Diagnostic Errors: A Real Threat to Patient Safety
Today’s speaker is Rachel Rosen, RN, MSN, Senior Patient Safety & Risk Consultant, MedPro Group
(Rachel.Rosen@medpro.com)

Rachel has more than 20 years of experience in patient safety, quality, and risk management — both as an internal leader and as an external consultant.

Her healthcare industry customers have included multihospital systems, large acute hospitals, long-term acute care facilities, critical access hospitals, healthcare services, and managed care organizations.

Rachel has extensive experience in standards preparation and compliance, strategic organizational improvement planning and implementation, quality measurement, patient satisfaction, and medical staff quality and peer review.

Rachel is a graduate of Ball State University with a bachelor of science degree in nursing, and she earned a master of science degree in nursing administration from Indiana University. Rachel is a member of the American Society for Healthcare Risk Management and the Indiana Society for Healthcare Risk Management.
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Today's faculty, as well as CE planners, content developers, reviewers, editors, and Patient Safety & Risk Solutions staff at Medical Protective have reported that they have no relevant financial relationships with any commercial interests.
Objectives

At the conclusion of this program, you should be able to:

• Discuss claims data and trends related to diagnostic and other medical errors.
• Identify and analyze contributing factors/root causes of diagnostic errors that affect patient safety.
• Design and implement processes and systems that reduce and prevent diagnostic and other medical errors.
• Identify at least one risk-reduction strategy that you can implement in your practice.
Registration Polling Results

- Organization collect, trend, review data
- 100% Use of E.H.R
- Misdiagnosis due to first symptom
- Written process for handoffs
- Have patients repeat back to you
- Document all non-office visit communication
- Always document patient noncompliance

Yes  No
Today’s Program

Today’s speaker is Melanie Osley, RN, MBA, CPHRM, CPHQ, ARM, DFASHRM, Senior Patient Safety & Risk Consultant, MedPro Group (Melanie.Osley@medpro.com)

Melanie provides risk management services for MedPro Group insureds in the Northeast, ranging from Maine to Maryland. Melanie has worked in healthcare for more than 25 years, with 20 of those years dedicated to healthcare professional liability. Her experience includes working with self-insured hospitals, off-shore insurance captives, and physician insurance carriers.

Melanie speaks frequently on topics that include quality initiatives, patient safety, insurance models, and risk management. In addition, she has published numerous articles for peer-reviewed journals and texts. Melanie is a member of the American Society of Healthcare Risk Management (ASHRM) and the Connecticut and Massachusetts Societies of Healthcare Risk Management. Melanie’s clinical specialty areas include prior certification in both critical care (CCRN) and emergency (CEN) nursing, and advanced cardiac life support instructor (ACLS) status. She has also completed the Fundamental Critical Care Support course offered by the Society of Critical Care Medicine.

Melanie earned a bachelor of science in law enforcement from the University of Evansville and a bachelor of science in nursing from the University of Maryland. She completed an MBA in healthcare administration at City University (WA), is a certified paralegal, and holds a current Connecticut insurance adjuster's license. She is certified in both healthcare quality and risk management, and has designations as a Distinguished Fellow of ASHRM in New England (DFASHRM), and an Associate in Risk Management from the Insurance Institute of America.
Today’s speaker is Viviane Jesequel, RN, HCRM, Senior Patient Safety & Risk Consultant, MedPro Group (Viviane.Jesequel@medpro.com)

Viviane provides comprehensive risk management services to healthcare systems, hospitals, clinics, and physicians in Florida. She has more than 25 years of experience in the healthcare industry and has achieved an understanding of the challenges and opportunities facing both clinicians and hospitals.

Viviane has been actively involved in healthcare risk and quality management for many years. In previous positions, she provided services to hospitals, nursing homes, physicians, and other allied health professionals.

Viviane’s expertise includes consulting with clients regarding patient safety and quality/performance improvement, identifying and evaluating potential liability exposures, and developing solutions to reduce or eliminate loss severity.

Viviane earned her RN degree from Mount Saint Mary College in New York. She also earned a bachelor of science degree in business administration from Mount Saint Mary College, and she is licensed as a healthcare risk manager by the state of Florida.
NPDB: Countrywide Allegations

Percentage of Claims by Allegation Group, 2004-2013

- Diagnosis Related: 54%
- Surgery Related: 18%
- Anesthesia Related: 6%
- Treatment Related: 4%
- Obstetrics Related: 24%
- Others: 4%

Diagnosis Related: Top Allegations

- Failure to Diagnose: 36%
- Delay in Diagnosis: 18%
- Improper Performance: 10%
- Improper Management: 5%
- Improper Performance: 7%
- Failure to Recognize a Complication: 4%
- Others: 6%

Average Indemnity by Allegation Group, 2004-2013

- Obstetrics Related: $551
- Diagnosis Related: $327
- Anesthesia Related: $300
- Treatment Related: $257
- Surgery Related: $243
- Others: $376

Diagnosis Related: Average Indemnity

- Delay in Diagnosis: $388
- Improper Management: $356
- Failure to Diagnose: $350
- Failure to Recognize a Complication: $336
- Others: $324
- Improper Performance: $300

Indemnity paid physician claims 2004-2013. Data does not include payments by patient compensation funds.
**Contributing factors** are broad areas of concern that may have contributed to allegations, injuries, or initiation of claims. These factors reflect issues that may be amenable to loss-prevention strategies. A claim may have several contributing factors identified, or none.

