Reviewing Test Results

THE MYTH

All test results must be sent to and reviewed by a patient's primary care physician (PCP).

DEBUNKING THE MYTH

To the best of our knowledge, there is no federal regulatory policy mandating that all test results be sent to and reviewed by patients' PCPs. In fact, the results reporting standards of the Clinical Laboratory Improvement Amendments, a Centers for Medicare and Medicaid Services program that ensures quality laboratory testing, requires that laboratory results be released to the ordering clinician and—as mandated by the 21st Century Cures Act—the patient.[1,2] As the AMA STEPS Forward® EHR Inbox Reduction Checklist phrases it, "You order it, you own it".[3]

To support this transparency, the Office of the National Coordinator for Health Information Technology guidance emphasizes that the ordering clinician should be identifiable on all ordered tests and test reports in the electronic health record (EHR). This guidance also stresses that, if available, the clinician responsible for follow-up should be listed as well.[4,5] Unless the patient's PCP is the ordering physician or the physician responsible for follow-up, they do not need to be notified of test results. However, if the patient's PCP requests a copy of a test result from another clinician or health system, this request should be honored because an unnecessary delay could be considered information blocking under federal regulation.[2]

BACKGROUND

Studies have demonstrated that EHR inbox burden significantly contributes to physician burnout and decisions to reduce clinical hours or leave medicine altogether.[6] In an analysis of PCP inbox management, findings showed that most inbox time is spent on addressing test results.[7] Further, in cases where multiple tests are ordered for a single patient, each individual result is often sent as a separate inbox notification, unnecessarily increasing the inbox volume.

The delivery of test results to a physician's inbox is a critical part of the diagnostic and treatment process. The Joint Commission identified closed-loop communication as a National Patient Safety Goal in 2005.[8] "Closing the loop" on test results—ensuring test results are communicated with patients and acted on by care teams in a timely manner—helps prevent missed or delayed diagnosis and protects patient safety. However, when test results are reported to multiple clinicians, there can be confusion concerning whose responsibility it is to review test results, communicate them with patients, and initiate follow-up: the ordering physician/allowed non-physician practitioner or the patient's PCP.

Health systems have begun developing standards and policies that guide staff on how diagnostic test results should be reviewed and followed up on. For example, Veterans Health Administration policy places responsibility upon the ordering clinician for initiating follow-up of abnormal test results unless another qualified clinician was authorized to receive test results in the ordering clinician's absence.[4,9]

CASE EXAMPLE

Physicians and other staff at a large not-for-profit regional hospital medical center became inundated with lab result alerts to the point they were no longer meaningful nor manageable and contributed to burnout. A message for each individual result was sent at the exact time the result was generated, even when it was part of a test panel. This meant that multiple alerts for one test could be sent to staff inboxes nearly simultaneously or hours apart.

To find a solution to this issue, the hospital worked with a health care data integration company to implement a new message delivery system that automated the generation, consolidation, and delivery of certain message types. Through their solution, all results for a single order, including a panel, were aggregated into one result message. The consolidated messages were then sent to the EHR on a specified schedule, preventing physicians from being overwhelmed with a constant stream of lab result alerts. With consolidated patient results delivery, physicians could better focus on diagnosing and providing informed medical care to patients.

AMA Policy

• D-260.995 Improvements to Reporting of Clinical Laboratory Results

• Code of Medical Ethics 2.1.5 Reporting Clinical Test Results

Resources

• "EHR Inbox Management: Tame Your EHR Inbox" STEPS Forward Toolkit–Ed Hub Module

• STEPS Forward EHR Inbox Reduction Checklist for Health Care Organizations (PDF)

• The Electronic Health Record Inbox: Recommendations for Relief

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