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.

Who is responsible for follow up?

RISK: UNRECONCILED SPECIALIST OPINION/RECOMMENDATION

Lack of follow up with patient due to inadequate office practice system to reconcile record from specialist visits

Closed Malpractice Case

A 74-year-old male was advised, during a hospital stay, to see a pulmonologist for a specific opacity in his right upper lobe suspicious for carcinoma seen on a CT scan. The patient was seen shortly thereafter by his PCP, who made a referral to a pulmonologist. The PCP saw the patient for regular visits for the next four years, but was not aware of the pulmonologist's recommendation for additional follow up regarding the lung concern. At age 78, the patient was diagnosed with stage IV lung cancer and died three months later.

Diagnostic Process of Care in Ambulatory Diagnosis Cases*

A mismanaged referral is a contributing factor in 13% of CRICO (21% 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. If referrals fail to reach the office, patients, or specialists, or if the information is not integrated into the care plan, patients may be at risk.

   SAFER CARE: To avoid "person specific" referral management, develop reliable processes to ensure 1) patients are referred to specialists in a consistent manner, 2) outstanding visits are followed up, and 3) specialist reports are brought to the attention of the patient and the care team.

2. Communicate clearly with patients your clinical reasons for referrals and their urgency. Breakdowns in communication with the patient regarding test results, change in medical status, and when to return for unresolved concerns can lead to poor patient outcomes.

   SAFER CARE: When all parties are involved in referral transactions they reduce the opportunities for patients (or reports) to fall through the cracks. Inadequate systems for closed-loop communications of referrals can lead to gaps in patient care. Build a redundant system incorporating all members of the care team, including the patient.

 The CRICO *Are You Safe?* case studies offer suggestions for assessing and addressing patient safety and should not be construed as a standard of care.

Who is responsible for follow up? (continued)

Quick Assessment

1. Has this type of event happened at our practice?
2. What did the providers in this case do well? Where did communication breakdown (or where did things go wrong)?
3. What is our system for referral management? What role does each team member (including the patient) play?
4. How do we communicate high-priority referrals to the clinical team and patient?
5. Do we document all patient communication in the medical record?

Improvement Opportunities

RECOMMENDED PRACTICE	CURRENT STATE	HOW TO IMPROVE (IF NECESSARY)
1. Referrals are ordered and documented in the EHR		
2. The reason and urgency for the referral is communicated to the patient and specialist, and an appointment is made for the patient prior to leaving the office		
3. A procedure to identify which referrals are outstanding		
4. A system to track and log completed referrals		
5. Provider review of all incoming referrals is tracked		

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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

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.

