PHYSICIANS | CLINICS | HEALTH SYSTEMS

Risk Report

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Reducing Diagnostic Error in Your Clinic

In our analysis of Constellation® outpatient medical professional liability claims*, **diagnostic error is the #1 most costly and #2 most frequent allegation.**

#1 Total incurred cost

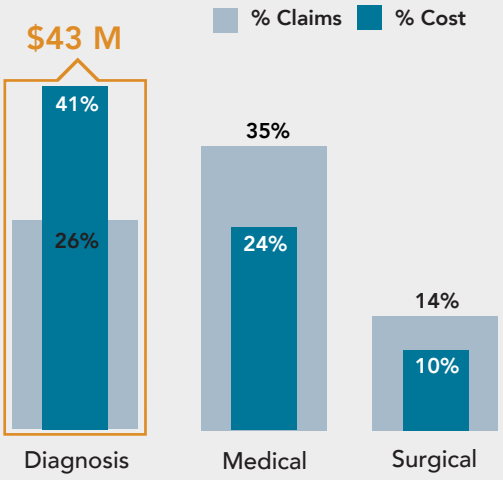
#2 Occurrence

Did you know?

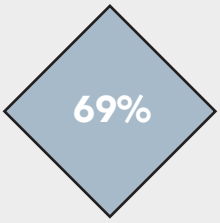
With over half of the cases involving follow-up system failures, analysis reveals that accurate and timely diagnosis depends nearly as much on the health care team and systems as it does on the diagnosticians themselves.

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.

Allegations Triggering Outpatient Claims



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...

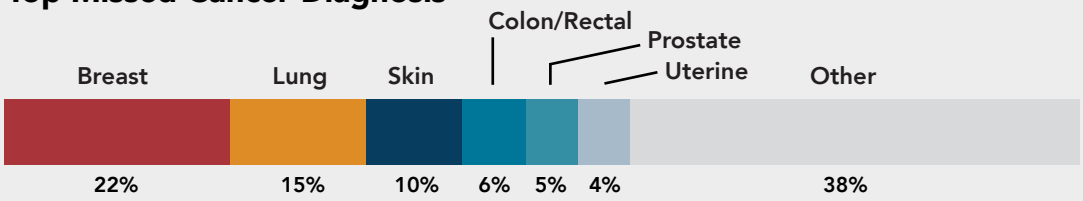
49% involve a delay/failure to order a diagnostic test.

43% involve a failure to assess and evaluate symptoms.

42% involve a failure to establish a differential diagnosis.

A claim may involve more than one factor.

Top Missed Cancer Diagnosis



*Constellation MPL claims reviewed 12/31/2020

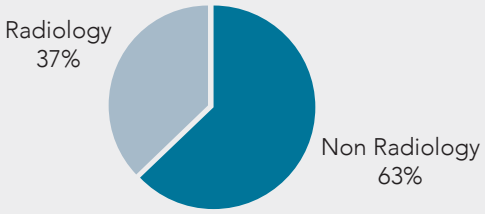
Tests and Results Processing

23%

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



X-rays are often read by primary care providers and specialists, but the data indicates **consulting a radiologist can help avoid a missed or wrong diagnosis.**

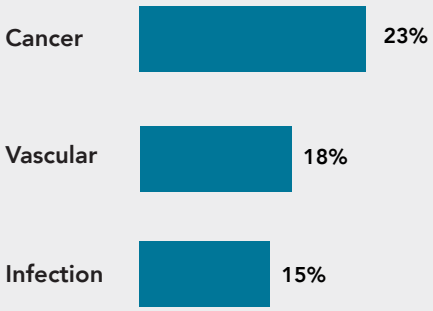
Follow-Up and Coordination

52%

Problems with follow-up and coordination occur in over half of claims.

A family physician ordered a pre-op chest X-ray on a 53-year-old woman. The radiologist noted an abnormality and recommended follow-up imaging. Due to a follow-up system failure, the family physician never saw the radiologist's report so there was no communication to the woman about the abnormality and the need for follow-up imaging. Three years later, the woman was diagnosed with lung cancer.

Top Missed Diagnoses Involving Follow-up and Coordination Failures



What You Can Do to Reduce Diagnostic Error Harm Events

Learn about the causes and contributing factors to diagnostic error

Assess your risk for diagnostic process failures

Enhance communication with patients and among the diagnostic care team

Analyze diagnostic error harm events and implement strategies to reduce risk

Good for care teams. Good for business.

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10 Things You Can Do to Reduce Diagnostic Error Harm Events and Claims

Educate Your Team & Patients

1. Understand the causes and contributing factors that lead to diagnostic error. **Watch our Diagnosis Error on-demand webinars.**
2. Invest in team training and communication skills with TeamSTEPPS, SBAR and/or I-PASS. **Watch our Communication on-demand webinars.**
3. Educate and engage patients to be part of the diagnostic team with **The Patient's Toolkit for Diagnosis and Ask Me 3.**

Assess & Analyze

4. Assess your organization's risk for diagnostic errors **by taking our Diagnostic Error Risk Assessment.**
5. Assess your ability to respond effectively to a harm event **by taking our HEAL® assessment.**
6. Evaluate your testing and referral management systems using **AHRQ Improving Your Laboratory Testing Process A Step-by-Step Guide for Rapid-Cycle Patient Safety and Quality Improvement.**
7. Analyze harm events and share lessons learned **using tools found in our HEAL Prepare Toolkit, Unit-2 Event Response and Unit-4 Moving Forward.**

Implement Safer Care Processess

8. Enhance communication with patients and families after a harm event **using best practices found in our HEAL Prepare Toolkit.**
9. Consider consulting a radiologist to overread X-rays taken in the outpatient setting. Radiologists should implement a formal nonroutine communication process when discrepancies are noted.
10. Provide clinical decision support tools to help your clinicians consider potential serious diagnoses:
    - **CRICO's Breast Care Patient Safety Decision Support**
    - **Isabel Differential Diagnosis (DDx) Generator**
    - **The Society to Improve Diagnosis in Medicine Checklists and Tools for Diagnosis**

Sign in to ConstellationMutual.com:

- Report an Incident or Claim or Call 1.800.328.5532
- Risk Resources/Bundled Solutions/Preventing Diagnostic Error
- HEAL Prepare Toolkit

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