crico | are you safe?

Overview

More and more, health care is delivered at an office-based setting. For patients, clinicians, and non-clinical staff, the safety culture and systems underlying office-based care varies significantly from inpatient care—and from one practice to another. Through its Office Practice Evaluation (OPE) program and analysis of medical malpractice case data, CRICO and its primary care community identified six key safety principles in primary care. In concert with clinical experts and experienced office-based providers, CRICO produces *Are You Safe?* to help practices understand and address potential risks to patient safety via malpractice data and case examples.

The *Are You Safe?* case studies are designed to help all members of the team reduce the risk of patient harm in the course of diagnosis and treatment. Office-based events that trigger malpractice cases present valuable opportunities to identify vulnerabilities in communication, clinical judgment, and patient care systems. *Are You Safe?* is designed to meet the following objectives:

- Highlight common office-based malpractice risks
- Explore areas of improvement in your practice

FOCUS

Are You Safe? case studies are being developed for specific risks organized under a broader outline of six key safety principles in primary care:

- Establish and sustain a culture of safety
- Build and support effective teams
- Partner with patients and families in their care
- Ensure closed-loop processes for referrals and tests
- Develop systems for reliable diagnosis and delivery of evidence-based care
- Standardize communication among all care providers

Each *Are You Safe?* case study focuses on a single area of risk, but addresses issues that arise across a range of patient presentations, diagnoses, and clinical scenarios.

USING THE *ARE YOU SAFE?* CASE STUDIES

Download a PowerPoint

In addition to the two-page worksheet, CRICO has produced PowerPoint presentations for use by providers and practice staff interested in sharing one (or more) of the *Are You Safe?* case studies with colleagues. The PowerPoint presentations include additional data and complementary information. *Are You Safe?* presentations can be downloaded from the CRICO website.

Additional Resources

For each *Are You Safe?* case study, additional related materials developed by CRICO and other leaders in patient safety are made available on our website: www.rmf.harvard.edu/areyousafe. These include:

- CME bundles
- Podcasts
- Clinical decision support tools
- Patient safety alerts
- Additional case studies

Earn Category 2 Risk Management Credits

Each *Are You Safe?* case study is suitable for 0.25 Category 2 risk management credit for MA physicians. Practices may be able to earn additional CME credits by developing education sessions that employ multiple cases along with pre- and post-course testing.

Participation and Feedback

CRICO hopes the *Are You Safe?* case studies will help raise awareness about the patient safety issues that most commonly put patients and providers at risk. We know that you are our best source for what does and does not work in everyday practice, and we encourage you to share your ideas, concerns, and innovations with us and your peers across the CRICO-insured community.

Email comments, resources, or questions to areyousafe@rmf.harvard.edu.

Overview, continued

CASE STUDY COMPONENTS

Closed Malpractice Cases

The *Are You Safe?* case examples are drawn from actual events. Every case in the CRICO database is coded to catalogue what happened, and why. The provider-based and systems-based factors that led to the allegation of malpractice are the underpinning of CRICO's patient safety initiatives, and drive the case selection process.

Patient Safety Vulnerabilities

For each malpractice case presented, the *Are You Safe?* case studies identifies two or three key vulnerabilities exposed by the event. For each, Safer Care recommendations are included. These vulnerabilities and recommendations are designed to guide the risk assessment process for individuals or teams reviewing each module.

Data

Our goal is to present data and case examples that help caregivers anchor the underlying issues that pose risk to patients and providers. The data are drawn from malpractice cases filed against CRICO-insured providers as well as from our national comparative benchmarking system (CBS) repository of more than 350,000 claims and suits.

Quick Assessment: Could it Happen Here?

Each *Are You Safe?* case study features a quick assessment: 4–5 questions related to the closed malpractice case and the underlying patient safety issues. While each features topic-specific questions, all begin with "Has this type of event happened at our practice?" Providers and practice staff can complete the quick assessment either individually or, ideally, as a team.

Improvement Opportunities

Each *Are You Safe?* case study offers members of a practice or care team the opportunity to assess how their systems and protocols align with recommended practices. For those instances where there is a worrisome gap between the current state and a recommended practice, this exercise provides a chance to discuss how to close that gap.

Improvement Opportunities Matrix

Each *Are You Safe?* case study includes a list of recommended practices related to the patient safety vulnerabilities identified in malpractice data and case examples. Practices are encouraged to compare their current practice to the recommended practice and, if necessary, explore possible improvements.

RECOMMENDED PRACTICE	CURRENT STATE	HOW TO IMPROVE (IF NECESSARY)
Most often, the "recommended practice" is a general concept rather than a specific tool or methodology. This enables providers and practices to focus on the intended result rather than the approach. While the CRICO Are You Safe? modules offer suggestions for assessing and addressing patient safety, they should not be construed as a standard of care.	For the gap analysis to be productive, the current state ("how we do things now") should be compared to the identified recommended practices. To be most dynamic, this should be explored from a variety of perspectives—either by soliciting input from a cross-section of clinical and non-clinical staff, or via group discussion.	While some improvements may lend themselves to a quick fix, practices are likely to identify issues that require more time and thought. Addressing one issue at a time might be more productive than taking on too many improvements at once.

