# Risk Management 101 & 102: Risk Management and Tracking and Preventing Missed, Delayed, or Incorrect Diagnoses
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# Learning Objectives

- **Recognize strategies for implementing appropriate clinical policies and procedures to reduce risks to patients.**

- **Identify the most common patient safety risks nationwide and associated claims trends.**

- **Identify strategies to improve tracking and follow-up of test results, hospitalizations, missed appointments, and referrals.**

# Learning Objectives

- **Recognize breakdown points in the diagnostic process that may lead to missed, delayed, or incorrect diagnoses.**

- **Identify risk management strategies for commonly missed diagnoses.**

- **Identify strategies to prevent diagnostic error.**

- **Recall tips for documenting diagnostic information.**

- **Recognize strategies for handling noncompliant patients.**

# Polling Question 1

**Diagnostic errors in outpatient care affect at least 1 in 20 adults.**

A. True

B. False

C. Don't know

# Polling Question 2

**Approximately what percentage of diagnostic errors may lead to severe harm?**

A. 25%

B. 50%

C. 75%

D. 100%

# Polling Question 3

Diagnostic errors leading to claims are highest in which of the following areas?

A. Failure to order a diagnostic or lab test

B. Failure to refer

C. Diagnostic or lab test results not conveyed to patient

D. Inadequate or inappropriate follow-up plan

# Polling Question 4

Which of the following do you think is the most difficult to track?

A. Lab tests (bloodwork, pathology specimens, urine/throat/stool specimens)
B. Diagnostic imaging (radiographs, MRIs, other scans)
C. Hospital admissions or ED visits
D. Referrals to outside specialists

(ED = emergency department; MRI = magnetic resonance imaging)

# Polling Question 5

**Which do you feel is the most common communication breakdown?**

A. Gaps in provider-to-provider communication
B. Gaps in communication between management and frontline staff
C. Gaps in communication between providers and frontline staff
D. Gaps in communication from outside facilities
E. Other—not mentioned on this list

# FTCA University BINGO

- **Using the BINGO card you received, mark an "X" on the blocks when each concept is covered during the presentation**

- **HINT: When a concept is included on the BINGO card, you'll see this symbol on the slide:**

# Risk Management Basics

# The Importance of Risk Management and Patient Safety

**Adverse events in healthcare each year:**

- **There are more than 400,000 preventable patient deaths (hospital data)[*]**

- **Medical error is the third leading cause of death[†]**

- **About 5% of adults (>12 million people) experience diagnostic error in outpatient settings[‡]**

- **Nearly 4.5 million medication errors occur in ambulatory care[§]**

Sources: [*]James, *J Patient Saf* 2013; [†]Makary and Daniel, *BMJ* 2016; [‡]Meyer and Thomas, *BJM Qual Saf* 2014; [§]Sarkar et al., *Health Serv Res* 2011

# FTCA Claims Trends, Fiscal Year 2015

- **One-third of all claims were diagnosis-related**
  - Failure to diagnose
  - Wrong or missed diagnosis
  - Delay in diagnosis
  - Failure to instruct or communicate with patient
- **One-sixth of all claims were treatment-related**
  - Failure to treat
  - Improper performance
  - Failure to order appropriate test
  - Failure or delay in referral or consultation
- **Contributing factors included problems with policies, communication, documentation, and patient referrals**

# What Are Some Ways to Identify Risks?

- **Findings from internal reviews or assessments**

- **Incident report summaries**

- **Reports and trends of adverse events or unsafe conditions**

- **Medical record review**

- **Patient satisfaction surveys**

- **Patient complaints**

- **Patient safety alerts**

# What Are Key Components of a Risk Management Plan?

- **Guiding principles**
- **Day-to-day risk management activities**
- **Leadership and governance**
- **Definition of commonly used risk management terms**

- **Goals and objectives**
- **Functional interfaces with other departments (infection control, nursing)**
- **Monitoring**
- **Confidentiality**

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# Event Reporting

Unsafe conditions

Near miss

Adverse event

Critical or sentinel event

# What Type of Event?

- **A provider enters the exam room and begins talking with a patient and entering information. After a few minutes, the physician realizes that he is entering information into the wrong patient record (for a different patient with the same name). Provider checks date of birth, confirms it is the wrong patient, and accesses correct record for the rest of the visit.**

- **Patient calls the health center, speaks to the administrator, and says that she was sexually assaulted during her visit earlier that day.**

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# What Type of Event?

