Department of Veterans Affairs
VA Pittsburgh Healthcare System
Pittsburgh, PA 15240

MEMORANDUM TX-144

April 6, 2017

REPORTING IMAGING STUDY RESULTS

I. PURPOSE

This Medical Center Memorandum defines the policy for reporting imaging test results to ordering and treating practitioners at this VA Pittsburgh Healthcare System which includes the campuses of University Drive and HJ Heinz and the community based outpatient clinics.

II. POLICY

Veterans Health Administration (VHA) is committed to reporting test results in a timely manner so that appropriate and effective therapeutic action may be taken.

III. DEFINITIONS

1. Diagnostic Practitioner: A 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. 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 and (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.

2. Ordering Practitioner: An ordering practitioner is a practitioner authorized to enter and sign orders for diagnostic tests by privileges or acting under a scope of clinical practice. 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 and (4) Communicating outpatient test results to patients in accordance with the established time frame standards. Time frame standards are 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 and 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).

a. **STAT** This order option is to be utilized **ONLY** when a patient's condition is deemed to be life threatening or a critical medical decision is dependent on the results of the study. In addition to the electronic request all STAT requests should be called into the Imaging Service. The STAT requests are to be completed and have results reported to the responsible clinician within 24 hours unless otherwise indicated.

b. **ASAP/URGENT** Problem is directly related to the acute medical illness; should be answered in a timely fashion, usually within 14 days of the CID. . For exams ordered as ASAP, which corresponds to the Urgent status in CPRS, the ordering provider is to communicate with the Imaging Service at the time order entry or at patient check our form the ordering provider's clinic.

c. **ROUTINE** A routine order reflects no time sensitive immediacy (although, if a specific date/time frame is warranted, that information should be stated within the order and that request will be accommodated when possible). A routine request should be completed within 30 days of the CID.

3. 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 /Critical Value or Result: 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.

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). 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.

4. 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.

IV. PROCEDURE

It is the policy of the VA Pittsburgh Healthcare System that imaging findings will be communicated to the ordering clinician within a timeframe that allows prompt attention and appropriate action. To assure that critical information is communicated to ordering clinicians in a timely manner, VA Pittsburgh Imaging Service will utilize the VISTA radiology package to notify providers of imaging results

A. Procedure for Critical Abnormal Results (Attachment A) by Imaging Reporting is:

1. Dictate the report into Power Scribe;

2. Enter Code 4 (Abnormality; attention needed) into the report.. This automatically generates a View Alert.

3. Sign the report;

4. Call the ordering physician (or if unavailable, the designated alternative provider) and document time, date, and physician contacted within the imaging report.

B. Procedure for Non-Critical Abnormal Results (Attachment A) Reporting

1. Dictate the report into Power Scribe.

2. Enter Code 4 (Abnormality: attention needed) which generates a View Alert.

3. Sign the report.

4. Ordering practitioner receives a View Alert in CPRS alerting them of abnormal exam results.

C. If the ordering provider cannot be reached, the result will be conveyed to another provider in that service so that he/ she can take appropriate action. If an alternate provider cannot be reached the following alternative provider protocol will apply:

1. Inpatient-The radiologist will contact the on call physician and provide him/her with the patient's name, exam ordered, and critical result. The radiologist will document in the radiology report the name of the person he/she spoke with, date and time, and initiate a View Alert by designating the report as a Code 4

2. Outpatient: The radiologist will contact the ordering provider. If the ordering provider cannot be reached, the applicable Service Chief will be contacted. If the Service Chief cannot be reached, the Service VP will be contacted. If the Service VP cannot be reached , the Chief of Staff (or their designee will be contacted The radiologist will document in the radiology report the name of the person he/she spoke with, the date and time, and initiate a View Alert by designating the report as a Code 4

V. RESPONSIBILITY:

A. Chief of Staff (COS):

1. Reviewing monitors of test result communication and ensuring that any identified performance improvement issues are addressed.
2. Resolving with service chiefs any gaps detected in test result follow-up processes.
3. Ensuring the facility clinical service chiefs establish a chain of responsibility within their department for receipt of test results and communication of results to patients.
4. Ensuring that the diagnostic practitioner or designee:
   a. Identifies and communicates expediently all critical, emergent, or abnormal test values or results to the ordering practitioner, the practitioner's surrogate or the supervisor, as appropriate.
   b. Ensures that verified test results reports are available in the patient's electronic medical record in a timely manner.

c. Documents the time and means of such communication and the name of the practitioner contacted, in the medical record. This documentation is not required for abnormal tests that are not critical or emergent.

