ORDERING AND COMMUNICATING TEST RESULTS

MCP 11-06

Dayton VA Medical Center
Dayton, OH 45428

Signatory Authority:
Medical Center Director

Responsible Owner:
Chief of Staff

Rescinded Document:
MCP 11-06, Ordering and Reporting Test Results, dated October 25, 2022 and amendment May 8, 2024.

Effective Date:
April 7, 2026

Recertification Date:
May 7, 2031

1. POLICY

This medical center policy (MCP) establishes local policy on this subject.

2. JUSTIFICATION

VHA Directive 1088, Communicating Test Results to Providers and Patients (dated July 11, 2023) requires a local policy.

3. RESPONSIBILITIES

a. **Diagnostic Practitioners.**

(1) Therapeutic and Diagnostic Imaging Service providers will identify and directly communicate to the ordering provider or designee the following in accordance with paragraph 4f(1):

(a) Any finding that has the potential to be life threatening, or could cause serious harm, and that requires an urgent intervention or change in patient management.

(b) Any finding that would result in the cancellation of on-going or imminent treatment.

(c) Serious conditions or situations, such as (but not limited to): new unsuspected malignancy; new unsuspected pneumonia; unsuspected osteomyelitis or other infection; high probability V-Q scan; unsafe position of medical device; large reversible defect on myocardial perfusion scan; unsuspected acute fracture; concern for impending pathological fracture; pneumothorax; or active hemorrhage.

(2) Pathology and Laboratory Service providers identify and directly communicate to the ordering provider or designee all critical laboratory test results in accordance with paragraph 4f(1).

(3) All diagnostic providers will:

(a) Document in the electronic health record (EHR) the time and means of communication of critical life-threatening results and the name of the ordering provider or designee informed of these results.

(b) Ensure that verified test result reports are available in the patient's EHR as soon as the reports are verified.

b. **Clinical Service Chiefs.** Clinical Service Chiefs will:

(1) Establish written workflows consistent with VHA Directive 1088 (see paragraph 5 b (1) through (5)) within their service for:

(a) the receipt of test results from diagnostic providers to the ordering provider, or designee, and the communication of test results to patients by the ordering provider, or designee.

(b) Includes a process for assigning a designee when health care providers are no longer available, based on the service structure.

(c) Includes a process for assigning surrogates for health care providers when they are not available on a temporary basis based on service operations.

(2) Review procedures and practices for test result communication to both providers and to patients from each section or department they supervise as applicable.

(3) Monitor the effectiveness of the patient notification process and addressing performance improvement issues as needed. Monitoring must be documented in appropriate service level meeting or integrated clinical community meeting minutes. As part of this process periodically review the View Alerts Checklist on the Communicating Test Results SharePoint and take action as needed. Review must be on an annual basis at a minimum.

(4) Monitor the timely completion of EHR notifications. Monitoring must be documented in appropriate service level meeting or integrated clinical community meeting minutes.

(5) Ensure appropriate staff members are involved in the processes related to patient notification of all types of test results. Their participation must be within their scope of practice, functional statement, or position description.

(6) Ensure all providers have surrogates assigned when appropriate.

c. **Ordering Practitioners.** Ordering practitioners will:

(1) Place the initial order, including the appropriate contact information, and identifying the surrogate practitioner, when applicable

(2) Assign a qualified surrogate practitioner to receive critical or abnormal test result notifications when they themselves are unavailable to review results in a timely manner to prevent avoidable delays in treatment or response. Ensure that their or their designee's contact information is available and up to date.

(3) Initiate appropriate clinical action and follow up the results of any orders which they have placed.

(4) Document patient notifications and subsequent clinical actions in response to critical, urgent and clinically significant test results that require therapeutic intervention or action in the patient's EHR. If results are discussed within a patient visit, this should be documented within the visit progress note. The extent of documentation may vary depending on the context of the test result and resultant action plan or therapeutic intervention.

d. **Clinical Contact Center.** Clinical Contact Center staff will note requests for test results from Veterans the EHR and tag PACT team to address.

4. OTHER PARAGRAPHS:

a. The Communication of Test Results Toolkit SharePoint Site provides additional tools and information to include frequently asked questions.

b. Therapeutic and Diagnostic Imaging Service providers reference SOP 114-09 for implementation procedures to ensure compliance with VHA Directive 1088.

c. Pathology and Laboratory Service providers reference MCP 113-05 and SOP 113-03 for implementation procedures and guidance to ensure compliance with VHA Directive 1088.

d. All other providers reference their respective service guidance.

e. Monitoring of test result communication

(1) Assessment of critical value communication from diagnostic practitioners to ordering providers is reported at the Clinical Executive Board (Charter 11-01).

(2) Assessment of non-critical value from diagnostic practitioners to ordering providers is monitored at and documented in appropriate service level meeting or integrated clinical community meeting minutes.

(3) Assessment of test results communication to patients is monitored appropriate service level meeting or integrated clinical community meeting.

f. Communication Standards:

(1) Directly communicate critical results to an ordering provider or surrogate within two business days for first-time malignancy and one hour for all other critical laboratory results.

