Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

Amendment
January 24, 2022

VHA DIRECTIVE 1088(1)
Transmittal Sheet
October 7, 2015

COMMUNICATING TEST RESULTS TO PROVIDERS AND PATIENTS

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) Directive establishes policy regarding communication of test results to providers and patients.

2. SUMMARY OF MAJOR CHANGES: This amendment dated January 24, 2022 updates section 4.f.(8)(b) (page 6) to clarify the need to send a certified letter for test results requiring action when communication attempts have failed.

3. RELATED ISSUES: None.

4. RESPONSIBLE OFFICE: The Office of Primary Care (11PC) is responsible for the content of this directive. Questions regarding ordering tests and reporting test results to ordering practitioners may be directed to the Chief Consultant for Diagnostic Services (10P4D) at 919-382-8851. Questions regarding communication of test results to patients may be directed to the Chief Consultant for the Office of Primary Care (11PC) at 202-461-6259 or vha11pcprimarycareaction@va.gov.

5. RESCISSIONS: VHA Directive 2009-019, dated March 24, 2009, is rescinded.

6. RECERTIFICATION: This VHA Directive is scheduled for recertification on or before the last working day of October 31, 2020.

/s/ David J. Shulkin, M.D.
Under Secretary for Health

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COMMUNICATING TEST RESULTS TO PROVIDERS AND PATIENTS

1. PURPOSE

This Veterans Health Administration (VHA) Directive establishes policy regarding the communication of test results to providers and patients. **AUTHORITY:** 38 U.S.C. 7301(b).

2. BACKGROUND

a. VHA is committed to the timely communication of test results, which is essential to ensuring safe and effective health care.

b. Timely communication of test results to patients is essential for high quality patient-centered care. Lack of timely follow-up of abnormal test results has been identified as a contributor to poor outcomes and can be a source of considerable anxiety to patients and families. Patient involvement in test result follow-up is fundamental to improve safety in this area and is consistent with personalized proactive patient-driven care. Patients have a right to access personal health information and expect to be notified of test results in a timely manner. Enhancing timeliness of follow-up of test results is consistent with VHA's goals of providing Veterans with quality health care.

3. POLICY

It is VHA policy that all test results must be communicated by the diagnostic provider to the ordering provider, or designee, within a time-frame that allows for prompt attention and appropriate action to be taken. All test results requiring action must be communicated by the ordering provider, or designee, to patients no later than 7 calendar days from the date on which the results are available. For test results that require no action, results must be communicated by the ordering provider, or designee, to patients no later than 14 calendar days from the date on which the results are available. Depending on the clinical context, certain test results may require review and communication in shorter time-frames (see definitions paragraph related to abnormal and normal results). All VA medical facilities are expected to put into place appropriate systems and processes to ensure timeliness of appropriate communication and follow-up of test results.

4. RESPONSIBILITIES

a. **Veterans Integrated Service Network Director.** The Veterans Integrated Service Network (VISN) Director is responsible for ensuring implementation of this Directive in all VA medical facilities under their jurisdiction and periodically reviewing processes and procedures to ensure timeliness of follow-up based on test results.

b. **Medical Facility Director.** Each medical facility Director is responsible for development and implementation of a written policy regarding communication of test results to ordering providers and to patients. See Frequently Asked Questions (FAQs)

on the Communication of Test Results Toolkit SharePoint Site: https://dvagov.sharepoint.com/sites/VACOVHADUSHOM/10NC/10NC3/CTR/default.aspx . ***NOTE:*** *This is an internal VA Web site and is not available to the public*. This policy must:

(1) Define what test results are considered critical life threatening, the acceptable length of time between the availability of critical life threatening results and receipt by the ordering provider, or designee, and associated notification and read-back verification processes.

(2) Ensure that the facility accounts for the delegation of clear responsibility and accountability related to test result follow-up; especially when multiple providers are involved in the care of a patient. See FAQs on the Communication of Test Results Toolkit SharePoint Site: https://dvagov.sharepoint.com/sites/VACOVHADUSHOM/10NC/10NC3/CTR/default.aspx . ***NOTE:*** *This is an internal VA Web site and is not available to the public*. In most circumstances, ordering providers are responsible for all test results they order unless there are pre-existing, mutually agreeable, and clear arrangements made with a designee. Furthermore, policies should outline alternative procedures through which the diagnostic provider communicates critical test results when the ordering provider and his/her designee are unavailable. See FAQs on the Communication of Test Results Toolkit SharePoint Site: https://dvagov.sharepoint.com/sites/VACOVHADUSHOM/10NC/10NC3/CTR/default.aspx . ***NOTE:*** *This is an internal VA Web site and is not available to the public*.