Source: MedPro physician claims, originating in physician office/clinic, opened years 2003-2012
Clinical Judgment
Case Study: Failure to Accurately Dx. Cardiac Condition

Patient: 34-year-old male.

Chief complaint: Presented in ED with sternal pain after lifting a boat in his backyard.

Case overview: Pain increased when raising arms. ECG was negative. Cardiac enzymes were not obtained because muscle strain was determined diagnosis. Patient discharged to internist who okayed vacation.

Outcome: Two days later, patient died.
Specialty Comparisons: Focus on Clinical Judgment – Diagnostic Allegations

Source: MedPro physician claims, originating in physician office/clinic, opened years 2003-2012
Issues With Clinical Judgment

• The most prevalent risk issue in all allegations
• A broad category, including:
  o Patient assessment
  o Selection and management of therapy
  o Failure or delays in obtaining consults/referrals
  o Other factors
• Tends to present the most difficulty in terms of finding simple fixes
When the Patient’s Symptoms Don’t Fit a Pattern

- Information may be missing or incomplete.
- Cases may not be “typical.”
- Depends on clinical element selected, importance assigned to each, and how information is arranged and processed.
- Conclusions (diagnoses) may vary significantly.

Cognitive Mistakes

• Anchoring — a snap judgment, diagnose on the first symptom or lab abnormality

• Availability — using a prior experience, maybe what’s most available in your memory to diagnose

• Attribution — to mentally invoke a stereotype and attribute symptoms

Clinical Judgment: Risk Strategies

- Perform complete assessment.
- Update and review patient’s medical history on a regular basis.
- Review and update problem lists, medication lists, and allergies.
- Enable prompt access to diagnostic information.
- Implement and utilize clinical pathways.
- Formalize procedures for:
  - Over-reads — ECGs, imaging.
  - Peer review/quality improvement.
Clinical Reasoning Toolkit

The SIDM Education Committee recognizes the need to provide clinicians and teachers on the front lines of patient care and medical education with a centralized resource for learning about the cognitive processes that underlie diagnostic reasoning.

In the SIDM Clinical Reasoning Toolkit, users will find a collection of books, articles (links only), slide presentations, and videos grouped into four major topics. The Toolkit assembles and organizes materials for self-directed learning, but is not a fully integrated curriculum.

After reviewing the resources in this collection, users will be able to better analyze, teach, and improve the diagnostic process and share in our goal of making diagnosis safer and more reliable.
Issues With Communication

• Between providers
  o Consultation reports (consult vs. referral)
  o Coordination of care

• Between physician and patient
  o Phone calls
  o Informed consent
  o Education
  o Follow-up instructions
Issues With Communication

- Poor communication with staff and other providers involved in patient care
- Inadequate communication of pertinent clinical findings to radiologists and other providers
- Lack or delayed reporting of critical values
- Physician/staff distractions or lack of teamwork
- Care across multiple locations/providers
Handoffs

Approximately 80% of serious medical errors involve miscommunication during handoff.

Communication: Risk Strategies

• Standardize processes for handoffs, on-call, and after-hours care.
  o Identify all points of handoffs.
  o Determine the critical elements of each handoff identified.
  o Develop a policy and procedure — who, what, where, when, and how.
  o Use all this information to establish a checklist.

• Establish reliable call structure and response plans.
• Establish tickler system for high-risk patients.
Lead The Way In Safety With A Safer Sign Out

**Safer Sign Out** is a patient-centered, team-based innovation that was developed by emergency physicians to improve the safety and reliability of end of shift patient “handoffs.”

The Emergency Medicine Patient Safety Foundation (EMPSF), in collaboration with our innovation partners, brings you the **Safer Sign Out** protocol to help reduce risk, increase effectiveness and improve clinician and patient satisfaction.
Communication Strategies to Enhance the Relationship

• Explain the recommended procedure.
• Start with the diagnosis and educate the patient.
• Offer explanation and rationale on why this is an appropriate treatment plan.
• Go over treatment plan step by step.
• Ask the patient to repeat back proposed treatment plan and/or informed consent discussion.
• Provide written documentation for patient to take home, and document in chart.
• Reinforce patient teaching (staff).
Teach Back

“I want to be sure that I did a good job explaining your problem. Can you tell me:

• What your problem is?
• What you need to do?
• Why you need to do it?”
Printed Material — CDC’s Simply Put

- Instructions should be written for 4th–6th grade level.
- Font size of at least 12–14 points.
- *Italics are difficult to read.*
- ALL CAPS ARE DIFFICULT TO READ.
- Eliminate technical jargon.
- Most important information at the beginning and repeated at the end.

