crico | Protecting Providers. Promoting Safety.

Are You Safe?

Patient safety risks for office-based practices

Partnering with Patients:

Does my patient know why I ordered this test?

Opportunities for Improving Patient Safety

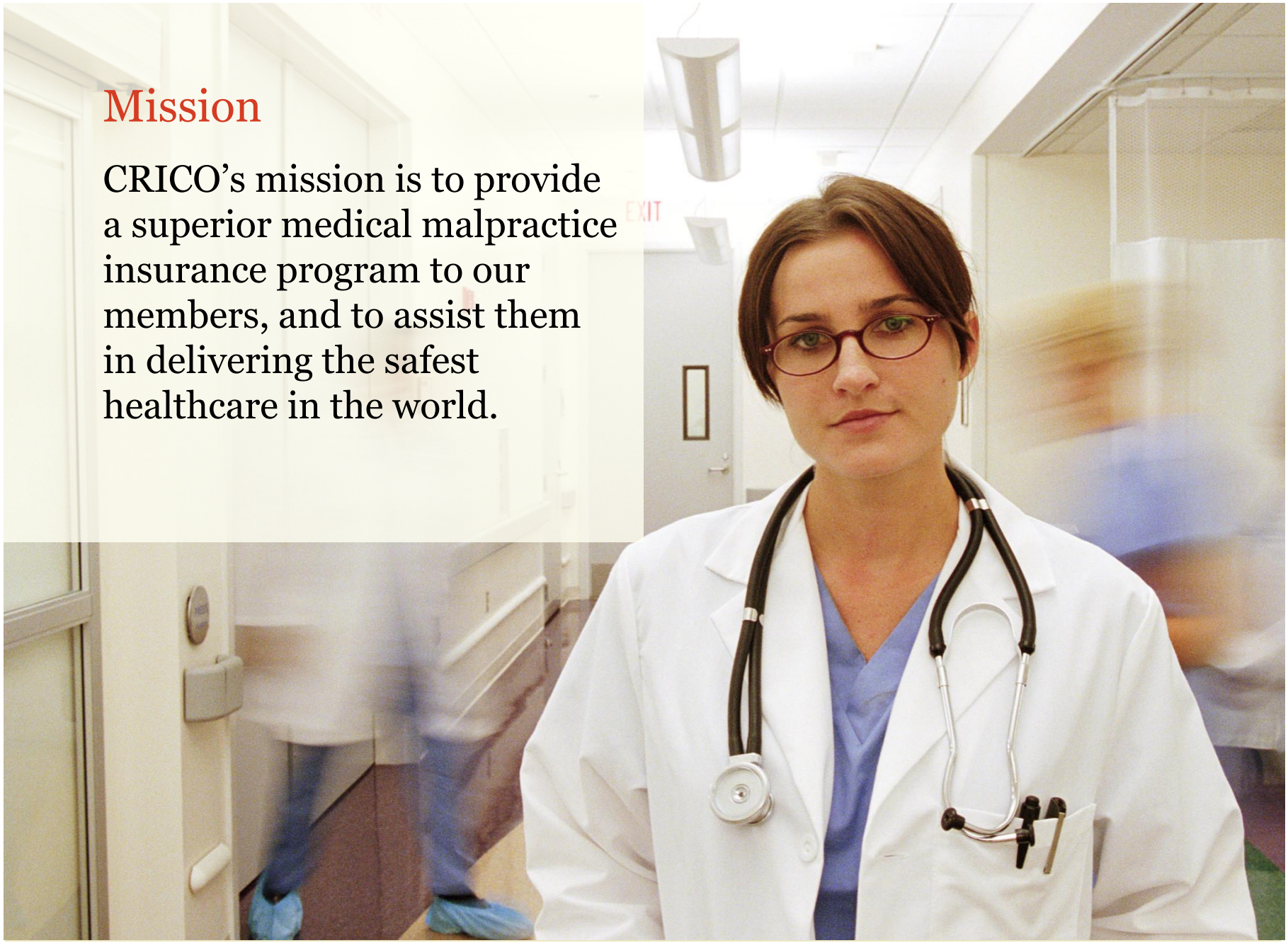
- **Identified through** CRICO's Office Practice Evaluation program and analysis of medical malpractice case data
- **Based on** real events that have triggered malpractice cases
- **Valuable lessons** in communication, clinical judgment, and patient care systems

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:
  - 12,400+ physicians *(including nearly 4,000 residents and fellows)*
  - 32 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

crico | are you safe?

