MINIMIZE RISK
REDUCING DIAGNOSTIC ERROR IN YOUR CLINIC

In an analysis of outpatient medical professional liability claims asserted from 2010 to 2015, diagnostic error is the #3 most frequent allegation and #1 most costly.

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

#3 Occurrence | #1 Total incurred cost

Initial Diagnostic Assessment

58%

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.

Top Major Allegations
Outpatient Claims
N=1,436 asserted 2010-2015

$38.4 million (28%)
281 cases (20%)

Surgical Medical Diagnostic

When diagnosis of cancer is missed...

43% of cases involve the failure to establish a differential diagnosis during the initial diagnostic assessment.

26% involve a failure/delay in ordering a diagnostic test.

Top Missed Cancer Diagnoses
N=90

Breast Lung Skin Colon/Rectal Prostate Uterine Other

23% 13% 11% 7% 4% 4% 38%
For help on reducing risk and improving the diagnostic process, contact your risk and patient safety consultant or Patient.Safety@MMICgroup.com
TEN THINGS YOU CAN DO TO REDUCE RISKS AND IMPROVE THE DIAGNOSTIC PROCESS

Resources are available at MMICgroup.com.
Login > Risk Management > Bundled Solutions > Preventing Diagnostic Error

Educate your team and patients
1. Explore the causes of diagnostic error Diagnosis Errors webinars; Spring Brink Magazine.pdf
2. Optimize your team’s communication skills with TeamSTEPPS, SBAR and I-PASS.
3. Engage patients as part of the diagnostic team NPSF The Patient’s Checklist for Getting the Right Diagnosis and NPSF Working with Patients and Families to Get the Right Diagnosis

Assess and analyze
4. Assess your risk for diagnostic errors Improving Diagnosis Self-assessment.pdf
6. Optimize the safe use of processes and EHR technology using the Test Results Reporting and Follow-Up SAFER Guide
7. Analyze your diagnostic error adverse events using NPSF RCA2 to identify causal and contributing factors and identify effective actions to prevent future events
8. Implement clinician feedback regarding diagnostic accuracy using tools such as Patient Safety Authority Diagnostic Error Measures Worksheet

Implement safer care processes
9. 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
10. Consider consulting radiologists to overread X-rays taken in the outpatient setting. Radiologists should implement a formal nonroutine communication process for when discrepancies are noted. ACR Practice Parameter for Communication of Diagnostic Imaging Findings

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