crico | Protecting Providers. Promoting Safety.

Are You Safe?

Patient safety risks for office-based practices

Closing the Loop:
Am I sure my patient got the test I ordered?

Opportunities for Improving Patient Safety

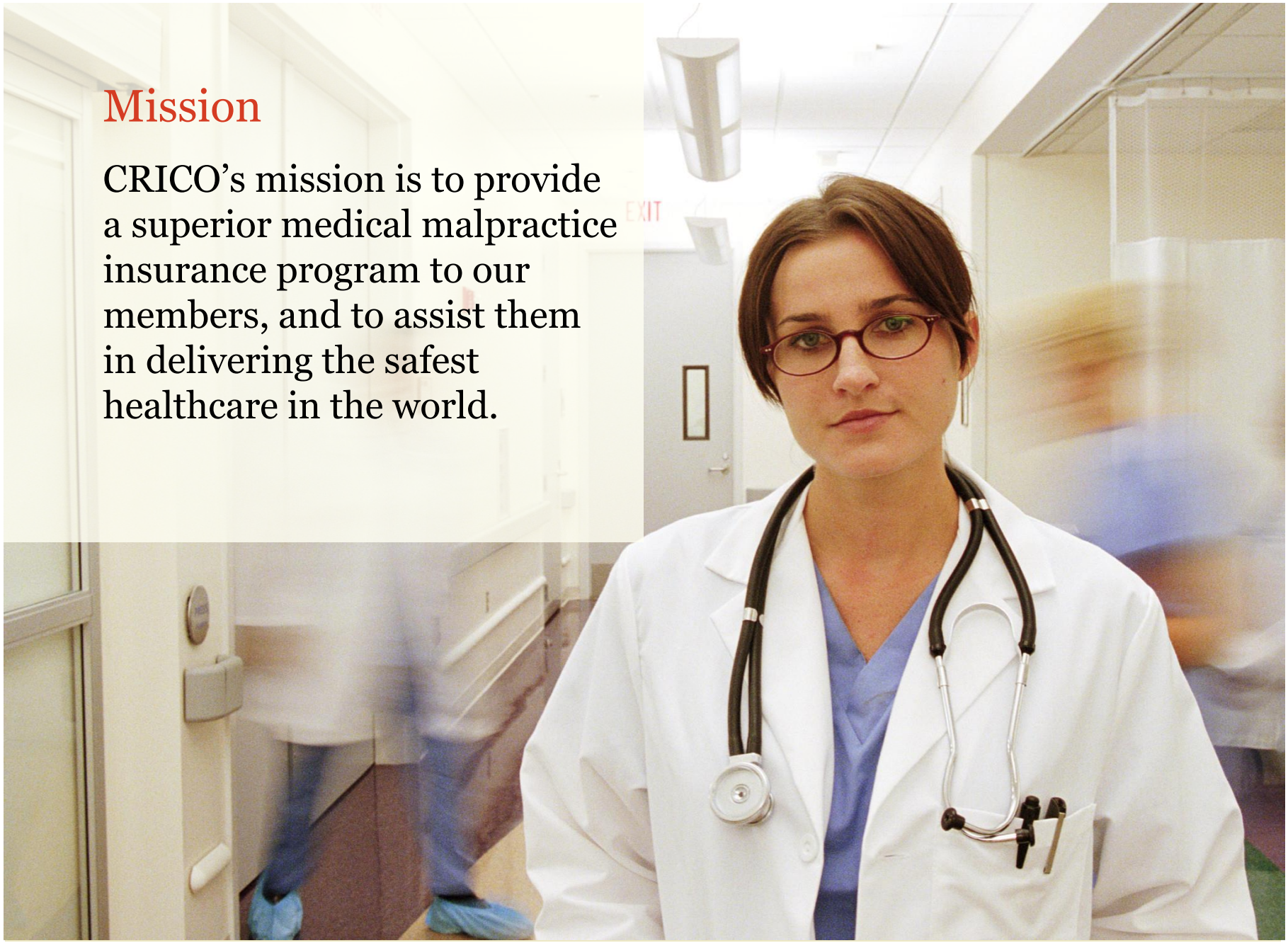
- **Identified through** CRICO's Office Practice Evaluation program and analysis of medical malpractice case data
- **Based on** real events that have triggered malpractice cases
- **Valuable lessons** in communication, clinical judgment, and patient care systems

Purpose

- Help all members of office-based teams reduce the risk of patient harm in the course of diagnosis and treatment.
- Raise awareness and begin discussions about the patient safety issues that most commonly put ambulatory care patients and providers at risk.

