



SAVING LIVES - REDUCING RISK

From The Editor

Welcome to the TSG Newsletter. Much is happening, particularly along the electronic medical record (EMR) front with meaningful use and integration of clinical decision support along with a high level of interest in TSG's new patient satisfaction courses. I don't believe we have ever had a more powerful opportunity to build risk and safety into the moment-to-moment practice of medicine as we have now with the widespread implementation of EMR systems.

Not that most EMR vendors have taken the time to address clinical issues or decision support! However, at TSG, we have been able to integrate our risk, safety and quality knowledge base into several systems. If you have any questions or need assistance in this critical area, let us know.

This quarter I wanted to take advantage of some

recent publications looking at emergency medicine malpractice from 20,000 feet and provide a drill-down all the way into the ground floor of our nation's emergency departments. We often use case presentations in the newsletter, but this quarter

we present information that demonstrates the key importance of the 'failure to diagnose' as the primary cause of emergency medicine malpractice. **Sometimes it's important to stand back and look at the big picture!** ■



The Failure to Diagnose at 20,000 Feet

Most fee-for-service emergency medicine groups consider their malpractice-related information proprietary, so it is often difficult to get adequate data to draw firm conclusions at a granular level. That is not a criticism;

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TSG EMRI Audit
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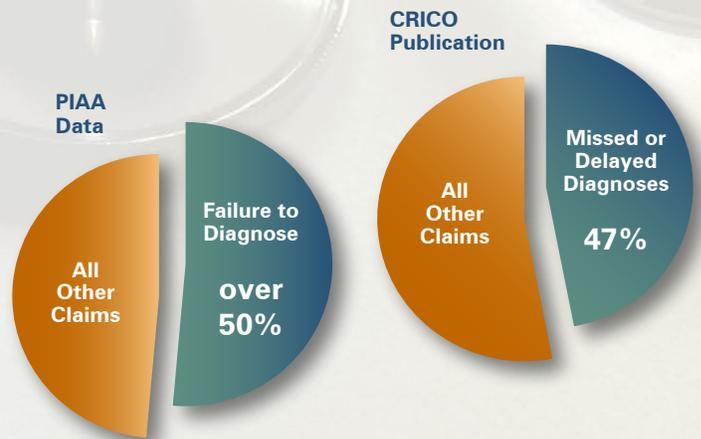
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that's just the way it is. But insurance companies and physician associations will often pool data and provide insights into the world of emergency medicine claims. That is the case now as the Physician Insurers Association of America (PIAA), The Doctors Company, and CRICO have recently published data that should be of particular interest to anyone in emergency medicine or involved with EM claims.

All three organizations mentioned above have recent publications that provide an overview of EM malpractice. The PIAA actually publishes an overview of all specialties every year that can be purchased online. The review by The Doctors Company provides an excellent detailed drill-down into the world of emergency medicine claims, so let's start there.

a 'failure to diagnose,' and an additional 10% were related to a 'delay in diagnosis.' That is a remarkable number. When you look at a pie graph of EM claims, it is immediately obvious that no other category of claims comes close to that frequency. The PIAA data year over year consistently demonstrates 'failure to diagnose' at over 50% of claims. In the recent CRICO publication, missed or delayed diagnoses represented 47% of all EM claims.

