

## Practice Policy & Guidelines

Policy: Diagnostic Tests Ordering/Tracking/Notification	Developed by:	Approved by:
Updated:	Signature:	Signature:

### **PURPOSE:**

To ensure appropriate tracking and follow up of diagnostic tests (labs, radiology, EKG, etc) as standard policy to assure quality medical care.

### **GOALS AND OBJECTIVES:**

To ensure that all diagnostic tests are ordered in a way that they can be tracked and followed up in a timely manner and ensure that patients receive communication regarding results within 2 business days for abnormal results and within 5 business days for normal results. For urgent diagnostic results, communication with patients/families should occur immediately.

### **RESPONSIBILITY:**

Clinical nursing staff and providers

### **DETAILS:**

Providers, or licensed nurses at the direction of the provider, will be responsible for ordering diagnostic test/imaging studies within the electronic health record (EHR) as part of the diagnostic ordering module. At the time of ordering, an appropriate target flag date will be set corresponding to projected receipt date of results by the practice. Currently, (insert practice name) receives diagnostic test results via fax and electronic exchange.

*(select or modify one based on which workflow type would work best for your practice)*

*Sample Workflow #1: The receptionist receives all results and reports received via mail, fax, and electronic exchange. All non-clinical reports are placed in the administrator's mailbox, and all clinical reports are placed in the provider's mailbox on an hourly basis for review.*

*Sample Workflow #2: When results/reports are received via electronic exchange, the assigned clinical nurse supervisor will review received results using the diagnostic test importer of the EHR system to transfer test results not "auto-matched" by the importer. Additionally, the clinical nurse supervisor will triage all results received via mail, fax, or electronic exchange for severity on an hourly basis and notify the provider (ie. ordering provider or covering provider) of urgent*

*results that require immediate action. All imaging reports, culture results, or laboratory results that may be clinically significant will be shared with the provider within 2 hours of receipt. All other results will be shared with the provider for review and sign-off within 24 hours.*

#### Communication with Patients/Families

The provider will either contact the patient/family of the results, or direct licensed nurses to notify the patient/family of results. Patient/parents/guardians are notified via their preferred communication method, which is noted in the patient/child's EHR record. Documentation of results notification and/or attempts at notification will also be entered in the message center within the patient's EHR chart. Patient/parents/guardian are asked to call if results are not received within the targeted time frame. If unable to contact via the preferred communication method, the following will take place:

- For routine results, the nurse will attempt to contact the patient/family by phone. Leaving a message on voicemail for normal or reassuring results if generally acceptable; however, exceptions include HIPAA restrictions requested by the patient or family "sensitive" lab results such as STI testing, etc. If there is no answer, or if the phone is disconnected, a postcard/letter should be sent indicating either that the tests were normal and can be downloaded via the patient portal, or that the patient/family can contact the office to discuss results.
- For non-urgent abnormal results, the provider or nurse will attempt to contact the patient/family by phone. A voicemail may be left requesting that the patient/family contact the office to discuss results. If there is no answer or if the phone is disconnected, a postcard/letter requesting that the patient/family contact the office to discuss results should be mailed.
- For urgent results requiring more immediate follow-up, the provider will attempt to contact the patient/family by phone. If no voice contact can be made within the day, depending upon the urgency, the provider will consider the following options: call emergency contacts, call DCFS, call police

#### Documentation

When diagnostic test results are received via postal mail, they are faxed to the server and imported into the EHR. Prior to importing into the EHR, staff should confirm that another copy of the same lab work has not already been scanned. All lab and imaging study results from outside providers are automatically or manually imported into the EHR and linked to the original order of the diagnostic test portion of the patient's EHR and sent to the ordering provider for review and sign off. All in house diagnostic test results, urinalysis, rapid strep, rapid flu, TB skin testing, hearing screen, vision screen and transcutaneous bilirubin are manually entered into the EHR and linked to the physician order auto sending to the ordering provider for review and sign-off.

Laboratory reports that are "preliminary" should not be scanned. For example, several copies of one culture report are routinely provided. For example, a blood culture report is provided at 24 hours, 36 hours, 72 hours, and 5 days. Each copy of the report does not need to be scanned. Only one copy of the report needs to be retained. For simplicity's sake, scan only the reports

marked "FINAL." Negative preliminary reports can be verbally reported to the family, but then can be discarded and shredded.

Patient/family communications and instructions, or changes made to the treatment plan will be documented contemporaneously in patient's EHR record.

Tracking Outstanding Results

Each provider will look at the outstanding diagnostic items for review within the EHR. Any outstanding labs/tests for review will cause the tab to show up in red with the count of items needing attention.

Additionally, every Wednesday a report will be run on any outstanding lab or diagnostic test results that have not been received by the flag date. Designated office staff under direct supervision of the clinical nurse supervisor will call the family to remind them of outstanding labs/tests requested by the provider. Calls will be made weekly for 3 weeks. If the patient has not had the labs drawn/tests completed by that time or if the patient chooses not to have the labs/tests done, the provider will be alerted, and the status will be changed to "defer" within the patient chart.

**MONITORING:**

The Quality Improvement (QI) Administrator will spot check 20 charts every 6 months to ensure compliance with this policy. Any problems will be presented to the providers and office staff and an appropriate QI initiative for improvement will be implemented.

**This policy shall be reviewed at least every 2 years.**

Approved Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**APPROVALS:**

Physician Partner: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Administrative Partner: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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