Mission

CRICO's mission is to provide a superior medical malpractice insurance program to our members, and to assist them in delivering the safest healthcare in the world.



Controlled Risk Insurance Company (CRICO)

- Captive insurer of the Harvard medical institutions
- Provides member organizations medical professional liability, general liability and other insurance coverage for:
  - 13,000+ physicians *(including 3,500 residents and fellows)*
  - 25 hospitals
  - 100,000+ employees (nurses, technicians, etc.)
- Services include underwriting, claims management, and patient safety improvement
- CRICO has been analyzing medical malpractice data to drive risk mitigation for more than 30 years

CRICO Member Organizations

- Atrius Health
  - Dedham Medical
  - Granite
  - HVMA
- Boston Children's Hospital
- Cambridge Health Alliance
- CareGroup
  - Beth Israel Deaconess Medical Center
  - Beth Israel Deaconess Needham
  - Beth Israel Deaconess Milton
  - Mount Auburn Hospital
  - New England Baptist Hospital
- Dana-Farber Cancer Institute
- Harvard Pilgrim Health Care
- Presidents and Fellows of Harvard College
  - Harvard Medical School
  - Harvard School of Dental Medicine
  - Harvard T. H. Chan School of Public Health
  - Harvard University Health Services
- Joslin Diabetes Center
- Judge Baker Children's Center
- Massachusetts Eye and Ear Infirmary
- Massachusetts Institute of Technology
- Partners HealthCare System
  - Brigham and Women's Hospital
  - Brigham and Women's Faulkner Hospital
  - Massachusetts General Hospital
  - McLean Hospital
  - North Shore Medical Center
  - Newton-Wellesley Hospital
  - Spaulding Rehabilitation Hospital

Malpractice Data Overview

Focus: Ambulatory Diagnosis-related Allegations

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46% of CRICO malpractice cases occur in the ambulatory setting.

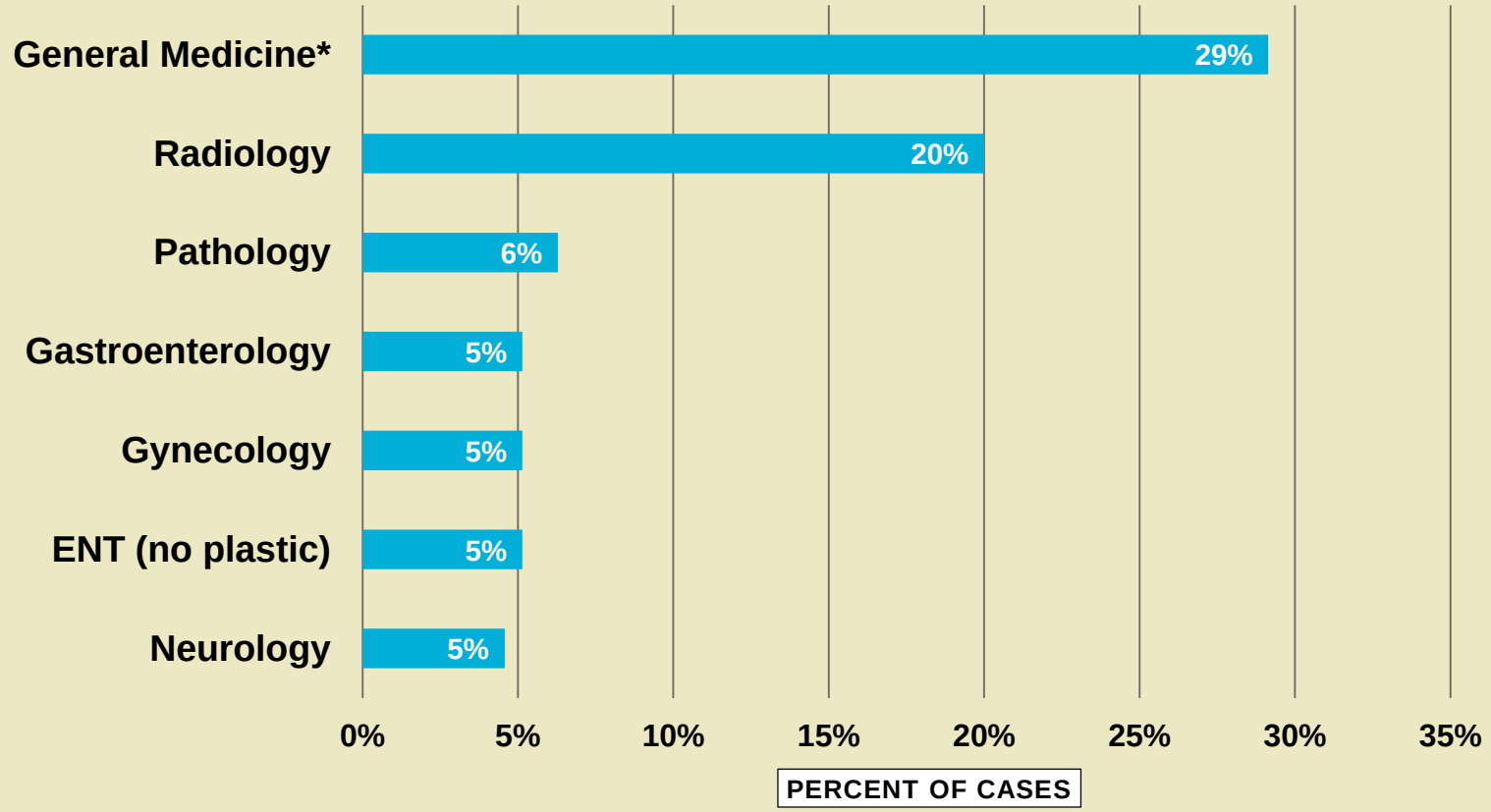
38% of ambulatory cases allege a wrong or delayed diagnosis.