- **After inclement weather, the floor of the office becomes wet and slippery.**

- **A patient receives a prescription for the wrong medication, fills it at the pharmacy, and begins taking the medication. When the patient returns to the health center, the provider realizes the error and corrects the prescription. The patient experiences no serious harm.**

BINGO

# What Are Some Risk Prevention Strategies?

- **Listen**

- **Survey**

- **Analyze**

- **Monitor**

# Listen

# Survey

- **Customer complaints analysis, satisfaction/experience surveys, and patient-assessed outcome tools can be used to identify risk.**

- **Target specific areas or departments within your health center to help hone in on opportunities for improvement.**

- **Staff satisfaction surveys are also a way to identify risks in how care is delivered.**

- **Environmental surveys and "walk-around" checklists can help to identify safety concerns.**

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# Analyze

- **Find out where you stand. Get a baseline. It is OK if results are not perfect.**

- **Determine what you need to work on by collating the results.**

- **Focus on those areas for improvement.**

- **Gauge progress by conducting the surveys at consistent intervals.**

BINGO

# Monitor
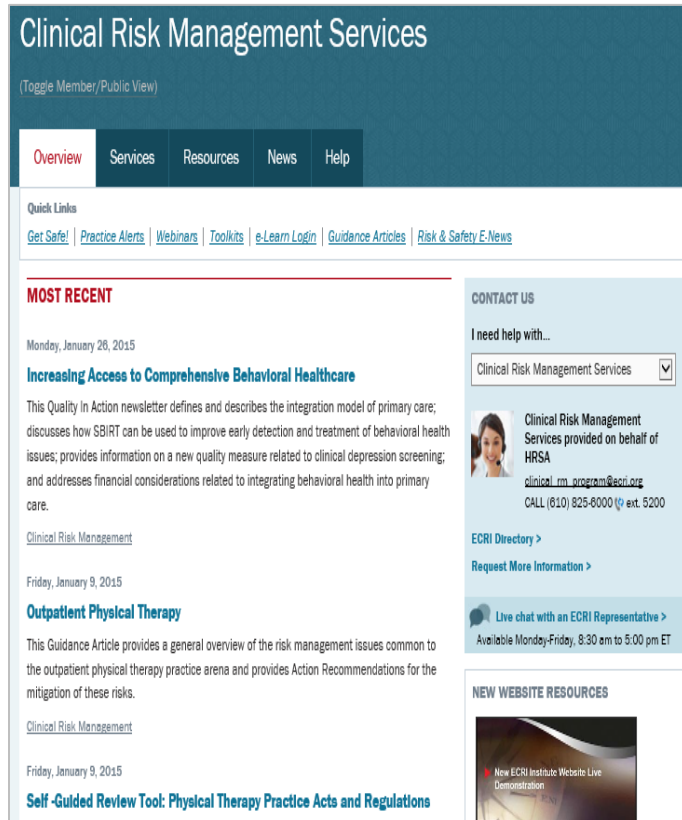
**Are the selected techniques working?**

- **Set standards for acceptable performance**
- **Compare actual results with expected results**
- **Correct substandard performance**
- **Alter unrealistic standards**

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# Clinical Risk Management Website



**Website resources:**

- **Self-assessment questionnaires**
- **Sample risk management plan**
- **Toolkits**
- **E-news**
- **Guidance articles**
- **Sample policies and tools**
- **Standards and guidelines**
- **Education and training tools**

# Tracking and Follow-up

# Think About …

Throughout today's presentation, think about these questions:

1. What are the biggest challenges you face related to tracking and following up on laboratory tests, referrals, hospitalizations, and no-show appointments?

