

Are You on Track?

Diagnostic Test Results, Consults and Referrals

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**Today's speaker is Brenda Wehrle, BS, LHRM, CPHRM,
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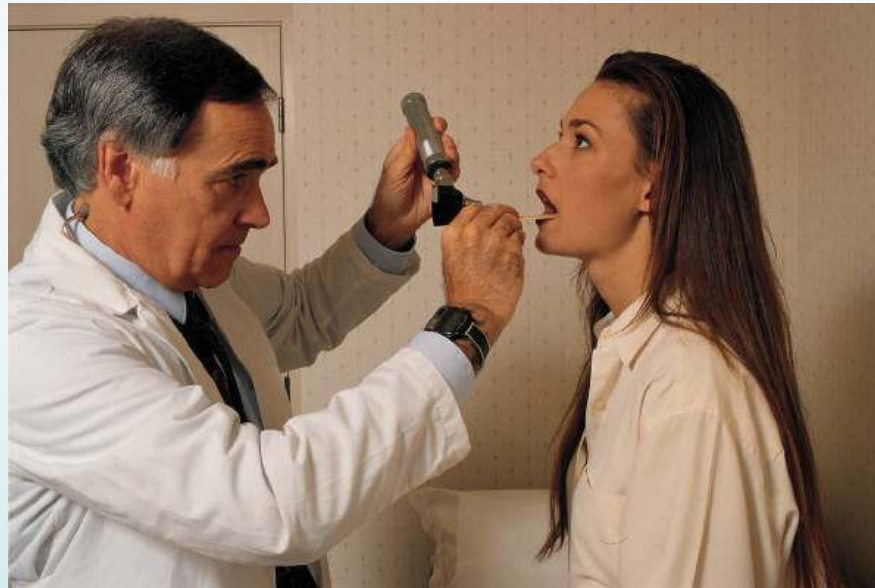
Brenda is an industry-recognized patient safety and risk management professional with more than 25 years of experience. Most recently, Brenda served as a corporate leader in clinical risk management. Her professional background also includes broad experience in community healthcare facilities, including acute care, long-term care, ambulatory surgery, behavioral health, and physician practices. These opportunities have afforded Brenda valuable insight into the challenges of providing healthcare in today's world and have provided her with extensive experience conducting site surveys, leading root cause analysis teams, developing innovative loss-prevention programs, and providing consultative risk management guidance.

Brenda also has been an instructor at the Florida Risk Management Institute and has presented training and educational sessions to introduce best practices at the national level. She has experience in infection control, patient and employee safety, quality, accreditation, and credentialing. As a TeamSTEPPS master trainer, Brenda helps healthcare leaders, providers, and staff use communication and teamwork strategies to improve working relationships, enhance patient safety, and reduce the risk of error.

Brenda earned a bachelor of science degree in medical microbiology from the University of Wisconsin. She is licensed as a healthcare risk manager in Florida, is a member of the American Society for Healthcare Risk Management (ASHRM), and has had her American Hospital Association certification as a professional risk manager (CPHRM) since 2004.



Risk Management in the Physician Practice



Malpractice Claims

Diagnosis-related

- Most common > 35% settlement dollars
- Most costly >\$385,000 average payment/claim
- Most likely to result in significant harm

BMJ Qual Safe 22 Apr 2013

Primary care: diagnostic errors

- Clinical encounter process
- Communication and patient compliance
- Diagnostic test tracking and follow up

JAMA Intern Med 25 Mar 2013

Frequency of Failure

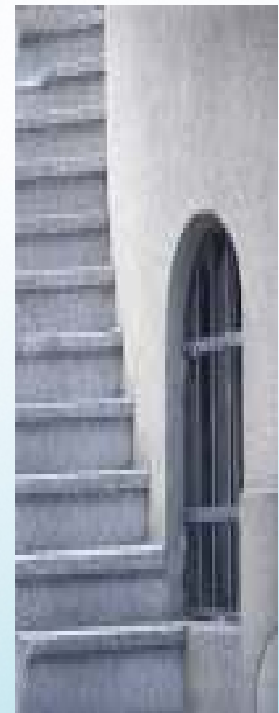
- Failures to inform patients of clinically significant test results occur in 1 out of 14 tests
- Testing-related errors can lead to serious diagnostic errors
- Few practices have rules for management of test results
- Practices with a partial “EMR” have the highest failure rate