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

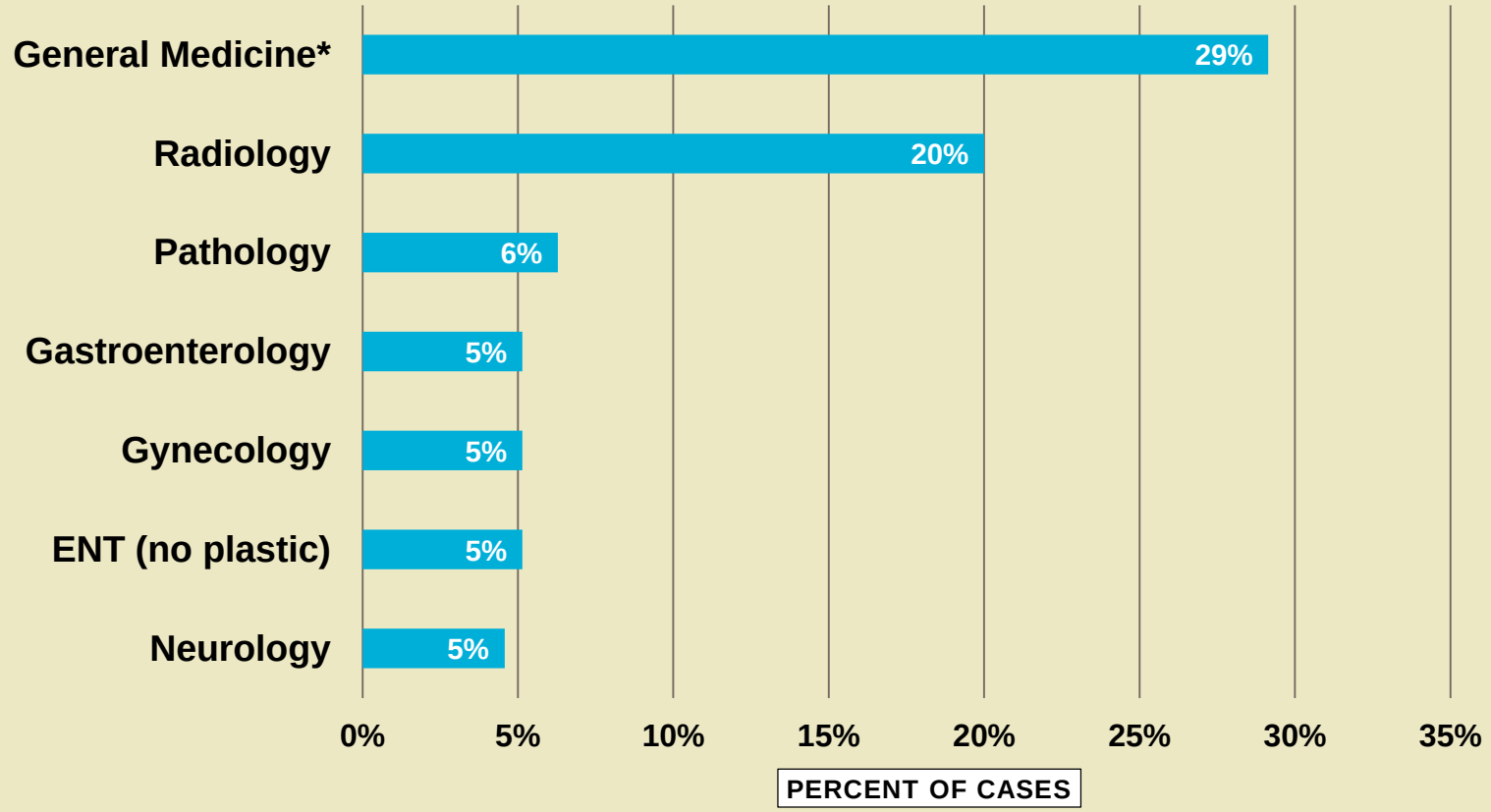
38% of ambulatory cases allege a wrong or delayed diagnosis.

*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.

General Medicine and Radiology are most frequently involved.

