

Alignment of Malpractice
Signals to Diagnostic Error:

What's Out There?



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COVERYS



Alignment of Malpractice Signals to Diagnostic Error: What's Out There?

- Disclosure

Judy Klein has no relevant financial relationships to disclose.

Alignment of Malpractice Signals to Diagnostic Error: What's Out There?

- Objective
 - Review case scenarios and data for diagnostic error medical professional liability claims and strategies to mitigate risk.



Diagnostic Error

- Diagnostic Error – definition – National Academy of Medicine/formerly known as Institute Of Medicine
 - Failure to
 - a) establish an accurate and timely explanation of the patient's health problem(s)

And

- b) communicate that explanation to the patient.



<http://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2015/Improving-Diagnosis/DiagnosticErrorReportBrief.pdf>

Johns Hopkins Study: \$38 Bil Spent on Diagnosis-related Payouts

- Review of 25 years of U.S. malpractice claim payouts
- Diagnostic errors — not surgical mistakes or medication overdoses — accounted for the largest fraction of claims, most severe patient harm, and highest total payouts
- Estimated the number of patients suffering misdiagnosis-related, potentially preventable, significant permanent injury or death in the U.S. ranges from 80,000 to 160,000 annually
- Diagnosis-related payments amounted to **\$38.8 billion** between 1986 and 2010

• Source: Johns Hopkins Study Published on April 23, 2013 in BMJ Quality and Safety

Diagnostic Error – Most Frequent Allegation for Malpractice Cases

- MPL (Medical Professional Liability) Association formerly PIAA (Physicians Insurers Association of America)
- Department of Veterans Affairs
- Kaiser-Permanente Healthcare System
- CRICO-RMF (Harvard)
- NPDB (National Practitioner Data Bank)
- Coverys

Malpractice Data: Divining Rod for Patient Safety...

Malpractice Data

- Deeply analyzed cases, particularly valuable if causation factors can be aggregated
- Provides important “signal data” that can guide what to look for in present-day setting
- Has dollars associated with it

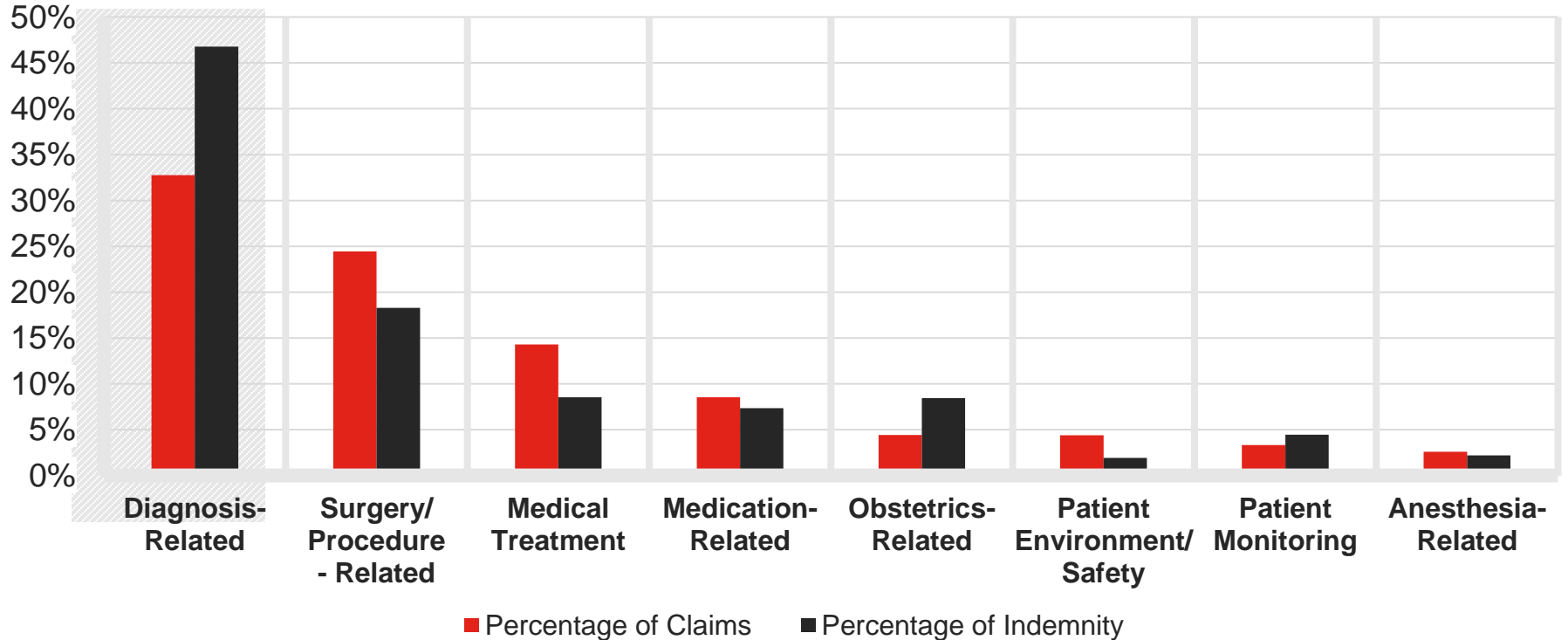
Limitations:

- Always a look to the past
- Small numbers raise question of statistical significance
- Unique convergences of factors don't generally repeat themselves in exactly the same way



