Diagnostic follow-up: don’t let it fall through the cracks

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Objectives


Misdiagnosis

Objectives

- Understand the relevance of failure to follow-up
- Identify pitfalls that may lead to failed follow-up
- Appreciate how technology can assist with follow-up but should not be the only means of communication
- Engage one or more actions discussed to decrease your risk of failed follow-up and potential litigation

Why diagnostic follow-up matters

- Every year, thousands of diagnostic results do not receive appropriate follow-up which may cause substantial patient harm.
- Cancer is perhaps the most recognizable diagnosis in this category though others can be just as serious. For instance, bacterial meningitis, bacterial endocarditis, acute coronary syndromes, and more.
- Taking a proactive approach is imperative to avoid such missteps which are generally avoidable.

Data

Misdiagnosis risk by the numbers

~10k

cases asserted involving misdiagnosis across all areas of medicine from 2018 to 2025

65%

classified as high severity or resulting in death

76%

of cases are closed

Case setting distribution

57%
ambulatory

24%
emergency

18%
inpatient

The cost of misdiagnosis claims

$423k

Average incurred loss per case

Indemnity and expenses, 7,600 closed cases

Expense growth between 2007 and 2016

3.5%

Defense expenses

4.7%

Zero-indemnity cases*

Inflation benchmark

1.8%

Average inflation (CPI)

*Zero-indemnity cases often cost tens of thousands of dollars to defend.

Studies

Studies

Doing Better With Critical Test Results.

TJC Journal on Quality and Patient Safety, editorial 2005

- Fail-safes
- Redundancy
- Closed loop communication

Timely Follow-up of Abnormal Diagnostic Imaging Test Results in an Outpatient Setting.

JAMA Internal Medicine 2009

- 123,000 images
- 1,414 not acknowledged
- 92 detrimental to Pt.

The Safety Implications of Missed Test Results for Hospitalised Patients: A Systematic Review.

BMJ Quality & Safety 2011

- 20-year lit rev.
- 12 studies
- Critical results and results when Pts move between departments

Case study

Delayed cancer diagnosis

Initial ED visit (age 58)

- Sent to the ED by his PCP to R/O AAA
- CT ABD: AAA negative
- Incidental findings: Radiologist noted “nodular densities” in the right lung and an “indeterminate” right renal lesion
- Recommendation: F/U CT ABD and renal US

Gaps

- Complete results not reviewed by ED physician
- Complete results not reviewed by PCP
- Patient not notified
- No timely follow-up arranged

Follow-up (2 years later)

- Patient sees a new PCP for a productive cough
- Previous CT findings reviewed
- CT repeated as the radiologist had recommended 2 years prior

Delayed cancer diagnosis continued

Clinical outcome

- CT showed an 8cm mass in the right lung
- PET scan showed advanced disease with lymph node involvement and metastasis from a renal carcinoma.
- Treatment: Aggressive chemotherapy
- Result: Patient expired 18 months later

Legal/ financial impact

- Allegation: failure to follow up on potentially deadly incidental findings
- Case settled for >$500,000

Who dropped the ball?

Radiologist

What happened

- Incidental findings documented in report
- Follow-up recommendation included
- Report delivered via standard electronic workflow

Opportunities

- Incidental findings not highlighted
- Recommended, follow-up not emphasized
- No direct communication with ED physician and/or PCP

ED physician

What happened

- Radiology report available in the chart
- AAA ruled out
- Patient was discharged after life threat was ruled out

Opportunities

- Full report may not have been reviewed
- Incidental findings not discussed with radiologist
- Patient not informed of incidental findings needing follow-up

Primary care physician

What happened

- Radiology report allegedly received by PCP
- AAA rule out noted
- Incidental findings included with follow-up recommendations

Opportunities

Incidental findings may not have been noticed

Patient not notified or educated about risks of incidental findings

Follow-up not initiated

Contact attempts, if any, not documented

2,174 cases with $640 million paid where patients did not follow-up as directed.

Not in my house:
Avoiding failed diagnostic follow-up

Generally

- Clinical processes and procedures are a collaboration between practitioners and the staff in their respective organizations
- Physicians and other clinical leaders must be included in a multidisciplinary team that optimizes processes to prevent results from falling through the cracks
- Any event where a diagnostic result does fall through the cracks should undergo a root cause analysis in a proper venue protected from legal discovery. This should occur even in the absence of patient harm

Generally Continued…

- Though individual actions and responsibilities are important, human factors engineering is a vital tool to create procedures and processes in which staff are most likely to be compliant and successful
  - Insufficient integration of this discipline leads to short-cuts and workarounds that may undermine the anticipated success of a given process or procedure
- For the most part, “if you order it, you own it.” Although sometimes impractical in the ED, it should be a rule of thumb in other practice settings
- Back-up mechanisms for follow-up must be in place with consideration of shift changes and diagnostics resulted after a physician or patient has left the facility

