

## **Catching those who fall through the cracks: integrating a follow-up process for emergency department patients with incidental radiologic findings.**

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Barrett TW, & Garland NM, Freeman CL, et al. Ann Emerg Med. 2022;80(3):235-242. &nbsp;  
<https://psnet.ahrq.gov/innovation/catching-those-who-fall-through-cracks-integrating-follow-process-emergency-department>

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[Appropriate](#) followup of incidental abnormal findings is an ongoing patient safety challenge. Inadequate follow-up can contribute to [missed or delayed diagnoses](#) and [adverse patient outcomes](#).

The ED informatics team and hospital health IT team at one large quaternary care system developed a process to standardize reporting of important radiology findings to ED clinicians in real time. If the radiologist reading the imaging study identifies an important clinical or incidental finding, these findings are communicated via the critical alert messaging system which activates an alert on the for the clinical team on the ED trackboard. The system also has a failsafe in place; if the alert is not acknowledged within 60 minutes, the hospital operator communicates with the ED attending physician directly. The ED clinical team then follows a standardized process for communicating the incidental finding to the [patient or family member](#), and communicates the result to the case manager or cancer center navigator using a standardized follow-up request form.

Over the first 13 months of implementation, the system reported 982 incidental findings. Nearly all of the in-network patients with incidental findings were referred to their primary care provider or a specialist and approximately 85% of out-of-network patients received an out-of-network referral to primary care, specialty care, or a federally qualified health care clinic.