crico | Protecting Providers. Promoting Safety.

Safer Care for Office Practice

Referral Management:
Unreconciled Specialist Opinion/Recommendation

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

(applies 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.

Facilitator's Guide: Referral Management

Risk: Unrecognized specialist opinion/recommendation

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.

CASE CHRONOLOGY

74-year-old male admitted for treatment of encephalitis

Day 1 (while in the hospital)

- CT scan reveals a specific opacity in right upper lobe of lung, suspicious of carcinoma
- Patient advised to visit a pulmonologist after discharge
- Suspicious finding was communicated to patient's PCP at discharge

Day 11

- Patient visits PCP regarding his concern
- PCP makes a referral to a pulmonologist

Day 28

- During pulmonology appointment, pulmonologist reviewed CT, which did not have all the lung fields
- Pulmonologist requested full chest CT, planned to review with radiologist and follow up with PCP
- The pulmonologist wrote a letter to the PCP summarizing the visit

Next Four Years

- Patient has regular visits with PCP
- PCP unaware of pulmonologist's recommendation for additional follow up regarding lung concern
- Pulmonologist did not follow up with patient

OUTCOME

- Patient (now age 78) diagnosed with Stage IV lung cancer
- He dies three months later
- ***Case Disposition: Settled for > $1 million***

KEY LESSONS

- 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?
- Having all parties involved in referral transactions reduces the opportunity for patients (or reports) to fall through the cracks. Build a redundant system incorporating all members of the care team, including the patient.

Opportunities for Improving Patient Safety

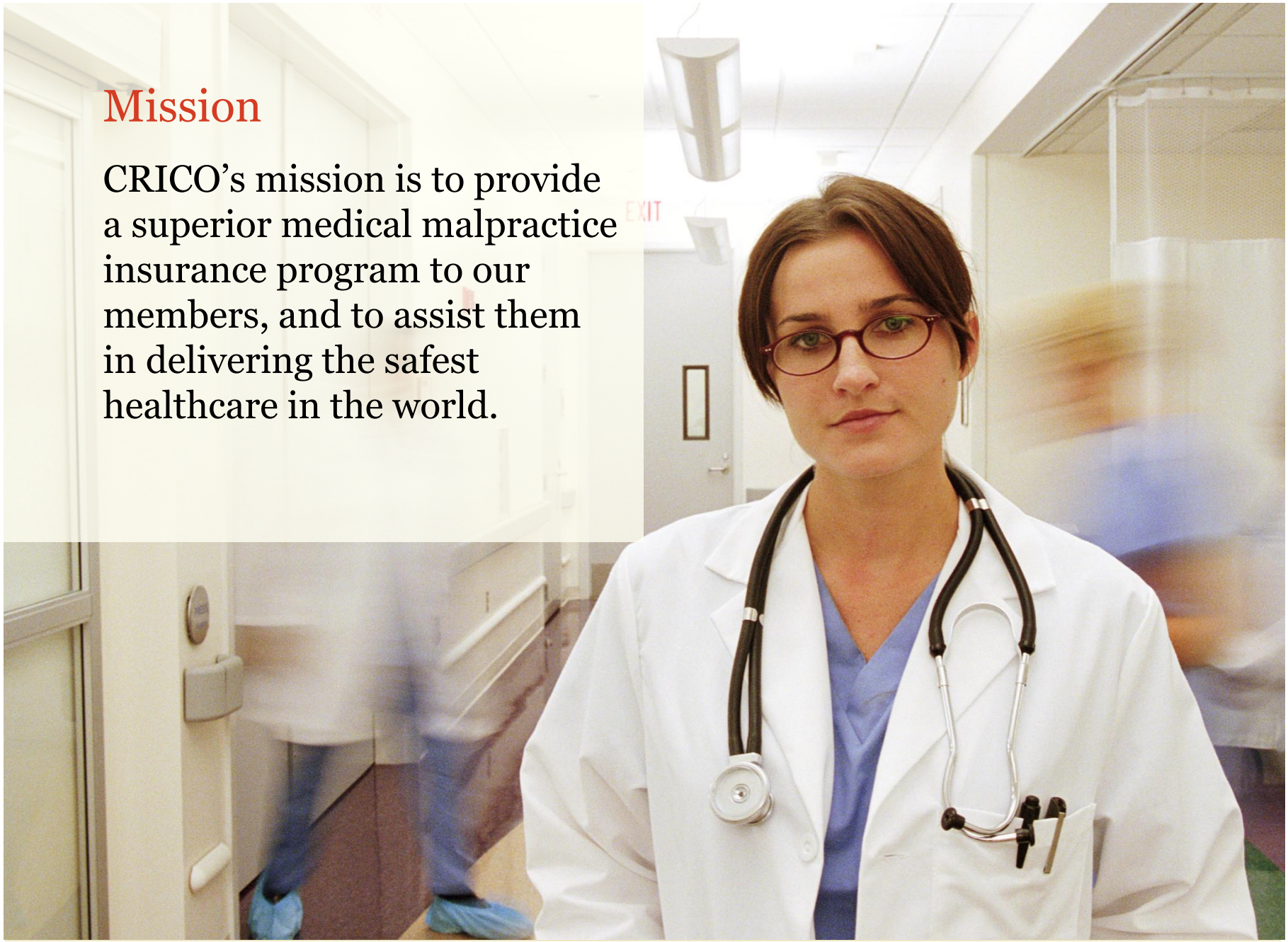
- **Identified through** CRICO's Office Practice Evaluation program and analysis of medical malpractice case data
- **Based on** real events that have triggered malpractice cases
- **Valuable lessons** in communication, clinical judgment, and patient care systems