Top Allegation Categories

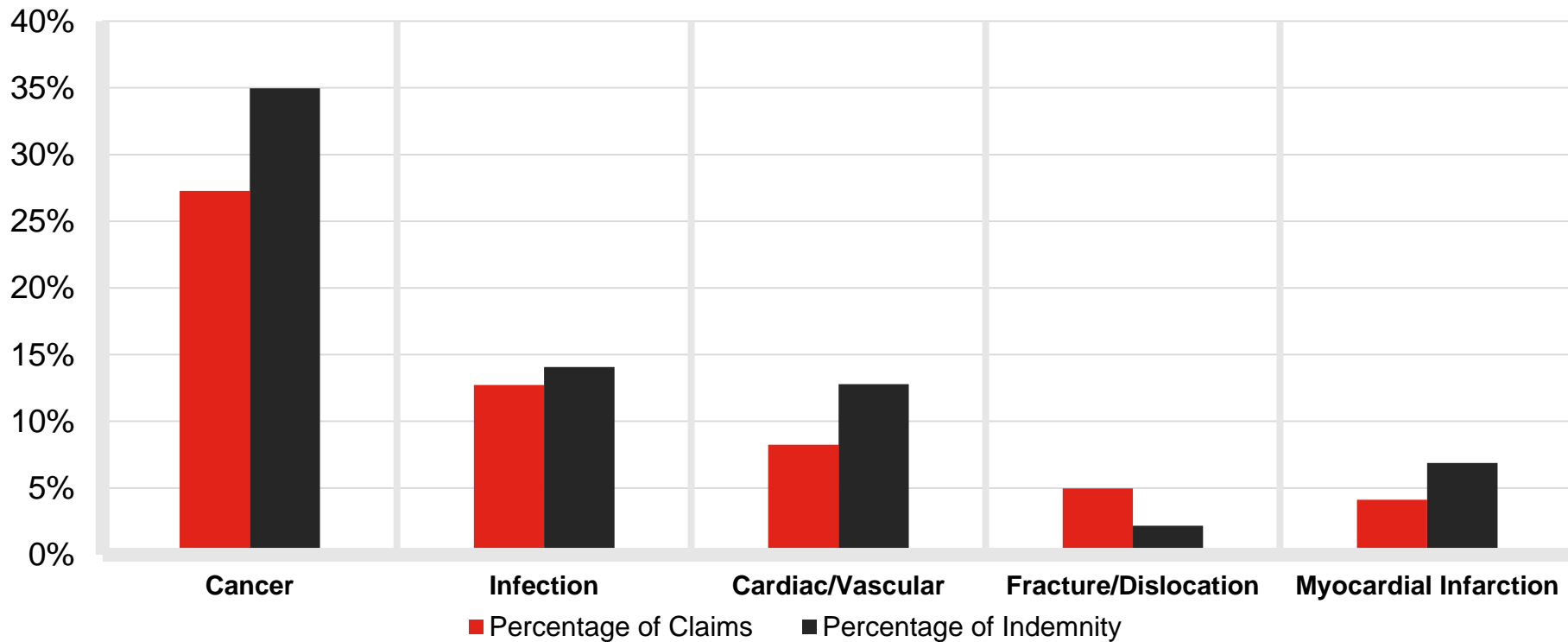
2013-2017
Diagnosis-Related Closed Claims



8 Selection: N=10693 closed claims from 2013-2017

Top Conditions

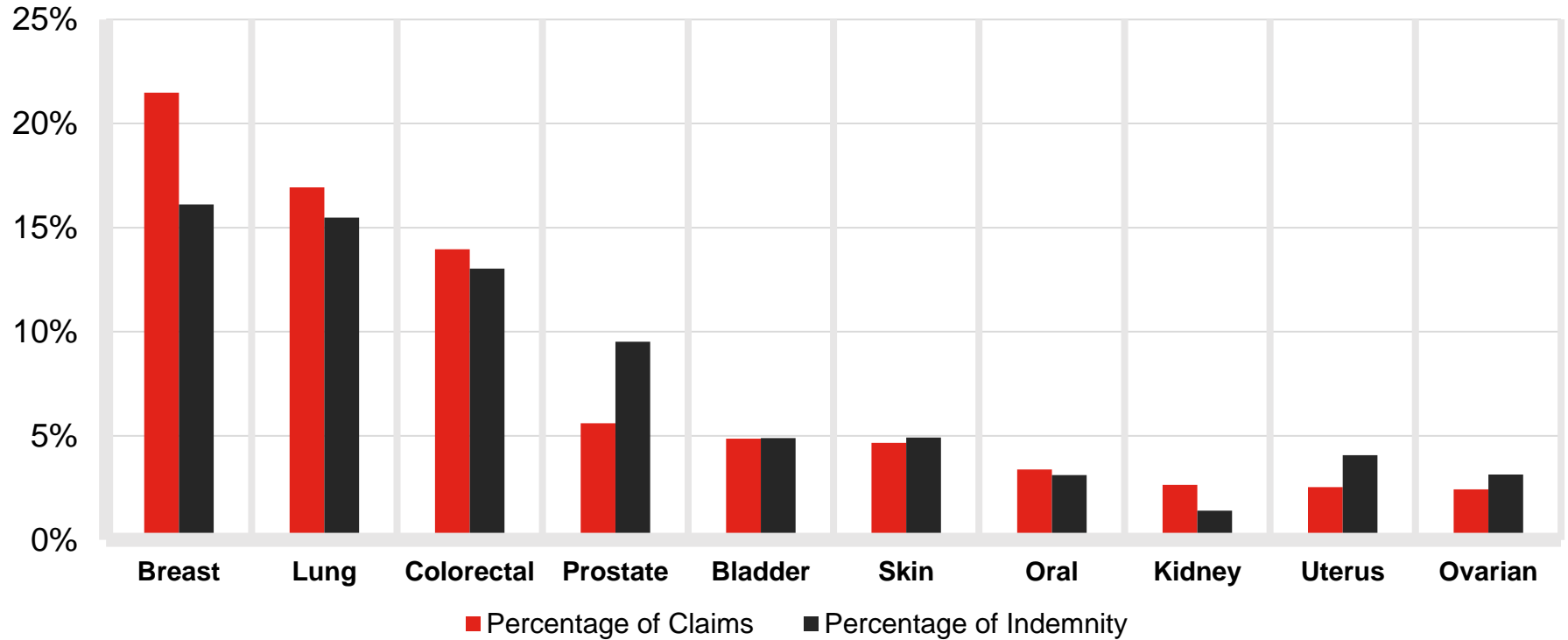
2013-2017
Diagnosis-Related Closed Claims