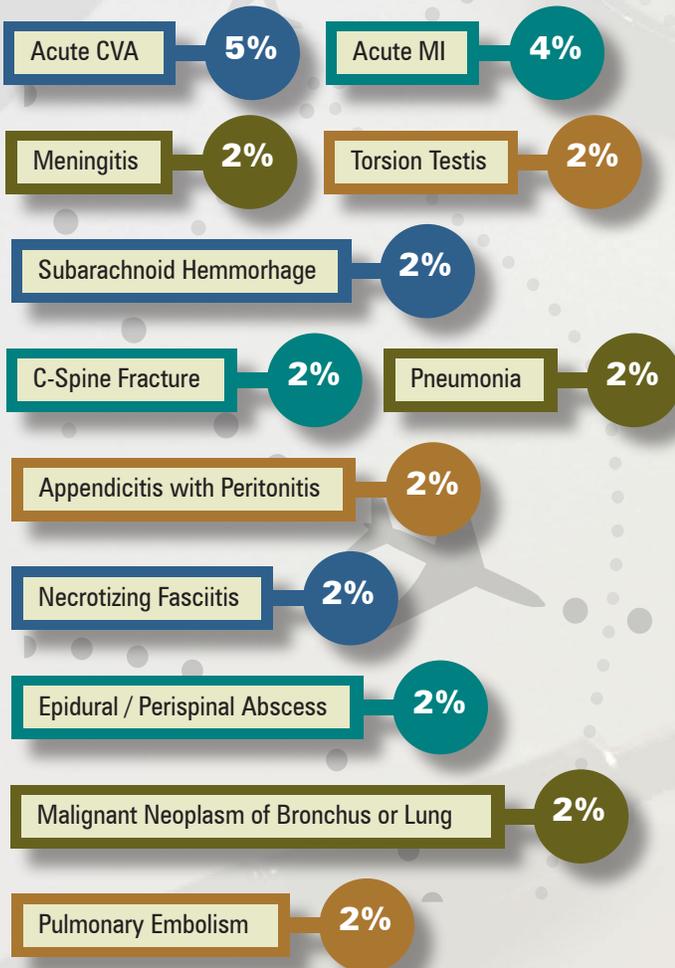


In their recent analysis of 581 emergency medicine claims (all cases were reviewed by medical professionals), the authors determined that 67% of the cases were related to

Every significant analysis of EM claims in recent memory has arrived at the same conclusion. Our key issue is the 'failure to diagnose' / 'delay in diagnosis,' not cases involving AMA, informed consent, improper performance of procedures, or any number of entities from a long list of potential claims (not to say that these areas are unimportant). The **key point** is that if you want to get your arms around EM medical errors, patient safety issues and medical malpractice, you must target the **failure to diagnose**. ■

The Failure to Diagnose at 10,000 Feet

Okay, so it's failure to diagnose. Thanks a lot. How does that help? It doesn't yet; we need to take another big step. So what are we failing to diagnose? Well, the list depends upon the year, sample size and other factors. But let's take a look at The Doctors Company data.



There are some very interesting lessons to learn from these results:

1. Several items on the list such as MI, torsion, C-Spine and others represent the usual cast of characters.
2. The incidence of CVA-related claims is striking. In our experience, those claims relate to both the failure to administer a lytic and administering a lytic in violation of some aspect of protocol with an allegedly related patient injury. Also, the severity of these claims can be staggering, as patients allege a lifetime of paralysis or other impediments to activities of daily living.
3. The cause of MI-related cases seems to be changing in character; the failure to diagnose is decreasing somewhat compared with historical data, and claims related to factors delaying arrival in the cath lab and inflation of the balloon are increasing. In the ED, that often relates to time-to-ECG and general throughput issues.
4. The relative newcomers are necrotizing fasciitis and epidural abscess. Interestingly, these may have a common denominator. Many of the necrotizing fasciitis cases appear to be related to early mismanagement of cutaneous MRSA. A cutaneous MRSA infection often looks like a bug bite or just a rash, so the diagnosis is delayed, or the diagnosis is made, but the antibiotic choice is wrong.