*Losses are “total incurred losses,” which includes reserves on open and payments on closed cases.

**Ambulatory care cases involve an outpatient but exclude cases occurring in Emergency departments. CRICO N=175 MPL cases with claims made date1/1/11 – 8/31/16.

General Medicine and Radiology are most frequently involved.

The Clinical Service Responsible for the Patient's Care at the Time of the Event

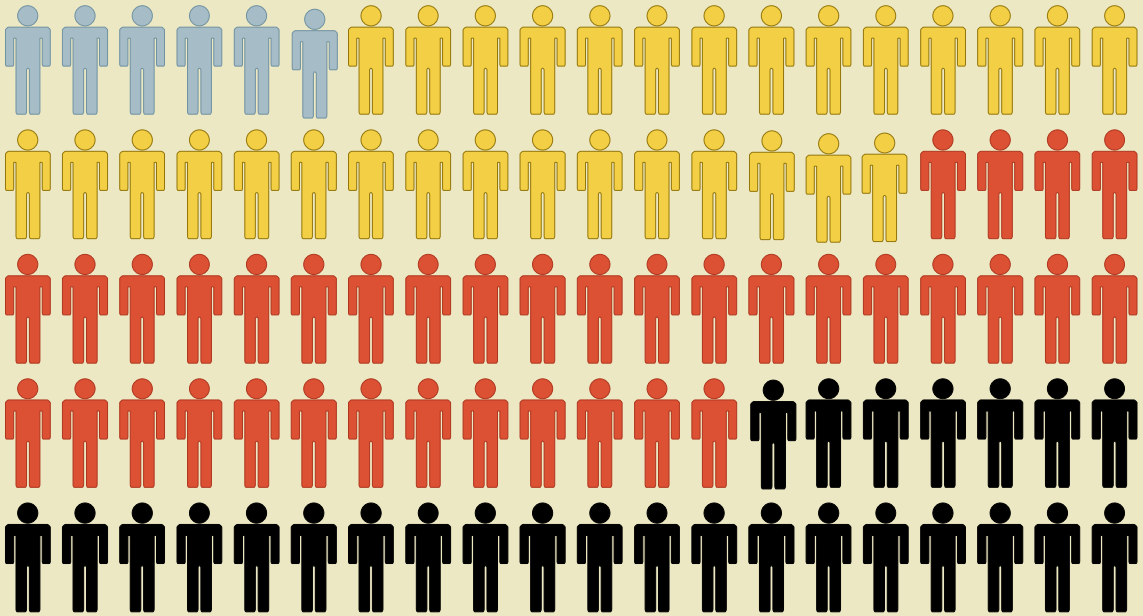


CRICO N=175 MPL cases with claim made date 1/1/11–8/31/16 involving ambulatory care and alleging diagnostic failure.

