Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Summary Report

Management of Test Results in Veterans Health Administration Facilities

Report No. 11-02869-272

September 7, 2011

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections evaluated the management of test results in Veterans Health Administration (VHA) facilities. The purposes of the evaluation were to follow up on a previous report *Healthcare Inspection Summary Review – Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results* (Report No. 01-01965-24, November 25, 2002) and to assess facilities' compliance with The Joint Commission's national patient safety goal regarding communicating critical test results. The objectives were to determine whether facilities:

1. Complied with VHA policy and Joint Commission standards related to communicating critical clinical laboratory, radiology, and anatomic pathology test results.
2. Periodically monitored communication of critical test results to evaluate effectiveness.
3. Documented appropriate notification and follow-up actions in medical records when critical test results were generated.
4. Notified patients of normal test results.

Inspectors evaluated the management of test results at 25 facilities during Combined Assessment Program reviews conducted from October 1, 2010, through March 31, 2011.

In response to our 2002 report, VHA provided system-wide guidance for management of test results. We identified significant improvements related to diagnostic clinician communication and documentation of critical results compared with our previous review. However, we identified three areas where compliance with VHA requirements needs to improve. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensures that:

- Facilities' written policies are comprehensive and define the processes for monitoring the effectiveness of communicating critical results to practitioners and patients.
- Ordering practitioners or designees notify patients of all critical results within the defined timeframe.
- Practitioners notify patients of normal results and that managers monitor compliance.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Under Secretary for Health (10)

SUBJECT: Combined Assessment Program Summary Report – Management of Test Results in Veterans Health Administration Facilities

Purpose

The VA Office of Inspector General Office of Healthcare Inspections evaluated the management of test results in Veterans Health Administration (VHA) facilities. The purposes of the evaluation were to follow up on a previous report *Healthcare Inspection Summary Review – Evaluation of Veterans Health Administration Procedures for Communicating Abnormal Test Results* (Report No. 01-01965-24, November 25, 2002) and to assess facilities' compliance with The Joint Commission's (JC's) national patient safety goal regarding communicating critical test results. The objectives were to determine whether facilities:

1. Complied with VHA policy and JC standards related to communicating critical clinical laboratory, radiology, and anatomic pathology (AP) test results.
2. Periodically monitored communication of critical test results to evaluate effectiveness.
3. Documented appropriate notification and follow-up actions in medical records when critical test results were generated.
4. Notified patients of normal test results.

Background

U.S. health care facilities complete approximately 12 billion diagnostic (laboratory, radiology, and AP) tests every year. While most of the test results are negative, approximately 1 to 5 percent are abnormal or critical and require follow-up by the referring physician.[1] Health care facilities have a legal, ethical, and moral obligation to ensure that these results are communicated to the responsible practitioner or care team for action. Diagnostic services' clinicians are required to communicate critical results to

[1] Lisa Fratt, "Critical Test Results Management: The Human Touch," *Health Imaging & IT*, Vol. 6, No. 3, March 2008, pp 14–15.

appropriate practitioners rapidly and effectively so that quality patient care can be rendered.

Since 2006, The JC has identified timely communication of critical results as one of its national patient safety goals. The JC requires health care organizations to develop written procedures for managing the critical results of tests and diagnostic procedures that address the following:

- The definition of critical results of tests and diagnostic procedures.
- By whom and to whom critical results of tests and diagnostic procedures are to be reported.
- The acceptable length of time between the availability of and the reporting of critical results of tests and diagnostic procedures.

In addition, health care organizations are required to implement procedures for managing and evaluating the timeliness of critical results of tests and diagnostic procedures.

In our 2002 report, we made recommendations for the Under Secretary for Health, in conjunction with VHA managers, to:

- Develop system-wide policies requiring timely communication of abnormal test and procedure results to providers and patients and the documentation of these notifications in medical records.
- Ensure that diagnostic clinicians document on their test reports when they notify providers of abnormal results.
- Emphasize to treatment providers the importance of complete documentation, including documentation of any follow-up action, when they notify patients of abnormal test results.
- Ensure that managers evaluate the effectiveness of their view alert systems.