Selection: N=3466 closed claims from 2013-2017 with a Diagnosis-Related allegation

Top Cancers

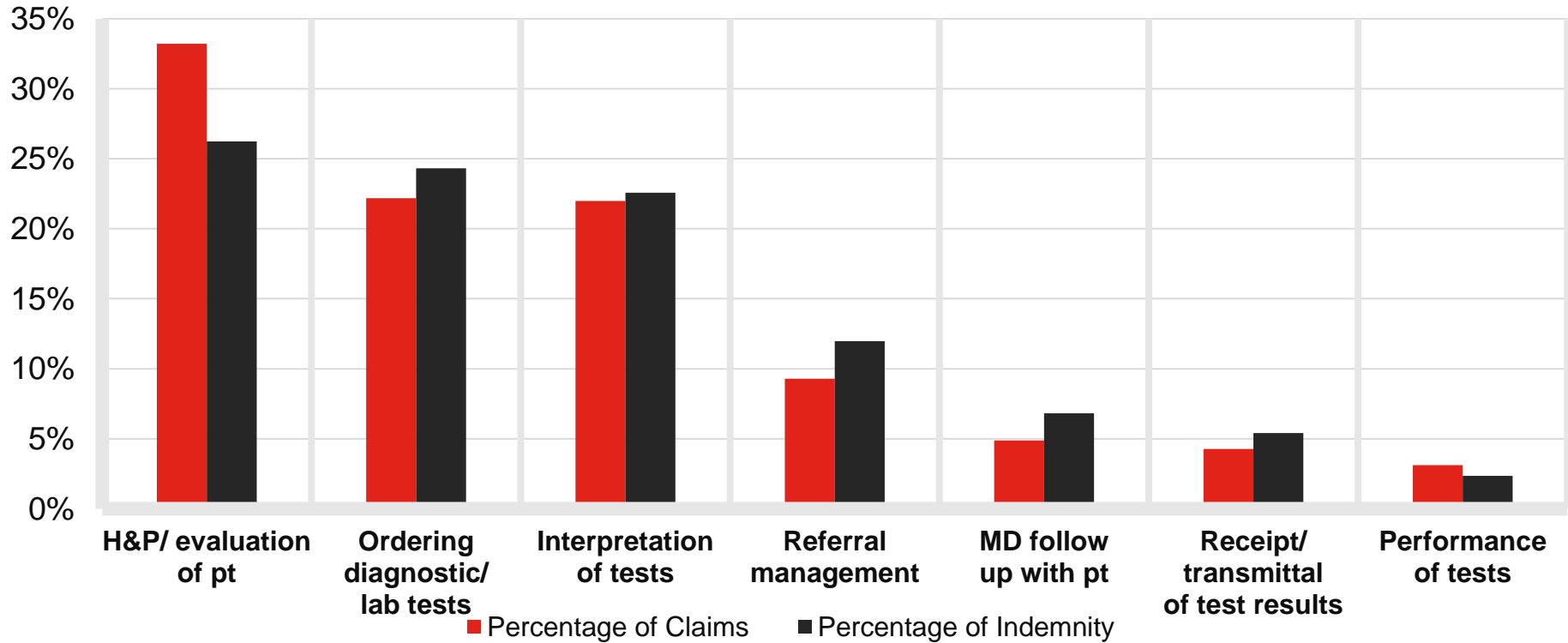
2013-2017
Diagnosis-Related Closed Claims



Selection: N=945 closed claims from 2013-2017 with a Diagnosis-Related cancer allegation

