healthcare RISK MANAGER

Volume 9, Number 19, 2nd Quarter 2003

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Reliable Follow-up Systems Are Essential to the Practice of Medicine

Failure to Provide Patient Care Follow-up Results in Malpractice Claims Epidemic

Avoidable claims arising from the physicians' failure to adequately track diagnostic studies, test results and provide follow-up care continue to cost millions of dollars in jury awards and settlements annually.

Physician Insurers Association of America (PIAA) reports that from 1985 through 2001, communication failures by physicians provided an average paid indemnity of $305,861. Delays in review and follow-up of diagnostic studies, breakdowns in communication between physician and patient, and between physicians, often resulted in a reduced life expectancy for patients due to a delay in diagnosis and/or treatment.

A recent research study investigated physician practices in the handling of patients' test results. The survey included 161 attending physicians practicing at a large urban teaching hospital and physicians at 21 suburban primary care practices. The common findings were:

- All respondents believed it was important to notify patients of abnormal results
- 36 percent did not always notify patients of abnormal test results
- 72 percent said they do not notify patients of normal findings
- 77 percent said they had no method, or no reliable method, for tracking whether patients with abnormal test results had received the recommended follow-up care

It is apparent that when the results of diagnostic tests are allowed to "fall through the cracks," harmful delays in treatment or diagnosis occur. An analysis of these systems and the areas that could break down should be undertaken. Based on this analysis, protocols could be established to minimize or eliminate potential breakdowns to help prevent diagnostic delays and other errors.

Understandably, physicians feel they cannot be held fully responsible for what the patient chooses to do or not to do. Although patients are expected to take responsibility for their own healthcare, a review of cases shows that courts expect physicians to play a part in ensuring the patient receives appropriate care.

More help from MAG Mutual

For more information on how to implement a tracking system for diagnostic tests, referrals and appointments refer to your *MAG Mutual Risk Management Handbook for the Medical Office Practice*; Section III. "Tracking System for Diagnostic Reports."

MAG Mutual Healthcare Solutions, Inc. (MMHSI) can assist with the confusing and overwhelming job of determining the right tracking system for your medical practice. We have experienced practice management consultants who can help design, develop and implement the right system for your practice—whether it is an electronic or manual system. If you are interested, David Miller of MMHSI may be reached at 770-931-7700 or 1-888-624-6474.

MAG Mutual Case #1

A 26-year-old woman presented to her family practitioner's office complaining of a right breast mass that she noticed one year earlier. The patient elected to have a needle aspiration rather than a surgical biopsy. The physician instructed the patient to call back in two to three days for the lab results.

The pathology report returned "unsuitable for diagnosis." The physician's medical record reflected that a call was placed to the patient's home, but there was no answer. The physician's usual practice was to keep a patient's medical record on his desk until the lab results were conveyed to the patient. However, in this case there was no further follow-up by the physician or his office staff. The patient/plaintiff stated that she called the physician's office and was told by a staff member that the results of the lab report "must not have been significant" since she was not contacted.

Two years after being evaluated by the insured physician (#1), the patient was seen by an out-of-state physician, who referred her to another physician for the breast biopsy. The patient decided that she did not want to wait to be examined and voluntarily left the physician's office. Three years after being examined by the initial insured physician (#1), the patient presented to a second MAG Mutual-insured physician (#2) for a routine examination. The right breast mass was noted. The second insured physician recommended that the patient schedule and obtain a mammogram and return. No appointment was made for the patient.

The patient did not schedule or obtain a mammogram as recommended. The second insured physician (#2) made no attempt to follow up on the situation.

Approximately one year later, the second insured physician (#2) saw the patient again. At that visit, neither the breast mass nor the mammogram report were addressed or mentioned in the medical record. Four months later, the patient presented to another facility and was diagnosed with metastatic breast cancer. The patient filed suit alleging that the delay in diagnosis allowed the cancer to metastasize. Although the patient's noncompliance with recommended treatment was a major contributing factor in the progression of her disease state, the over-riding failures to follow up on diagnostic tests on the part of the two insured physicians led to a settlement by MAG Mutual on their behalf for a large sum of money.

MAG Mutual Case #2

A pregnant patient had a Class III Pap smear with a recommendation by the pathologist that a biopsy be done. The report was placed on the patient's medical chart and overlooked by her physician. Her baby was delivered by Caesarean section. Following delivery a repeat pap was done and returned as Severe Class II. Because of heavy bleeding, a cervical biopsy was not performed. No system was in place to ensure a future biopsy was performed. The patient was later admitted to a local hospital and diagnosed with infiltrating carcinoma of the cervix. She later expired due to complications related to metastatic cancer of the cervix. The allegation was failure to follow-up on a Class III Pap smear and failure to obtain a cervical biopsy.

