Radiologists and emergency physicians need to work together on communicating incidental findings.

This article is part two of a two-part series about incidental findings. Part one is available here.

When patients have an incidental finding on their emergency department (ED) imaging study, each hospital has its own policy on how to handle it. But if the patient left the hospital without finding out about the incidental finding, is a making a phone call or sending a letter good enough? How do you know that the patient received the information and understands the importance? Maybe the communication satisfies the ACR requirements, but the bigger issue is whether the patient needs additional medical care and doesn't know or get it. “No one is willing to take responsibility for this problem,” said Paul Chang, MD, professor and vice chairman of radiology informatics at the University of Chicago Medical Center.

“The real big point is it’s a collaborative effort between the radiologist and emergency physician, and ultimately we have to share that responsibility, to some extent, on who is holding the buck to ultimately ensure the patient understands the seriousness or implications of those findings,” said Ryan Thompson, MD, emergency medicine fellow at University of Wisconsin Hospital in Madison.

The Problem with Follow-Up

Current radiology reporting systems do a decent job of addressing things that can kill a patient in a few hours or weeks, said Chang, however they don’t do as good a job at things that might kill a patient in five years. A report showing needed follow-up months later is generally worthless, because there’s no urgency attached, he said.

Plus, emergency department patients are the least likely to get follow-up for incidental findings, especially those who use the ED as their primary care provider, said Michael Bruno, MD, professor of radiology and medicine, and director of quality services and patient safety at Penn State’s Milton S. Hershey Medical Center. “This population is particularly at risk for incidental findings that fall through cracks.”

Many in radiology, said Chang, believe that if the report is better structured, more impactful and actionable, it will increase the follow-up rate. While high quality reports are important, “it makes a fundamentally strong and incorrect assumption. It makes the assumption that the consumer of the report is perfect,” Chang said. “The consumer of the report is human and imperfect. It doesn’t matter if they acknowledge [receiving the follow-up recommendation]. They don’t [follow-up].”

He cited a JAMA Internal Medicine study which showed that even when physicians acknowledged receiving electronic medical record alerts about abnormal radiology findings, they still didn’t order follow-up testing or treatment. After realizing this, he changed his approach, no longer relying on written radiology reports to encourage additional testing for incidental findings.

Our recent article The Elusive Incidental Finding shared some of the frustrations that doctors have trying to reach patients once they’ve left the hospital. Sometimes their contact information is incorrect or they don’t respond to letters or phone calls.

For these reasons, Bruno and Chang spearheaded programs at their medical centers to address incidental findings, so patients won’t fall through the cracks.

Failsafe

The Failsafe program at Hershey Medical Center positions the patient in the middle of the communication chain between radiology and their primary doctor, said Bruno. They loosely based the idea on the Joint Commission’s National Patient Safety Goal of encouraging patient involvement in care as a safety strategy.

With Failsafe, radiologists interpreting ED studies send a letter to patients who have an incidental finding unrelated to the ED visit that doesn’t require immediate action. The program is designed to encourage follow-up of non-urgent findings that have a potential significant risk of patient harm if ignored, and for issues that normally wouldn’t be handled at an ED visit.

To comply with HIPAA, the minimally customized letter informs patients that the radiologist found
something on the study unrelated to the ED visit, but it doesn’t go into detail. It urges patients to
seek advice from their primary care physician, offering them access to Hershey Medical Center’s
family medicine department if they don’t have a doctor.
They usually send six to eight letters a week, said Bruno. Committee members take turns reviewing
the flagged cases to make sure they meet the program parameters before the letters are sent.
They’re considering adding the letter to the patient portal as well.
While their family medicine department has long waiting lists, they agreed to see any of these ED
patients within two weeks. Bruno said that Failsafe started in 2012, but only two patients have taken
advantage of the family practice offer. “They either get back with their original primary care doctor
or perhaps they’re not following up as they should,” he said.