Casalino et al., Frequency of Failure to Inform Patients of Clinically Significant Outpatient Test Results. *Arch of Int Med* 2009;169(12)

Risk Assessment Principles

- Steps in the process
- Define governance
- Identify indicators
- Know fundamentals
- Review risk experience
- Set goals
- Focus on highest risk



Clearly define governance



Risk Assessment Fundamentals



- Ensure that process reflects business objectives
- Prioritize efforts
- Build support
- Determine best plan for implementation

Leading indicators provide insight into potential risks



Review experience and resources

- Incident reports
- Identified near misses
- Corporate request
- Patient complaints
- Self assessment results
- Literature
- Significant change in system or process



Goals of the risk assessment

Determine:

- Effectiveness & reliability of current system
- Adequacy of policies and procedures
- Level of staff comprehension and implementation
- Inherent risk and potential for system failure
- Provide risk strategies to improve patient safety / prevent harm

What are the highest risks?

- Diagnostic errors
- Laboratory errors
- Communication breakdowns

AMA: Research in Ambulatory
Patient Safety: A 10-Year Review
(2011)

Don't sweat the small stuff! (yet)



RCA Results

Most Common Contributing Factors

- Coordination: inadequate follow-up planning
- Delayed scheduling
- Inadequate tracking of test results
- Absence of a system to track patients
- Team decision making: miscommunication of urgency between providers
- Providers' lack of knowledge about a patient's situation
- Communication failures

Giardina, T, et al, Root Cause Analysis Reports Help Identify Common Factors In Delayed Diagnosis and Treatment Of Outpatients. *Health Affairs*, 32, no.8 (2013):1368-1375

What we know:

- Offices and systems vary, so there is no single “best” office system.
- Offices with a team approach to patient care, good communication among all staff, mutual trust and support, and a commitment to patient safety are more likely to discuss mistakes and problems.
- Offices with fewer testing errors and greater patient safety have:
 - Written procedures that are readily available to all staff.
 - A process for updating and informing staff of changes in office procedures.
 - Office systems that focus on and support collaboration among staff rather than individual performance.

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Assessing the Readiness of your Office

Office Readiness Survey

Date _____ Survey No. _____

This tool can be used to assess your office's readiness for quality and safety improvement.
Circle the number between 1 and 5 that most accurately describes how you feel about your office.

Practice Improvement	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. The leadership (e.g., medical director, office manager, head nurse, or other leader) at this office demonstrates a commitment to quality and patient safety.	1	2	3	4	5
2. Communication among staff, physicians, and leadership promotes mutual respect and trust.	1	2	3	4	5
3. All staff in this office work as a team.	1	2	3	4	5
4. All staff are asked to provide input on decisions about office processes.	1	2	3	4	5
5. Monthly meetings are held, and quality of care is a regular item on the agenda.	1	2	3	4	5

Comments:

Quality and Safety of the Testing Process					
6. This office has written procedures describing how to handle testing and test results.	1	2	3	4	5
7. Everyone in this office has read and follows the testing procedures.	1	2	3	4	5
8. Medical testing errors in this office do not harm patients.	1	2	3	4	5