Malpractice Data Signals: Top Allegation Details

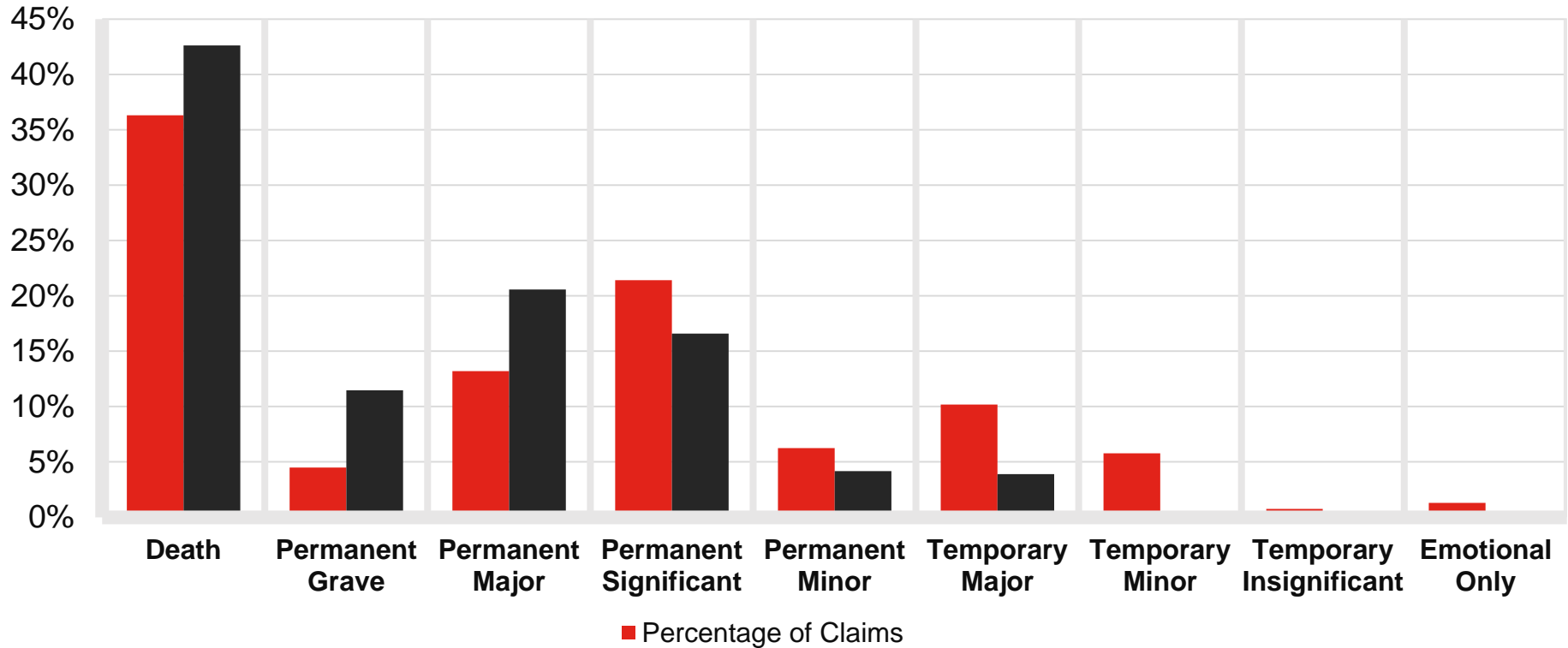
2013-2017
Diagnosis-Related Closed Claims



Selection: N=3466 closed claims from 2013-2017 with a Diagnosis-Related allegation

Injury Severity

2013-2017
Diagnosis-Related Closed Claims

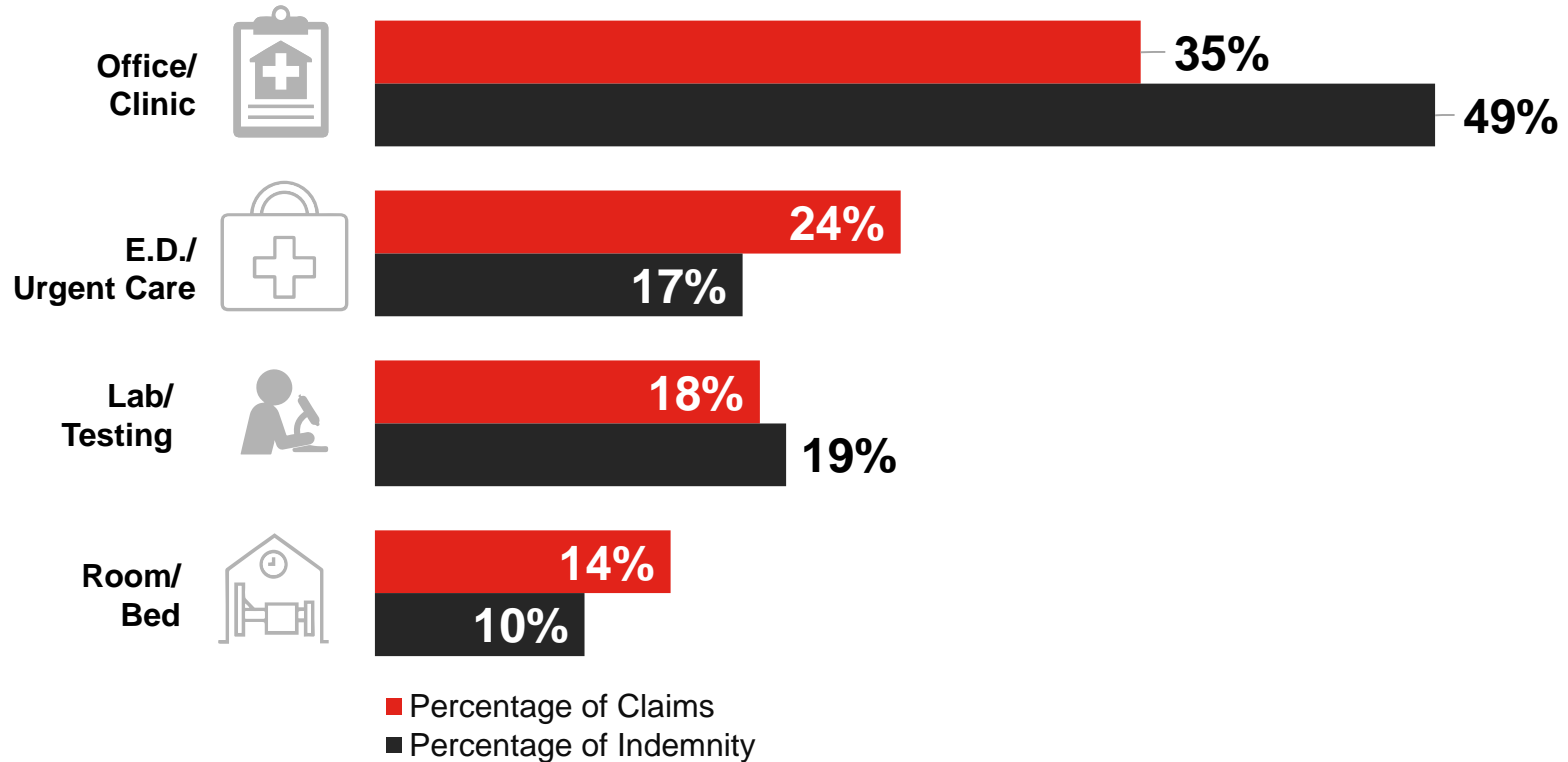


Selection: N=3466 closed claims from 2013-2017 with a Diagnosis-Related allegation

Footnote: Injury severity based on National Association of Insurance Commission (NAIC) codes.

