



Healthcare

ALERTBULLETIN®

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Test Result Management: Toward a Systematic Reporting Process

Laboratory test integration is a common function of the electronic health record (EHR). Today's EHR systems can track pending test results, alert providers to significant findings, document receipt of results and follow-up actions taken, and notify providers and others of possible delivery problems.

The electronic management of laboratory and diagnostic data also yields a number of performance improvement and cost containment benefits, including, but not limited to, the following:

- **Rapid identification of high risk patient groups**, which enables providers to manage a population of patients who share similar disease characteristics, thereby reducing health disparities and improving group outcomes.
- **Enhanced capabilities to track incoming results for quality purposes**, including reporting times, critical alerts and delivery failures.
- **Improved coordination of care** through prompt reporting of results to the treatment team and referring providers.
- **Fewer test requisitions** due to ready access by providers to available test results.

However, while digital technology may help systematize test management and reporting, it does not eliminate risk. Potential errors include misidentification of patient or provider, delays in sending and acknowledging results, data inaccuracies, failure to flag critical findings, lapses in follow-up and inadequate documentation. These reporting issues can lead to misdiagnoses, delayed diagnoses, gaps in continuity of care, and other occurrences with patient safety and/or liability implications.

To enhance quality and reduce liability exposure, healthcare facilities and medical practices must implement an effective test result management program that addresses all five stages in the process:

1. Implementation of a tracking system in order to ensure that patients receive ordered tests.
2. Review of results by the ordering provider and clinical treatment team.
3. Facilitation of patient access to laboratory and diagnostic test results.
4. Communication of results to the patient, along with recommendations for follow-up.
5. Development of an appropriate treatment plan and/or referral to an outside provider.

Failure to complete and document any of these steps can lead to diagnostic failures and allegations of patient neglect or abandonment, as well as assertions of illegal information blocking.

This edition of *AlertBulletin*® offers seven essential strategies to help healthcare facilities and providers enhance the efficiency and timeliness of their laboratory test reporting and follow-up procedures, as well as a range of practical risk management strategies.

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1. Ensure the test reporting platform of the EHR system operates in a reliable, efficient and user-friendly manner.

When determining which EHR system to adopt, or contemplating improvements and updates to an existing system, consider the ease of use and error prevention capabilities of the test reporting software, its efficiency in collecting and displaying test orders and results, and how readily it facilitates data exchange between the laboratory information system and ordering providers.

Risk management considerations:

- **Conduct a self-assessment of test result reporting and follow-up practices** in order to identify risk exposures associated with the electronic communication and management of diagnostic test results. See the [SAFER Self-assessment Guide](#), issued by the Office of the National Coordinator for Health Information Technology.
- **Select a test management platform** that enables providers to track and monitor the status of all orders and test-related procedures, e.g., specimen ordered and collected, test completed, results reported, provider receipt acknowledged.
- **Ensure that the system permits sorting of results in the EHR inboxes of providers** by clinically relevant criteria, such as severity, unread status, date and time.
- **Require that test result notifications remain in the inboxes of providers until receipt is acknowledged** in order to ensure that important findings do not go unread.
- **Determine whether test results and related information are easy to forward** from one provider to another, and also between members of the treatment team, as well as units and departments.

2. Facilitate prompt patient access to laboratory and diagnostic test results, in compliance with the [21st Century Cures Act \(Cures Act\)](#).

The Cures Act prohibits information blocking (IB), which is defined as business, technical and organizational practices that prevent or materially discourage the access, exchange or use of electronic health information. Patients may experience IB when trying to access their laboratory or diagnostic data through EHR-based access portals, or via traditional release-of-information protocols. A policy that purports to delay patient access to data until an ordering provider has reviewed the results may implicate the IB provision of the Cures Act.