In response to our report, VHA issued a directive delineating the procedures for communicating test results to practitioners and patients.[2] On March 24, 2009, the directive was renewed and reissued as VHA Directive 2009-019.

Scope and Methodology

Inspectors evaluated the management of test results at 25 facilities during Combined Assessment Program reviews conducted from October 1, 2010, through March 31, 2011. The facilities reviewed represented a mix of size, affiliation, geographic location, and Veterans Integrated Service Networks (VISNs). Reviews focused on fiscal year 2010 outpatient test results generated from the laboratory, radiology, and AP. We interviewed

[2] VHA Directive 2003-043, *Ordering and Reporting Test Results*, August 6, 2003.

selected program managers and reviewed policies, medical records, facility self-assessments, and other applicable documents.

We generated an individual Combined Assessment Program report for each facility. For this report, we analyzed and summarized the data from the individual facility Combined Assessment Program reviews. Some of the areas reviewed did not apply to all VHA facilities; therefore, denominators differ in our reported results. For those review elements not mentioned further in this report, we generally found acceptable compliance.

Inspectors conducted the reviews in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Issue 1: Facility and Diagnostic Services' Policies

VHA requires facilities to develop written policies regarding communication of results from diagnostic clinicians to ordering practitioners.[3] Policies need to describe the reporting process and timeframes for results that require prompt clinical attention. Facilities must monitor that communication of results to practitioners and patients occurs according to policy and requirements. Additionally, facilities need to monitor these communication processes to ensure that they are effective.

We reviewed 21 facility, 24 laboratory, 24 radiology, and 20 AP policies. Table 1 below summarizes review elements.

Table 1

Element	Facility Policy		
• Policies did not describe a process for monitoring the effectiveness of communicating critical results to patients.	10/21 (48%)		
Element	**Laboratory**	**Radiology**	**AP**
• Policies did not specify timeframes for reporting critical results to practitioners.	No problems identified	No problems identified	4/20 (20%)
• Policies did not describe a process for monitoring the effectiveness of communicating critical results to practitioners.	4/24 (17%)	5/24 (21%)	2/20 (10%)

[3] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

We concluded that facilities' (and their diagnostic services') written policies needed to be more comprehensive and needed to define the processes for monitoring the effectiveness of communicating critical results to practitioners and patients.

Issue 2: Patient Critical Results Notification

VHA requires facilities to communicate critical results to patients within defined timeframes.[4] We reviewed 710 outpatient medical records to determine whether ordering practitioners or designees documented in the medical record when they notified patients of critical results and whether the notifications were timely. Table 2 below summarizes medical record review results.

Table 2

Element	Laboratory	Radiology	AP
• Patients not informed of critical results.	10/255 (4%)	26/239(11%)	8/219 (4%)
• Patients not notified of critical results within the defined timeframe.	6/245(2%)	22/213 (10%)	26/211 (12%)

Although compliance is fairly high, we concluded that ordering practitioners (or their designees) needed to consistently notify their patients of all critical results within the defined timeframes.

Issue 3: Patient Normal Results Notification

VHA requires practitioners to communicate outpatient test results, including normal results, no later than 14 calendar days from the date on which the results are available to the ordering practitioner.[5] We reviewed the medical records of 547 outpatients who had normal laboratory or radiology results to determine whether practitioners notified patients of the results and whether communication occurred within the required timeframe. Table 3 below summarizes medical record review results.

Table 3

Element	Total Records Reviewed	Laboratory	Radiology
• Patients not informed of normal results.	178/547 (33%)	54/270 (20%)	124/277 (45%)
• For those patients notified of normal results, communication did not occur within the required timeframe.	25/369 (7%)	13/216 (6%)	12/153 (8%)

[4] VHA Directive 2009-019.
[5] VHA Directive 2009-019.

We concluded that practitioners needed to improve considerably in notifying their patients of normal results and that facility managers needed to monitor compliance.