2. What strategies have you implemented to improve your tracking and follow-up processes?

3. What are some key lessons you've learned from your efforts that you can share with others?

# Key Topics to Get on the Right Track

- **Tracking test results**
- **Following up on no-show appointments**
- **Identifying patients in your center who have been seen in the ED or admitted or discharged from the hospital**
- **Tracking referrals to specialists or other outside providers**

# Tools for Tracking

- **Logs**

- **Electronic health records (EHRs)**

- **Policies and procedures**

- **Staff education**

- **Open communication**

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# Elements of a Test Tracking Policy

- **Communicate all test results (including normal results) to patients**
- **Specify time frame targets for each type of result (critical, abnormal, and normal)**
- **Include fail-safe contingency plans ("what if's")**
- **Ensure EHR automatically flags overdue results, or assign specific staff to monitor tracking logs**
- **Stress need for follow-up and who is accountable**
- **Periodically audit results to be sure that providers have acknowledged them**
- **Document everything**

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# Abnormal vs Critical Test Results

- **Immediately notify patient of any CRITICAL test result (in some areas these are known as "panic values")**

- **Document notification (date/time/person spoken with) and follow-up recommendations, including coming to the health center or going to the ED**

- **Make sure you know what to do if the patient can't be reached**

- **DO NOT leave critical or abnormal lab results on voicemail**
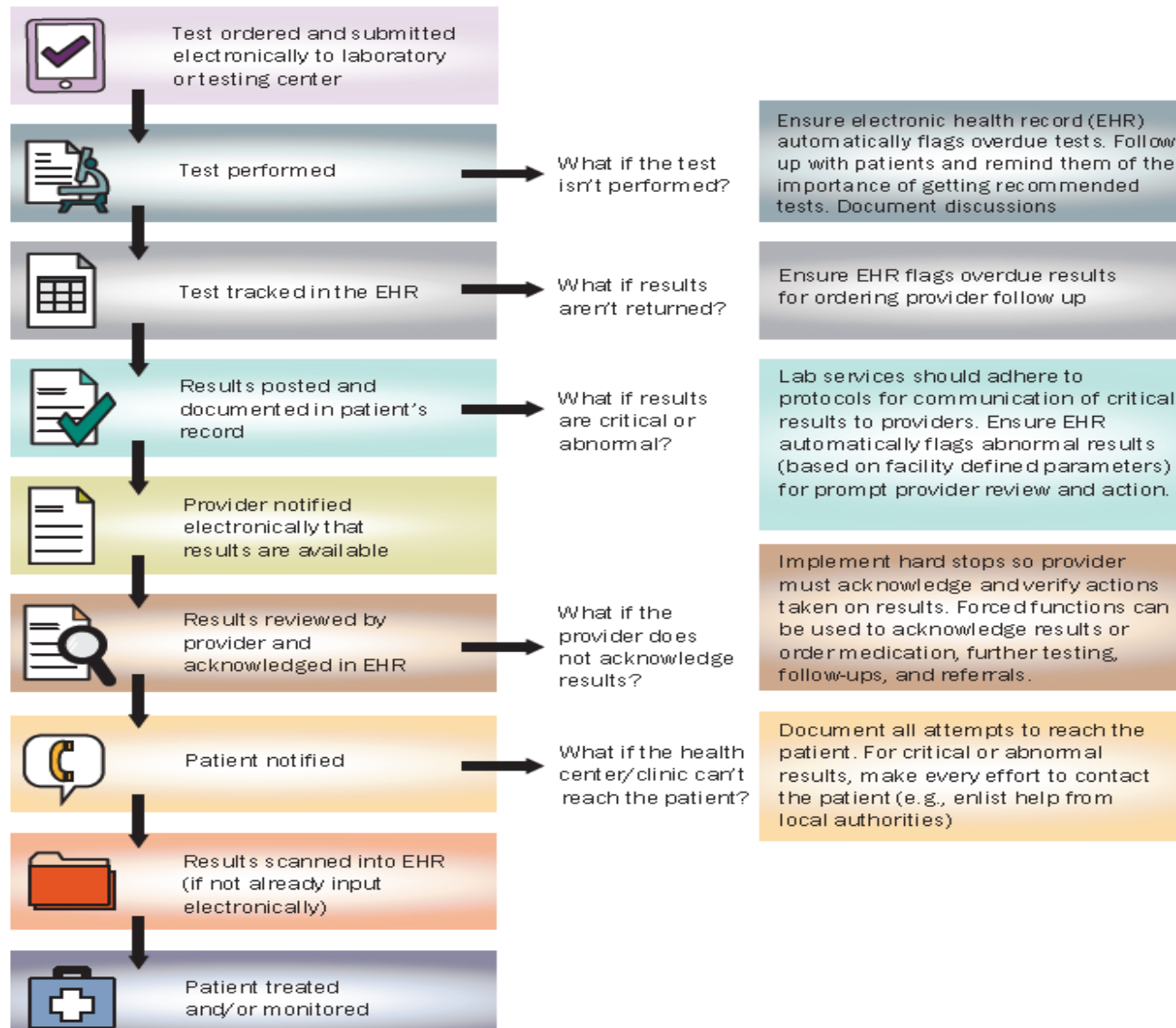
BINGO