(2) Electronically communicate all non-critical imaging test results to the ordering practitioner or surrogate within 48 hours. Use appropriate diagnostic codes when indicated to generate view alerts to the ordering clinician for abnormal, but not critical imaging results.

(3) Electronically communicate non-critical pathology test results to the ordering practitioner, or surrogate, within 1 hour for STAT requests, 2 hours for Urgent requests and 4 hours for routine requests.

(4) For telephonic reporting of critical values or results, the complete test result must be verified by having the person receiving the information “read back” the complete test values or results. It is expected that:

(a) The receiver of the information writes down the complete critical values or results and enters it into the EHR system.

(b) The receiver of the information reads back the critical values or results.

(5) If the ordering practitioner and surrogate practitioner are not available, communication needs to be made to the supervisor/Service Chief. Diagnostic providers will communicate critical test results to the supervisor or service chief when the ordering provider and his/her designee are unavailable. See Attachment 1 for the facility reporting algorithm.

(6) Communication of test results to patients by ordering provider or designee:

(a) All test results requiring action must be communicated to patients no later than 7 calendar days from the date on which the results are available to the VA medical center ordering Provider or designee.

(b) For test results that require no action, results must be communicated to patients no later than 14 calendar days from the date on which the results are available to the VA medical center ordering Provider or designee.

(c) Critical lab values will be communicated to the patient within 24 hours.

(d) Critical imaging results will be communicated to the patient no later than 2 business days.

(e) If potentially life-changing test results are being provided to a Veteran with a High Risk for Suicide – Patient Record Flag, the ordering provider or designee must coordinate communication to the patient with the Mental Health Treatment Coordinator, mental health provider(s) or the Suicide Prevention Coordinator to devise an appropriate strategy within the time standards above.

(7) If the patient lacks decision making capacity, results will be communicated to the patient and the personal representative of the patient as defined in this policy.

(8) If, despite best efforts, it is not possible to communicate test results to the patient (e.g., the patient has moved and left no contact information), all attempts to contact the patient are documented in the EHR. At a minimum, a certified letter should be sent for all test results requiring action.

(9) Communicating test results in acute care settings. Settings of acute care such as inpatient, emergency, or urgent care often involve extensive, repetitive testing with rapidly changing clinical conditions. Therefore, for patients in the inpatient, emergency, or urgent care setting, it is not required or expected that each individual test result is communicated to the patient. The ordering provider or the patient's care team should strive to effectively communicate relevant information to the patient about the patient's medical condition, as needed, to ensure the patient is able to engage effectively in the treatment plan. Results of specific tests may be included in this communication, as appropriate.

(10) Communicating test results to patients after discharge. When results of tests ordered and performed while the patient is inpatient become available after discharge, they are communicated to the patient by the ordering inpatient provider, or their designee, unless responsibility is transferred to an outpatient provider, or their designee, and the transfer is documented in CPRS.

g. When a transfer of responsibility from an inpatient provider to an outpatient provider is required, it must be documented in the EHR. The transfer of responsibility may occur via synchronous or asynchronous communication. This also applies to test results that are ordered to be performed in the future in the outpatient setting.

h. During patient check-in, appropriate staff or electronic process should verify and update as necessary contact information for all patients in the EHR.

5. DEFINITIONS

a. **Ordering Practitioner.** Ordering Practitioner is a practitioner authorized to enter and sign orders for diagnostic tests by privileges or acting under a scope of clinical practice.

b. **Diagnostic Practitioner.** Diagnostic Practitioner is a practitioner who performs or supervises the performance and interpretation of diagnostic tests by privileges or acting under a scope of practice.

c. **Test Results.** Test Results include the results of laboratory testing, diagnostic imaging, and diagnostic procedures.

d. **Critical Value or Result.** A critical test result is defined as those values or interpretations that, if left untreated, could be life threatening or place the patient at serious risk. Critical values or results are those results from laboratory, cardiology,

radiology departments and other diagnostic areas that upon analysis are determined to be "critical" regardless of the ordering priority. These include finding that are associated with a high likelihood of short-term poor outcome and requires either immediate therapeutic intervention or close monitoring. Emergent tests are also considered critical.

e. **Abnormal Test Result.** Abnormal Test Result is a diagnostic finding that requires attention by the ordering practitioner, but not necessarily in an immediate time frame.

f. **Direct Communication.** Direct Communication is the transmission of test results by direct, dialogue between the diagnostic practitioner and the ordering practitioner, or surrogate practitioner, by MS Teams message, telephone or face-to-face conversation, or hand carried report.

g. **Electronic Communication.** Electronic Communication is the transmission of test results by electronic means (e.g., view alerts, e-mail, FAX, etc.).

h. **Personal Representative.** Personal Representative is a person who under applicable law has authority to act on behalf of the individual. This may include power of attorney, legal guardianship of an individual, the executor of the estate of a deceased individual, or someone under Federal, state, local or tribal law with such authority (e.g., parent of a minor).