Conclusions

In response to our 2002 report, VHA developed system-wide guidance for management of test results. We identified significant improvements related to diagnostic clinician communication and documentation of critical results compared with our previous review. However, compliance with VHA requirements needs to improve in the areas of written policies, monitoring the effectiveness of communication processes, and patient notification of critical and normal results.

Recommendations

Recommendation 1. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that facilities' written policies are comprehensive and define the processes for monitoring the effectiveness of communicating critical results to practitioners and patients.

Recommendation 2. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that ordering practitioners notify patients of all critical results within the defined timeframes.

Recommendation 3. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that practitioners notify patients of normal results and that managers monitor compliance.

Comments

The Under Secretary for Health concurred with the findings and recommendations. The implementation plan is acceptable, and we will follow up until all actions are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: August 5, 2011

From: Under Secretary for Health (10)

Subject: **OIG Combined Assessment Program Summary Report – Management of Test Results in Veterans Health Administration Facilities (VAIQ 7134066)**

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report and concur with the report's recommendations. Attached is the Veterans Health Administration (VHA) corrective action plan for the report's recommendations.

2. Thank you for the opportunity to review the draft report. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10A4A4) at (202) 461-7014.

(original signed by:)
Robert A. Petzel, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Combined Assessment Program Summary Report: Management of Test Results in Veterans Health Administration Facilities (VAIQ 7134066)

Date of Draft Report: July 10, 2011

Recommendations/ Actions	Status	Completion Date

Recommendation 1. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that facilities' written policies are comprehensive and define the processes for monitoring the effectiveness of communicating critical results to practitioners and patients.

VHA Comments

Concur

VHA Office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM) will reinforce policy in VHA Directive 2009-19, Ordering and Reporting Test Results, on notification of critical results during the Network Director and Chief Medical Officer (CMO) conference call.

In process September 30, 2011

The DUSHOM will establish a national monitoring tool to determine if policies are comprehensive and include effective processes, documenting treatment actions in response to the results as required by VHA Directive 2009-19, paragraph 4b(5)(d), for critical results notification to practitioners and patients. Veterans Integrated Service Networks (VISN) will be expected to provide leadership oversight and management to achieve compliance. The DUSHOM will follow-up with VISN leadership to ensure that corrections to local policies are in effect.

In process September 30, 2011

Recommendation 2. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that ordering practitioners notify patients of all critical results within the defined timeframes.

VHA Comments

Concur

The DUSHOM will reinforce VHA's policy on notification of critical results during the Network Director and CMO conference call.

In process September 30, 2011

The DUSHOM will publish a memorandum highlighting policy expectations and tasking VISN Directors with developing effective critical results follow up systems to mitigate patient safety risks. The Test Results Communication Workgroup (see rec. 3 below) will provide standardized recommendations and tools to ensure timely reporting of all results.

In process September 30, 2011

Recommendation 3. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that practitioners notify patients of normal results and that managers monitor compliance.

VHA Comments

Concur

The DUSHOM will reinforce VHA's policy on notification of results during the Network Director and CMO conference call.

In process September 30, 2011

The DUSHOM has already formed the Test Results Communication Workgroup to develop a standardized national approach for notification of results for all tests. The objectives of the workgroup are to develop:

- toolkit and guidance
- monitoring parameters and tracking methodology
- implementation and communication plan

The workgroup will also explore and recommend enterprise level technology solutions for patient notification and monitoring, tracking and trending.

The toolkit will be available January 31, 2012, and monitoring in accordance with the recommendations of the Workgroup will be ongoing.

In process	Tool Kit will be available January 31, 2012

Appendix B

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Contributors	Daisy Arugay, MT, Project Coordinator Annette Acosta, RN Lisa Barnes, MSW Paula Chapman, CTRS Jennifer Christensen, DPM Myra Conway, RN Kathy Gudgell, RN, JD Elaine Kahigian, RN, JD Gayle Karamanos, PA Cathleen King, RN Sarah Lutter, RN, JD JoDean Marquez, RN Jeanne Martin, PharmD Claire McDonald, MPA Karen Moore, RN Reba Ransom, RN Kathleen Shimoda, RN Carol Torczon, ACNP Cheryl Walker, NP Susan Zarter, RN

Appendix C

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