(3) Ensure that the VA medical facility follows practices and procedures to better manage Computerized Patient Record System (CPRS)-based notifications (sometimes known as “view alerts”) related to test results. CPRS-based notification is the most widely used method for asynchronous communication of test results from diagnostic providers to ordering providers or designees. To ensure that CPRS notifications are effective, responded to in a timely manner, and do not create unnecessary information burdens on ordering providers or designees, facilities should evaluate the numbers and types of notifications providers are receiving and use mandatory notifications judiciously. See FAQs on the Communication of Test Results Toolkit SharePoint Site: https://dvagov.sharepoint.com/sites/VACOVHADUSHOM/10NC/10NC3/CTR/default.aspx . ***NOTE:*** *This is an internal VA Web site and is not available to the public*.

(4) Describe how the VA medical facility ensures inclusion and participation of other members of the ordering provider’s team to facilitate processes related to patient notification of all types of test results. This team could include Nurse Practitioners, Physician Assistants, Registered Nurses, Licensed Vocational Nurses, Licensed Practical Nurses, Clinical Pharmacists, and other staff as appropriate within their scope of practice, functional statement, or position description. According to VA Handbook 5005/53, Medical Support Assistant (MSA) GS-0679 Qualification Standard, General Schedule (GS) 6 clerks may notify patients of normal lab results. Inclusion of other team members should follow robust principles of teamwork including clarity of task delegation, clarity of roles of team members, clarity of key responsibilities on test result related action, and contingency planning. These processes should include working with

nursing staff and administrative executives to ensure that their staff members are well integrated into care teams and working to their maximal potential to facilitate test result communication. See FAQs on the Communication of Test Results Toolkit SharePoint Site: https://dvagov.sharepoint.com/sites/VACOVHADUSHOM/10NC/10NC3/CTR/default.aspx . ***NOTE:*** *This is an internal VA Web site and is not available to the public*.

(5) Describe how the VA medical facility:

(a) Maintains updated contact information for all patients in CPRS and all providers and their designees who have access to CPRS.

(b) Makes this contact information available to all staff involved in the test result notification processes.

(6) Demonstrate how communication of results to patients is being periodically monitored to document adherence to this VHA Directive.

c. **Chiefs of Staff or Associate Director for Patient Care Services.** Each facility Chief of Staff or Associate Director for Patient Care Services is responsible for:

(1) Reviewing monitors of test result communication and ensuring that any identified performance improvement issues are addressed. VA medical facilities should develop a performance improvement process to ensure appropriate and timely follow-up of test results. See FAQs on the Communication of Test Results Toolkit SharePoint Site: https://dvagov.sharepoint.com/sites/VACOVHADUSHOM/10NC/10NC3/CTR/default.aspx . ***NOTE:*** *This is an internal VA Web site and is not available to the public*.

(2) Ensuring that each service (and section(s) or department(s) within each service) has written policies and procedures consistent with this Directive that identify all providers and staff who can communicate test results to patients. These policies and procedures should also specify what type of test results providers and staff can communicate, and how the results are communicated (e.g., synchronous versus asynchronous). For certain types of tests and certain types of patients, synchronous methods are preferred (see definitions section).

(3) Resolving with service chiefs any gaps detected in test result follow-up processes.

d. **Service Chiefs, Associate Nursing Service Chief, and Administrative Executives.** Service Chiefs, Associate Nursing Service Chief, and Administrative Executives are responsible for:

(1) Establishing procedures consistent with this Directive within their department or section for 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. These procedures should include plans for the delegation of authority and specify which team members can receive test results from diagnostic providers and/or

notify patients of test results as appropriate within their scope of practice or position description. These procedures should also describe processes so that each provider will have coverage at all times in the provider's absence by a designee within their scope of practice or position description. If none of the previously identified personnel are available, test results should be reported to the ordering provider's service chief or an equivalent supervisor. See FAQs on the Communication of Test Results Toolkit SharePoint Site: https://dvagov.sharepoint.com/sites/VACOVHADUSHOM/10NC/10NC3/CTR/default.aspx . ***NOTE:*** *This is an internal VA Web site and is not available to the public*. The emergency department (ED) should not be the primary service responsible for receiving afterhours test results that are not life threatening unless ordered by ED providers.

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

(3) Monitoring the effectiveness of the patient notification process and addressing performance improvement issues as needed.

e. **Diagnostic Provider.** Each diagnostic provider is responsible for:

(1) Identifying and communicating all critical life threatening test results and urgent non-life threatening abnormal test results to the ordering provider or their designee (as determined by each facility's policies or procedures). See FAQs on the Communication of Test Results Toolkit SharePoint Site: https://dvagov.sharepoint.com/sites/VACOVHADUSHOM/10NC/10NC3/CTR/default.aspx . ***NOTE:*** *This is an internal VA Web site and is not available to the public*.