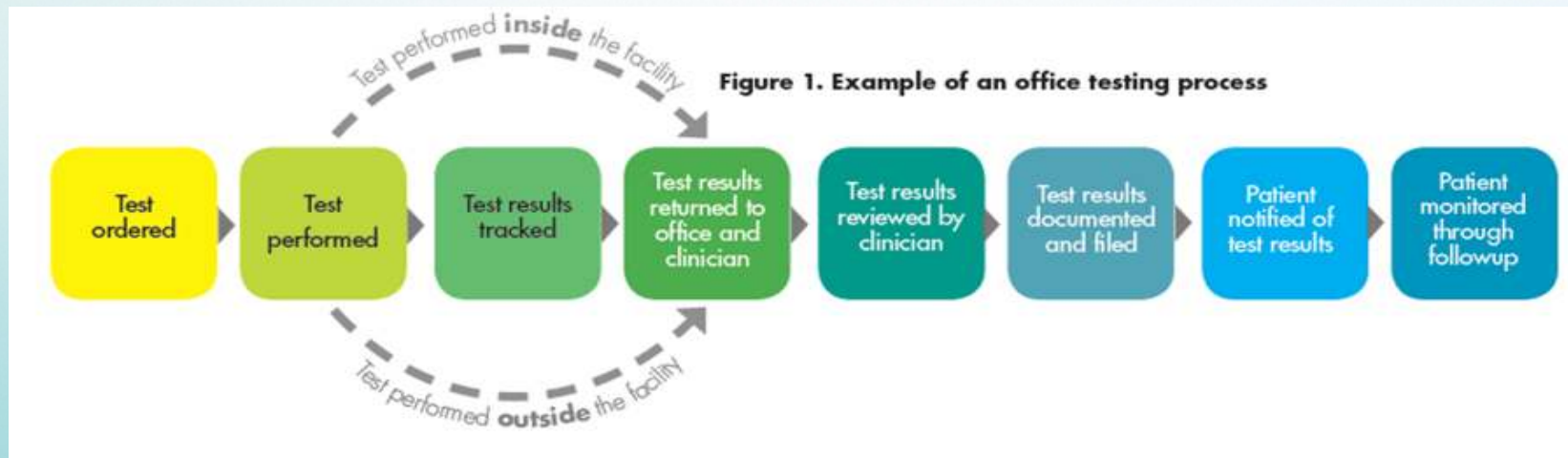
Assessing your Readiness

- Discuss why the entire staff should be involved in all patient safety projects, and describe the approach
- Have staff describe their work using data and information and their experience
- Ask staff to identify problems or workarounds in the testing process that consume time and effort.
- Ask staff to identify possible solutions. Be sure to record and keep this information for future meetings.
- Promise to bring relevant practice improvement tools to the next meeting.



Planning for Improvements

- Well-designed office systems make errors less likely.
- Breaking complex processes into parts will help you decide where a change might make a difference. One change can impact many parts of the testing process.
- Regular staff meetings can improve communication and collaboration and promote shared responsibility for office processes.
- Even if an improvement involves changes for only a few people, it is important to include everyone in the improvement process to foster a culture of safety in your office.

