Malpractice Claims
Lessons Learned from Experience

Betty Van Woert
RN, BSN, CCM, CPHRM
Senior Risk and Patient Safety Consultant

© 2018 Constellation. All rights reserved.
Advisory notice

This presentation has been abridged from a variety of sources and is intended for informational and advisory purposes only. MMIC does not undertake to establish any standards of medical practice.

This presentation is provided as guidance relating to risk management and claim prevention. Specific legal advice should be obtained from a qualified attorney when necessary.

If you have any questions please contact MMIC.
Learning objectives

one

Identify the most frequent and expensive malpractice allegations made against clinics.

two

Understand the causes and contributing factors of breakdowns in care processes, teamwork and systems that lead to patient injury, malpractice claims and poor business performance.

three

Implement strategies to reduce patient injury and malpractice claims and improve business performance.
Learning from Malpractice Claims
How we dig deeper

In 2013, MMIC partnered with Harvard-based CRICO Strategies to leverage their proprietary clinical taxonomy to code medical malpractice claims.

Comparative Benchmarking System (CBS)

- 400,000 cases
- 175,000 physicians
- 400 hospitals
- 30% of US MPL cases
Top major allegations across all settings

N=2,867 asserted 2010-2015

484 cases (17%)

Surgical: 25%  
Medical: 22%  
Diagnosis: 17%

#3 occurrence across all settings
Top major allegations across all settings

N=2,867 asserted 2010-2015

$84.7 million (22%)

484 cases (17%)

#3 occurrence across all settings

#2 total incurred cost
What is diagnostic error?

Diagnostic error is the failure to establish an accurate and timely explanation of the patient's health problem and communicate that to the patient.
How we dig deeper

CRICO’s 12-Step Diagnostic Process of Care Framework

Initial Diagnostic Assessment

Testing & Results Processing

Follow-up & Coordination

Unique adverse events

... have common underlying factors

Contributing factors are mapped to the diagnostic process of care steps for analysis.
Diagnosis-related allegations

Initial diagnostic assessment

- Delayed diagnosis of uterine cancer due to bias of recurring episodes of UTI
- Patient death from cardiac arrest due to failure to consider cardiac condition

Testing and results processing

- Delayed diagnosis of renal carcinoma due to misread CT scan
- Missed ankle fracture by PA and MD with no overread by radiologist

Follow-up and coordination

- Delayed diagnosis of adenocarcinoma in lap chole patient/radiologist reported incidental liver lesion/surgeon advised 6 month follow-up/patient never followed up
Origin of diagnosis-related cases

- Outpatient: 58%
- Emergency: 24%
- Inpatient: 18%

58% originate in outpatient settings
Average indemnities – inpatient vs. outpatient

**Inpatient Claims**
- N=1,030 PL closed cases asserted 2010-2015
  - OB-related: $1,029,917
  - Diagnosis: $687,259
  - Surgical Treatment: $528,828
  - Medication: $369,065
  - Medical Treatment: $252,738
  - Average indemnity: $616,906

**Outpatient Claims**
- N=1,314 PL closed cases asserted 2010-2015
  - Anesthesia: $298,212
  - Medication: $333,074
  - Diagnosis: $229,337
  - Surgical Treatment: $219,519
  - OB-related: $204,476
  - Medical Treatment: $286,449
  - Average indemnity: $229,337

Average indemnity of diagnosis cases is higher in the inpatient setting, but four times more frequent in the outpatient setting.
Session roadmap

PART ONE
The impacts

PART TWO
Breakdowns in care processes

PART THREE
Closing the loop
Part One
Impacts
What’s not working

Diagnostic test and image volume increasing

• 40% PCP visits involve testing

Clinical teams lack structure and failsafe processes

• Team-based care model not prevalent
• Inefficient workflows
• Clinicians performing clerical duties
What’s not working

Clerical burden increasing

• 2:1 ratio EHR work time vs. patient face time
• 37% of patient visit spent on EHR tasks

EHR use not optimized

• 25% don’t track ordered tests
• 73% not using EHR full capability
• 40% under-users
• Test results and patient data siloed in EHR
• Unnecessary alerts contribute to alert fatigue
What’s not working

Tests pending after discharge

- 70% discharges had tests pending after discharge
- 18% noted in discharge summary

Incidental findings

- 56% ED abdominal scans had incidental findings
- 9.8% disclosed on discharge from ED
- 40% of life-threatening findings had documented f/u
What it could cost your patients