Risk management considerations:

- **Review policies and procedures related to healthcare information requests with legal counsel** and update content, as needed, to comply with IB regulations and requirements.
- **Consult IT staff regarding existing controls on the access, exchange and use of electronic health information** in order to ensure the IB-related compliance program protects the privacy of laboratory and diagnostic data.
- **Delineate in written policy the [eight exceptions](#) to patient access, exchange and use of electronic health information**, and ensure that providers apply each exception as narrowly as possible and in a non-discriminatory manner.
- **Develop and document criteria by which providers may exercise professional judgment when releasing test results**, considering such factors as the provider-patient relationship, the context of the test itself and whether third parties may gain access to the results through their release.
- **Document all decisions to restrict access to laboratory and diagnostic data** in the patient healthcare information record, including the supporting rationale.

3. Develop and implement written policies for staff, and reinforce them through ongoing training.

Sound test management policies – supported by comprehensive, ongoing training of all staff involved in the reporting process – are essential to achieving consistency. Policies should encompass such basic issues as reporting time frames, treatment of high priority findings, documentation, and backup and escalation procedures. Training sessions should focus on conveying basic expectations, delineating individual roles and responsibilities, and instructing laboratory technicians and support staff on the test reporting system and the operational procedures that support it.

Quick Links:

- [“Diagnostic Stewardship and Test Result Management Using EHRs.”](#) A resource issued by ECRI, March 8, 2019.
- Giannini, R. [“Diagnosing Communication Gaps in Diagnostic Test Reporting.”](#) Posted on *ECRI Blog*, November 25, 2019.
- Slivochka, S. and Warner, D. [“Understanding the Eight Exceptions to Information Blocking.”](#) *Journal of American Health Information Management Association*, February 25, 2021. (Member access only.)

Risk management considerations:

- **Utilize laboratory requisitions and test reports that clearly identify the name of the ordering provider**, as well as any other clinicians responsible for follow-up.
- **Draft protocols for reporting test results at shift handoffs**, during staff absences, and following the departure of providers from the facility or practice. Reinforce these procedures during training sessions.
- **Maintain an updated contact list of all practicing providers** and their coverage schedules, and make this information available to laboratory and diagnostic services.
- **Specifically address the issue of planned and unplanned provider absences** and the potential effect of these absences on the reporting of test results.
- **Devise an alternative method, such as urgent electronic alerts, for communicating significant test results** if the primary provider is unavailable or unresponsive.
- **Create an escalation procedure for urgent or high priority test results that are not acknowledged by ordering providers** within the specified period, and communicate this procedure to personnel responsible for test result reporting.
- **Establish backup procedures in the event that the EHR system malfunctions**, or for any reason, cannot accept test result information, and train staff in these contingency plans.
- **Explain test reporting procedures and duties during provider and staff member orientation**, and “shadow” new employees after hiring to monitor their knowledge of and adherence to these protocols.

4. Formalize the communication responsibilities of ordering providers and treating clinicians.

Even the most sophisticated test management system is susceptible to communication breakdown at multiple points, such as between outside laboratory personnel and the facility or practice, providers and staff, and caregivers and patients. Therefore, every provider and staff member must be made aware of the necessity of proactively following up if test results are not available when needed, or include incomplete or questionable findings. This responsibility should be incorporated into the quality improvement process and emphasized in organizational policies, job descriptions and performance reviews.

Risk management considerations:

- **Clarify the responsibilities of ordering and other treating providers**, especially with respect to conveying and following up on time-critical results.
- **Institute time frames for reviewing test results**, and consider compliance with these protocols when evaluating provider performance.
- **Assign a dedicated staff member to track ordered tests** and reconciling them against results received.
- **Require providers to confirm receipt of test results in the patient healthcare information record**, noting the reason for ordering the test, key findings, differential diagnoses made and follow-up clinical actions taken.

5. Clearly mark high alert test results.

Critical, unexpected or clinically abnormal test results must be imparted to ordering providers in a concise and unambiguous manner. By consistently using standardized terminology – e.g., *normal*, *abnormal*, *urgent*, *critical* – staff entrusted to report test results can reduce the risk of miscommunication and ensure that clinically significant findings receive due attention.