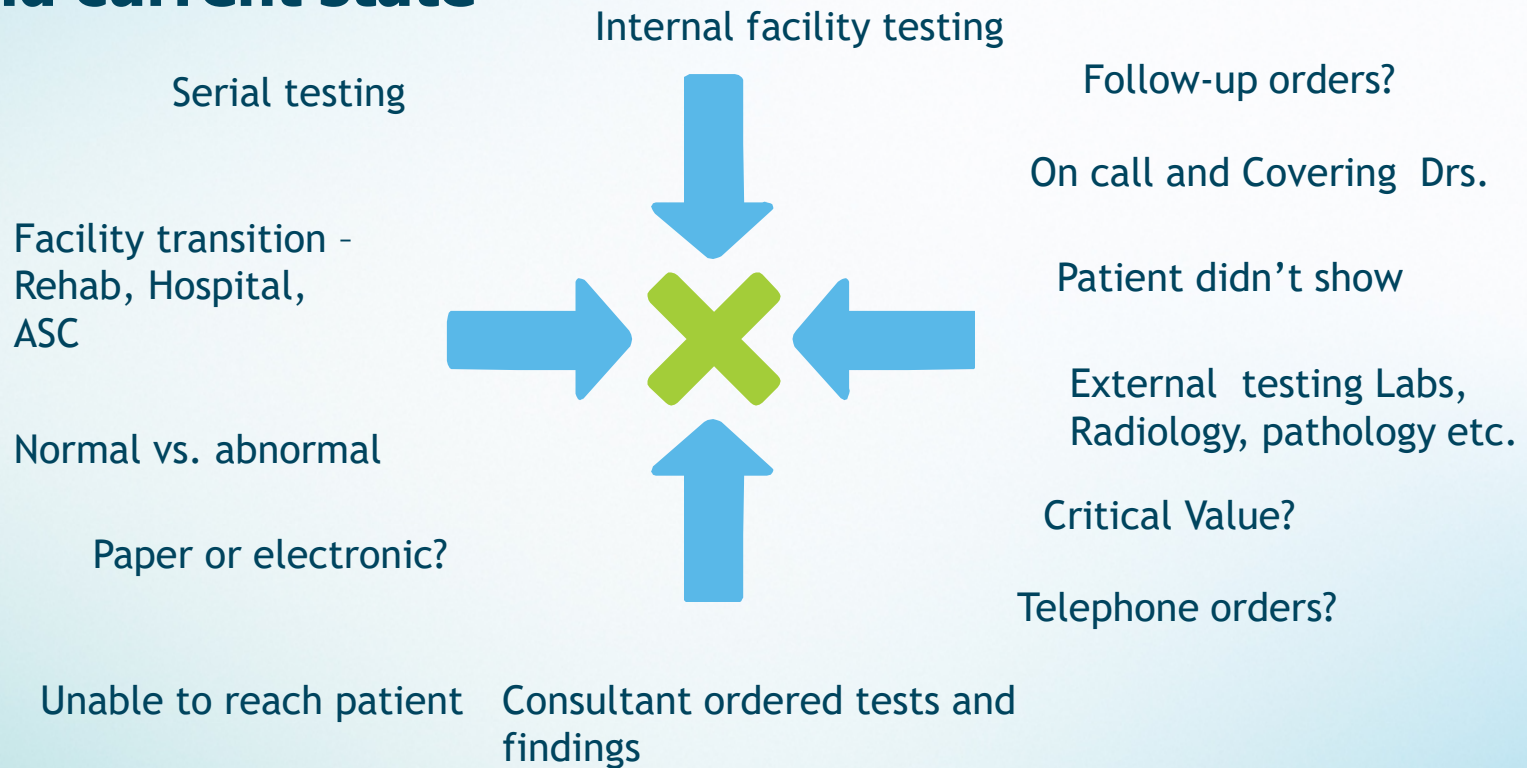


Testing Problems



- Pre-analytic
 - Ordering the test
 - Implementing the test
- Analytic
 - Performing the test
- Post-analytic
 - Reporting results to the clinician
 - Responding to the results
 - Notifying patient of the results
 - Following-up to ensure the patient took the appropriate action based on test results

Understand current state



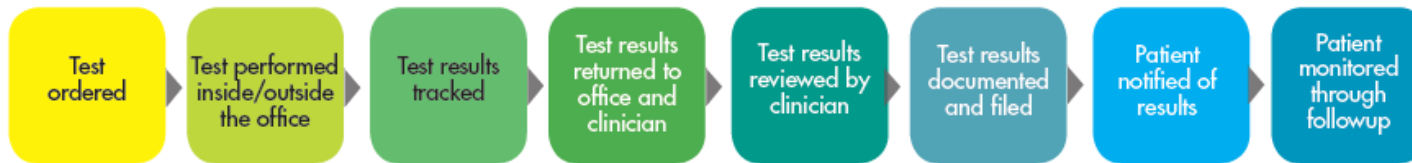
Tracer Methodology

- Define where to start and end process
- Select a variety of patient or test types
- “Walk through” process as it happens with staff



Planning for Improvements Tool

This tool can help you design changes to improve your office system for managing lab test results and patient followup. Use other tools found in this toolkit to measure whether your change(s) led to improvements in the testing process within your office.