Allegations of a delay in diagnosis and treatment are difficult to defend. Juries expect physicians to have systems and procedures in place to prevent this from happening and are generally unforgiving when a failure occurs. The case was settled on behalf of the insured for a large sum of money.

MAG Mutual Case #3

A 57-year-old female presented to her pulmonologist with complaints of chest pain, cough, recurrent sinus congestion and reflux-like symptoms. A chest x-ray was ordered, but not noted in the medical record. The x-ray was read and over read by MAG Mutual-insured defendant radiologists. The chest x-ray report described a left upper lobe infiltrate and concluded "left-upper lobe pneumonia." The ordering pulmonologist never received a copy of the chest x-ray report, nor was there ever a discussion between the pulmonologist and the radiologists regarding the report finding.

Neither the pulmonologist nor the radiologists had a tracking system in place to assure the ordering physician received the communication of the results of this film. No efforts were made by either the pulmonologist or the radiologists to communicate regarding the x-ray findings. The pulmonologist relied entirely on the radiologists and the hospital, and the radiologists relied completely on the hospital and transcription company to transmit the report to the ordering physician. Each party expected the other to be responsible for the results. On deposition, the pulmonologist could not remember having a conversation with the patient regarding a chest x-ray, as no notation was written in the medical record, nor could he recall why he ordered the chest x-ray. The patient was able to produce a prescription note for the chest x-ray that was signed by the pulmonologist.

Seventeen months after the chest x-ray, the patient presented to a neurologist with an unrelated complaint. Shortly thereafter she was diagnosed with metastatic carcinoma of the lung, brain and spine. MAG Mutual was able to settle on behalf of the pulmonologist for a large sum of money.

Risk Management Issues

Common issues which arose in these three cases included:

- Lack of an effective tracking system for diagnostic tests and consultation
- Ineffective communication between physicians to discuss test and x-ray results
- Communication breakdown between the physician and the office staff regarding office procedures for tracking and follow-up of diagnostic reports
- Diagnostic tests being placed on the medical record without the physician first reviewing and initialing the report and directing follow-up treatment
- Non-existent medical record documentation, i.e. failure to send a letter to the patient regarding results of a lab report after unsuccessful attempts to contact the patient by phone
- Failure to note the identified medical problem and to address the patient's failure to obtain requested diagnostic test
- Lack of effective patient notification system
- Lack of patient recall/follow-up appointment system
- Poor patient education regarding the disease process and recommended treatment plan
- Failure to address and document the patient's continuing patterns of non-compliance with the prescribed treatment plan

Attorneys who believe that the patient's injury was caused by a physician/office system failure are more likely to file a lawsuit. Still, outcomes can be improved and potential damages mitigated if effective follow-up systems are in place.

Reliable Tracking Systems are Essential to the Practice of Medicine

Lives are at stake in medical offices, and it seems there are few systems in place to prevent patient care from falling through the cracks. A physician's medical training gives him/her a better understanding of the consequences of various treatment options, as well as the consequences of delaying treatment. Therefore, the physician is expected to encourage the patient to obtain the necessary tests or consults. When there are test results or other information to report to the patient, the physician should make a reasonable effort to ensure the patient knows what these results are, how they relate to his/her condition and what is likely to happen next.

The goal of a follow-up system is to ensure that all information is available to the physician in a timely manner for clinical decision-making, and that clinical treatment is carried out. A well-designed tracking system should accomplish the following:

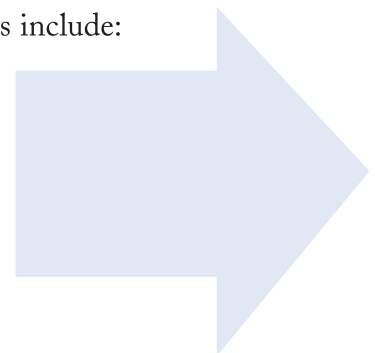
- Tracks all diagnostic studies, consultations and missed/cancelled appointments
- Alerts the staff when reports or follow-up visits are overdue
- Schedules symptomatic patients for a follow-up visit after test results are expected to be received. This strategy can aid in picking up noncompliant patients and misfiled reports
- Assigns specific staff responsibility for maintaining the follow-up system
- Provides for daily updates
- Assures no reports or correspondence are placed in the medical record until after the physician has reviewed, initialed the information and made his/her determination regarding the action to be taken
- Provides for patient notification of all diagnostic test results and follow-up appointments
- Details written policies that (1) describe how the system works, (2) require physician review and initial of all reports before they are filed, (3) require a physician to direct the follow-up action and (4) require documentation of all action steps in the medical record

Note: It is acceptable to ask a patient to call back for their reports **if** the physician or staff does not contact them within a specified time frame. However, the physician or staff should make a solid attempt to convey the test results.