(2) Documenting in the medical record the time and means of communication of critical life threatening results and the name of the ordering provider or designee informed of these results.

(3) Ensuring that test results reports are available in the patient's electronic medical record as soon as the reports are verified.

f. **Ordering Provider or Designee.** Each ordering provider, or designee, is responsible for:

(1) Initiating appropriate clinical action and follow-up for any orders that they have placed.

(2) Assigning a qualified designee to receive test results when the ordering provider is unavailable. The designee assumes the responsibility to initiate appropriate clinical action and follow-up and to ensure that patients are notified of test results in a timely manner. When tests are ordered by residents or other health professions trainees, the supervising practitioner is the designee and has the responsibility for ensuring that the required communication and documentation occurs.

(3) Ensuring that their or their designee's contact information is available and up-to-date.

(4) Communicating outpatient test results to patients in accordance with the following time frame standards: all test results requiring action must be communicated by the ordering provider, or designee, to patients no later than 7 calendar days from the date on which the results are available. For test results that require no action, results must be communicated by the ordering provider, or designee, to patients no later than 14 calendar days from the date on which the results are available. Depending on the clinical context, certain test results may require review and communication in shorter time-frames (see definitions paragraph for abnormal and normal results). Patients enrolled in MyHealth*e*Vet Premium Accounts are able to view certain test results in earlier time-frames (usually within 3 days of the date on which the results are available). All communication should occur within a time-frame that minimizes risk to the patient. See FAQs on the Communication of Test Results Toolkit SharePoint Site: https://dvagov.sharepoint.com/sites/VACOVHADUSHOM/10NC/10NC3/CTR/default.aspx . ***NOTE:*** *This is an internal VA Web site and is not available to the public*. Additional communication recommendations are listed below.

(a) Content and Method of Communication. The content of communication might vary from case to case but must be sufficiently detailed to allow the patient to be informed and engaged in their health care. When test results indicate that an action or therapeutic intervention is needed, the ordering provider is expected to discuss potential actions or therapeutic intervention options with the patient and initiate action. This discussion can occur synchronously (examples: in person or by telephone) or asynchronously (examples: in writing, through template-generated letters, or via secure messaging in MyHealth*e*Vet). For communication by telephone, reasonable steps should be taken in order to verify the identity of the person on the other end of the phone. For certain types of tests and certain types of patients, synchronous methods might be preferred. Automated test results released through MyHealth*e*Vet or other methods, such as template-generated letters, are acceptable methods of communicating results not requiring action or therapeutic intervention. These communication methods are still emerging and thus processes and good clinical practices in this area will evolve. Patient identifiable information must never be communicated via an unsecured method. Communication methods may need to be adjusted for Veterans with certain types of functional impairments. See FAQs on the Communication of Test Results Toolkit SharePoint Site: https://dvagov.sharepoint.com/sites/VACOVHADUSHOM/10NC/10NC3/CTR/default.aspx . ***NOTE:*** *This is an internal VA Web site and is not available to the public*.

(b) Documentation. Patient notifications and subsequent clinical actions must be documented in CPRS by the ordering provider(s) or designee(s) in response to critical, urgent, and clinically significant test results that require therapeutic intervention or action. 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.

(c) Exceptions. In exceptional circumstances, it may be necessary to delay communication of test results beyond the timeframes identified above. For example, communicating a diagnosis of terminal cancer or Human Immunodeficiency Virus (HIV) in a sensitive, empathic manner may require a face-to-face visit at a time convenient to the patient, which could extend beyond the 7 day time frame. Due to the sensitive nature of certain test results, the determination of how to report these results are best made on a case-by-case basis. Review and discussion of test results need to be provided to the patient, or patient's personal representative, with an opportunity for questions and discussion.

(6) 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. The transfer of responsibility to the outpatient provider may occur via synchronous or asynchronous communication. The requirements for transfer of responsibility, such as acknowledgment or acceptance by the outpatient provider, should be determined by the local facility. The same principles also apply to results of tests that are ordered to be performed in the future in the outpatient setting. See FAQs on the Communication of Test Results Toolkit SharePoint Site:
https://dvagov.sharepoint.com/sites/VACOVHADUSHOM/10NC/10NC3/CTR/default.aspx . ***NOTE:*** *This is an internal VA Web site and is not available to the public*.

(7) 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.

(8) Taking additional measures in the following special situations:

(a) If the patient lacks decision making capacity, communicate results to the personal representative of the patient as defined in this Directive (see definitions section).