List each step needed to accomplish the task you are changing

Who performs this step?

Who performs this step when the primary person is absent?

Assessing your testing process

We know that:

- The risk of an event is related to its frequency and the likely severity of harm.
- Balancing these two aspects of risk can be challenging. More common events with less severe harm are easier to overlook, as the risk to patients can be underestimated. The risk to patients of an uncommon event that may cause severe harm (a sentinel event) is often overestimated.
- It is important to stay focused on office systems in managing risk.

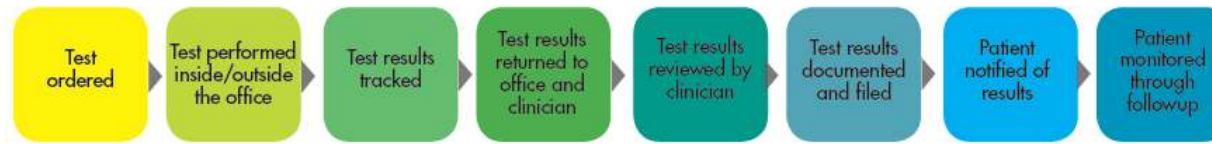
Assessing Your Testing Process Survey

Date _____ Survey No. _____

This survey is used to collect staff estimates of the frequency of errors and their potential degree of harm.

Describe your experience in the testing process:

- Circle the number that you feel most accurately describes the frequency of errors for each step.
- Circle the number that you feel most accurately describes the harm associated with the error.



Tasks where errors may occur	How often does this happen?			What is the usual harm for patients?				Don't know/ Not applicable	Total
	Rarely (Less than once a month)	Occasionally (Once a month)	Frequently (2 or more times per month)	None	Mild	Moderate	Severe		
1. Ordered test not done	1	2	3	1	2	3	4	1	
2. Test performed incorrectly	1	2	3	1	2	3	4	1	
3. Test results not logged/tracked	1	2	3	1	2	3	4	1	
4. Test results not returned to the physician	1	2	3	1	2	3	4	1	
5. Physician does not review all results	1	2	3	1	2	3	4	1	
6. Test results not entered in patient's chart	1	2	3	1	2	3	4	1	
7. Patients not notified of all test results	1	2	3	1	2	3	4	1	
8. Patients with abnormal results not monitored through followup	1	2	3	1	2	3	4	1	



Patient Engagement

- Patients often do not know what test has been ordered or why it has been ordered.
- Patients may not know when to expect test results.
- Patients often assume or may be told that “no news is good news” and so may not take the initiative to get their results.
- Patients encounter challenges in following up on abnormal results and may require additional support.

Case Study: Care Transitions

A 70 year old healthy male presents to his primary care doctor (a 3rd year resident) for routine visit. The resident is in his final month of training and will leave the practice on completion.

A PSA is ordered to screen for prostate cancer. It returns markedly elevated at 83ng/ml. The patient is not immediately notified as the electronic alert was sent to the primary care provider. Who in the interim has graduated. No system for hand-offs relating to pending tests and alerts was in place.

Eight months later the patient presents with new onset back pain. Imaging confirms metastatic prostate cancer.

Patient Engagement Survey

Date _____ Survey No. _____

Instructions:

- Ask patients in person or by phone about their experiences. Complete only one section for each patient, depending on where they are in the testing process.
- Tell the patient that this survey will be used to improve patient safety in the office and that his/her responses will not be shared with other staff, including physicians.

