PHYSICIANS | CLINICIANS | CLINICS

Risk Report

MMIC UMIA ARKANSAS MUTUAL | Constellation® Together for the common good.

Reducing Diagnostic Error in Your Clinic

In our analysis of Constellation outpatient medical professional liability claims*, **diagnostic error** is the **#3 most frequent** allegation and **#1 most costly.**

#3 Occurrence | **#1** Total incurred cost

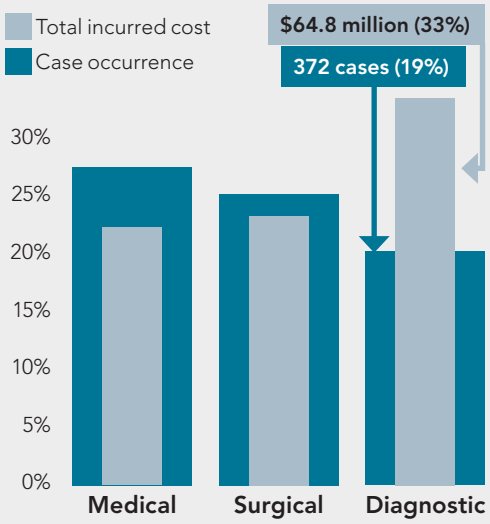
Did you know?

With over half of the cases involving follow-up system failures, analysis reveals that accurate and timely diagnosis depends nearly as much on the health care team and systems as it does on the diagnosticians themselves.

Investing time and resources in boosting care team member communication skills, re-engineering diagnostic workflows, and implementing reliable HIT systems creates stronger care teams, improves efficiency and productivity and enhances the diagnostic process.

Top Major Allegations Outpatient Claims

N=1,927 asserted 2010-2017



66%

Initial Diagnostic Assessment

Over half of all diagnostic errors in outpatient claims begin with issues that arise during the initial diagnostic assessment.

A family physician failed to consider and rule out breast cancer after a 27-year-old woman with a family history of breast cancer complained of bloody nipple discharge. Three years later, she was diagnosed with bilateral breast cancer.

Cancer is the #1 missed diagnosis in outpatient claims.

When diagnosis of cancer is missed...

49% of claims involve a delay/failure to order a diagnostic test.

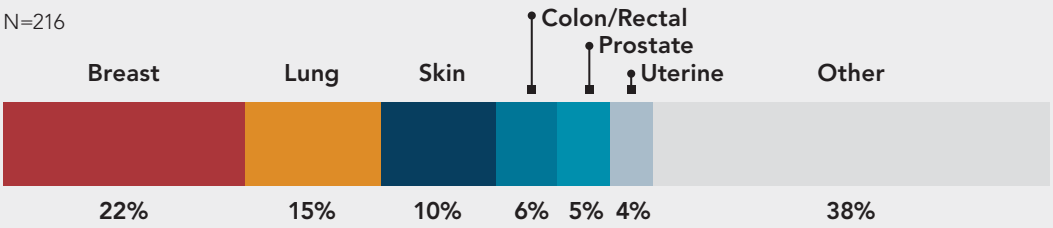
43% involve failure to assess and evaluate symptoms.

42% involve failure to establish a differential diagnosis.

*A claim may involve more than one factor

Top Missed Cancer Diagnoses

N=216



37%

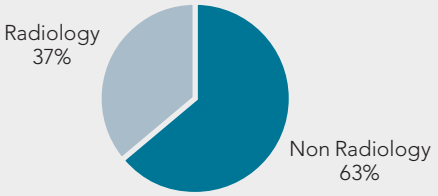
Testing and Results Processing

Issues also arise during diagnostic test and results processing.

A family physician missed a fracture on a 12-year-old's X-ray and failed to see the radiologist's overread report indicating a Salter-Harris II fracture. The delayed diagnosis resulted in surgery, extended recovery and impairment.

Misread X-rays

N=30



X-rays are often read by primary care providers and specialists, but, when considering case rate against quantities of X-rays read by each, the data indicates consulting a radiologist can help to avoid misreads.

51%

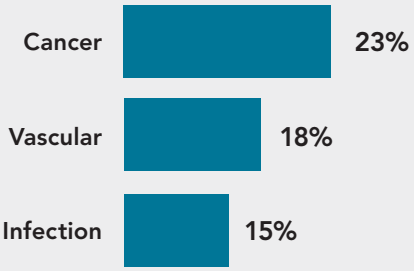
Follow-Up and Coordination

Problems with follow-up and coordination occur in almost half of cases.

A family physician ordered a preop chest X-ray on a 53-year-old woman. The radiologist noted an abnormality and recommended follow-up imaging. The family physician never saw the radiologist's report. Three years later, the woman was diagnosed with lung cancer.

Top Missed Diagnoses Involving Follow-up and Coordination Failures

N=307



For help on reducing risk and improving the diagnostic process, contact your risk and patient safety consultant or **PatientSafety@ConstellationMutual.com**

Good for care teams. Good for business.

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*Constellation MPL claims asserted from 2010 to 2017