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

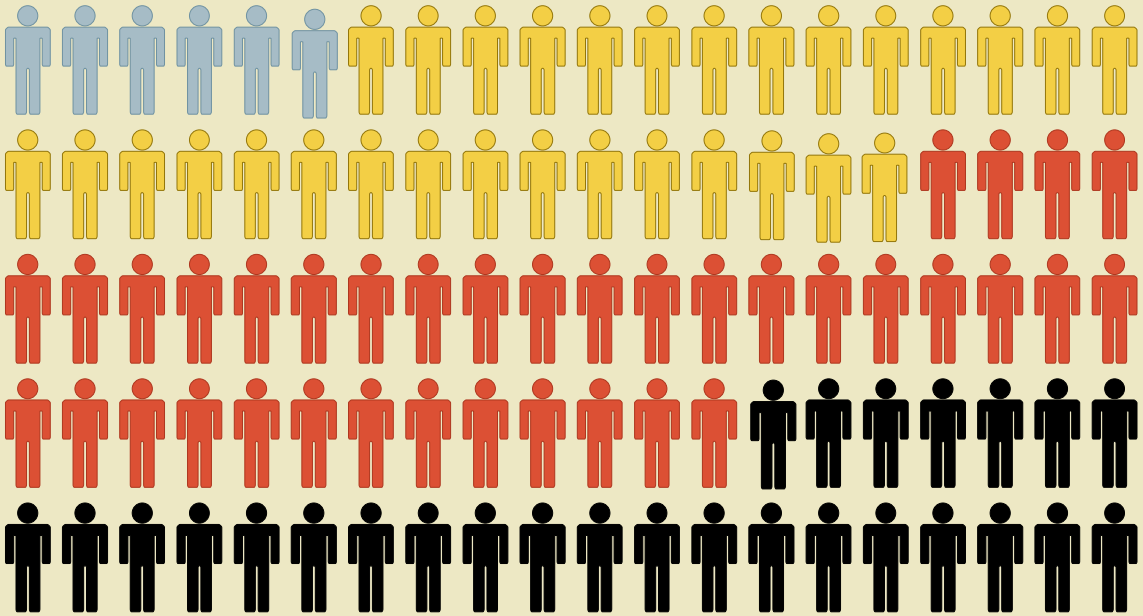


CRICO N=175 MPL cases with claim made date 1/1/11–8/31/16 involving ambulatory care and alleging diagnostic failure.

*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: Partnering with Patients

Does my patient know why I ordered this test?

The following example is from a closed malpractice case.

crico | are you safe?

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: Patient Assessment

35%
of cases

had an error in patient assessment identified as a contributing factor, i.e., the patient's complaints or symptoms were not thoroughly addressed

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

Case Study

Patient

Francis, 17-year-old male, no prior medical history

Month 1

He is seen by his family medicine physician office with a request to complete a high school physical exam form.

A note was provided for school and documentation in the medical record noted a complete and normal physical exam.

Case Study

Francis, 17-year-old with no prior medical history

8 months later

Francis sees his physician to complete a college physical examination form.

On this form, it notes all systems are normal except the MD did not check normal in the box beside the heart. Notation in the description section “? Slight systolic murmur”

There was no documentation in the office record regarding this office visit.

Case Study

Francis, 17-year-old with no prior medical history

One month later

An echocardiogram was scheduled for the patient. However, the patient did not keep the appointment.

The physician's office was notified but there was no outreach to the patient in follow up to the missed appointment.

Case Study

Francis, 17-year-old with no prior medical history

Next two years

Over two years, Francis was seen at his family practice physician's office

During this time, there is no discussion or follow up of the murmur nor recommended echocardiogram.

Case Study

Francis, 17-year-old with no prior medical history

Outcome

At age 20 while playing football, Francis fell to the ground. Despite aggressive medical treatment he could not be resuscitated and died.

On autopsy, the patient was diagnosed with hypertrophic cardiac myopathy.

Case Study

Francis, 17-year-old with no prior medical history

Vulnerability

Reliance on memory, and failure to document all patient encounters in the medical record, creates missed opportunities for follow up on new findings or recommended tests.

Safer Care Recommendation

Contemporaneously document your clinical rationale, and any patient communication that may otherwise be forgotten. Include your differential diagnosis and clinical rationale for recommended treatment and follow up.

Case Study

Francis, 17-year-old with no prior medical history

Vulnerability

Sharing uncertainty with patients and family members about potential consequences of an incidental finding implies a need for follow up.

Safer Care Recommendation

Explaining your concerns (and any uncertainty) and the risks of potential new findings and rationale for needed follow up is important to ensure patient/family understanding.

Practice Assessment

Has this type of event ever happened here?

Practice Assessment

Partnering with Patients

Does our practice communicate missed appointments to the ordering provider?