1. After patients have medical tests:

1. Do you know what medical tests were ordered for you at your last office visit? Yes No
2. Do you know why the test (or tests) was ordered? Yes No
 Routine check-up or screening check current condition identify the cause of symptoms don't know other
3. Do you know when to expect your test results? Yes No
4. Do you know what to do if you don't hear from us when your test results are due? Yes No
5. Did you tell us how you would like to be contacted with your test results? Yes No
 office visit phone call card/letter electronic patient portal email to _____

2. After patients receive their results:

1. Did you receive your test results? If the answer is "no," the survey is complete. Yes No
2. Were you given clear instructions, advice, or information about following up on your test result? Yes No
3. Does the patient's response correspond with his/her medical record? Yes No

We know that:

- Many patients will not follow up to obtain their test results without notification or encouragement from the office.
- Patients have better outcomes when they know the reasons for their tests, take some responsibility for making sure they get their test results, and understand what the results mean.
- The teach-back method in which a patient repeats what they have been told has been shown to enhance patient understanding.



Defining expectations

Patient Handout Patient Name _____

Instruction: Complete the appropriate section of this form and give it to the patient.

Reason for Medical Test(s)

check-up manage my health understand the cause of my symptoms.

1. After having a test:

I will hear from the office with my results by _____ (date)

If I don't hear back, I should call _____ (phone number) and ask for _____ (office contact person)

2. After getting a test result:

When I got my result(s), I was told (please check all that apply):

Do nothing

The result was normal

Continue my same medication or treatment

Change my medication or treatment

Return to the office for more tests _____ (date and time)

See a specialist or go to another facility _____ (name/address/phone)

Auditing the record

We know that:

- Chart audits are widely used to provide information about office systems.
- Chart audits rely on documentation, which may not accurately reflect actual care or practice.
- Electronic health records automate many processes but do not eliminate all errors.
- A failure to monitor automated processes may introduce patient safety risks.

Chart Audit Tool

Date of Audit _____

Instructions: Use one form for each test.
Enter all available information about a specific test from each medical record.

Patient Name & ID	Type of Test
	<input type="checkbox"/> blood test <input type="checkbox"/> non-blood test <input type="checkbox"/> imaging (CT, MRI, xray, etc) <input type="checkbox"/> mammogram <input type="checkbox"/> other _____
1. Is there an order for this test in the patient's chart?	Date ordered _____ yes <input type="checkbox"/> no <input type="checkbox"/>
2. Is the test result in the chart?	Date result recorded _____ yes <input type="checkbox"/> no <input type="checkbox"/>
Is the signature dated?	yes <input type="checkbox"/> no <input type="checkbox"/>
3. Is there evidence in the chart of the response to the test result (e.g., normal, further testing, etc)?	yes <input type="checkbox"/> no <input type="checkbox"/>
4. Is there documentation in the chart that the patient was notified of the test result?	Date patient notified _____ yes <input type="checkbox"/> no <input type="checkbox"/>
5. Is there documentation that the patient was notified of the follow-up plan?	yes <input type="checkbox"/> no <input type="checkbox"/>
6. Is there documentation that the patient acted on the follow-up plan?	yes <input type="checkbox"/> no <input type="checkbox"/>

Office Practice Assessment Tool - Test Results

Date:		
Practice Name:		
Date / Time	Process	Queries
	Dr./PA orders test (Consider process for telephone orders; is readback included)	Is tracking centralized?
	Record shows Patient understands that test is ordered and why	Is tracking on paper or computer?
	Test is entered into system	Who is responsible?
	Test order and specimen received by lab	Who is back-up?
	Pending results are monitored	How are they trained?
	Test results are received	Who can receive phone results?
	Results are reviewed by Dr/PA	Are results ever faxed?
	Results are communicated to patient	What is process if specimen is rejected or test cannot be completed?
	Patient is informed of next steps	Who is informed?
	Additional tests or consults are scheduled	Is a decision tree for result management defined?

Evaluating your EHR

- New systems may not address specific needs and processes.
- Staff responsibilities for using EHR reports to monitor the testing process may not be defined.
- EHRs automatically complete some tasks in the testing process. However, offices with EHRs that automatically document steps in the testing process do not eliminate all errors.
- Most EHRs do not automatically document these tasks:
 - Interpretation of test results by providers.
 - Notification of patients about their results.
 - Follow-up on abnormal tests

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Electronic Health Record (EHR) Evaluation Tool

For these questions, a "test" is defined as any type of laboratory or imaging test.