Poor patient experience

• Unnecessary or repeat testing
• Financial burden
• Loss of trust in system

Poor medical outcomes

• Diagnosis errors
• Delayed or no treatment
• Disability and death
What it could cost your organization

Reputation damage

Financial loss

- Poor patient experience scores
- Hospitalizations and preventable readmissions
- Poor outcomes impact value-based care metrics
- Inefficient workflows = decreased productivity
- Turnover due to workload burnout and second victim burnout
- Recruitment costs due to turnover

Accreditation loss

Malpractice claims
Part Two
Breakdowns in process
Analyzing the diagnostic process

Initial Diagnostic Assessment
- Care Sought, Problem Noted
- History and Physical Conducted
- Patient Assessed and Symptoms Evaluated
- Differential Diagnosis Established
- Diagnostic Test(s) Ordered

Testing and Results Processing
- Tests Performed
- Tests Interpreted
- Test Results Transmitted to/Received by Ordering Physician

Follow up and Coordination
- Physician Follows up with Patient
- Referrals/Consults
- Patient Information Communicated Among Care Team
- Patient and Providers Establish Follow-up Plan

CRICO’s 12-Step Diagnostic Process of Care Framework.
https://www.rmf.harvard.edu/Clinician-Resources/Article/2014/CBS-Diagnostic-Process-of-Care-Twelve
CRICO’s 12-Step Diagnostic Process of Care Framework.
https://www.rmf.harvard.edu/Clinician-Resources/Article/2014/CBS-Diagnostic-Process-of-Care-Twelve

Analyzing the diagnostic process

- Problem Noted, Care Sought
- History and Physical Conducted
- Patient Assessed and Symptoms Evaluated
- Differential Diagnosis Established
- Diagnostic Test(s) Ordered

- Tests Performed
- Tests Interpreted
- Test Results Transmitted to/Received by Ordering Physician

- Physician Follows up with Patient
- Referrals/Consults
- Patient Information Communicated Among Care Team
- Patient and Providers Establish Follow up Plan

58%
Analyzing the diagnostic process

Initial Diagnostic Assessment
- Problem Noted, Care Sought
- History and Physical Conducted
- Patient Assessed and Symptoms Evaluated
- Differential Diagnosis Established
- Diagnostic Test(s) Ordered

Testing and Results Processing
- Tests Performed
- Tests Interpreted
- Test Results Transmitted to/Received by Ordering Physician

Follow up and Coordination
- Physician Follows up with Patient
- Referrals/Consults
- Patient Information Communicated Among Care Team
- Patient and Providers Establish Follow up Plan

CRICO’s 12-Step Diagnostic Process of Care Framework.
https://www.rmf.harvard.edu/Clinician-Resources/Article/2014/CBS-Diagnostic-Process-of-Care-Twelve
Phase 2: Testing and results processing (35%)
Outpatient diagnostic process

6. Tests performed

7. Test interpreted

8. Test results transmitted to/received by ordering provider
Top misinterpreted tests

- X-ray: 28%
- CT Scan: 22%
- Ultrasound: 10%
- Biopsy: 9%
- MRI: 9%
- Mammogram: 8%
Misread X-rays in outpatient claims

When considering the volume of X-rays read by radiologists vs. non-radiologists, our data indicates that consulting a radiologist can help to avoid misreads.
Analyzing the diagnostic process

CRICO's 12-Step Diagnostic Process of Care Framework.
https://www.rmf.harvard.edu/Clinician-Resources/Article/2014/CBS-Diagnostic-Process-of-Care-Twelve
Phase 3: Follow up and coordination (45%)  
Outpatient diagnostic process

9. Physician follows up with patient
10. Referrals/consults
11. Patient information communicated among care team
12. Patient and providers establish follow-up plan
Patient vs clinician expectations

I saw a doctor.
They know my PCP.
They talk.

Patients remember what we tell them.
PCPs review ED discharge notes.
Patients read discharge summary instructions.
Scope of Follow-up System Failures (FUSF)

42% of MMIC cases with a major or minor dx-related allegation involves an FUSF factor.
42% of MMIC cases with a major or minor dx-related allegation involves an FUSF factor.

Even when appropriate clinical steps are done to lead to the correct diagnosis, we still have diagnostic error.
What’s different about follow-up system cases?