Recommended Practices

- Set up a tickler system to track ordered tests/images
- Develop processes on how missed appointments will be communicated to the ordering provider

Practice Assessment

Partnering with Patients

How confident are we that patients receive recommended tests?

Recommended Practices

- Establish a prioritization matrix for high-risk tests and imaging studies
- Engage patients in shared decision making, explain purpose of tests/images to patients/family and document your conversation in the medical record

Practice Assessment

Partnering with Patients

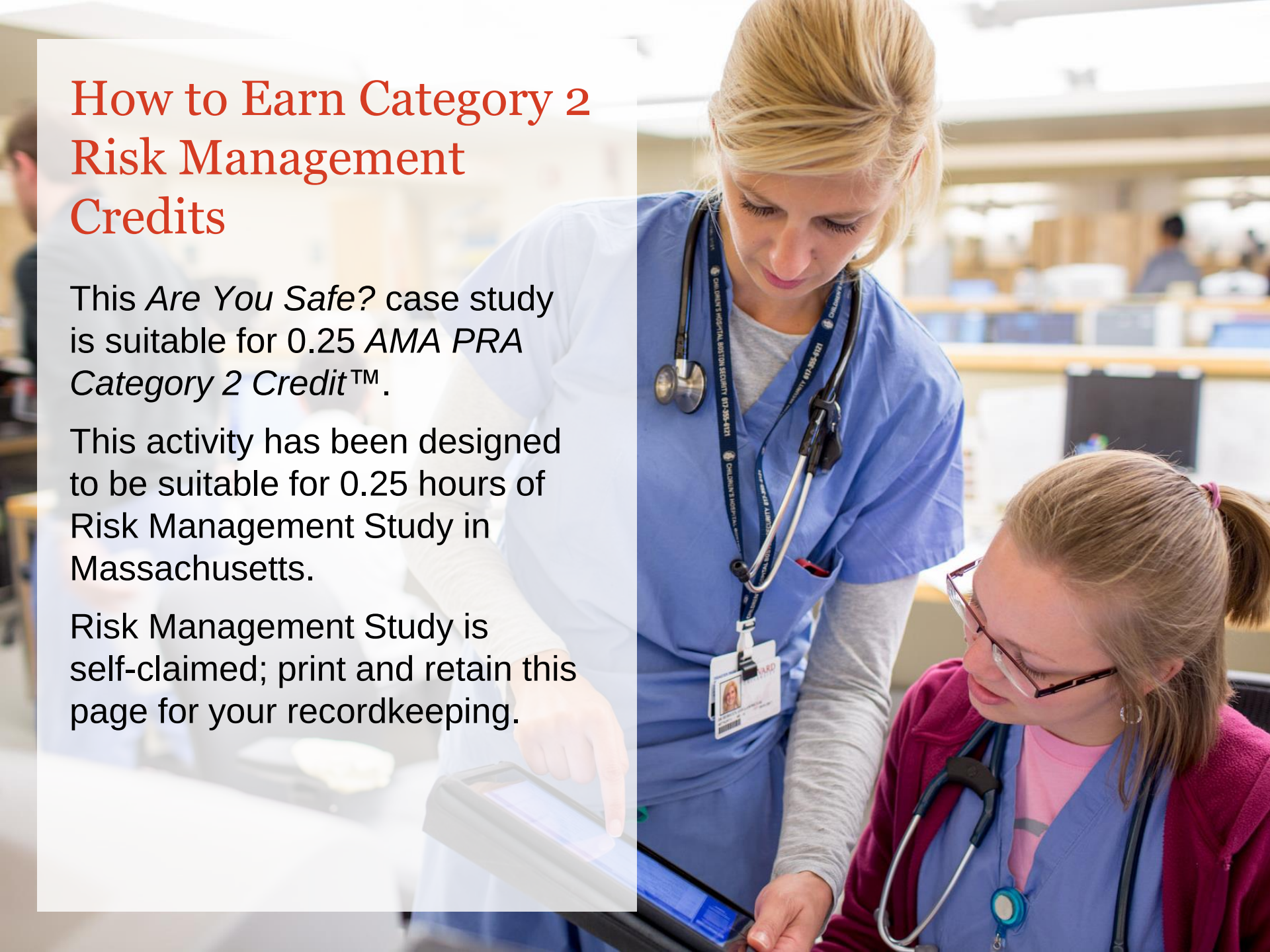
Does my patient understand why I ordered this test?

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

Partnering with Patients:
Does my patient understand why I ordered this test?

Are You Safe? extras

For more information

Email

areyousafe@rmf.harvard.edu