(b) If, despite best efforts, it is not possible to communicate test results to the patient (e.g., the patient has not returned phone calls or secure messages), all attempts to contact the patient should be documented in the EHR. A certified letter should be sent for all test results requiring action when communication attempts have failed.

5. REFERENCES

a. VA Handbook 5005/53, Medical Support Assistant (MSA) GS-0679 Qualification Standard.

b. VHA Handbook 1400.01, Resident Supervision.

c. VHA Handbook 1400.04, Supervision of Associated Health Trainees.

d. VHA Handbook 1605.1, Privacy and Release of Information.

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p. Singh H, Thomas EJ, Sittig DF, Wilson L, Espadas D, Khan MM et al. Notification of abnormal lab test results in an electronic medical record: do any safety concerns remain? The *American Journal of Medicine* March 2010; 123(3):238-244.

q. Sittig DF, Singh H. Improving Test Result Follow-up through Electronic Health Records Requires More than Just an Alert. *Journal of General Internal Medicine* October 2012; 27(10):1235-1237.

6. DEFINITONS

a. **Asynchronous Communication.** Asynchronous communication is when parties involved in communication are not present at the same time, such as electronic notifications in Computerized Patient Record System (CPRS), secure messaging, AudioCARE, FAX, or letter.

b. **Designee.** For this Directive, a designee is a clinical team member authorized by the ordering provider in a manner consistent with VA medical facility policies who acts on behalf of the ordering provider to receive information from the diagnostic provider (in the absence of the ordering provider) and/or notifies patients of test results in a timely manner and discusses such results with the patients, in accordance with this Directive.

c. **Diagnostic Provider.** A diagnostic provider is a provider who performs or supervises the performance and interpretation of diagnostic tests either through privileges or by acting under a scope of practice.

d. **Ordering Provider.** An ordering provider is a provider authorized to enter and sign orders for diagnostic tests.

e. **Patient Notification.** Patient notification is communicating test results to patients or, if appropriate, to their personal representatives, including additional context and follow-up action as needed. Patient notification could occur through any synchronous or asynchronous method. For certain types of tests and certain types of patients, synchronous methods are preferred.

f. **Personal Representative.** A 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).

g. **Supervising Practitioner.** Supervising practitioner refers to a licensed, independent practitioner, who has been credentialed and privileged at a VA medical

facility in accordance with applicable requirements. ***NOTE:*** *'Supervising practitioners' are often referred to as 'attendings'. See VHA Handbooks 1400.01, Resident Supervision, and 1400.04, Supervision of Associated Health Trainees.*

h. **Synchronous Communication.** Synchronous communication is when parties involved in a communication are all present at the same time, such as in person, telephone conversations, or Clinical Video Telehealth (CVT).

i. **Test Result.** Test results include the results of laboratory and pathology testing, diagnostic imaging, and diagnostic procedures. Test results are categorized as abnormal or normal as determined by a clinical provider and are further defined as follows:

(1) **Abnormal Test Results.** Abnormal test results are results that fall outside a specified normal reference range, are unexpected, or could indicate the presence of disease. An abnormal test may or may not require action and therapeutic intervention, depending on the clinical context. There are three types of abnormal test results that require action or therapeutic intervention:

(a) Critical Life Threatening. Any diagnostic finding which must be acted upon by the ordering provider or their designee immediately or within a short window of time and could result in severe morbidity or mortality if left untreated. (Example: critically elevated Potassium).

(b) Urgent Non Life Threatening. Any diagnostic finding which must be acted upon by the ordering provider or their designee within a relatively urgent timeframe (as clinically indicated to ensure timely, appropriate and effective therapeutic action). An example of this is a Chest x-ray with newly discovered nodule, which is categorized as "Critical Not Life Threatening" with an Equivalent Radiology code such as 1001-Significant abnormality - attention needed or 1003-Possible malignancy.

(c) Clinically Significant. A diagnostic finding that requires action by the ordering provider, or their designee, but not necessarily in an immediate or urgent time-frame. (Example: High Cholesterol).

(2) **Normal Test Results.** While the significance of a "normal" test result needs to be determined clinically, in the context of this Directive it is defined as a diagnostic finding that falls within the normal reference range for the test and may or may not require immediate action or change in treatment depending on clinical circumstances. (Example: Patient on Warfarin whose international normalized ratio (INR) is sub-therapeutic but in the "normal" range; low-density lipoprotein (LDL) =120mg/dl with coronary disease) Radiologic tests can also be considered normal when radiologists use something equivalent "*Radiology Code: 1000-No Alert Required-No significant finding or provider is already aware.*"