State of Washington
Medical Quality Assurance Commission

Guideline

Title:	Communicating Test Results to Patients	GUI2016-02
References:	N/A	
Contact:	Michael Farrell, JD, Policy Development Manager	
Phone:	(509) 329-2186	E-mail: michael.farrell@doh.wa.gov
Effective Date:	November 4, 2016	
Approved By:	Warren Howe, MD, Chair (signature on file)	

Background

Patients deserve to receive their test results and an adequate explanation of the results in a timely manner. The failure to do so can cause unnecessary worry and, in some cases, lead to serious consequences for the patient. It can also lead to a complaint to the Commission. Unfortunately, studies confirm the Commission's experience that many practices do not have good systems in place.[1]

In 2011, the Commission issued a guideline on the "Transmission of Time Critical Medical Information" focusing on practitioners' obligation to communicate critical test results to other practitioners. http://www.doh.wa.gov/Portals/1/Documents/3000/MD2015-02TransOfTimeCritMedInfoApproved1-9-2015.pdf

The Commission issues these guidelines to assist practitioners to communicate test results directly to patients.

Guidelines

All practitioners should have an effective system that will ensure timely and reliable communication of test results to patients and appropriate follow up. While the system will vary depending on the type of practice, the Commission recommends that it be in writing and, at a minimum, contain the following elements:

1. Clear definitions to distinguish between test results that are routine and test results that are critical.
2. A mechanism by which the ordering physician is notified of the receipt of critical test results from the diagnosing physician.

[1] Elder N, McEwen T, Flach J, Gallimore J, Management of Test Results in Family Medicine Offices, *Ann Fam Med.* 2009 Jul;7(4):343-351. https://www.ncbi.nlm.nih.gov/pubmed/19597172

3. A process to communicate the test results to the patient in a manner-- whether in writing, electronic, telephonic or in person-- that ensures the patient receives the test results.
    a. The communication should be in a format and in language that is easily understood by the patient.
    b. The practitioner should document in the medical record who made the communication, how the communication was made, and when the communication was made.
    c. The communication should comply with the privacy requirements of the Health Insurance Portability and Accountability Act and Washington State law.
4. Confirmation that the patient received the test results. Verification of receipt should be documented in the medical record.
5. Clear instructions to the patient to enable the patient to contact the practitioner and ask questions about the test results and schedule a follow up appointment with the practitioner. The instructions should be documented in the medical record.
6. If the test results indicate that treatment may be necessary, the ordering practitioner should discuss potential options with the patient and initiate treatment.
7. When the ordering practitioner is unavailable, there must be a qualified designee who will assume responsibility to receive test results, notify the patient, and initiate appropriate clinical action and follow up.
8. The system should not depend solely on the attentiveness of human beings, but be backed up by technology that prevents test results from being missed, lost or inadequately communicated to the ordering physician or to the patient.

Resources

Communicating Test Results to Providers and Patients, Department of Veterans Affairs, Veterans Health Administration, VHA Directive 1088. October 7, 2015. file://doh/user/fr/mlf1303/Desktop/1088_D_2015-10-07.pdf

Hanna D, Griswold P, Leape L, Bates D, Communicating Critical Test Results: Safe Practice Recommendations, Journal of Quality and Patient Safety, Feb 2005: Volume 31 Number 2, 68-80. https://www.ncbi.nlm.nih.gov/pubmed/15791766