Health Literacy: Accurate, Accessible and Actionable Health Information for All

Health Literacy: the capacity to obtain, process, and understand basic health information and services to make appropriate health decisions.

Spotlight
- Encourage plain language in your organization with these new materials.

Health Literacy Activities by State

Click on any highlighted state to view health literacy activities.
Specialty Comparisons: Focus on Documentation – Diagnostic Allegations

Source: MedPro physician claims, originating in physician office/clinic, opened years 2003-2012
Issues With Documentation

- Patient compliance, including missed/cancelled appointments
- Treatment plan changes
  - Receipt of diagnostic results
  - Follow-up
  - Patient response
  - Telephone conversations
- After-hours contact
- Consults
Issues With Electronic Health Records (EHRs)

• Documentation gaps in transition from paper to electronic
• New error pathways, particularly when trying to force old habits on new system
• Inconsistencies in use and following policy
• Flow of information not intuitive
• Build up of incomplete charts
• Failure to use system capabilities, e.g., alerts/reports
• Hybrid systems
• First-year of use
EHR: Risk Strategies

• Adopt collaborative strategies to include all system users when evaluating the need to make changes or updates.
• Set stringent documentation guidelines and eliminate workaround processes.
• Tailor the system’s alert function to specific patient populations.
• Use system reporting functions to support an active performance improvement plan for risk reduction.
• Develop a comprehensive policy to define the legal patient record.
Health IT Tools and Resources

AHRO and its community of contractors and grantees have developed tools to help health care organizations plan for, implement and evaluate health information technology (IT). These tools describe and recommend strategies for addressing some of the common challenges organizations encounter when working with health IT systems. The tools are freely available, but proper citation should be used when referenced on the Web or in print.

Tools and Resources

**Workflow Assessment for Health IT Toolkit**
This toolkit is designed for people and organizations interested or involved in the planning, design, implementation, and use of health IT in ambulatory care.

**Health IT Evaluation Measures: Quick Reference Guides**
These Health IT Evaluation Measures: Quick Reference Guides provide details about individual measures that can be incorporated into a health IT evaluation plan.

**AHRQ Funded Project Resources Archives**
This toolkit provides sample resource documents, such as project schedules, business associate agreements, and requests for proposals (RFPs) from organizations that have successfully adopted health IT applications.

**Health IT Evaluation Toolkit**
Evaluations allow us to determine whether or not what one has set out to accomplish has been accomplished, and to help us to understand what has worked in a given project and what has not.
Behavioral Issues
Specialty Comparisons: Focus on Patient Behavioral Issues – Diagnostic Allegations

Source: MedPro physician claims, originating in physician office/clinic, opened years 2003-2012
Patient Behavioral Issues: Risk Strategies

• Establish expectations upfront.
• Address and document all noncompliance.
• Use health history to screen.
• Make appropriate referrals.
• Negotiate the process of care.
• Access community resources.
• Ensure adequate follow-up care.
• Set firm limits.
• Terminate relationship as a last resort.
Provider and Staff Behavior: Risk Strategies

- Acknowledge your own emotional response to patients.
- Elicit feedback on your communication skills.
- Improve your listening and understanding skills.
- Improve partnership with the patient.
- Improve skills at expressing negative emotions.
- Increase empathy.
Clinical Systems and Administrative Factors
Specialty Comparisons: Focus on Clinical System Issues – Diagnostic Allegations

Source: MedPro physician claims, originating in physician office/clinic, opened years 2003-2012
Clinical Systems/Administrative Factors: Risk Strategies

- Standardize process for tests/referrals/consults.
  - Returned and reviewed.
  - Initialed by physician.
  - Patient informed and included.
- Verify patient identifiers.
- Report critical values immediately.
- Assign responsibility.
- Utilize process improvement methodologies.
Improving Your Office Testing Process

A Toolkit for Rapid-Cycle Patient Safety and Quality Improvement

This toolkit provides information and resources to help physicians' offices, clinics, and other ambulatory care facilities assess and improve the testing process in their offices.
Summary

• Significant opportunity exists to reduce diagnostic errors.

• Root cause analysis of diagnostic errors and surgical complications identifies clinical judgment issues as the top driving force behind these errors.

• Effective strategies to reduce medical and diagnostic errors include designing and implementing processes and systems to address issues with:
  - Clinical judgment
  - Communication
  - Documentation
  - Behavior-related issues
  - Clinical systems
  - Administrative
  - Technical skill
What questions do you have?

Thank You!