# Activity

- **Use a separate sheet of paper to write down, in order, the steps your center or clinic uses for test ordering, tracking, and follow-up. You can also open a new document on your computer to document these steps.**

- **For example:**
  - **STEP 1:** Test ordered
  - **STEP 2:** Test performed

# Algorithm: Outpatient Testing



Test ordered and submitted electronically to laboratory or testing center

Test performed

What if the test isn't performed?

Ensure electronic health record (EHR) automatically flags overdue tests. Follow up with patients and remind them of the importance of getting recommended tests. Document discussions

Test tracked in the EHR

What if results aren't returned?

Ensure EHR flags overdue results for ordering provider follow up

Results posted and documented in patient's record

What if results are critical or abnormal?

Lab services should adhere to protocols for communication of critical results to providers. Ensure EHR automatically flags abnormal results (based on facility defined parameters) for prompt provider review and action.

Provider notified electronically that results are available

Results reviewed by provider and acknowledged in EHR

What if the provider does not acknowledge results?

Implement hard stops so provider must acknowledge and verify actions taken on results. Forced functions can be used to acknowledge results or order medication, further testing, follow-ups, and referrals.

Patient notified

What if the health center/clinic can't reach the patient?

Document all attempts to reach the patient. For critical or abnormal results, make every effort to contact the patient (e.g., enlist help from local authorities)

Results scanned into EHR (if not already input electronically)

Patient treated and/or monitored

https://www.ecri.org/components/HRSA/Pages/OAPol32.aspx

# Test Tracking and Follow-Up Toolkit

**Published** 2/9/2017

🔖 SAVE

🖨 PRINT

⬇ DOWNLOAD

Because the processes related to ordering and following up on diagnostic tests are complex and involve multiple individuals—including patients, physicians, other providers, administrative staff, and laboratory personnel—there are many opportunities for errors to occur. Such errors may result in missed or delayed diagnoses or delayed interventions to improve care, thus putting patients at risk for adverse outcomes.

The toolkit contains a sample policy, lists of critical tests, test tracking logs, sample letters to patients about test results, and other tools and resources that health centers and free clinics can download and adapt for their own use.

## Toolkit Documents

- Sample Policy: Reporting Test Results
- Algorithm for Outpatient Critical Value Reporting Process
- Algorithm for Outpatient Testing Process
- Critical Test Value Communication: Adult Blood Gases and Chemistry
- Critical Test Value Communication: Adult Cardiology
- Critical Test Value Communication: Adult Radiology
- Diagnostic Test Tracking and Follow-Up
- Sample Letter to Patient about Test Results
- Test Tracking Log for Physician Practices
- Tracking Hospitalizations: Patient Card and Procedures

**RELATED RESOURCES**

- Test Tracking and Follow-Up

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# Managing No-Show Appointments

# Group Discussion: No-Shows

- **What is your health center's definition of a no-show?**

- **What is your health center's no-show rate?**

- **What are you doing to manage no-show appointments?**

- **What strategies have you found most effective?**

# Why Follow Up on No-Shows? It Is Just One More Thing to Do …

A missed appointment can present several problems:

- Possible health consequences

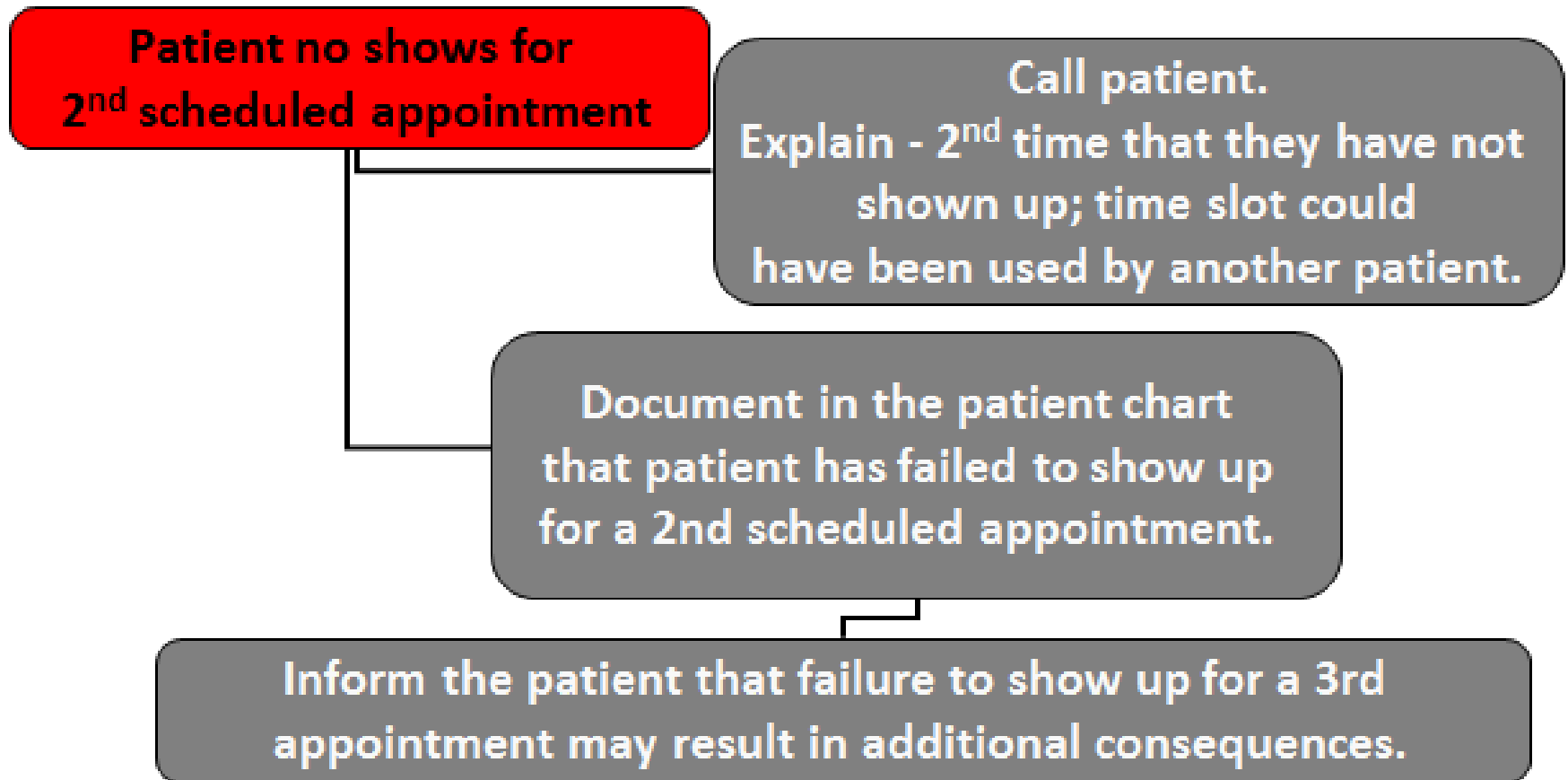- Liability risk

- Reduced accessibility

- Lost revenue

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# Algorithm to Manage 1st No-Show

Patient does not show up for scheduled appointment

Call patient and invite them to reschedule

Document in the chart that call was made and appointment was rescheduled

# Algorithm to Manage 2nd No-Show

Patient no shows for 2nd scheduled appointment

Call patient. Explain - 2nd time that they have not shown up; time slot could have been used by another patient.

