Safer Care for Office Practice

Test Results Management:
Misfiled Results
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

© 2015 CRICO. The CRICO Safer Care guides offer suggestions for assessing and addressing patient safety and should not be construed as a standard of care.
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>Notes</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</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• involving ambulatory care**</td>
</tr>
<tr>
<td>194</td>
<td>$162M</td>
<td>• filed 2009–2013, and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• involving ambulatory care, ** and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 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

© 2015 CRICO. The CRICO Safer Care guides offer suggestions for assessing and addressing patient safety and should not be construed as a standard of care.
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
Case Study: Test Result Management
Misfiled Results

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: 
Test Result Management

3% 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.
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.
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
Test Result Management

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

Test Result Management

*What is our system to ensure patients complete recommended testing?*

**Recommended Practice**

A redundant system to identify that patient had recommended test.
Practice Assessment

Test Result Management

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

Test Result Management

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

Misfiled Results

*What else can we do to avoid a similar event?*
Additional Resources

Test Result Management: *Misfiled Results*

**Safer Care extras**

For more information

Email

safercare@rmf.harvard.edu
Facilitator’s Guide

This Guide supports presentation of a CRICO Safer Care module via the print, online, and presentation format.

Purpose

CRICO’s Safer Care modules provide a brief overview illustrating how a systems-based problem in an office practice led to an actual malpractice case. For each module, the vulnerabilities that most likely triggered the malpractice allegation are highlighted, along with recommended best practices, discussion questions, and prompts to assess your practice’s processes related to the risks identified in the case. Together, the components of each module can help you identify opportunities to improve your practice.

Audience

The Safer Care modules draw on experiences from primary care providers in Internal or Family Medicine practices. However, many of the inherent lessons are applicable to outpatient specialty care practices. The modules are intended for all members of your team (physicians, advanced care providers, nurses, medical assistants, allied health professionals, administrative staff). Each module highlights ambulatory patient safety risks/vulnerabilities to stimulate discussion and help your practice identify opportunities to assess and (if necessary) improve systems.

Feedback to CRICO

Please help improve and expand the value of the Safer Care modules by sharing feedback about the content and the learning process with CRICO via safercare@rmf.harvard.edu.

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 healthcare 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.

© 2015 CRICO. The CRICO Safer Care guides offer suggestions for assessing and addressing patient safety and should not be construed as a standard of care.
Facilitator’s Guide: Test Result Management

Risk: Misfiled results

CASE CHRONOLOGY

Patient: 62-year-old male, 40-year history of smoking 1-2 packs per day

First MD Appointment
• Presents with rib pain after hearing a rib “crack” at home
• No worrisome findings on exam
• Patient sent for a chest X-ray

Test Result:
• Radiologist notes 3 x 1.5cm mass in left lung and recommends follow-up CT
• Radiologist completes report, does not call PCP with finding or recommendation
• Office practice’s outstanding test results tickler system calls for placing patient’s medical record “in a pile.” Records are filed after receipt and review of test/imaging report.
• This patient’s medical record was filed before Radiology report was received/reconciled

Next Primary Care Appointment
• One year later, patient returned with complaint of cough, chest pain, and congestion for approximately one month
• A chest X-ray was repeated and identified enlargement of mass seen on previous X-ray
• Radiologist called PCP with results of second X-ray

OUTCOME
• Patient diagnosed with stage IV adenocarcinoma with metastasis to brain
• Patient received palliative care; died within one year

Case Disposition: Settled

KEY LESSONS
• A test result management processes that ensures receipt/review of new findings is critical to safe patient care
• Team-based processes to close a potential gap in receipt and review of test and imaging results is recommended (need not be electronic, paper-based solutions are frequently easier to initiate)

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.