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

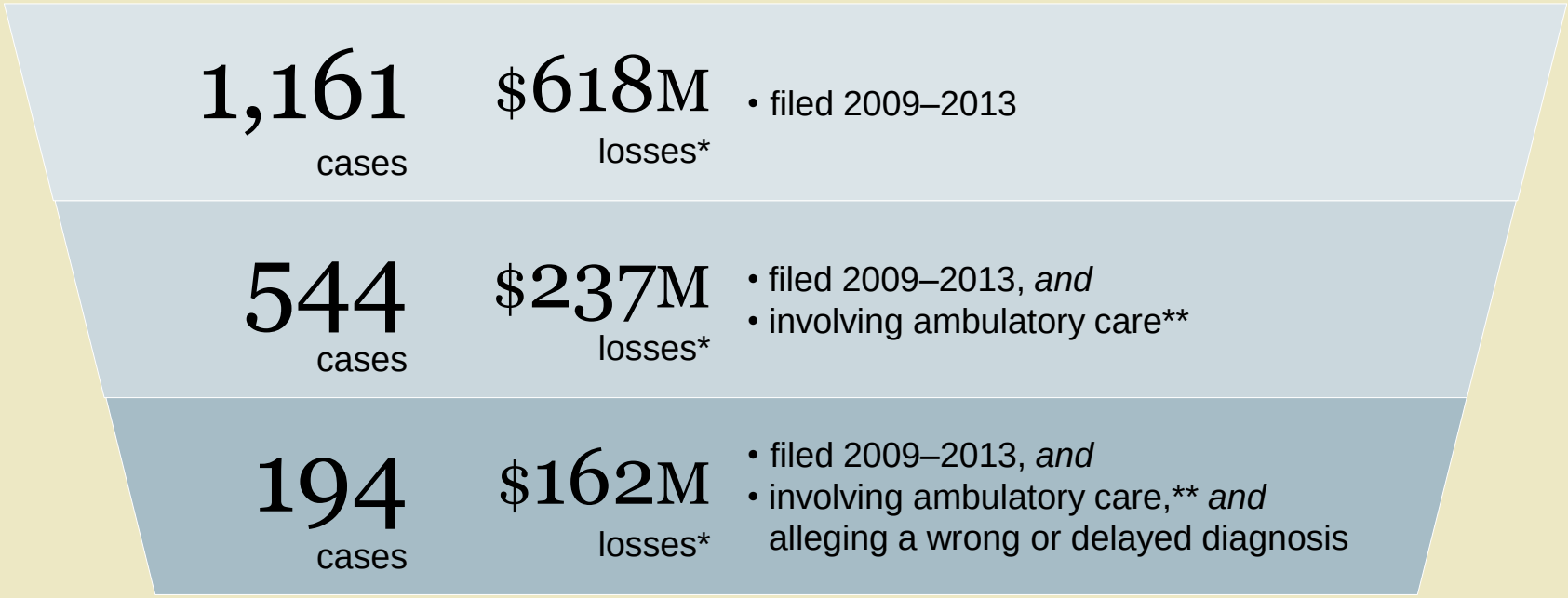
- Atrius Health
  - Dedham Medical
  - Granite
  - HVMA
- Boston Children's Hospital
- Cambridge Health Alliance
- CareGroup
  - Beth Israel Deaconess Medical Center
  - Beth Israel Deaconess Needham
  - Beth Israel Deaconess Milton
  - Mount Auburn Hospital
  - New England Baptist Hospital
- Dana-Farber 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