Significantly more about...
Systems that support diagnosis and communication

Significantly less about...
The thinking side of diagnosis
Part Three
Closing the loop
Teamwork and collaboration is key

Each team member has a role in the whole process

Closing the loop next steps

1. Re-engineer processes
2. Employ policies, teamwork and tools
3. Engage, educate and support
Leverage performance improvement methods

Such as...

- Process mapping
- FMEA
- PDSA
- Automated audits
- Safety Scorecards

...and focus on what we learned from claims

- Communication with patient/family
  - Follow-up instructions
- Communication between providers
  - Regarding patient’s condition
  - Management of patient
  - Documentation
- Patient compliance factors
  - With treatment regimen
  - With follow-up call or appointment
- Clinical Systems
  - Reporting revised findings
  - Reporting new findings
  - Patient received no report or wrong report
  - Clinician did not receive results
1. Test ordering
2. Specimen handling
3. Receipt of test results
4. Review of test results
   • TPAD, revised findings/discrepancies
5. Communication among providers
   • Critical test results
   • Incidental findings
   • Transitions of care
6. Communication with patients
7. Referral management process
8. Follow-up care/care coordination
Modeling closing the loop

Based on CRICO’s 12-Step Diagnostic Process of Care Framework and AHRQ Improving Your Laboratory Testing Process A Step-by-Step Guide for Rapid-Cycle Patient Safety and Quality Improvement
Modeling closing the loop

Test ordered → Test performed → Test interpreted → Result transmitted to ordering provider → Result reviewed by ordering provider → Abnormal?

- Patient notified via phone
- Referral & consult made
- Patient information shared with care team
- Follow-up plan established with patient

What about paper orders? and other variations?

CPOE orders inside facility
CPOE orders outside facility
non-CPOE orders inside facility
non-CPOE orders outside facility

What about paper orders? and other variations?
Modeling closing the loop

AHRQ Improving Your Laboratory Testing Process Toolkit for Rapid-Cycle Patient Safety and Quality Improvement
Failure to review result

What happens when the ordering provider does not review the result report?
Failure to review result

What happens when the ordering provider does not review the result report?

Questions to ask every time

- What are the steps within this process?
- When could it fail?
- What causes it to fail?
- What happens when it fails?
- How likely is it to happen?
- Will anyone notice?
- How severe is the impact?
### FMEA

#### Failure to review result

<table>
<thead>
<tr>
<th>Steps in the Process</th>
<th>Failure Mode</th>
<th>Failure Causes</th>
<th>Failure Effects</th>
<th>Likelihood of Occurrence (1 -10 high)</th>
<th>Likelihood of Not being detected (1-10 high)</th>
<th>Severity (1-10 high)</th>
<th>Risk Profile Number (RPN)</th>
<th>Actions to Reduce Occurrence of Failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test result reviewed by ordering provider or delegate for clinical decision making</td>
<td>Ordering provider or delegate does not review test result and no clinical decision making occurs</td>
<td>No tracking process for review of test results non-CPOE</td>
<td>Delayed or missed diagnosis</td>
<td>8</td>
<td>10</td>
<td>8</td>
<td>640</td>
<td>Engineer failsafe process for tracking all tests ordered for review by ordering provider or delegate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No alert of incoming results triggered for CPOE</td>
<td>Delayed or no treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Configure EHR to alert delegate of incoming normal reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provider alert burden too high – alert fatigue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Configure EHR to alert ordering clinician of abnormal reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td>EHR not configured for delegate alert</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Periodic audits of alert logs for outstanding results to be reviewed</td>
</tr>
</tbody>
</table>

Scores depend on setting, specialty, patient demographics, etc.

http://www.ihi.org/resources/Pages/Tools/FailureModesandEffectsAnalysisTool.aspx
Re-engineered result review

Re-engineered steps in the process:

- New process for tracking all ordered tests for result review (CPOE and non CPOE)
- All results to EHR
- EHR configured to alert delegate team member with normal results
- EHR configured to alert ordering provider with abnormal results
- Alert log audits done weekly to identify outstanding results not returned or reviewed
Automated medical record audits

EHRs & HIT empower organizations to automate performance improvement
Medical record audits or monitoring through reports

What fields are in the EHR?
- Encounter ID
- Type of test
- Date ordered
- Date/time result posted
- Date/time to provider signoff (or calculation)
- Evidence of response to test result (e.g. normal, further testing, etc.)