Location

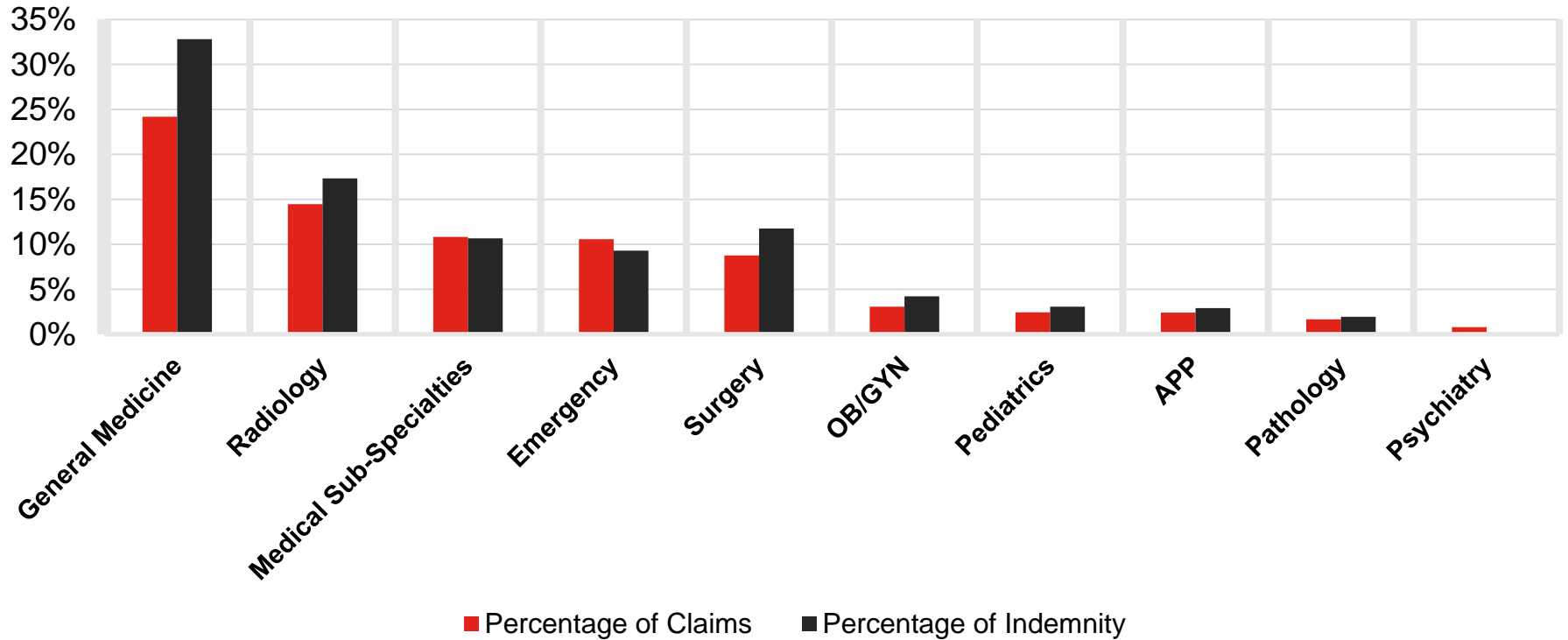
2013-2017
Diagnosis-Related Closed Claims



13 Selection: N=3466 closed claims from 2013-2017 with a Diagnosis-Related allegation

Top Specialties

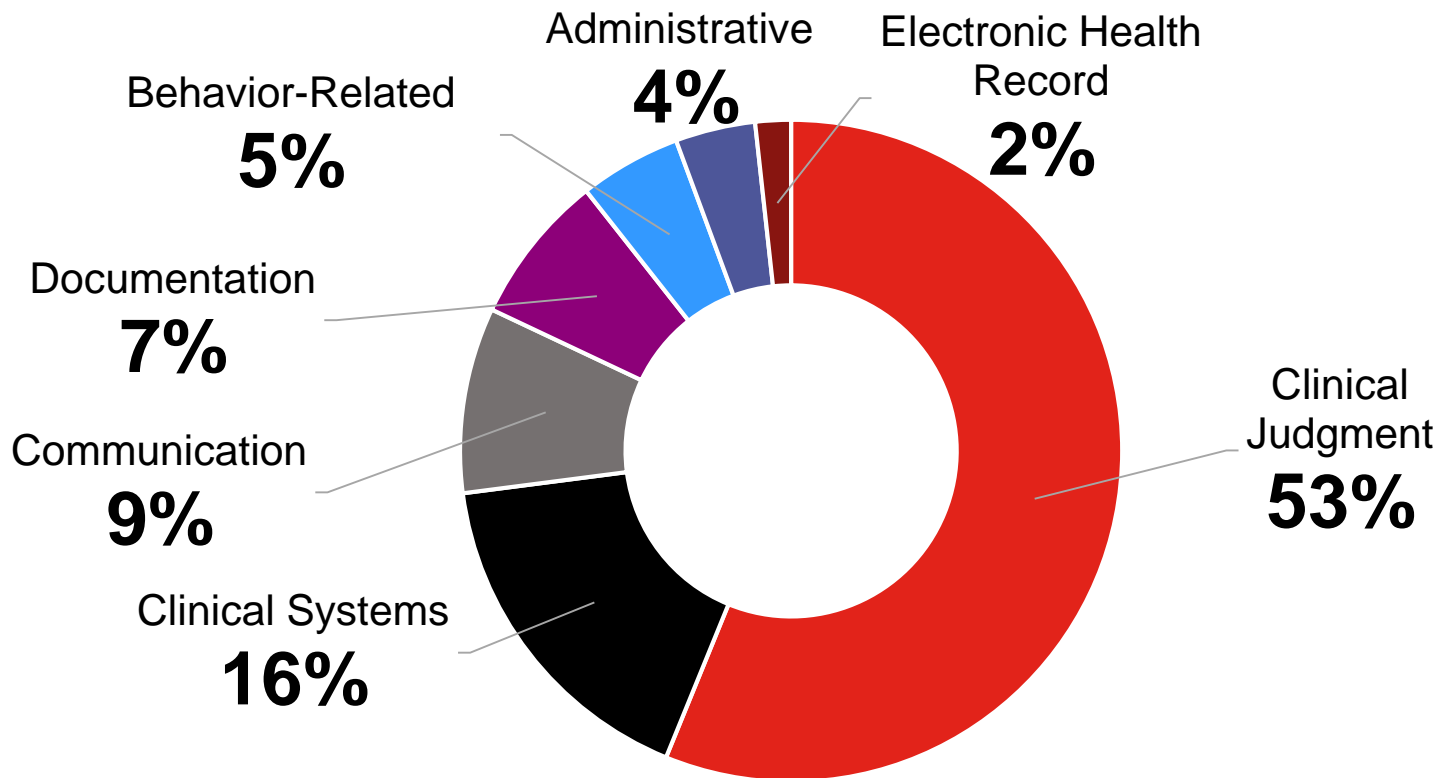
2013-2017
Diagnosis-Related Closed Claims



