Pathology and Recall/Reminder Self Audit Tool

What is it?

The self-audit tool is a page of statements to which you respond by ticking the appropriate response which will then provide a snapshot of “where a practice is at” with regard to their recall and pathology management systems.

How to use the self-audit tool

Ideally the doctors and key practice staff of a practice would go through the audit tool at a staff meeting and then agree on the procedures necessary for implementation of improvements to the recall and pathology management systems. A division staff member could facilitate such a meeting. All suggestions and decisions made **MUST** be documented at the meeting and afterwards printed for the others to review. Further meetings and/or training may be required to assist the implementation process.

Requirements

A more efficient pathology management and recall system depends on:

- **consistency** by all GPs in how pathology and recall is handled
- **teamwork** between GPs and staff
- **a willingness to learn new ways** in doing things (especially if using electronic methods)
- **an agreement on definitions**, e.g. all GPs have a common definition of **Urgent, No Action** and **Discuss** when marking off results

Outcomes of using the self-audit tool

Using the audit tool should lead to:

1. **Creating a Policy:** What the practice wants to achieve and why it wants to achieve it
2. **Developing a Procedure:** How it is going to do be done

And thus provide:

- the best clinical outcomes for patients
- protection against litigation
- compliance with Government initiatives
- compliance with Accreditation/Re-accreditation expectations.

With thanks to Noel Stewart, North East Valley Division of General Practice, for producing this resource. (13)

Principal question:

	Yes	No	Sort of
Are you confident that you that you have all the processes and procedures in place with your pathology/recall systems to protect you from adverse clinical outcomes and/or patient litigation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OTHER IMPORTANT QUESTIONS:

INVESTIGATIONS	YES	NO	SORT OF	RECALL/REMINDER	YES	NO	SORT OF
All patients are recalled for abnormal results (Urgent Return) within 1 week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	All GPs in the practice know how to initiate a recall (and do so)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All patients marked as "Discuss" are recalled within 1 month	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recalls are added for abnormal results (e.g. Repeat PAP Smear in 3 months)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 attempts are made to contact patients with abnormal results	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recalls are proactively undertaken and followed through	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attempts made to contact patients are recorded in the patient's record	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Staff create recall lists on a regular basis and patients are contacted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient record is marked as "notified" by all GPs once results are discussed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If a patient does not respond to the first reminder a follow-up letter or phone call is initiated and added to notes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am able to identify patients who have not presented for ordered investigations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Is a 3 rd reminder sent by registered mail?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The pathology management procedures are followed up by all GPs of the practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	All attempted contacts are clearly recorded in the patient's record	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is a procedure in place to ensure the patient has attended a specialist appointment after abnormal results	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The recall management procedures are followed by all GPs in the practice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All abnormal PAP smears are discussed and any referrals and follow-up tests monitored and recorded	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reminder systems are in place for adult and child immunisations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All practice staff are aware of the pathology management procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	All staff are aware of the recall/reminder procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The investigations policies and procedures are clearly documented in the "Policy and Procedures" manual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The recall/reminder policies and procedures are clearly documented in the "Policy and Procedures" manual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A procedure is in place for results to be checked by another doctor when a doctor is sick or absent at short notice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Accurate records are kept to avoid sending recalls to deceased or inactive patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GENERAL QUESTIONS

	YES	NO	SORT OF
I feel very confident that our pathology management and recall/reminder systems are working well.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel overwhelmed by the complexity of setting up pathology management and recall/reminder systems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am confident that our pathology management and recall/reminder systems would successfully pass accreditation/reaccreditation scrutiny.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My practice has a successful "team" approach by all members of the practice in its pathology management and recall/reminder systems and this is documented.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I would appreciate assistance by my division in helping to set up pathology management and recall/reminder systems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix 4

(on following page)

Diabetes Management Checklist for Patient Record

Diabetes Management Checklist – Patient's Name:		<u>DoB:</u>				
TEST	Initial	3 mth	6 mth	12 mth	24 mth	Notes
Date						
Blood Glucose (HbA1c <7%- normal – needs improvement if >1% above normal)						<ul style="list-style-type: none"> • Every 3-6 months for insulin treated patients • Every 6-12 months for non-insulin treated patients • Consider referral to diabetes educator, dietician, endocrinologist if HbA1c >7% • Adjust medication if HbA1c >7.1%, add insulin if on maximum doses. Consider less tight control in high risk patients eg frail elderly, epilepsy, hypo unawareness
Height (m)						<ul style="list-style-type: none"> • Initial visit, then every 3 months • More often if on weight reduction program
Weight (kg)						
BMI (20-25kg/m ²)						
Blood Pressure (<130/80)*	SUPINE	SUPINE	SUPINE	SUPINE	SUPINE	<ul style="list-style-type: none"> • Every visit, measure both supine and erect • Step 1 - non pharmacological measures should be tried first • Step 2 - ACE inhibitors or ARAs (if ACE not tolerated) • Step 3 – ACE inhibitor and diuretic • Step 4 – B blocker or calcium channel blocker
*<125/75 if proteinuria > 1g/d	ERECT	ERECT	ERECT	ERECT	ERECT	
Dyslipidaemia: Total Cholesterol (<4.0 mmol/L) Triglycerides (< 2.0 mmol/L) HDL (≥ 1.0 mmol/L) LDL(< 2.5 mmol/L)* *≤1.8mmol/L following CV event		*If insulin		*If insulin		<ul style="list-style-type: none"> • Every 1 –2 years if normal, 3- 6 months if abnormal or on treatment • Non pharmacological measures should be tried first • Preferred agents are HMG CoA reductase inhibitors for hypercholesterolaemia. Fibrates should be added as a second line treatment
Foot						<ul style="list-style-type: none"> • Patients need to know and practice routine foot care • Check 6 monthly for factors predisposing to problems, reduced circulation or sensation, abnormal foot structure, poor hygiene • High risk patients should be reviewed by a podiatrist (PVD, foot deformity, past history or current ulcers, peripheral neuropathy)
Eye						<ul style="list-style-type: none"> • At diagnosis, and then every 1-2 years • Refer to optometrist or ophthalmologist: initially and then intermittently, if declining visual acuity at subsequent visits, if any retinal abnormalities are detected, if unable to get a clear view of the retina
Urinary Albumin Exc. < 20 µg/min (or 30mg/d) in a 24 hour collection For spot urine albumin to creatinine ratio refer to your lab as reference ranges vary						<ul style="list-style-type: none"> • At diagnosis and then every 12 months if normal. Abnormal readings should be repeated twice within 3-4 months • Monitor plasma creatinine to estimate changes in GFR • Microalbuminuria is an indicator of high CV risk • Control of BGL and BP to reduce renal damage • Watch for asymptomatic urinary tract infections
Healthy Lifestyle						<ul style="list-style-type: none"> • Discuss smoking cessation • Discuss healthy food choices • Discuss appropriate activity – at least 30 mins a day on most days • Alcohol intake ≤2 standard drinks (20g)/day for men ≤1 standard drink (10g)/day for women
*Other as appropriate						<ul style="list-style-type: none"> • Prophylactic aspirin (75-325mg/d) unless contraindicated • Commercial and private driver licences • Immunisations • Oral health professional • Counselling • Erectile dysfunction • Pre-Pregnancy counselling • Travel, sick day management • Lifestyle interventions

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