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

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

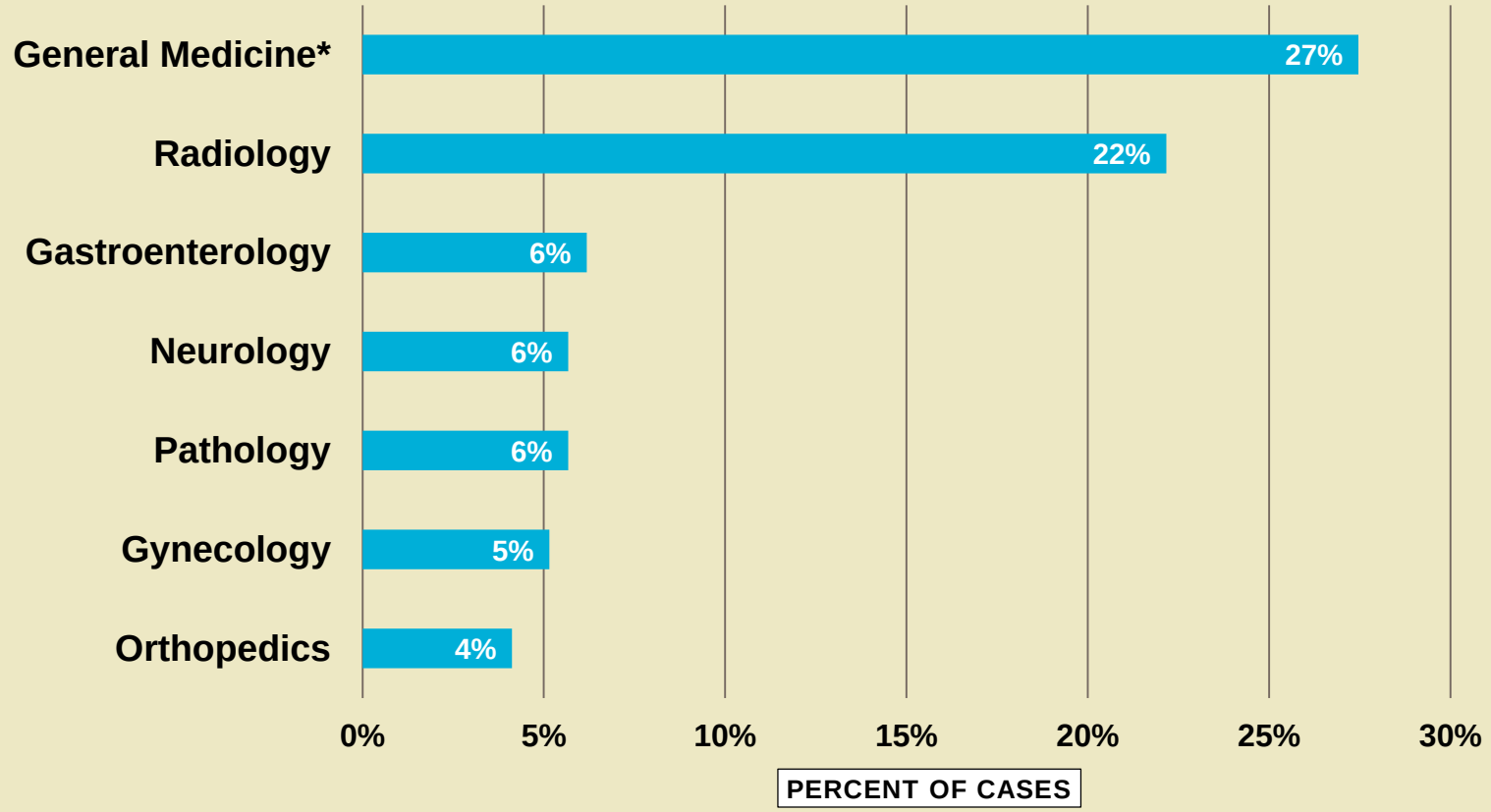


*Losses are "total incurred losses," which includes reserves on open and payments on closed cases.