Selection: N=3466 closed claims from 2013-2017 with a Diagnosis-Related allegation

Top Risk Management Categories

2013-2017
Diagnosis-Related Closed Claims



Selection: Closed PL claims from 2013-2017, N=3466 with a Diagnosis-Related allegation and an identified Risk Management issue

Footnote: A claim can have more than 1 Risk Management issue.

Top Risk Management Details – Clinical Judgment

2013-2017
Diagnosis-Related Closed Claims

Clinical Judgment – *Percentage of Claims*

21%

Narrow
Diagnostic
Focus

19%

Inadequate /
Inappropriate
Testing

17%

Misinterpretation
of Diagnostic
Studies

10%

Failure to
Adequately
Assess
Patient's
Condition

8%

Failure to
Obtain
Specialty
Consult or
Referral

Selection: Closed PL claims from 2013-2017, N=1840 with a Diagnosis-Related allegation and a Clinical Judgment Risk Management issue

Top Risk Management Details – Clinical Systems

2013-2017
Diagnosis-Related Closed Claims

Clinical Systems – *Percentage of Claims*

17%

Failure to Manage
Patient's Follow-
up Care

16%

Insufficient
Studies (e.g.,
Imaging)

13%

Results/Specimen
Lost, Misfiled, or
MD Unaware of
Results

10%

Lack of
Coordination of
Care

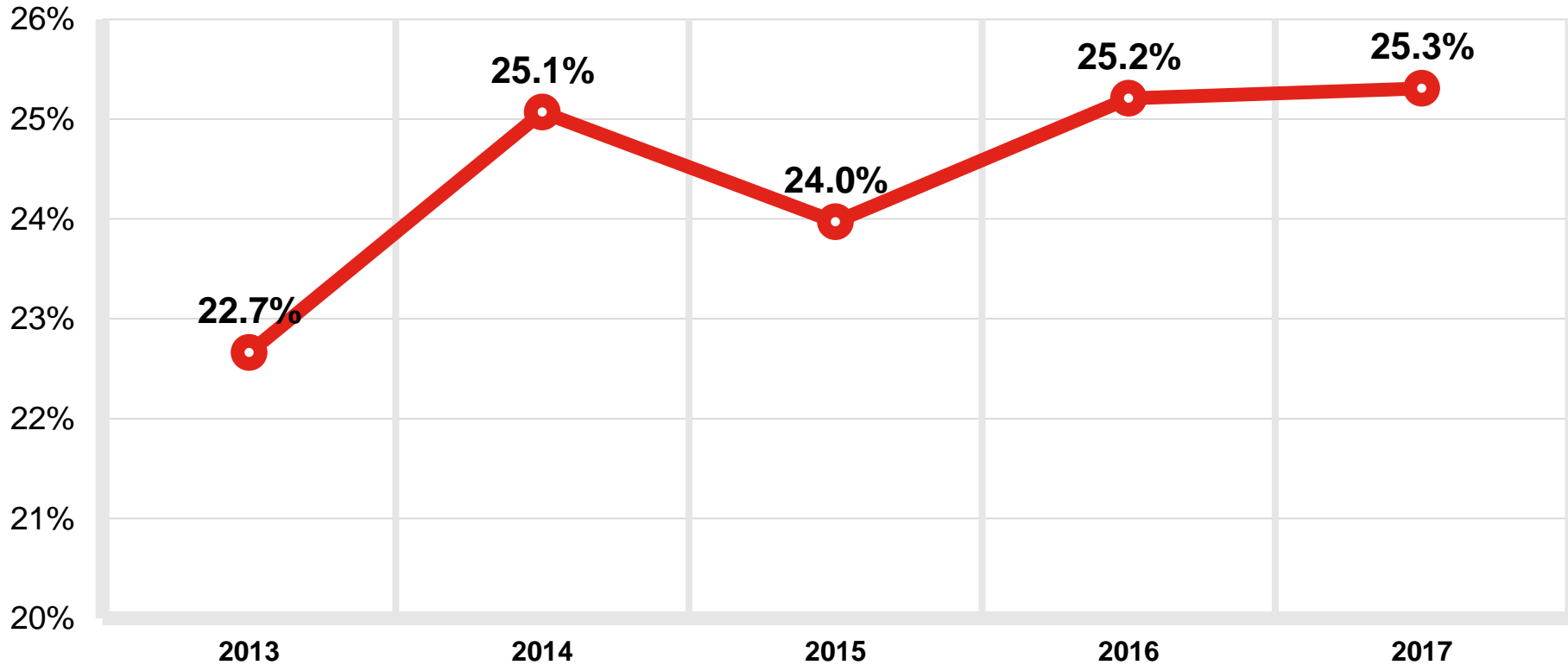
8%

Failure to Inform
Patient of Test
Results

Selection: Closed PL claims from 2013-2017, N=550 with a Diagnosis-Related allegation and a Clinical Systems Risk Management issue