Document in the patient chart that patient has failed to show up for a 2nd scheduled appointment.

Inform the patient that failure to show up for a 3rd appointment may result in additional consequences.

# Be Proactive Rather than Reactive

- **Call patients 24 to 48 hours ahead to remind them of their appointment**

- **Examine and review the no-show appointments to see if there was a "gap" in communication (e.g., language barrier)**

- **Develop a written policy on how the health center will handle no-shows and communicate it to patients during scheduling and with reminder calls**

# Tracking Hospital Admissions, Discharges, and ED Visits

# Group Discussion: Hospital Admissions and ED Visits

- How many of you have a primary hospital or ED that is used for the majority of your patients?

- How many have a large number of your patients who go to urgent care clinics or minute clinics?

- How many have effective communication with your affiliated hospital?

- Does anyone have information integrate into your EHR from the hospital system? How is that handled?

# Why Track Something That Happens Outside the Health Center?

**Providers need to know!**

- **If a patient was seen in the health center and then goes to the ED or urgent care for the same problem**

- **If a patient goes to the ED as a result of office visit treatment**

- **If a patient is seeking care elsewhere for a recurring complaint**

# Hand-offs Are Critical…

- **The hand-off after discharge can cause a "voltage drop" in information, creating what has been called the Achilles heel of the hospitalist model.**



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# Strategies to Manage Communication with Hospitals

- **Make sure that all local hospitals and urgent care clinics have contact information for your health center (business cards with telephone and fax numbers).**

- **Include the ability to notify the health center or provider on call of any overnight ED visits or hospital admissions in your after-hours coverage plan.**

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# Strategies to Manage Communication with Hospitals *(cont'd)*

- Check the fax machine in the morning (for any patient ED visits that may have occurred overnight) and frequently throughout the work day. Be sure that a provider reviews all correspondence from the hospital prior to filing or scanning it into the patient record.

- Set up a same-day urgent slot to accommodate a patient who may have been seen in the ED or discharged from the hospital.

# Strategies If You Are Using an EHR

- Determine whether an automatic interface can be established between the hospital and your EHR for your patient's information.

- If no interface exists, identify how test results and hospital summaries that the health center receives will be reviewed and incorporated into the EHR.

# Strategies If You Are Using an EHR *(cont'd)*

- **Identify the types of reports that may come in to the health center and be sure that they are properly identified and flagged in the EHR for easier access.**

- **Be sure there is a review process by a provider before the item is scanned to identify any items in the follow-up plan that may be time-sensitive.**

❖**Results and other information must be reviewed and followed up, regardless of how they arrive at the health center.**

# Referral Tracking

# Important Aspects of Managing Referrals

- **Monitor availability and access to specialist appointments**

- **Know what specialists see patients with particular insurance**

- **Educate providers on how to manage (and document) noncompliance**

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# Referral Tracking

- **Educate providers on tracking referrals**

- **Create a centralized communication system**

- **Follow up with patients 30–60 days after the date the referral was made**

- **Notify the provider who made the referral if the patient has chosen NOT to follow through with the referral**

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# Referral Tracking

- **Use interfacing electronic records to allow easy referral and order form completion**

- **Create a "check out" procedure for patients to get assistance with scheduling referrals before they leave the office**

- **Print out information sheets with the telephone number and address of the referral office**

# Elements of a Referral Tracking Policy

- **Enter every referral into a tracking log (electronic or paper)**

- **Specify targets for each type of referral (urgent, routine, and patient requested)**

- **Identify contingency plans ("what if's")**

- **Pinpoint referral follow-up and who is accountable**

- **Address patient noncompliance in referrals**

- **Document appropriately**

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# Preventing Missed, Delayed, or Incorrect Diagnoses

# Why Are Diagnostic Errors a Concern?

- **Diagnostic error, with its associated harms, has been labeled a public health problem.**

- **Diagnostic errors in outpatient care affect at least 1 in 20 adults.**

- **One-half of diagnostic errors potentially lead to severe harm.**

- **Diagnostic errors may be difficult to detect; often errors are discovered in retrospect.**

Sources: Tehrini et al., *BMJ Qual Saf* 2013; Singh et al., *BMJ Qual Saf* 2014; Agency for Healthcare Research and Quality 2014 http://www.ahrq.gov/news/newsroom/press-releases/2014/diagnostic_errors.html

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# What Are the Types of Diagnostic Errors?

