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.
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
47% of CRICO malpractice cases occur in the ambulatory setting. 

35% of ambulatory cases allege a wrong or delayed diagnosis.

<table>
<thead>
<tr>
<th>Cases</th>
<th>Losses*</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,161</td>
<td>$618M</td>
<td>filed 2009–2013</td>
</tr>
<tr>
<td>544</td>
<td>$237M</td>
<td>filed 2009–2013, and involving ambulatory care**</td>
</tr>
<tr>
<td>194</td>
<td>$162M</td>
<td>filed 2009–2013, and involving ambulatory care, and alleging a wrong or delayed diagnosis</td>
</tr>
</tbody>
</table>

*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

- **General Medicine***: 27%
- **Radiology**: 22%
- **Gastroenterology**: 6%
- **Neurology**: 6%
- **Pathology**: 6%
- **Gynecology**: 5%
- **Orthopedics**: 4%

CRICO N=194 MPL cases asserted 1/1/09–12/31/13 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

CRICO N=194 MPL cases asserted 1/1/09–12/31/13 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

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60% of 194 ambulatory diagnosis-related cases involve a cancer related allegation.

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

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Case Study: Cancer Assessment

Patient-detected Breast Lump

The following example is from a closed malpractice case.
CRICO maps contributing factors to the way care is experienced by the patient.

CRICO Diagnostic Process of Care

<table>
<thead>
<tr>
<th>STEP</th>
<th>CRICO % CASES</th>
<th>CBS % CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient notes problem and seeks care</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>2. History/physical</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>3. Patient assessment/evaluation of symptoms</td>
<td>39%</td>
<td>26%</td>
</tr>
<tr>
<td>4. Diagnostic processing</td>
<td>45%</td>
<td>34%</td>
</tr>
<tr>
<td>5. Order of diagnostic/lab test</td>
<td>43%</td>
<td>31%</td>
</tr>
<tr>
<td>6. Performance of tests</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>7. Interpretation of tests</td>
<td>32%</td>
<td>23%</td>
</tr>
<tr>
<td>8. Receipt/transmittal of test results (to provider)</td>
<td>3%</td>
<td>5%</td>
</tr>
<tr>
<td>9. Physician follow up with patient</td>
<td>26%</td>
<td>18%</td>
</tr>
<tr>
<td>10. Referral management</td>
<td>11%</td>
<td>19%</td>
</tr>
<tr>
<td>11. Provider-to-provider communication</td>
<td>13%</td>
<td>12%</td>
</tr>
<tr>
<td>12. Patient compliance with follow-up plan</td>
<td>8%</td>
<td>15%</td>
</tr>
</tbody>
</table>

*A case will often have multiple factors identified.

CRICO N=194 MPL cases asserted 1/1/09–12/31/13 involving ambulatory care and alleging diagnostic failure.

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

CBS N=2,685 MPL cases asserted 1/1/09–12/31/13 involving ambulatory care and alleging diagnostic failure.
Malpractice case study focus: Patient Assessment

39% 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.
Case Study

Patient
Gina, 34-year-old female

Day 1
Gina is seen in her gynecologist’s office for a self-detected breast lump. Her physical exam is noted as normal. The gynecologist orders a mammogram, but does not indicate Gina’s complaint (lump) on the order.
Case Study
Gina, 34-year-old female

Four months later

• Gina undergoes a screening mammogram, which is reported as “normal” with a “very dense stromal pattern” noted.

• The gynecologist receives the Radiology report, which does not recommend an ultrasound.
Case Study
Gina, 34-year-old female

*Nine months later*
Gina returns to her gynecologist, complaining of the same breast lump. The gynecologist palpates the lump and orders a diagnostic mammogram and surgical consult. The workup reveals breast cancer.
Case Study
Gina, 34-year-old female

Outcome

• Gina undergoes a radical mastectomy and axillary node dissection; she has metastases to her spine.
• After her diagnosis, Gina’s medical record was updated to reflect that her family history included a relative with breast cancer.
Case Study
Gina, 34-year-old female w/fh of Breast Cancer

Vulnerability
Failure to order the appropriate test and consult led to a delayed diagnosis.

Safer Care Recommendation
Prioritize efforts to decrease diagnosis-related harm through use of decision support tools such as the CRICO Breast Care Management Algorithm.
Case Study
Gina, 34-year-old female w/fh of breast cancer

Vulnerability
Failure to update Gina’s family history led to a missed opportunity to identify her as at increased risk for breast cancer.