5. Ensuring that the ordering practitioner:

a. Places the initial order, includes the appropriate contact information and identifies the surrogate practitioner, when applicable.

b. Ensures that providers enter the correct Clinically Indicated Date (CID) for exams and discontinue orders when the study is no longer clinically indicated.

c. Initiates appropriate clinical action and follows up the results of any orders which they have placed.

d. Assigns a qualified surrogate practitioner to receive critical, emergent, 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.

e. Documents treatment actions in response to critical, emergent, or abnormal test results in the patient's electronic medical record.

f. Communicates outpatient test results to patients in accordance VHA standards

B. The Chief of Imaging Service and the section chiefs will be responsible for developing and updating criteria and critical results/values for Imaging Service annually.

C. The Imaging Service Line is responsible for reporting critical test results and monitoring compliance

1. Measurement requirements will include verification of documentation of physician to physician contact for critically abnormal results (diagnostic code 4) and evaluate the timeliness of reporting the critical results of tests and diagnostic procedures. All imaging reports coded as 4 will be monitored by the Administrative Officer for the Imaging Service Line, or their designee. The Administrative Officer will determine if a telephone call to the referring provider was documented appropriately with date and time reflected on the imaging report. The standard for compliance is 100%. Additionally, the Chief of Imaging, or designee, will review 100% of all code 4 imaging reports to evaluate clinical content and appropriate clinical response. Results of the monitors will be reported quarterly to the medical center leadership. Deficiencies will be reported to the appropriate service line chief and / or the chief of staff immediately.

2. The Imaging Department ADPAC will generate through the Radiology package in VISTA a monthly listing of the imaging reports which have been identified as critical results. In the absence of the ADPAC the Administrative Officer for Radiology, Nuclear Medicine, and Radiation Therapy will assign a properly trained alternate to perform this function.

3. The ADPAC will also provide monthly summary reports of Critical Test Results (CTR) and associated statistics to determine the effectiveness of the CTR responses. These reports will be provided to the Chief of Imaging as wel toQuality and Patient Safety

4. A summary of the daily results will be prepared quarterly for reporting to Quality and Patient Safety.

VI REFERENCES

VHA DIRECTIVE 1088 – Communicating Test Results to Providers and Patients, October 7, 2015 American College of Radiology Standard for Communication: Diagnostic Radiology

The Joint Commission Comprehensive Accreditation Manual

VII. RESCISSION

Memorandum TX-144 dated August 6, 2015.

VIII. CONCURRENCES

001, 002, 11, 11D, 00S, 00B, All Service Line VP's, AFGE 2028

IX. EXPIRATION DATE

This memorandum will automatically expire on April 6, 2020.