Focus areas

Technology

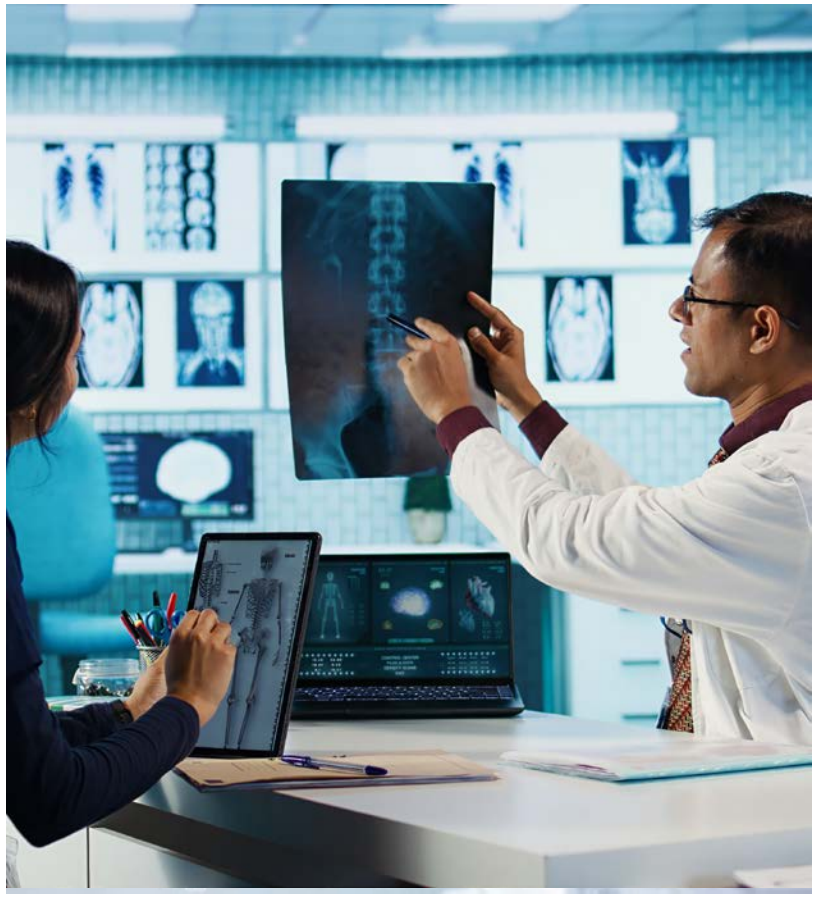
- Technology sufficiently modern to perform the expected tasks and processes
- Staff are trained to use technology efficiently and to its full potential
- IT vets all devices and software in use
- Updates, upgrades, and end-of-life timelines are tracked and managed
- Diagnostic results reliably import into the physician's EMR notes
- Power outage or technology failure

Technology failure or improper electronic results routing was identified in 85 cases, with $46.1M paid

Radiology

- Adequate staffing for radiographic studies volume
- Fellowship training aligned with specialized services offered
- Defined turnaround times for stat, urgent, and regular reads
- Dedicated report section for incidental findings and recommendations
- Clear triggers for phone or in-person communication including incidental findings
- Downtime procedures clearly defined and regularly tested

Teleradiology concerns were identified in 173 cases, resulting in $62 million in paid losses.



Practitioners

- Clear protocols for prioritizing communication with radiologists and lab staff
- Standardized hand-offs at shift change (e.g. I-pass, sbar, 5 Ps)
- Incidental findings routinely discussed with patients and included in hard copy discharge summaries
- Clear, actionable discharge and follow-up instructions
- Practitioners understand what a medical record looks like when it is provided in response to a subpoena

Discharge and follow-up instruction deficits were identified in 1,198 cases with $498M paid

5,058 cases involved practitioner communication failures, totaling $2.1B paid

Communication was a factor in 40% of MPL cases and carried a 39% probability of indemnity payment

Other staff

- Staff understand their role in communicating diagnostic results to ordering practitioners
- Communication of results is documented, including recipient, date, and time
- Nurses discuss incidental findings with patients prior to discharge
- A clear process exists for patient follow-up when results are finalized after discharge and every follow-up attempt is documented
- Staff assigned to post-discharge follow-up are specifically trained for the role
- The follow-up process is routinely audited

Other practitioners

- Standardized method(s) to communicate test results to outside practitioners
- Result delivery automated through the EMR whenever possible
- Established protocol or process for forwarding info to a PCP when not automated
- Clear expectation of acknowledgement, electronic or otherwise

Takeaways

Takeaways

- Communication is the root of all…SUCCESS
- Documentation is the root of all…DEFENSE
- Ensure that tech is used to help and does not hinder
- Processes to communicate results amongst the care team should be standardized
- Processes to communicate results to patients after discharge must be clear and routinely audited
- Every attempt to contact a patient for follow-up must be documented

Questions?

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