Safer Care Recommendation
Consider using a checklist or template for details that are often overlooked (e.g., family history) but can be relevant for improving diagnostic reasoning.
Practice Assessment

Has this type of event ever happened here?
Practice Assessment
Cancer Assessment

*Does our clinical team use disease-specific recommended guidelines?*

*Recommended Practice*
Identify relevant clinical guidelines (e.g., [CRICO Breast Care Management Algorithm](#)) for all practice providers.
Practice Assessment

Cancer Assessment

How do we incorporate recommended guidelines into our provider education and practice?

Recommended Practices

• Educate staff regarding implementation of practice guidelines and periodically audit compliance.

• Establish a systems-based process to identify that patients undergo recommended tests per guidelines.
Practice Assessment
Cancer Assessment

What else can we do to avoid a similar event?
Cancer Assessment: Inadequate Management of a Patient-detected Breast Lump

**Safer Care extras**

For more information

Email
safercare@rmf.harvard.edu
Facilitator’s Guide

WHAT YOU WILL NEED
• Computer and projector, or handouts
• Enough time (e.g., 30 minutes) to discuss the patient safety concerns that relate to your practice

PREPARATION TIPS
• Do a test run (preferably in the actual venue) to ensure that all equipment is working correctly

PRESENTATION COMPONENTS
(appplies to all Safer Care module slide presentations)
1. Background (slides 1–6): CRICO’s role in patient safety
2. Malpractice data (slides 7–11): focus on ambulatory diagnosis related allegations
3. Diagnostic process of care vulnerabilities (slides 13–14): vulnerabilities identified in the diagnostic process of care via malpractice cases. CRICO’s coding taxonomy enables data analyses from patient access to the health care system to diagnosis to follow-up plan, and helps identify common breakdowns throughout the process.
4. Closed malpractice case chronology: follows the case from initial presentation to outcome
5. Vulnerabilities from case: one or two aspects of the case that most likely triggered the allegation of malpractice, with recommendations for avoiding similar missteps
6. Practice assessment and improvement opportunities: each module features a quick assessment, with questions related to the case example and the underlying patient safety issues. While each module features topic-specific questions, all begin with “Has this type of event happened at our practice?”
7. Safer Care extras: Links to additional topic-related content on the CRICO website, including case studies, decision support tools, and evidence-based articles.

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Facilitator’s Guide: Cancer Assessment
Risk: Inadequate management of a patient-detected breast lump

**CASE CHRONOLOGY**

**34-year-old female, benign health history**

**First MD Appointment**
- Patient presented to her gynecologist with a self-detected breast lump
- The gynecologist exam is documented as “normal”
- An order was placed for a screening (not diagnostic) mammogram. The order did not note the patient’s self-detected lump

**Four Months Later**
- Patient underwent screening mammogram
- Mammogram noted as “normal” with “very dense stromal pattern” (reduces sensitivity for cancer detection)
- Ultrasound not recommended
- Report reviewed by gynecologist; no further evaluation initiated

**Nine Months Later**
- Patient returns to gynecologist expressing concern re: same breast lump
- Gynecologist palpates lump and orders diagnostic mammogram and surgical consult

**OUTCOME**
- Patient evaluated by surgeon; ultrasound, MRI, and biopsy completed.
- Patient diagnosed with ductal carcinoma with lymph extension into 6 of 18 nodes

**Case Disposition: Settled in the high range ($500,000-$999,999)**

**KEY LESSONS**
- Following established decision support tools, e.g., [CRICO Breast Care Management Algorithm](#) can help reduce diagnosis-related harm. In this example, screening mammogram was ordered when diagnostic mammogram appropriate (even without knowledge of family history).
- Updating personal/family history at time of initial complaint can help clinical decision making.

**Discussion Tips**

Each Safer Care module includes prompts for discussing the vulnerabilities exposed by the case example, and for assessment of your practice/systems. Focus on the broader patient safety issues that may impact future care. Limit narrow analyses of the facts, this case is an illustrative example to initiate discussion.

- Acknowledge that discussions about medical errors, delays in care, or patient grievances are difficult for the individuals involved and impacts the entire care team/practice.
- Frame the conversation, for example: the purpose of this discussion is to learn from what occurred, identify opportunities to improve the system, and prevent recurrence of a similar event.
- Recognize that everyone comes to work to help others but, at times, systems do not support the individual.
- Engage multiple perspectives in discussions related to patient safety vulnerabilities by soliciting input from all disciplines.

**Practice Assessment & Improvement Tips**

This is a team-wide opportunity to review whether this could happen at your practice and identify improvement opportunities.