

# Managing Abnormal Radiology Results

## The Problem

Effective communication of critical findings is an essential element in diagnostic imaging, imperative to the delivery of high quality patient care. Critical findings of an urgent sort are reported directly by the radiologist to a caregiver. Important, though not urgent, findings, often unexpected, also require timely, direct notification of the caregiver, and frequently entail recommended follow-up. This process is time-consuming and difficult to verify when left to the radiologist.

## Aim/Goal

By developing, staffing, and implementing an actively managed, electronic bulletin board, for posting direct notifications, we aim to 1) communicate all, important, non-urgent abnormal results directly to the ordering physician within 48 hours, and 2) monitor and ensure recommended follow up.

## The Team

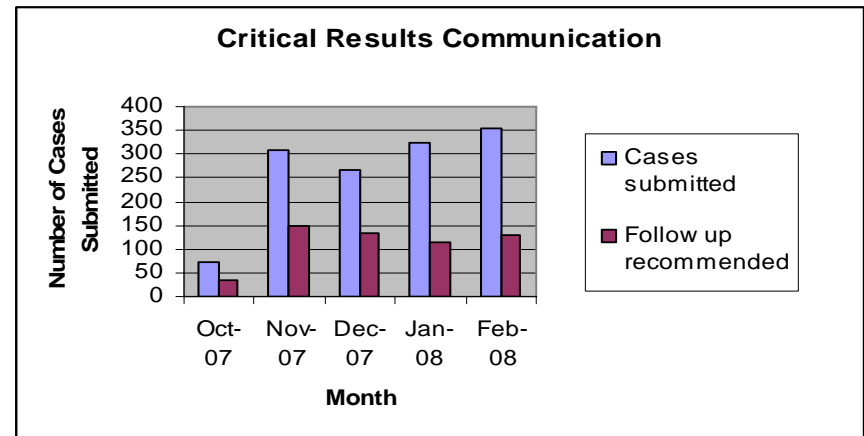
- Paul Spirn, MD and Jonathan Kruskal, MD Team leaders, Radiology
- Deborah Grophear and Erin Mcfadden, Communicators
- Donna Hallett, BA, Radiology Operations Director
- Kei Yamada, MD, Radiology QA resident
- Alexis Potemkin, RN, Radiology QA nurse
- Sam Yam, PHD, Radiology Software Engineer

## The Interventions

- Developed web-based dashboard for managing abnormal findings.
- Linked dashboard reports on CCC and POE system.
- Educated staff about use of dashboard.
- Hired and trained two fulltime communication facilitators.

## The Results to Date (10/01/07-2/29/08)

- 1324 cases posted on the bulletin board
- 1309 cases communicated within 48 hours (99%)
- Average time of communication, first 250 cases: 25 hours
- 559 cases recommended for follow up (42%)



## Lessons Learned

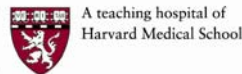
- By facilitating communication of abnormal results, more results are reliably communicated than without such a system.
- A few common abnormal findings occur most frequently, such as incidental lung nodules, renal stones and renal masses.
- Ordering physicians have different preferences for the method in which they receive abnormal results, some prefer email, others telephone.

## Next Steps/What Should Happen Next:

- Incorporate pop-up menus with evidence based follow up recommendations into the dashboard.
- Link follow up events to online medical records so that reminders can be automated and thus closing the loop.



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