**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



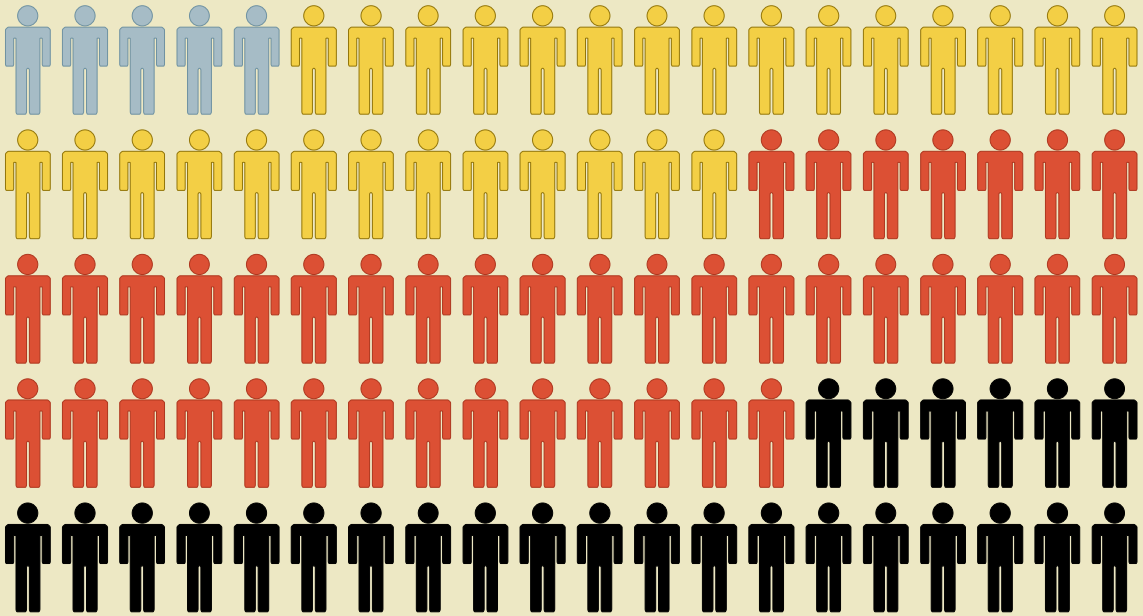
CRICO N=194 MPL cases asserted 1/1/09–12/31/13 involving ambulatory care and alleging diagnostic failure.

*General Medicine includes Internal Medicine and Family Practice.

194 cases

Two-thirds of cases involve permanent injury or death.

