

Diagnostic Test Results Scope and Data Maintenance

Last Modified on 12/01/2023 8:34 am EST

Overview

Office Practicum is committed to patient safety. This commitment guides us in determining the best practices we establish and follow regarding information that is displayed to clinical staff. This includes the results of Diagnostic Tests. Diagnostic Test results that are received, reviewed, and processed by office teams have a significant impact on providing appropriate medical care.

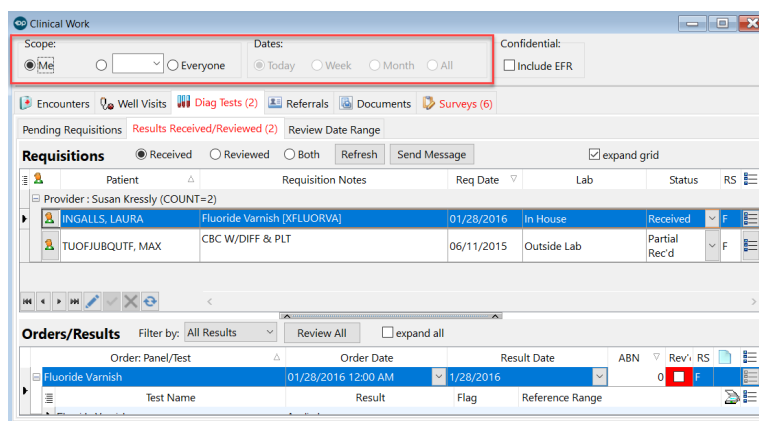
Stages for Processing Diagnostic Tests

With this in mind, there are three main stages of Diagnostic Tests that determine how the information is displayed in OP:

- **Received:** The Received stage is for results that are imported from external sources or are performed in office as in-house tests. This stage indicates the result is recorded and available for clinical staff and Providers to review.
- **Reviewed:** The Reviewed stage is for Diagnostic Test results that have been reviewed by appropriate team members. This stage indicates to others that someone has seen the results.
- **Informed/Complete:** The Informed or Complete stage is for Diagnostic Test results that have been conveyed to the patient or family member or patient representative.

While we're aware that each practice has its own workflow depending on the complexity of their office teams and what works best, all practices should be following these general stages regardless of who performs which stage of the workflow for Diagnostic Test results.

In the Clinical Work window, Diagnostic Tests that are not at a final stage are visible to end users without them having to change the Dates settings. The Diagnostic Test tab defaults to Results Received/Reviewed and has **Scope** setting of **Me** and **Dates** setting of **All**.



This means that, for example, staff do not have to search for labs that come in over a holiday or weekend by changing the Dates to Last Week or Last Month.

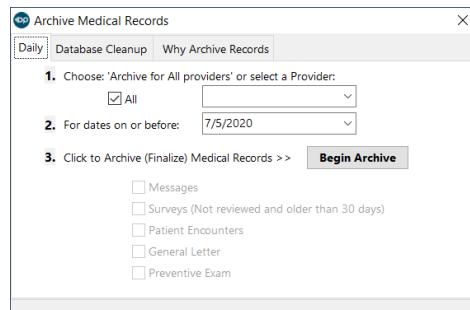
It is a best practice, however, for someone on the clinical team to change the person Scope for providers who are not in the office on a given day. This helps to ensure that those providers' important Diagnostic Test results are processed in an appropriate time frame.

Archiving Results for Diagnostic Tests

We are aware that, due to unique workflows or practice habits, some offices may have a significant number of older Diagnostic Test results that are displayed in OP. This may impact the speed/performance of the system. In addition, having a large list of older Diagnostic Tests can be visually distracting to staff and may increase the cognitive load for processing this information, which may in turn distract the staff from attending to the most important information.

If a practice has a large volume of older Diagnostic Test results that were never processed to the Informed/Complete stage, you can process these results through the Archive Records functionality. Access to this functionality is often reserved to those with Administrator privileges within each Practice. To access this function, navigate to **Admin > Archive Records**.