Percentage of Claims Closed with Indemnity Payment

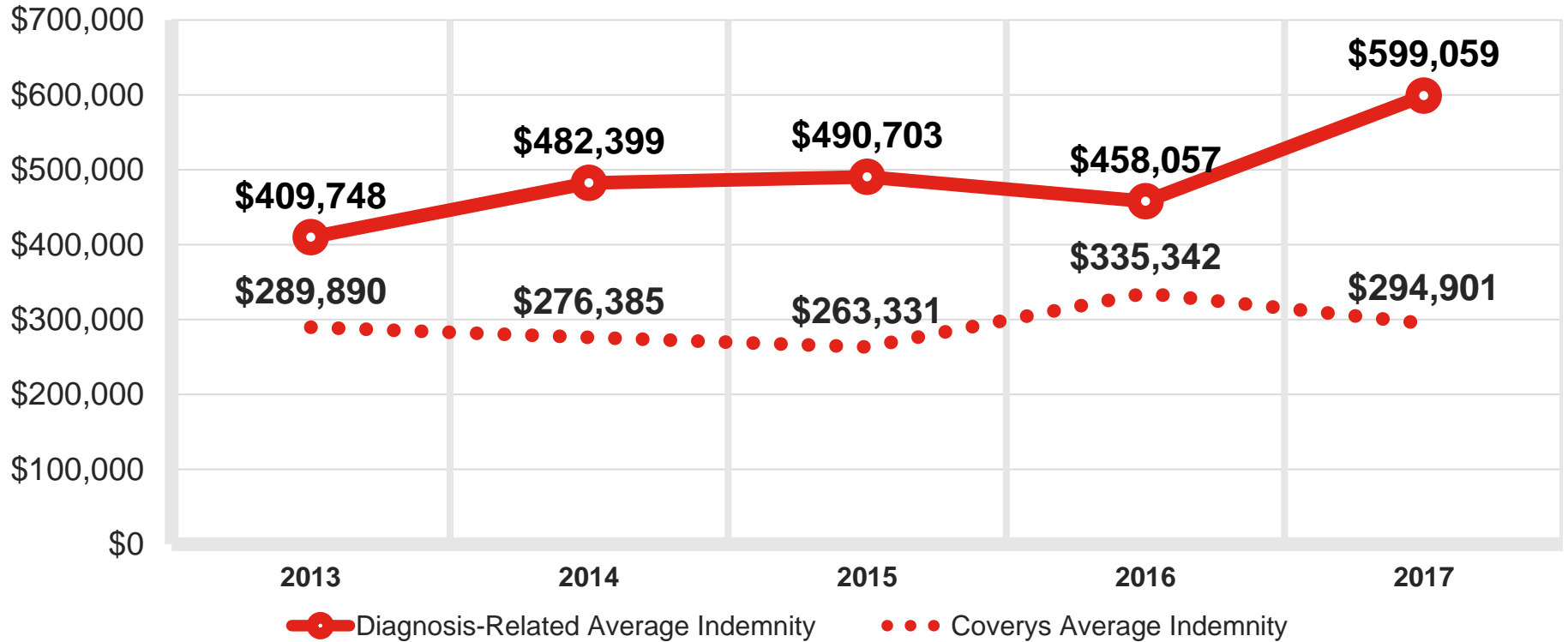
2013-2017
Diagnosis-Related Closed Claims



Selection: N=846 closed claims from 2013-2017 with a Diagnosis-Related allegation and with an indemnity payment

Diagnosis-Related vs Coverys Average Indemnity Payment

2013-2017
Diagnosis-Related Closed Claims



Selection: N=846 closed claims from 2013-2017 with a Diagnosis-Related allegation and with an indemnity payment

Diagnostic Error – Case Study

FTD Ovarian CA

- 40 y/o female patient with hx uterine fibroids
 - GYN follows with annual pelvic US
- US showed:
 - 4 cm left ovarian mass:
 - Septated cystic lesion containing an irregularly thickened septum with no obvious associated blood flow
 - Solid portion of the left ovary appeared abnormal
 - Two uterine fibroids were observed
 - MRI recommended for further evaluation of the ovary
- The GYN attempted to contact patient:
 - Phone
 - Letter
 - No response from patient



Diagnostic Error – Case Study

FTD Ovarian CA

- Patient returns one year later for annual GYN examination
 - Severe lower left abdominal pain
- US obtained/showed:
 - 18 cm (previously 4cm) complex solid left ovarian mass suggestive of neoplasm
 - Bowel Obstruction suggested
- Patient referred to GYN oncologist, taken to OR for exploratory laparotomy
 - Patient aspirated, suffered hypoxic respiratory arrest at time of induction of anesthesia and died
- Autopsy:
 - Dx of ovarian cancer confirmed
 - Large ovarian tumor caused subacute bowel obstruction which, when anesthesia was induced, caused the patient to aspirate and die



Diagnostic Error – FTD Ovarian CA

Risk Management Issues

- COMMUNICATION

- MD to Patient:

- OB/GYN's language/manner of communicating US findings/ need for follow up was insufficient under the circumstances

- Phone call attempts were not documented

- Only one letter sent to patient.