Injury Severity in Ambulatory Diagnosis Cases



5% low

28% medium

67% high

including death

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

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: Referral Management

Unreconciled Specialist Opinion/Recommendation

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

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

*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: Referral Management

11%

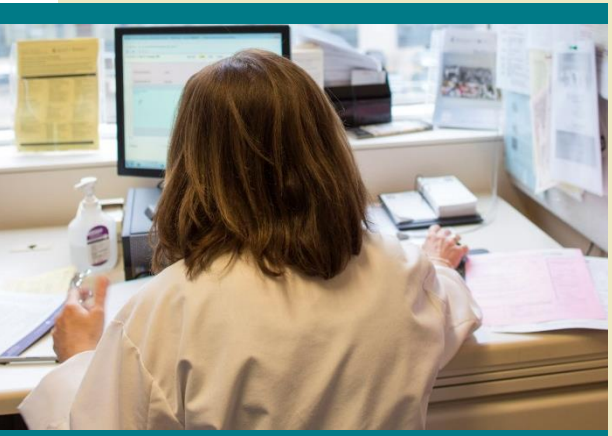
of cases

had an error in referral management identified as a contributing factor, i.e., appropriate referrals to specialists (or consults) are not made or adequately managed, or identification of the physician responsible for ongoing care is unclear.

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

Case Study

Referral Management:
Unreconciled specialist opinion/recommendation



Patient

Anjelo, 74-year-old male

Day 1

During a hospital stay for encephalitis, Anjelo is advised to see a pulmonologist for a specific opacity in his right upper lobe (suspicious for carcinoma) seen on a CT scan.

Case Study

Referral Management: Anjelo, 74-year-old male w/upper R lobe opacity

Day 11

Anjelo sees his PCP, who refers him to a pulmonologist.

Case Study

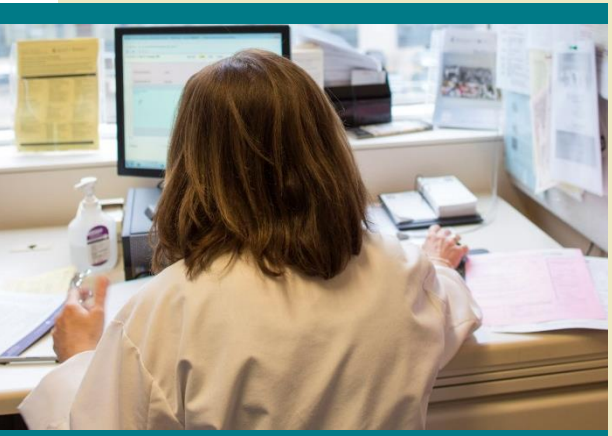
Referral Management: Anjelo, 74-year-old male w/upper R lobe opacity

Day 28

Anjelo sees the pulmonologist, who notes a spot on the lung and advises additional follow up.

Case Study

Referral Management: Anjelo, 74-year-old male w/upper R lobe opacity

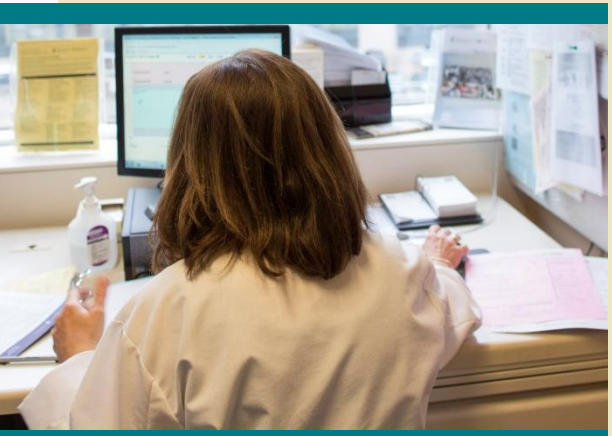


Next four years

Over four years, Anjelo has regular visits with his PCP, who is unaware of the pulmonologist's recommendation for additional follow up regarding the initial lung concern.