When accessing the Archive Medical Records functionality, it is important to understand that archiving records makes them unalterable.



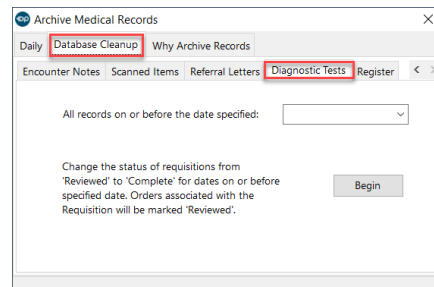
The screenshot shows the 'Archive Medical Records' window with the 'Why Archive Records' tab selected. The window contains the following steps and options:

1. Choose: 'Archive for All providers' or select a Provider:
 All
2. For dates on or before: 7/5/2020
3. Click to Archive (Finalize) Medical Records >> **Begin Archive**

Below the steps, there are several checkboxes for record types to be archived:

- Messages
- Surveys (Not reviewed and older than 30 days)
- Patient Encounters
- General Letter
- Preventive Exam

To archive Diagnostic Test results, the Administrator clicks on the **Database Cleanup** tab of the Archive Medical Records window and then clicks the **Diagnostic Tests** tab.



The screenshot shows the 'Archive Medical Records' window with the 'Database Cleanup' tab selected. The 'Diagnostic Tests' sub-tab is also selected. The window contains the following options and a 'Begin' button:

All records on or before the date specified: [Date Selector]

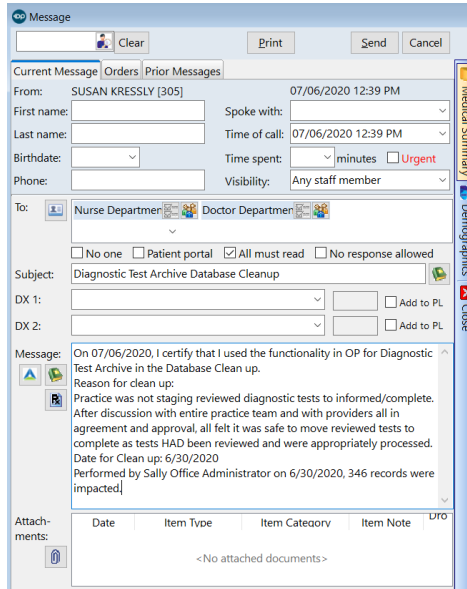
Change the status of requisitions from 'Reviewed' to 'Complete' for dates on or before specified date. Orders associated with the Requisition will be marked 'Reviewed'.

Begin

Before using this functionality, practices need to understand several important points:

1. This functionality is not meant to be used on a regular basis to clean up ongoing work and to compensate for not following best practice recommendations. **Practices should have a clear understanding why this work is needed and educate their team members to make workflow adjustments and habits** in order to establish best practices that prevent the need to use this functionality repeatedly.
2. By using the archive function, practices must be certain that there is no chance of creating a different patient-safety issue (such as families not being informed of an abnormal result and appropriate medical care negatively impacted). For example, practices must choose the archive date carefully. Any results that may still be staged and awaiting practice team members to connect with families should not be archived inadvertently thus interfering with patient-practice communications.
3. The archive functionality only changes results that have been processed to the Reviewed stage. It does not impact those results that are Received but have not been Reviewed.
4. If at all feasible, all attempts to clean up individual Diagnostic Tests at the patient level should be accomplished before using the archive functionality.

- At this time, this functionality is not captured in the Audit Trail. Office Practicum recommends that any practice that chooses to use this archive functionality for Diagnostic Tests first create documentation that can be produced if needed at a future date for medical, legal, or other purposes. This can be done in an external record that the office maintains, and/or by creating a non-patient message in OP, which can be sent to appropriate clinical staff, providers, office manager or no recipient. Information should include details of who is doing the archiving, who is aware, why the decision was made, what archival date was used, and how many records were affected.



If it is recorded in an OP message, it will be searchable by the title for future reference.