//Signed//
KARIN MCGRAW, MSN, FACHE
Medical Center Director

Attachment A: Reporting of Critical Results

Attachment A
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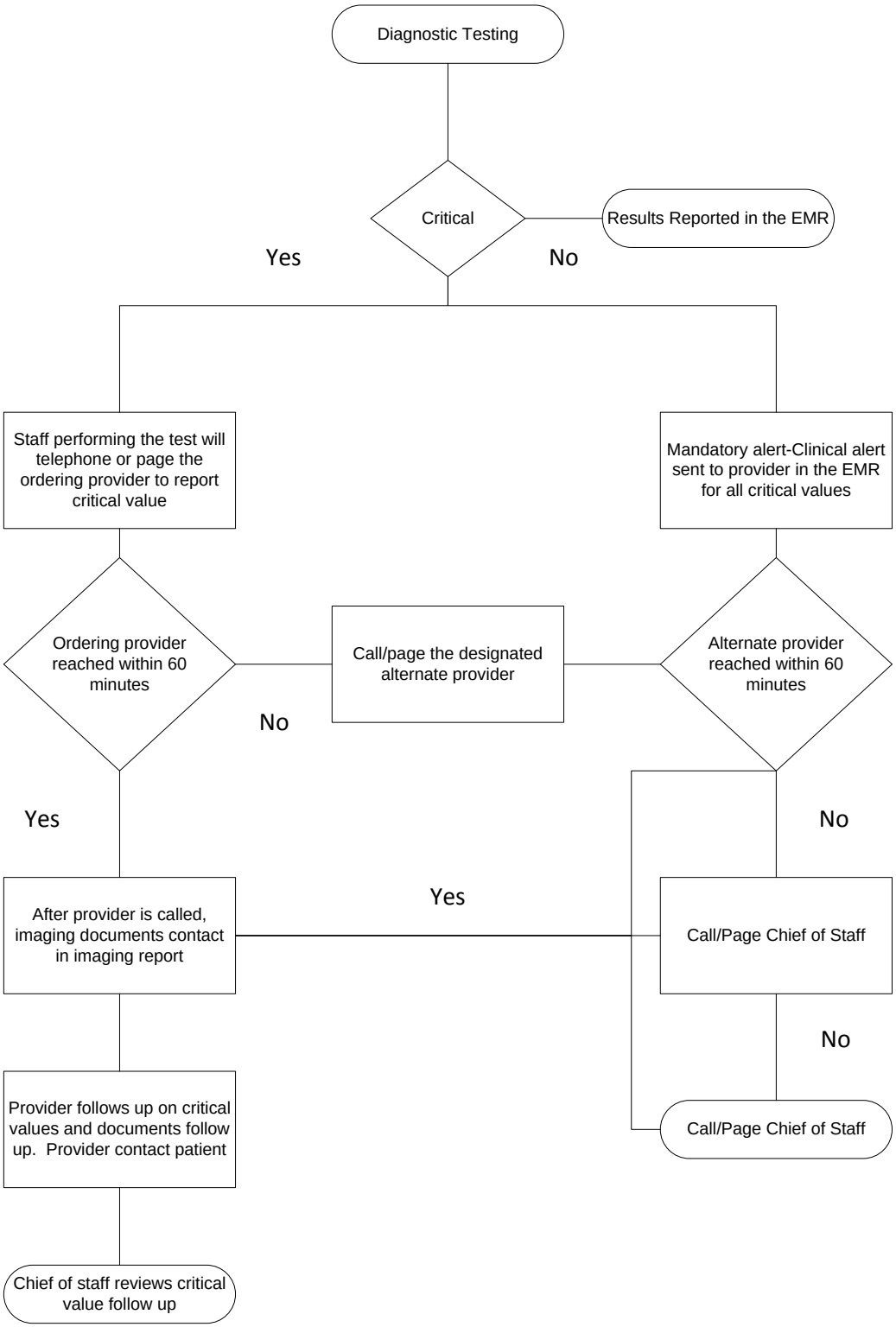
REPORTING OF CRITICAL RESULTS

The following are considered to be critical findings and will generate a telephone call from the Radiologist to the responsible physician and or surrogate as outlined in this policy:

1. New pneumothorax
2. Significant line / tube misplacement
4. Mediastinal emphysema
5. New and /or significant pericardial effusion
6. Unexpected abdominal abscess
7. Intraoperative foreign body
8. Acute traumatic visceral injury
9. Acute volvulus (definite)
10. Retroperitoneal hemorrhage
11. Diverticulitis
12. Unexpected pancreatitis
13. Unexpected bowel or biliary obstruction
14. Acute cholecystitis
15.New bone fracture
16. New bone infection
17. Bone lesion at risk for pathological fracture
18. Discitis
19 Acute myocardial infarction / ischemia
20. Life threatening arrhythmias
21. Hypertensive crisis
22. Active GI bleed


Diagnostic Testing
Critical
Results Reported in the EMR
Yes
No
Staff performing the test will telephone or page the ordering provider to report critical value
Mandatory alert-Clinical alert sent to provider in the EMR for all critical values
Ordering provider reached within 60 minutes
Call/page the designated alternate provider
Alternate provider reached within 60 minutes
No
Yes
No
After provider is called, imaging documents contact in imaging report
Yes
Call/Page Chief of Staff
No
Provider follows up on critical values and documents follow up. Provider contact patient
Call/Page Chief of Staff
Chief of staff reviews critical value follow up