Case Study

Referral Management: Anjelo, 74-year-old male w/upper R lobe opacity

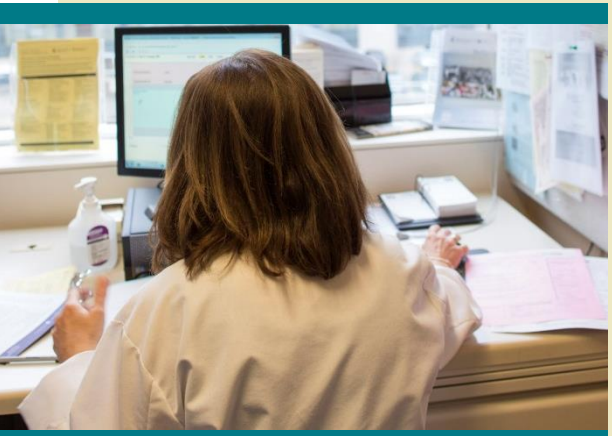


Outcome

At age 78, Anjelo is diagnosed with Stage IV lung cancer. He dies three months later.

Case Study

Referral Management: Anjelo, 74-year-old male w/upper R lobe opacity



Vulnerability

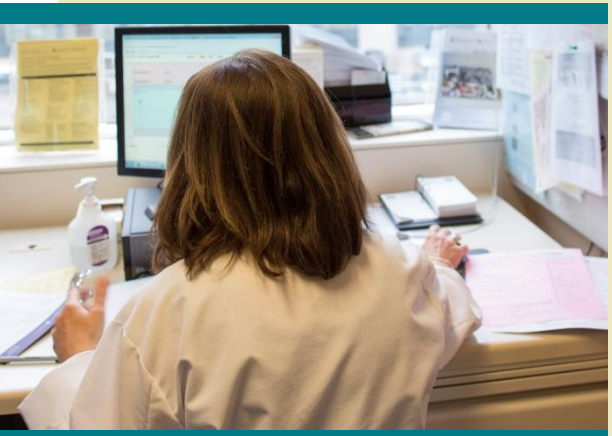
Anjelo's PCP was not notified by the pulmonologist and the PCP did not pursue any information regarding the referral visit.

Safer Care Recommendation

To avoid a "person specific" referral management process, 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 care team and patient.

Case Study

Referral Management: Anjelo, 74-year-old male w/upper R lobe opacity



Vulnerability

Anjelo failed to appreciate the importance of his pulmonology referral and, thus, did not alert his PCP to the pulmonologist's recommendation for follow up.

Safer Care Recommendation

Having all parties involved in referral trans-action reduces the risk of patients or reports falling through the cracks. Referral systems without closed-loop communication create gaps in patient care. Build a redundant system for the entire care team and patient.

Practice Assessment

Has this type of event ever happened here?

Practice Assessment

Referral Management: *Unreconciled Specialist Opinion/Recommendation*

What is our system for referral management? What role does each of us (including the patient) play?

Recommended Practices

- Referrals are ordered and documented/scanned in the EHR.
- A process to identify which referrals are outstanding and which are completed.

Practice Assessment

Referral Management: *Unreconciled Specialist Opinion/Recommendation*

How do we communicate high priority referrals to the clinical team and patient?

Recommended Practices

- The reason/urgency for the referral is communicated to the patient and specialist, and an appointment is made for the patient prior to him/her leaving the office.
- Embed decision support tools in electronic health record to assist in maintenance of patient's personal and family medical history.

Practice Assessment

Referral Management: *Unreconciled Specialist Opinion/Recommendation*

Do we document all patient communication in the medical record?

Recommended Practice

- Provider review of all incoming referrals is tracked.

Practice Assessment

Unreconciled Specialist Opinion/Recommendation

What else can we do to avoid a similar event?

Additional Resources

Referral Management:
Unreconciled Specialist Opinion/Recommendation

Safer Care extras

For more information

Email

safercare@rmf.harvard.edu