Risk Matters: Tracking Procedures

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Missed diagnosis is a top claim received at SVMIC. The tracking of lab and diagnostic test results, as well as referred patients and missed or canceled appointments, is essential to avoid delays in diagnosis and/or treatment. A patient may fall through the cracks if an abnormal test result is misplaced or filed away without taking appropriate action, or when a patient fails to keep a recommended appointment either with the referred physician or your practice. If a patient suffers consequences from not receiving the lab test that you ordered or from not seeing the consultant to whom he/she was referred, you could be named in a medical malpractice lawsuit. This Risk Matters advice focuses on the delivery of test results.

A consistent method for notifying patients of **all** test results and instructing them to call the office if they have not received the results within the expected time frame should be established. These instructions to the patients, as well as actual patient notification, should be documented in the medical record. Although instructing the patient to call for test results does not absolve the doctor of the duty to inform the patient, it does act as another safety net to ensure that important test results do not get overlooked and is a legitimate means of

vesting the patient in his/her own healthcare. The more layers of redundancy that can be built into a system, the better.

It should be noted that, irrespective of a facility's statutory responsibility to report test results, (e.g., mammograms), the physician is not alleviated of responsibility to ensure the patient has been notified of **all** test results as outlined above. Likewise, when an *unsolicited* test result is received regarding an established patient of the practice, it should be handled the same way as one that was personally ordered. The patient needs to be notified that the provider is in receipt of the report in error and has or will notify the ordering physician. Do not automatically assume "normal" results do not require action, as occasionally results within normal range of the laboratory may not be the expected result for the patient. Rather, attempt to contact the ordering physician. Additionally, the testing facility needs to be contacted and notified that the provider is not the ordering physician, and the result should be delivered to the physician who ordered the test. If the patient is not known to the provider, there is still a limited duty of care owed to the patient. Much of this obligation would be minimized by confirming with the ordering physician (if possible) that he or she received and addressed the test result. In any event, the testing facility should be notified that the provider is in receipt of the report in error, and it should be delivered to the ordering physician. *If the report indicates a panic value or grave condition* and the provider is not able to confirm that the ordering physician is in receipt of the report, an attempt should be made to contact the patient. In both cases, this notification includes contacting the patient and arranging for any appropriate follow-up care.

Practices can make use of electronic patient portals for notification of normal, non-sensitive test results for those patients who have signed a written consent or electronically agreed to receive information via the portal. However, it is not reasonable to assume all patients are able or choose to use the portal. Practices should verify that patients have accessed the portal before utilizing this as the sole vehicle of notification of normal non-sensitive results. Patients who do not use the portal should be notified of normal test results through another mechanism. It is not acceptable, from a risk or customer service perspective, to advise patients that the only method of normal test notification available will be through the portal.

Practices should be familiar with the general requirements of the U.S. Department of Health and Human Services Office of the National Coordinator for Health Information Technology's (ONC) Cures Act Final Rule, also known as the ONC Information Blocking rule, which became effective in 2021. Among other aspects of compliance with the regulation, practices should have documented procedures pertaining to how both in-house and outside lab results are made available to patients and when an exception to access may apply. While clinicians are not required to make in-house test results immediately available, they are required to promptly respond to a patient's request for access. Medical practices should be mindful that outside lab results may be immediately posted to a patient's EHR and implement a policy requiring prompt review of posted results as well as personal communication with any patient with an abnormal result, sensitive information or a result requiring immediate action.

The required follow-up *for non-adherent patients* or to communicate test results is not clearly defined. However, there is an expectation that the physician has superior medical knowledge and therefore owes a duty to the patient to thoroughly explain the results of the tests and any recommended treatment course. Follow-up should be appropriate for the individual patient's specific circumstances. The reasonableness of the effort to contact the patient will depend on the clinical importance of the test results, the severity of the patient's medical condition, and the risk associated with failing to notify the patient of the results.