Choosing Your Follow-up System

Some of the more common follow-up systems used in medical office practices include:

- A log or notebook
- A tickler file using index cards for each patient
- An accordion file
- A computer-assisted system



Log or Notebook System

A log or notebook system should contain the following information:

- Patient's name and identifying information
- Brief description of the report to be tracked
- Date specimen sent, diagnostic study to be performed or date of consultation
- Name of lab, radiological department or physician consultant where patient is being sent
- Date report received by the practice
- Date of the return appointment
- Date follow-up action taken and staff member's signature

This is a simple, effective non-computerized follow-up/tracking system that requires staff to update information daily. At the end of each day, the medical assistant or nurse reviews the encounter forms for the day and records the patient name, phone number and all diagnostic tests ordered into a log or a notebook. When the results are received, the medical assistant or nurse notes this in the log or notebook and gives the reports to the doctor to review and initial. The doctor may make additional orders on the report and return the report to the nurse to carry out the orders and contact the patient, or the physician may decide to call the patient. The final step is to indicate on the log or notebook that the patient has been contacted. One glance at the log/notebook will confirm whether a test has been ordered, whether it has been completed and whether the patient has been notified and given a return appointment. It is important that the log/notebook be checked daily to monitor that results are returned in a timely manner. Patient contact and all instructions should be documented in the patient's medical record.

X-Rays and Mammography

It is best not to release original x-rays and mammograms. If these films are released, a tracking system should be maintained and meticulous follow up should be done to assure the films are retrieved in a timely manner. A log or notebook can be utilized for this purpose. The log should contain information as to:

- Name of patient
- Name of physician or group receiving the films
- Date sent
- Date films are returned
- Who received the films
- Date films were returned to the files
- Who returned the films

Tickler File

A tickler file uses index cards for each patient. These cards indicate the test ordered and are filed behind the date and month the patient or test is to return. The procedures for this system include:

- Create an index card containing patient's name, phone number, reason for recall, date to be recalled and a space for results of the contact
- Never allow cards to be placed in the medical record
- Fill out the patient's card when treatment is completed. Note what should be checked at the next visit and the month and date for that visit
- Also note, in pencil, the month of the next recall on the patient's medical record folder. If the patient returns before the next scheduled visit, the staff will know where to find the card in the recall file
- Keep recall cards in a file with 12-month divisions. The card is filed alphabetically behind the month in which the patient is due to be recalled for his/her return appointment
- During the last 10 days of the month, the cards for the patients to be recalled the next month are pulled. The number of working days in that month is determined and the cards are divided evenly among them
- Call patients and write the appointment time and date on the card and in the appointment book. The card is then placed behind the confirmed date in another file with divisions numbered one through 31. Hold the card there until the recall appointment

Note: If an appointment can't be made when the assistant calls, the reason should be noted on the card and in the medical record. Re-file the card under the date the assistant plans to call the patient again.

Accordion File

The dividers in an accordion file should have dates for each day of the month. Place a copy of the order for the test or consultation in the appropriate date. The procedure for maintaining this system is the same as that previously described for the tickler system.

Computer-Assisted System

Computers can easily be used to standardize a test-result tracking system. All tests can be logged into the computer system and checked off as the results are received. The ordering doctor is notified if they do not return after the designated time period. To notify patients of their results, a letter template (all of which are available on the system) is used and the appropriate values and comments are filled in. The physician plans the appropriate follow-up at the same time the letter is generated and puts a reminder into the system.

The following is a sample listing of software products available on the market that have been designed and developed as computer-based practice management, diagnostic test result and recall notification systems for the physician's medical office practice. The costs will vary according to the number of users, location sites and

other specifics. **MAG Mutual does not recommend or endorse any particular product or company**. This information is offered for informational purposes and should not be interpreted in any manner as a formal endorsement by MAG Mutual.

Computerized software and contact information

PhoneTree Pro & PhoneTree 3550 - Trion Solutions Group LLC - www.trionsolutions.com

Test Trakker v2.0 for the Palm OS Platform - Cedar Cove Technologies, Inc. www.cedarcovetech.com

Medic – Misys Healthcare Systems – www.misyshealthcare.com

Healthmantix – A4 Healthsystems - www.a4healthsystems.com

Medical Manager – www.medicalmanager.com

For more information on medical software reviews and new releases, a source list can be viewed at www.civicresearchinstitute.com/health/sourcelist.html. The American Healthcare Information Management Association maintains a listing of available software for the physician practice under their Vendor heading at www.ahima.org. Software information may also be found on the American Medical Association's website, www.ama-assn.org.

Patient Notification and Recall

Many physicians say that notifying all of their patients of every test result is too costly, time consuming and unrealistic. Notifying patients with abnormal results is problematic enough.