Which reports are you able to obtain from your EHR?

1. A report that identifies all tests ordered during a specific time period?

If yes:

Are you able to organize the report by test type?

2. A report that identifies all outstanding test orders?

If yes:

Are you able to organize the report by test type?

Are you able to organize the report by lab/imaging center?

Does your EHR automatically notify you if test results are not returned within a predetermined timeframe?

3. A report that identifies the time it takes for results to be returned to your practice?

If yes:

Are you able to organize the report by test type?

Are you able to organize the report by lab/imaging center?

4. A report that indicates how long it takes to review results after they are available in the EHR?

5. A report that identifies those patients who did not receive their results?

6. A report that identifies all abnormal results for a specific time period?

If yes:

Are you able to determine how long it took to notify the patient after the result was received by the office?

Develop Action Plan

- Define how you will address the gaps
- Assign who will be responsible for implementation
- Establish a time frame
- How will you monitor your improvements for effectiveness?



Features of an ideal result management system

- Determines when an ordered test is completed
- Highlights urgent results which require attention
- Results presented in context of previous results, medications, and problem lists
- Forwarding capability and use of surrogates during absences
- Ability to order additional tests or treatments while reviewing results
- Creates timed reminders
- Allows selection of important or critical test results for more urgent review
- Customizable alerts to prevent fatigue
- Population based review that allows easy identification of results that have not been reviewed

AHRQ web M&M “No News May not be Good News “August 2012

Patient Notification Strategies

- Implement a policy of notification to patients of *all results*.
- Standardize process for normal and abnormal findings and management of urgent and non-urgent status.



- Determine with patient the best means to contact them
- Clarify if messages may be left specific to location (home, work, family)
- Do not leave a message stating results were abnormal
- Define actions when patient cannot be reached
- If electronic means are used to post results, ensure that patient has been informed and understands the process

Strategies for Reviewing Test Results

- Review (timely) by practitioner prior to filing in the medical record
- Establish back-up process if ordering practitioner is not available
- Report urgent or critical test results immediately to the practitioner or designee by policy
- Document handing off of test results, including date, time, and person

Serial Testing Strategies

- Identify tests repeated at recommended intervals
- Identify drugs requiring baseline and subsequent monitoring
- Identify patients by condition that require serial testing or monitoring
- Establish a process to track t subsequent tests have been ordered and completed
- Advise patient of purpose and need for follow-up





Next steps

- Summarize findings for providers and leaders
- Celebrate strengths and successes
- Describe gaps or system weakness
- Communicate plan for risk reduction
- Implement improvements
- Reassess the process

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Successful practice improvement requires:

- The desire to improve.
- Support of office leadership for improving quality and safety.
- Teamwork—everyone should be involved in the improvement process.
- Commitment to honest and open communication.
- Regular discussion of performance improvement at staff meetings.
- A focus on office systems rather than individual performance.
- Persistence—a promise to stick with it.





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Questions?



Resources & References

- Eder M, Smith SG, Cappelman J, et al. Improving Your Office Testing Process. A Toolkit for Rapid-Cycle Patient Safety and Quality Improvement. AHRQ Publication No. 13-0035. Rockville, MD: Agency for Healthcare Research and Quality; August 2013.
- Patient Safety in the Office-Based Practice Setting
https://www.acponline.org/acp_policy/policies/patient_safety_in_the_office_based_practice_setting_2017.pdf
- **PREVENTING ERRORS IN YOUR PRACTICE** Four Principles for Better Test-Result Tracking
 - <https://www.aafp.org/fpm/2002/0700/p41.html>
- Communicating Critical Test Results
 - <http://www.macoalition.org/Initiatives/docs/CTRgriswold.pdf>
- **Failure to Follow-Up Test Results for Ambulatory Patients: A Systematic Review**
 - <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3445672/>
- **Medpro: Communicating Effectively with Patients to Improve Quality and Safety**
 - <https://www.medpro.com/fa/rm-guidelines>