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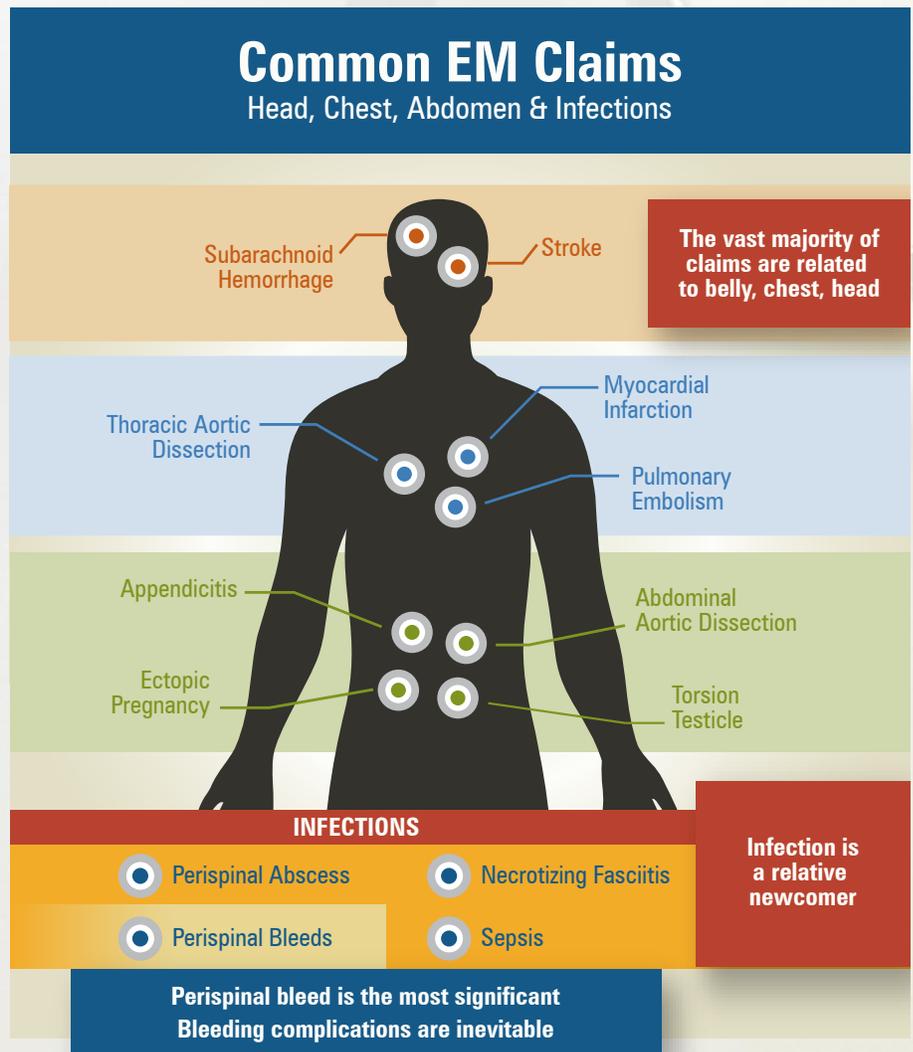
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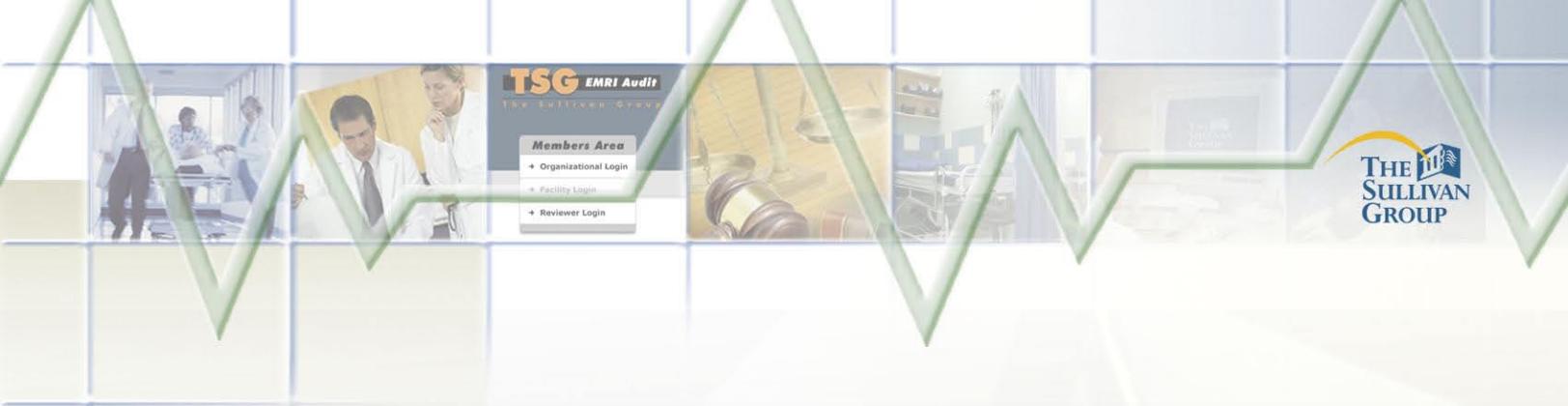
Take a look at TSG's current analysis of common claims against emergency physicians, strategically segregated into body sections and by cause.