University of Chicago
At the University of Chicago, Chang said he tried and failed with several iterations of his follow-up
program, but he finally thinks he has a solid one. “We had the solution all along,” he said, the breast
imaging program. “We communicate directly with the health consumer. In breast imaging, I’m sure
the doctor reads the report, but more importantly, the patient reads the report.” By minimizing
dependence on the ordering physician and giving the information to the person who cares the most
about the results, the patient has an incentive to get the follow-up studies.
Chang’s program is an enterprise approach, versus Hershey’s which is only used for emergency
department patients. Both programs involve putting incidental findings into a database. But
University of Chicago’s system sends e-mail notifications to doctors of record (if the doctor is part of
their medical system) when it’s time to follow up on the incidental finding. If the study isn’t done, the
doctor has to close the ticket and acknowledge why, like if outside studies were performed or the
patient isn’t getting the study for another reason. Doctors who don’t respond at all get a second
“strike,” with another e-mail, copied to the department chair.
If there’s still no response, the hospital sends a certified letter to the patient, saying that the
radiologist interpreting that study strongly suggests that the patient discuss the report with the
ordering physician. If that doesn’t work, a traveling nurse goes to the patient’s house. Chang said
that many of their patients come from the underserved south side community, and the city’s
traveling nurses will knock on doors to make sure patients get the care they need. While expensive,
this traveling nurse program is covered by the city.
For patients who aren’t part of the University of Chicago system, the first step is to send a letter to
the patient, followed by the visiting nurse.
Chang’s goal is to automate the process as much as possible to minimize human error. They’ve
written software so that when a nodule is identified on the PACS, it automatically goes into the
database. He’s working with Philips to develop an intelligent PACS tool to import recommendations
for when to follow-up on various findings. Many radiologists don’t know the recommendations for
each finding, he said, whether it’s three months, six months, or a year. Plus, recommendations
change frequently. Clinical context plays a role as well. Without knowing the variables, a radiologist
might recommend unnecessary radiation or waste money on the test, he said. The University of
Chicago system will be fully integrated in PACS, so they can measure the nodule, look into clinical
context, and determine the appropriate recommendation, and have that automatically entered into
the database. Chang’s goal is to eliminate solving the problem with people, relying more on
computers.

Isn’t it Hard to Build a System?
It might seem overwhelming to develop a program to follow up on incidental findings in the
emergency department, but it doesn’t have to be. St. Thomas Rutherford Hospital at Murfreesboro in
Tennessee has a program for lung modules, said Mark Reiter, MD, president of the American
Academy of Emergency Medicine, and an associate professor and residency director at the hospital.
When encountering a lung nodule, the radiologist clicks on a health record module to add it to the
discharge planning. This prompts one of their nurses to engage the patient in the follow-up process,
and schedule a time to get the patient in for further testing.
Chang said that developing a computer program to follow-up requires complex event processing
(CEP) that other businesses and departments routinely use, like in billing systems. “This stuff is good
old information technology,” said Chang. “It’s routine. We do this all the time. It’s just that radiology
doesn’t do it.” Like with a billing system, you need to populate a database. Then the computer
queries the database with specific rules, sending out letters based on the results, just like patients
get a letter when a bill is due.
A hospital might already have such a system in place, Chang said. University of Chicago took
software previously developed for breast imaging’s letter-writing program. “We didn’t have to build
anything new,” he said. The recommendations tool, however, is more advanced and is being built into a new integrated PACS plug-in.

Of course someone has to take responsibility for making it happen, but the work is a team effort, said Chang. He recommends that radiology take the lead and responsibility for the effort.

“Radiologists have to demonstrate our relevance and value to the enterprise,” said Chang. “This has everything to do with leadership. And radiology has to show more leadership.”

management, quality, administration, legal counsel, radiology, emergency medicine, and family practice.

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After The Letter

When they first set up Failsafe, Bruno was concerned that patients would be terrified after receiving the letter. He called some of the patients, asking them if the letter made them unduly frightened, and the answer was no. While 80% of the patients in a 2013 round of follow-up calls made appointments as a result of the letter, he didn’t have the same success a year later. Many of those patients didn’t respond or show interest in following up. “We have some issues with patient engagement,” Bruno said, and they’re trying to figure out how to address this, especially for those who don’t have a primary care provider.

Hershey staff members are now making follow-up calls to patients within two weeks of sending the letter. They’re setting up a Failsafe office staffed by nurses to reach out to these patients. Funded by the hospital, Bruno anticipates that it will cost less than $60,000 a year, using registered nurses to make the calls. “While this isn’t the type of investment that is feasible for individual radiology groups, it certainly makes sense for a hospital,” he said.

Legal versus Patient Care

Physicians are concerned about patients not getting the medical care they need after an incidental finding is detected, which can cause serious health concerns later. They’re also worried about their legal exposure, said Bob Pyatt, MD, president of both Chambersburg Imaging Associates and the Chambersburg Hospital medical staff.

“I hear a lot of radiologists at meetings talking about incidental findings,” said Pyatt. “We worry about hearing from a lawyer, even if I documented that the emergency department received it and did everything required by the Joint Commission, I still worry.”

The hospital lawyers say that the Failsafe program goes above and beyond the standard of care, said Bruno, supplementing the usual communication channels. When they send the incidental findings letter to the patient, they’re not required to document that or send it via certified mail, but they do both. “We don’t expect that Failsafe will protect us in a lawsuit,” Bruno said. “We hope it will prevent problems, including the risk of lawsuits, by reducing the risk of patient harm. It’s primarily a tool to protect patient safety and not to protect us against legal claims.”

Though it’s difficult to follow-up with patients about incidental findings, eventually this issue will be less relevant, said Chang. He thinks that a natural consequence of health care reform is that it will be easier to contact patients, especially with the consolidation of Accountable Care Organizations.

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