- Tone of the message lacked any sense of urgency

- Didn't want to frighten patient

- MD to MD

- OB/GYN did not attempt to contact the patient's PCP to discuss findings, or see if he was aware of them, or if he could provide assistance in contacting patient

Diagnostic Error – FTD Ovarian CA

Risk Management Issues

- CLINICAL JUDGMENT

- Some thought findings on US were reflective of ovarian cancer until proven otherwise
- OB/GYN left much up to the initiative of the patient
 - Patient needed prompt arrangement for either MRI, a laparoscopic excision of the abnormal ovary, or a referral to a GYN Oncologist for further management
- Personal and family history considerations
 - Maternal grandmother and 2 maternal cousins with Ovarian CA
 - Patient had personal history of breast cancer at young age
 - Patient not referred from BRCA genetic testing
 - Did order annual CA125

Diagnostic Error – FTD Ovarian CA

Risk Management Issues

- CLINICAL SYSTEMS

- US report indicated patient's PCP was to receive a courtesy copy of the report but due to a hospital systems issue, it was not sent.

- OTHER

- PATIENT ENGAGEMENT

- Difficult patient to engage
 - No voice mail – never answered calls for 2 months
 - Didn't respond to letter, but returned 1 year later for annual, and experiencing severe abdominal pain

- ? Insurance Issues

- ? Anxiety/Avoidance

- DOCUMENTATION

- OB/GYN didn't document his phone calls to patient
- Didn't document patient's claim of insurance issues as cause for her failure to follow up sooner

Diagnostic Error- Risk Management Strategies

- Consider using diagnosis-specific clinical decision support resources.
- Implement a formal test tracking and follow-up system that includes standardized procedures, definitions of key terms e.g. critical result, abnormal result
 - Patient name, Test, Date test ordered, Date test report received, Date patient notified of test result and Suggested follow-up
 - Clear guidelines regarding who is responsible for following up on the completion and results of all ordered diagnostic tests and consultations.
- Take advantage of second opinions.
 - If you are unsure about a diagnosis, refer the patient.



Diagnostic Error- Risk Management Strategies

- Speak directly with who is providing the results (e.g., radiologists, pathologists).
- Communicate all results, including normal results, to patients and establish time frames for reporting all types of test results.
- Empower patients to serve as safety double-checks.
 - Educate them on which tests are being ordered; why, when and how the results will be communicated; and the importance of following up on tests or recommended treatments.
 - Ensure that patients know how to get back to you if symptoms persist or change.



Diagnostic Error- Risk Management Strategies

- Develop policies for addressing patient noncompliance with recommended tests, referrals and treatments.
- Document a patient's refusal to undergo any suggested screening test
- Document all actions pertaining to test ordering, tracking and follow-up.
- Document and update family/personal history e.g. of Cancer on an ongoing basis.



Diagnostic Error- Risk Management Strategies

- Establish and adhere to cancer screening guidelines.
 - Encourage screening –explain to patients the importance of cancer screening when appropriate for age
 - Document all Cancer screening tests suggested and performed
 - Send reminders
- Using technology is not a fail-safe method for test tracking and follow-up; have a process for a designated individual to actively check results and follow procedures for responding to tests and following up with patients.
- Monitor processes for test tracking and follow-up on a regular basis and make improvements as necessary.



Diagnostic Error- Risk Management Strategies

- Start Talking about Diagnostic Errors/Missteps
 - These aren't always easy to identify
 - Encourage reporting and discussing to learn in non-punitive environment
 - Hold provider-to-provider error discussions under auspices of Risk Management/Quality Improvement Committee.
 - Depending on state peer review protection, practices can achieve protection by participating in a Patient Safety Organization (PSO).



Diagnostic Error- Risk Management Strategies

- Use opportunities in your daily work flow to look for diagnostic errors.
 - Include patients in this process. Talk with them when you are not certain about a diagnosis. Advise patient to call if they are not improving or have other symptoms.
- Request follow-up from consulting providers and invite discussion about what could have been done differently.
- Follow-up with other providers when you have questions about the care they provided to your patients. Your approach can be from a personal learning perspective vs. accusatory.



Where Do Malpractice Signals Lead Us?

Prevention of Diagnostic Errors

- Reliable office-based systems/process that support
 - Thorough documentation
 - Explain thought process
 - Routine updating of clinical history/family history
 - Receipt of test results by ordering providers
 - Tracking/managing follow-up steps related to patient's subsequent care
 - "Close-the-loop" management and accountability of specialty referrals
 - Clarity around results of diagnostic tests and recommended next steps
 - Communication of all test results to patients
- Ongoing, interval-based education of clinicians to avoid fixation, narrow diagnostic focus
- Decision-support tools embedded into the flow of care
- Patient engagement



Diagnostic Error-Resources

- Institute for Healthcare Improvement/National Patient Safety Foundation
 - https://npsf.site-ym.com/Login.aspx?returl=%2fmembers%2fmy_groups.asp%3f
- National Academy of Medicine
 - <https://nam.edu/programs/SocietytoImprove>
- Society To Improve Diagnosis in Medicine
 - <http://www.improvediagnosis.org/page/Checklist>

Diagnostic Error-Resources

- Agency for Healthcare Research and Quality
 - <https://www.ahrq.gov/professionals/education/ahrq-toolkits.html>
- IMreasoning
 - <http://imreasoning.com>
 - Podcast to inspire critical thinking
- The Human Diagnosis Project's Global Morning Report
 - www.humandx.org/gmr/about
 - Cases to be solved on mobile devices