There is a dramatic increase in the incidence of epidural abscess. Although it is too early to tell with certainty, TSG's analysis, including canvassing several hundred ED medical directors, indicates that many of these cases are MRSA-related. MRSA may have an unusual predilection for the perispinal space, changing this presentation that historically required a risk factor such as IV drug abuse. The other issue regarding this entity is that it can be incredibly difficult to diagnose early.

This analysis could take up the rest of this newsletter. But as you can see, the drill-down to 10,000 feet is helpful. So we know it is 'failure to diagnose' and we know some of the entities we are failing to diagnose. Is that enough information for the practitioner to employ system solutions to keep patients safe? Not yet.



Once again, there are a few interesting points about these results. Anatomically, the first two are head-related claims.



Satisfy ABEM MOC

The American Board of Emergency Medicine (**ABEM**) has affirmed that the TSG **RSQ[®] Clinical Assessment** (EMRI Audit) can be used by ABEM certified physicians toward fulfillment of a current ABEM Maintenance of Certification of Practice Performance (APP) – Practice Improvement (PI) requirement.

“Physicians certified by the American Board of Emergency Medicine may satisfy one current Assessment of Practice Performance requirement by completing this activity.”

If you practice at one of the 400 EDs that currently use the **RSQ[®] Clinical Assessment** (EMRI Audit), please contact TSG or ABEM to learn more about how this activity meets the Assessment of Practice Performance Maintenance of Certification requirement.

If you are interested in implementing the **RSQ[®] Clinical Assessment** at your facility, please contact Brant Roth for more details.

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The next three are all chest claims. The next four are all belly-related claims (torsion often presents as lower abdominal pain). The rest are infections other than perispinal bleed. A few key points:

1. The vast majority of ED claims are related to the belly, chest and head.
2. Infection is a relative newcomer (as discussed above).
3. Why are people bleeding into the perispinal space? They are actually bleeding into a number of potential spaces, but the perispinal bleed is the most significant; the reason is that the number of people on aspirin, platelet inhibitors or anticoagulants has skyrocketed. Bleeding complications are inevitable.



Again, much more can be said about this list, but the key points are there. This analysis, still at 10,000 feet, begins to give us some glimpse at the granularity we need to create a system solution for risk and safety in the ED. ■



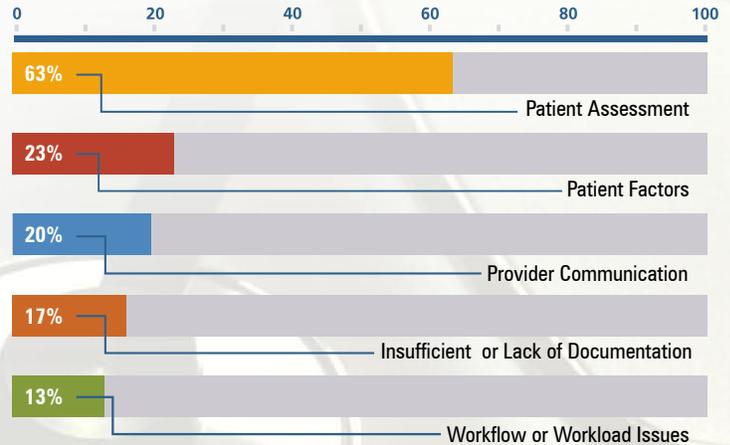
The Failure to Diagnose at 5,000 Feet

Now we know that it is the 'failure to diagnose,' we have a sense of what we are failing to diagnose and an awareness of the highest risk anatomical areas. Where do we go next?

The Doctors Company had medical experts review all 581 claims in an effort to profile those specific elements that seemed to be related to the 'failure to diagnose.' Below is a list of some of the factors that seemed to be responsible. Although this list is not complete, we include those elements that are easily amenable to a system solution.