Nevertheless, good physician/patient relationships are needed as much as ever. A recent study by Bookhaker et al. demonstrates the importance of the physician-patient relationship. This study found that 79 percent of patients want to be notified of all test results, whether normal or abnormal. Notifying patients of test results not only encourages them to be informed members of the health-care team but also to accept responsibility for their own healthcare. It also helps strengthen the physician/patient relationship. Patients do not generally sue physicians they like and with whom they have a good, strong association.

Physicians should notify their patient of test results and findings. The patient should be told "You will hear from us, regardless of the results, in ____ days after the test. If we have not contacted you by then, call us and ask what your results are." If the patient refuses to make a recall appointment, the assistant should note this in the medical record and give this information to the physician for further follow-up.

Document each attempt to contact the patient in their medical record. Generally, follow-up attempts include one or two phone calls; and if that is unsuccessful, then a postcard or letter. If the condition is serious e.g., possible cancer, then more concerted efforts should be taken, including sending a registered certified letter with return receipt requested. Retain the receipt in the patient's chart. If the certified letter is returned, both the letter and the envelope should be kept in the medical record. Attempts should be made to verify the address and a second copy of the letter should be sent by registered certified mail to the correct address. It is essential that all reasonable actions be taken and that the patient's response be documented in the patient's medical record. This can be extremely useful if needed to prove the patient's non-compliance with the recommended treatment plan.

Electronic "Telephone In" Service

Another way to contact patients is to utilize an electronic messaging or "telephone in" service. The patient is given access to his or her own test results. When the lab or imaging tests are ordered, the patient is given a card with a phone number to access the system. The patient's PIN is his/her medical record number. The patient is told to call the system for his/her test results within a certain time frame. When the test results are received, the doctor notes the findings and makes comments on the report, then the nurse or medical assistant records a message in the system for the patient to hear. Several benefits to this type of system are:

- Staff find it more productive to record a message than mail a letter
- Involves the patient and gives them some control
- Decreases the number of phone calls to the office staff
- It is confidential – only the patient can access the result with the PIN
- May increase the odds of actually reaching patients with their test results

It is essential that all staff members understand the importance of a follow-up/tracking recall system and how to implement it. If an office system fails, one of the first questions asked by the plaintiffs' attorney would be concerning the adequacy of the

practice's employee orientation program. All employees should be trained in how to utilize the follow-up/tracking recall system. Its use should be closely supervised and results monitored.

Final Tips for Improving Your Patient Recall

If your recall notices are not as successful as you would like, the following tips from Laura Sachs, *The Professional Practice Solver* may help to improve your results:

- Sign the letter. A doctor's signature makes it seem much more personal, even if it's a form letter
- Attribute the idea of the notice to the doctor. "Dr. Jones wanted me to send you this note"
- Remind the patient that he/she already knows that he/she needs the appointment: "As Dr. Jones recommended to you at your last appointment, you'll need to see him this month to…"
- Write an explanation for the appointment
- Enclose an educational brochure or pamphlet that describes the dangers of neglecting the problem
- Tell the patient to call a specific person in the practice directly, giving the name and phone number or extension. Sometimes this motivates a better response than a vague invitation to "Call our office"
- Improve the appearance of your recall notices so that they are more easily recognized and remembered. Use extra large cards in a bright color. Include small pressure-sensitive labels that patients can stick on their calendars
- Ask patients to address their own cards during their last appointment. They will notice a card that is addressed in their own handwriting. They may then remember that you have already discussed the need for this appointment

Office system errors are a major concern in medical practice, both from the quality of care and professional liability perspectives. Fortunately, many diagnostic errors can be prevented or at least mitigated, using sound risk management principles and practices. As expectations for diagnostic accuracy grow among patients, physicians need to become more vigilant and aggressive in the course of their diagnostic evaluations.

Sources:

Risk Management Principles & Commentaries for the Medical Office, American Medical Association/Specialty Society Medical Liability Project

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The Professional Practice Problem Solver, Laura Sachs, Prentice-Hall, 1991.

Principles for Better Test Results Tracking, White, Brandi Family Practice Man… July/August, 2002.

E.A. Boohaker, R.E. Ward, J.E. Uman and B.D. McCarthy. Patient notification and follow-up of abnormal test results. *Arch Intern Med.* 1996; 156:327-331.

MAG Mutual does not presume to establish any standard of care or establish rules for the practice of medicine. The particular patient-care strategies or range of patient-care strategies mentioned in this newsletter should be tempered by the physician's judgment.

This publication is produced to inform you of issues relating to medical professional liability insurance and other matters of importance to physicians. Material given in this newsletter does not constitute legal advice or opinion. If you have questions in any of the areas discussed in this publication, you should seek a qualified legal opinion.

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