6. REFERENCES

a. VHA Directive 1088, Communicating Test Results to Providers and Patients, dated July 11, 2023, LINK.

b. MCP 113-05, Ordering, Collection, and Result Reporting of Laboratory Tests, dated March 30, 2023, amended August 15, 2024.

c. SOP 113-03, Ordering, Labeling, & Result Reporting Anatomical Tissue & Cytology Specimens, dated November 9, 2022.

d. SOP 114-09, Reporting Imaging Test Results, dated September 14, 2022, amended December 10, 2025.

7. RESCISSION

MCP 11-06, Ordering and Reporting Test Results, dated October 25, 2022, and amendment May 8. 2024.

8. REVIEW

Review required at recertification, when there are changes to the governing document and any regulatory requirement for more frequent review.

9. RECERTIFICATION

This MCP is scheduled for recertification on or before May 7, 2031. This MCP will continue to serve as local policy until it is recertified or rescinded. In the event of contradiction with national policy, the national policy supersedes and controls.

10. SIGNATORY AUTHORITY

4/7/2026

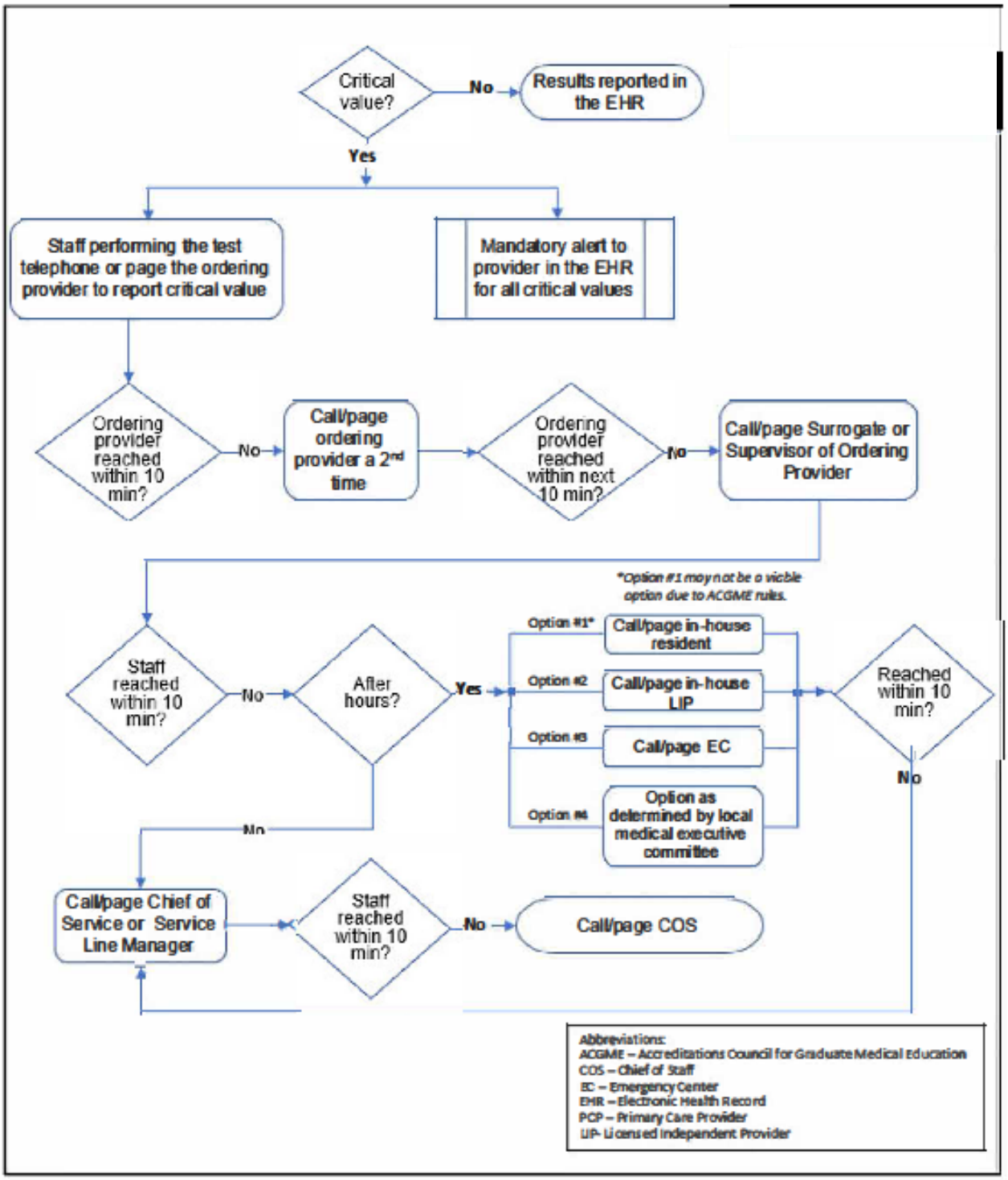
X

Jennifer DeFrancesco, DHA, FACHE
Medical Center Director
Signed by: JENNIFER DEFRANCESCO

Date Approved: April 7, 2026

Attachments: 1

NOTE: *The signature remains valid until rescinded by an appropriate administrative action.*

DISTRIBUTION: MCPs are available at: Dayton Medical Center Policy SharePoint.

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