What can be calculated?
- Date/time to patient notification of result (or calculation)
- Date/time to patient notification of follow up plan (or calculation)
- Date for patient reminder for follow up to be scheduled
- Outstanding order reports
- Abnormal order reports
Track progress with HIT Safety Scorecards

<table>
<thead>
<tr>
<th>Patient received no report or wrong report</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>YTD</th>
<th>Prev YTD</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of events reviewed</td>
<td>6</td>
<td>7</td>
<td>1</td>
<td>8</td>
<td>7</td>
<td>9</td>
<td>11</td>
<td>4</td>
<td>...</td>
<td>53</td>
<td>48</td>
<td>-10.4%</td>
</tr>
<tr>
<td>Severity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>...</td>
<td>14</td>
<td>12</td>
<td>-16.7%</td>
</tr>
<tr>
<td>Medium</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>...</td>
<td>13</td>
<td>12</td>
<td>-8.3%</td>
</tr>
<tr>
<td>High</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>...</td>
<td>26</td>
<td>26</td>
<td>0.0%</td>
</tr>
<tr>
<td>Configured correctly, EHR/HIT didn't work (vendor issue)</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>...</td>
<td>11</td>
<td>11</td>
<td>0.0%</td>
</tr>
<tr>
<td>EHR/HIT design/configuration improvement needed (internal)</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>...</td>
<td>21</td>
<td>24</td>
<td>12.5%</td>
</tr>
<tr>
<td>Process improvement needed (clinical + HIT team)</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>...</td>
<td>15</td>
<td>13</td>
<td>-15.4%</td>
</tr>
<tr>
<td>Training content improvement needed (HIT + training team)</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>...</td>
<td>19</td>
<td>18</td>
<td>-5.6%</td>
</tr>
<tr>
<td>Individual training needed (training team)</td>
<td>0</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>...</td>
<td>13</td>
<td>12</td>
<td>-8.3%</td>
</tr>
<tr>
<td>HIT prevented near miss</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>...</td>
<td>25</td>
<td>26</td>
<td>3.8%</td>
</tr>
</tbody>
</table>

*all numbers above created by random number generator for demo purposes*

Adapted from PCPI’s “Closing the Referral Loop” and ongoing work of ECRI Institute’s Partnership for Health IT Patient Safety Workgroup
Employ policies, teamwork and tools

- Simplify, standardize, re-engineer processes
- Reduce variation
- Audit compliance
- Enforce standards
- Test management
- Specimen handling
- Critical test result reporting
- Patient portal communication
- Referral management
- Missed/cancelled appointments
Employ policies, teamwork and tools

Delegate test and referral management
- In-basket management
- Pre-visit planning
  - Test ordering
  - Expanded rooming
  - Result reconciling
- Team documentation
- Post-visit activities
  - Referral management
Employ policies, teamwork and tools

Tools

Process tools
- Algorithms
- Care maps
- Standing order sets

Communication tools
- IPASS
- SBAR
- Huddles
- Team meetings

Performance improvement tools
- Self-assessments/checklists
- Process mapping
- FMEA
- RCA
- Automated EHR audits
- Action plans
Engage, educate and support

Clinician and team education
• Use diagnostic error storytelling
• Define follow-up system failures
• Outline roles and accountabilities
• Integrate performance improvement into roles
Engage, educate and support

Clinician and team education
• Team-based care model
• Communication tools
  • TeamSTEPPSS
  • IPASS, SBAR, huddles
• Health literacy
• Ask Me 3
• Teach-back
• Empathetic communication
• Resilience and well-being support
  • Second victim support
Engage, educate and support

Patient and family education
• Testing rationale
• Testing and result process
• Roles and responsibilities
• Being an engaged member of the team
  • Patient visit summary
  • Patient testing summary
  • Patient referral form

Ask Me 3
1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?
Conclusion
Closing the loop:
√ Good for patients
√ Good for care teams
√ Good for business
References


• ECRI Partnership for Health IT Patient Safety [https://www.ecri.org/HITPartnership/Pages/default.aspx](https://www.ecri.org/HITPartnership/Pages/default.aspx)

• Health IT.gov Test Results Reporting and Follow-Up SAFER Guide [https://www.healthit.gov/sites/default/files/safer_test_results_reporting.pdf](https://www.healthit.gov/sites/default/files/safer_test_results_reporting.pdf)