- **Missed**

- **Delayed**

- **Incorrect**

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# How Are Diagnostic Errors Discovered?

- Autopsy
- Case reviews
- Surveys of patients and physicians
- Voluntary reporting systems
- Second reviews

- Diagnostic testing audits
- Use of standardized patients
- Closed-claims review
- Trigger tools from EHRs

Graber, *BMJ Qual Saf* 2013

# Common Missed Diagnoses

A study of closed-claims data (2008–2012) found that the most common diagnostic-error claims were related to the following conditions:

1. Cardiac/cardiorespiratory conditions
2. Breast cancer
3. Lung cancer
4. Acute myocardial infarction/heart attack
5. Colorectal cancer

Physicians Insurers Association of America (PIAA) 2015 http://plusweb.org/Journal/Landing-Page/IssueID/52/April-2015-Volume-XXVIII-Number-4

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# Case Study: Breast Cancer Symptoms Thought to Be "Normal Changes"

A 29-year-old patient who was seven months pregnant reported burning pain and clear discharge leaking from her nipple. Her obstetrician told the patient the changes were normal during pregnancy and did not perform a breast exam. After the patient gave birth several months later, another physician at the practice found a breast lump and diagnosed triple-negative breast cancer. The patient underwent chemotherapy, mastectomy, and radiation. She later died from metastatic breast cancer at age 32.

Source: Medical Malpractice Verdicts, Settlements, and Experts

# Lessons Learned

- **Take patient concerns seriously**

- **Follow up on patient symptoms**

- **Consider the rare presentation**

# Case Study: Missed Colorectal Cancer

- **A 62-year-old patient has been seeing the same primary care provider for 20 years and often misses appointments.**

- **Provider never schedules colon cancer screening because he assumes the patient will miss the screening appointments.**

- **Patient seen for three years with complaints of abdominal, back, and chest pain.**

- **Documentation is incomplete; family history never noted.**

- **Patient dies of colorectal cancer one month after diagnosis.**

Source: Controlled Risk Insurance Company

# Lessons Learned

- **Develop protocols for colorectal cancer screening**
- **Create policies for missed appointments**
- **Conduct chart audits to identify deficits in:**
  - **Obtaining a family history**
  - **Documenting the patient's complaint**
  - **Documenting history and physical examination**
  - **Ordering, completion, and follow-up of screening examinations and testing**
- **Use clinical decision support tools effectively**

# Documentation

- **Never alter entries or delete information**
- **Document all treatment recommendations**
- **Document all tests ordered, received, and communicated to patient**
- **Document all phone calls and messages**
- **Document informed consent and refusal**

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# Engage the Patient

- **Educate patients on signs and symptoms to look for.**

- **Tell patients what tests are being ordered, why they are being ordered, and when and how results will be provided.**

- **Make sure the patient understands instructions and knows who will be managing his or her care.**

# Patient Noncompliance

- **Ask questions**
  - **Is there a reason that screening concerns you?**
  - **If (disease/condition) were detected, would you want to be treated?**
  - **Do you understand that by refusing screening, if you do have (disease/ condition) your treatment options and life expectancy may be limited?**
  - **Would you like to discuss this issue with another provider?**
- **Documentation is critical**
  - **Document all questions asked and patient responses in direct quotes.**

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# Group Discussion: Test Tracking, Referrals, No-Shows

1.  What are the biggest challenges you face related to tracking and following up on laboratory tests, referrals, hospitalizations, and no-show appointments?

2.  What strategies have you implemented to improve your tracking and follow-up processes?

3.  What are some key lessons you've learned from your efforts that you can share with others?

# Thank You

## Additional Questions?

### BPHC Helpdesk:

### 1-877-974-BPHC (2742)

### https://www.hrsa.gov/about/contact/bphc.aspx

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