*General Medicine includes Internal Medicine and Family Practice.

Two-thirds of cases involve permanent injury or death.

Injury Severity in Ambulatory Diagnosis Cases



6% low

30% medium

64% high

including death

CRICO N=175 MPL cases with claim made date 1/1/11–8/31/16 involving ambulatory care and alleging diagnostic failure.

Severity Scale: High=Death, Permanent Grave, Permanent Major, or Permanent Significant
Medium=Permanent Minor, Temporary Major, or Temporary Minor
Low= Temporary Insignificant, Emotional Only, or Legal Issue Only

60% of 175 ambulatory diagnosis-related cases involve a missed/delayed cancer diagnosis

- The top ambulatory diagnosis-related allegations in CRICO ambulatory malpractice cases are:
  - Cancers (top three: breast, lung, colorectal)
  - Diseases of the heart
  - Fractures

Case Study: Closing the Loop

Am I sure my patient got the test I ordered?

The following example is from a closed malpractice case.

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CRICO maps contributing factors to the way care is experienced by the patient.

CRICO Diagnostic Process of Care

STEP	CRICO % CASES	CBS % CASES
1. Patient notes problem and seeks care	1%	1%
2. History/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%

*A case will often have multiple factors identified.

CRICO N=175 MPL cases with claim made date 1/1/11–8/31/16 involving ambulatory care and alleging diagnostic failure.

CBS (Comparative Benchmarking System) includes >300,000 medical malpractice cases across the nation

CBS N=2,919 MPL cases with claim made date 1/1/11–8/31/16 involving ambulatory care and alleging diagnostic failure.

Malpractice case study focus: Test Result Management

4%
of cases

had a test result management error identified as a contributing factor, i.e., receipt/review of test result by ordering physician is not completed or is significantly delayed

CRICO N=175 MPL cases asserted 1/1/11–8/31/16 involving ambulatory care and alleging diagnostic failure.

Case Study

Patient

Henry, 62-year-old male w/40-year history of smoking (1-2ppd)

Day 1

Henry is seen in his PCP's office for a complaint of chest pain after hearing his rib "crack." His physician orders a chest X-ray.

Case Study

Henry, 62-year-old smoker

Day 1 (continued)

- The radiologist's report notes a 3 x 1.5cm mass on Henry's left lung, and recommends CT for further evaluation.
- The PCP's office test-tracking system requires that Henry's medical record be placed in a "pile" for outstanding results.
- Henry's chart is filed without review of the X-ray results. No CT scan is ordered.

Case Study

Henry, 62-year-old smoker

One year later

Henry returns to his PCP with complaint of cough, chest pain, congestion (for the past month). An X-ray identifies enlargement of the mass seen in the previous image.

Case Study

Henry, 62-year-old smoker

Outcome

Henry is diagnosed with Stage IV adenocarcinoma with metastasis to his brain. A year later, he dies.

Case Study

Henry, 62-year-old smoker

Vulnerability

Communication with the radiologist to ensure follow up of a concerning finding did not occur.

Safer Care Recommendation

Assure that concerning test results are brought to the attention of the primary care team. Validation that the result has been received is a critical step to ensure that results have been reviewed by the correct parties. Designated staff may help manage the process.

Case Study

Henry, 62-year-old smoker

Vulnerability

The PCP's test-tracking system failed.

Safer Care Recommendation

Providers are responsible for overseeing office-based processes. Designated staff may help manage the process in order to ensure that all relevant tests are reviewed, however, no one can act on unseen results. Establish criteria for successful closure of normal and abnormal results, and audit compliance.

Practice Assessment

Has this type of event ever happened here?

Practice Assessment

Closing the Loop

Where did communication break down in this case? How can we improve information transfer?

Recommended Practice

An alert system for test results requiring review.

Practice Assessment

Closing the Loop

What is our system to ensure patients complete recommended testing?

Recommended Practice

A redundant system to identify that patient had recommended test.

Practice Assessment

Closing the Loop

How is the ordering provider's review/ acknowledgement of outstanding imaging studies and other tests reconciled?

Recommended Practices

- A system to monitor receipt of all test results.
- Confirm physician review of critical test results and critical specialist reports before filing.

Practice Assessment

Closing the Loop

How do we communicate results (normal and abnormal) to the patient/family?

Recommended Practice

A process to notify the patient of all results, normal and abnormal.