Risk management considerations:

- **Utilize multiple visual indicators to flag clinically significant results.** Critical and abnormal values should be highlighted in a conspicuously distinct format, using boldface font, red type, asterisks or other eye-catching markers. (Note that color contrast should not be the only indicator, as it may not be visible in printouts.)
- **Sort test results in the EHR inboxes of providers by clinically relevant criteria**, such as severity, unread status, date or time.
- **Clearly flag results that have been amended**, notifying the appropriate provider(s) of the change and documenting both change and notification in the patient healthcare information record.
- **Verbally alert providers to life-threatening or critical test results**, such as positive cancer or HIV status findings. If the ordering provider does not respond within a specified time frame, contact an alternate provider in accordance with escalation protocols.
- **Exercise caution when employing a dual alert notification system** in which two providers receive the same test result from the testing laboratory. Such a system may lead to confusion regarding responsibility for patient follow-up.

6. Initiate appropriate patient follow-up.

In addition to explaining to patients the clinical significance of laboratory test results, providers must communicate treatment options and the importance of full compliance with therapeutic recommendations. In outpatient settings, providers also may offer to schedule necessary follow-up appointments and referrals.

Depending upon the nature of the findings, electronic patient portals may represent a suitable means of conveying follow-up actions and mutual responsibilities. However, if values and findings are abnormal, providers must supplement online tools with face-to-face communication, in order to provide additional information, answer questions and offer personal support.

Risk management considerations:

- **Draft a patient follow-up policy**, encompassing such issues as appropriate means of communication, number of contact attempts and documentation procedures.
- **To protect patient confidentiality, communicate high priority test results face-to-face whenever possible**, and make sensitive telephone calls from work areas offering a suitable degree of privacy.
- **Ask patients how they wish to receive notification of non-critical test results and respect their preferences**, within the limits of HIPAA privacy rules, applicable state laws and regulations.
- **Record all post-test patient education efforts made** in the patient healthcare information record.
- **Prepare a current, accurate and complete summary of care when discharging the patient from inpatient treatment or from outpatient services**, emphasizing any pending test results and necessary follow-up care.
- **Electronically relay this summary to the primary care provider of record**, if relevant, and document acknowledgment of receipt.

7. Track reporting system performance and promptly address deficiencies.

Test reporting and follow-up errors occur most frequently at transition points, including handoffs between clinicians (e.g., primary care physicians to specialty providers, or advanced practice providers to supervising/collaborating physicians) and transfers between units or from inpatient to ambulatory or home care settings. An ongoing tracking/auditing program should be implemented to detect test reporting deficiencies and inefficiencies, analyze causes and suggest effective remedial action.

Risk management considerations:

- **Adopt a set of pertinent test reporting quality measures for ongoing monitoring**, such as test results with the lowest follow-up rate, percentage of test results that have not been reviewed by ordering providers within a specified time frame, and frequency of review delays of a week or longer.
- **Review test results sent to the wrong provider**, as well as transmissions that fail due to a computer interface problem or patient/provider misidentification.
- **Monitor the electronic inboxes of providers for the number of unread test result notifications** and send deficiency notices, when indicated.
- **Track electronic acknowledgment and acceptance of test results** when laboratory notifications are forwarded from the ordering provider to another clinician.
- **Maintain error logs to help detect failure patterns**, such as lab results not being delivered, reporting delays, or requisitions/reports failing to identify or misidentifying the ordering provider.

Timely, accurate reporting of diagnostic test results is critical to maximizing quality of care and minimizing risk. Computerizing the test reporting process can help reduce communication lapses. However, it does not reduce the need for a facility- or practice-wide commitment to ensuring that clinically significant findings receive an appropriate level of attention, and to taking swift and effective action whenever problems arise.

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