CRICO's mission is to provide a superior medical malpractice insurance program to our members, and to assist them in delivering the safest health care in the world. CRICO, a recognized leader in evidence-based risk management, is a group of companies owned by and serving the Harvard medical community.

Should I use a decision support tool?

RISK: FAILURE TO DIAGNOSE

Inadequate management of a patient-detected breast lump

Closed Malpractice Case

During an appointment for a self-detected breast lump, a 34-year-old's physical exam was noted as normal. The gynecologist ordered a mammogram, but did not indicate the patient's breast complaint on the order. Four months later, a *screening* mammogram was done and reported as "normal," with a note of "very dense stromal pattern," which reduces sensitivity for cancer detection. The radiologist did not recommend an ultrasound; the gynecologist received the report with no recommendation for further testing.

Nine months later, the patient returned to her gynecologist complaining of the same breast lump. The physician palpated the lump on exam and ordered a *diagnostic* mammogram and a surgical consult. Subsequent work up revealed breast cancer. The patient underwent a radical mastectomy and axillary node dissection, and was found to have metastases to the spine. The patient's positive family history of breast cancer was not recorded until after her diagnosis.

Diagnostic Process of Care in Ambulatory Diagnosis Cases*

Inadequate patient assessment is a contributing factor in 35% of CRICO (31% of CBS) ambulatory cases alleging a missed or delayed diagnosis.

	PERCENT OF CASES**	
STEP	CRICO (N=175)	CBS† (N=2,919)
1. Patient notes problem and seeks care	1%	1%
2. History and physical	10%	8%
3. Patient assessment/evaluation of symptoms	35%	31%
4. Diagnostic processing	43%	35%
5. Order of diagnostic/lab test	40%	31%
6. Performance of tests	5%	3%
7. Interpretation of tests	37%	23%
8. Receipt/transmittal of test results to provider	4%	5%
9. Physician follow up with patient	21%	18%
10. Referral management	13%	21%
11. Provider-to-provider communication	12%	12%
12. Patient compliance with follow-up plan	14%	17%

* Cases with claim made date 1/1/11–8/31/16

** A case will often have multiple factors identified

† CBS is CRICO's Comparative Benchmarking System

Patient Safety Vulnerabilities

1. Failure or delay in ordering (appropriate) diagnostic tests, consults, or referrals can lead to missed or delayed diagnosis.

   SAFER CARE: Prioritize efforts to decrease diagnosis-related harm through use of decision support tools such as the *CRICO Breast Care Management Algorithm*.

2. Failure to regularly update pertinent family history can lead to missed identification of patients for increased risk related to that history.

   SAFER CARE: Consider using a checklist or templates for details that are often overlooked (i.e., family history) but can be relevant for improving diagnostic reasoning.

Should I use a decision support tool? (continued)

Quick Assessment

1. Has this type of event happen at our practice?
2. Does our clinical team use disease-specific recommended guidelines? Which ones? (e.g., *CRICO Breast Care Management Algorithm)*
3. Are the guidelines readily accessible?
4. How do we incorporate recommended guidelines into our provider education and practice?

Improvement Opportunities

RECOMMENDED PRACTICE	CURRENT STATE	HOW TO IMPROVE (IF NECESSARY)
1. Identify clinical guidelines for all practice providers		
2. Educate staff regarding implementation of practice guidelines		
3. Periodic audits to measure compliance with guidelines		
4. A systems-based process to identify that patients undergo recommended tests per guidelines		

CRICO *Are You Safe?* materials are designed to help all members of a multidisciplinary team reduce the risk of patient harm in the course of diagnosis and treatment. Office-based events that trigger malpractice cases present valuable opportunities to identify vulnerabilities in communication, clinical judgment, and patient care systems. Successful practices shared by local and national peers inform the *Are You Safe?* recommendations. CRICO works closely with your organization's Patient Safety and Risk Management staff to build expert resources for individual and team-based education and training.

Email comments, resources, or questions to areyousafe@rmf.harvard.edu.

Additional Resources

www.rmf.harvard.edu/safercare

Please visit the CRICO website for related:

- CME Bundles
- Podcasts
- Clinical Decision Support
- PowerPoint presentations to share with your team
- Patient Safety Alerts
- Additional topics in the *Are You Safe?* series

How to Earn Category 2 Risk Management Credits

This *Are You Safe?* case study is suitable for 0.25 Category 2 risk management credit for Massachusetts physicians. Risk Management Study is self-claimed; complete, date, and retain this page for your record keeping.

About CRICO

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