Practice Assessment

Closing the Loop

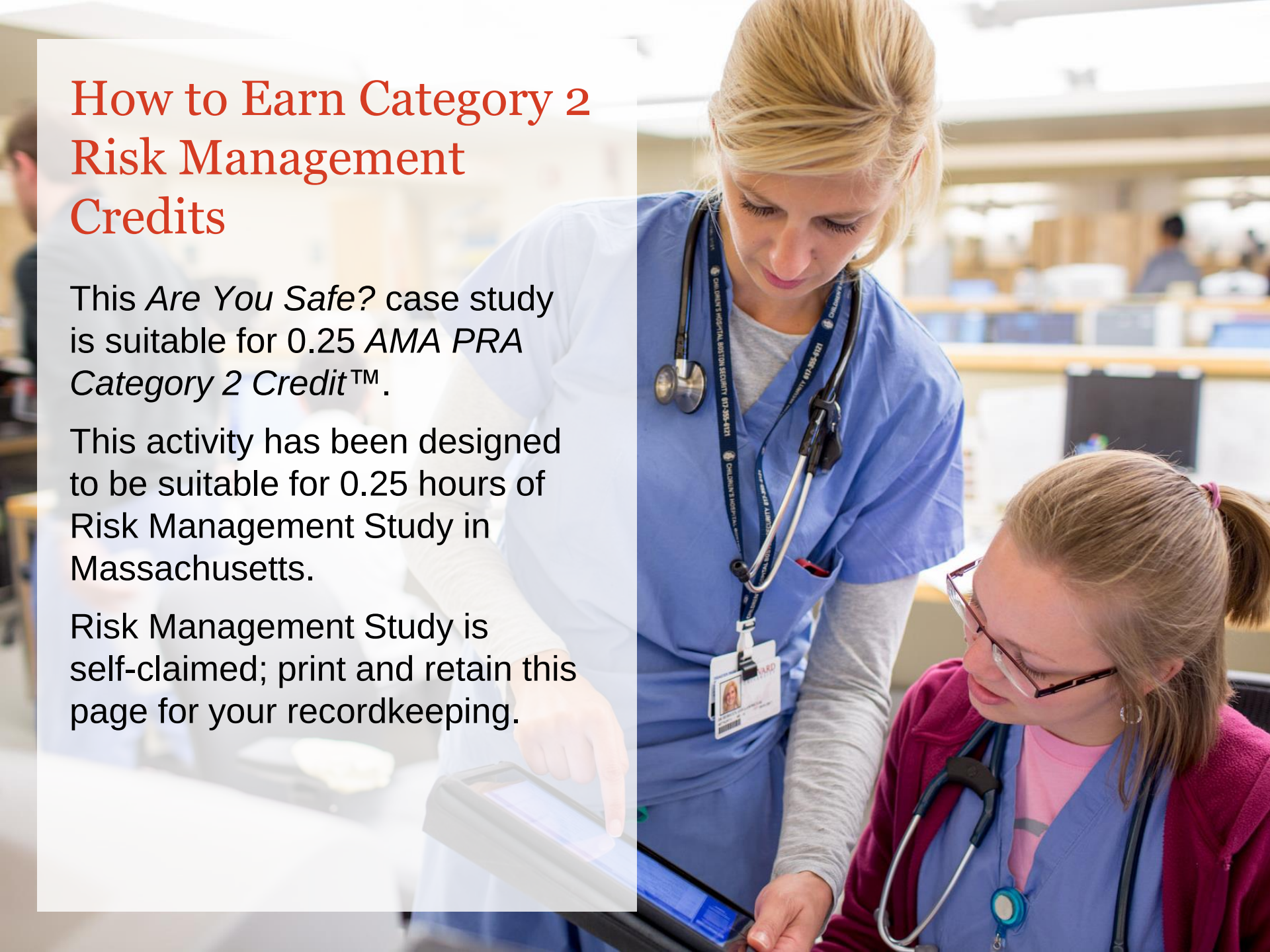
What else can we do to avoid a similar event?

How to Earn Category 2 Risk Management Credits

This *Are You Safe?* case study is suitable for 0.25 *AMA PRA Category 2 Credit*™.

This activity has been designed to be suitable for 0.25 hours of Risk Management Study in Massachusetts.

Risk Management Study is self-claimed; print and retain this page for your recordkeeping.



Additional Resources

Closing the Loop:
Am I sure my patient got the test I ordered?

Are You Safe? extras

For more information

Email

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