1. Patient Assessment issues were present in 63% of the cases.
 - a. Lack of or inadequate history and physical exam
 - b. Failure to establish a differential diagnosis
 - c. Failure to address abnormal findings (e.g., vital signs)
2. Patient factors were involved in 23% of the cases.



- a. Patient not compliant with a follow-up call or appointment
- b. Patient not compliant with a treatment regimen
3. Issues with communication among providers were present in 20% of the cases.
 - a. Failure to read or have available key elements of the medical record
 - b. Inadequate handoffs
4. Insufficient or lack of documentation was present in 17% of the cases.
5. Issues with workflow or workload were present in 13% of the cases.

Although it's only at 5,000 feet, this analysis sheds some very interesting light on the causes of errors and adverse outcomes, most of which have scalable, relatively easy-to-implement solutions.

Here are just a few examples:

1. Create high-quality medical record content. Modify the paper medical record or the EMR to highlight those key elements of the history and physical that are missing.



Do You Or Your Physicians Feel Vulnerable Documenting On An EMR?

TSG Has a Solution: RSQ® Assist



Many Emergency Medicine physicians are being forced to use an EMR that does not support their clinical practice or include **TSG's Risk Mitigation Module**. In response

to their frustration, TSG has redesigned its clinical decision support library that is currently installed in over 400 EDs to create **RSQ® Assist**.

The patented **RSQ® Assist** application is a free-standing, complaint-specific clinical decision support tool that assists providers in their clinical practice and documentation.

-  EBM Resources
-  Quick Consults
-  Interactive DDx
-  Dictation Templates
-  Medical & Clinical Calculators
-  Chief Complaint-Specific Clinical Resources

If you are interested in learning more about **RSQ Assist®**, please contact: Brant Roth at broth@thesullivangroup.com

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2. Consideration of a differential diagnosis is critical in high-risk cases. It is all too easy to anchor on an early impression and prematurely close the clinical thought process. The solution? Make a differential diagnosis **immediately** available inside the four walls of the medical record. The practitioner should not have to open a book, insert a user name and password, or pull a smart-phone app out of a pocket. It should be integrated into and become an integral part of the medical record.



3. Patient factors can be addressed through risk and safety-enhanced electronic discharge instructions.

Once again, we stop here for the sake of brevity; but as you can see, we can now begin to formulate some solid recommendations for scalable system changes that can truly make a difference in the risk and safety equation. ■

An Important Aside!

We offer an interesting and important aside. What is the average cost of a medical malpractice insurance claim against an



emergency physician? What is your gut impression? Most practitioners believe that number is somewhere between \$150,000 and \$400,000. That is what the TSG advisors thought as well. We were shocked at recent numbers published by CRICO. CRICO maintains the largest database of emergency medicine claims in the country.

| Type of Claim | Amount |
|---|------------|
| Average indemnity in non-failure to diagnose claims | \$ 212,000 |
| Average indemnity in failure to diagnose claims | \$ 508,000 |
| Average indemnity if the failure to diagnose claim was related to history or physical exam | \$ 816,000 |
| Average indemnity if the failure to diagnose claim was related to the failure to monitor clinical status (e.g., abnormal vital signs) | \$ 653,000 |

The point is that if the claim is related to the fundamentals - the history, physical, monitoring and the failure to diagnose - the cost of those claims is dramatically higher than any prior publication of the average cost of claims against emergency practitioners. The other key point is that it is precisely the focus of this analysis and the focus of our recommendations to solve medical error and patient safety issues. ■

Patient Satisfaction Is Here

What's Your Plan?

It has been a common belief that "Happy patients don't sue" and some organizations have relied on this as their risk management strategy. Furthermore, now that reimbursements have been tied to patient satisfaction scores, physician groups and hospitals have become even more invested in finding solutions that truly make a difference in their patient satisfaction metrics.



TSG has responded by developing a new Patient Satisfaction program called *PatientSET™* "Satisfaction Every Time". Championed by Dr. Doug Finefrock, *PatientSET™* looks to the literature to identify certain elements of behavior that patients would like to see displayed during the

physician /patient encounter. Delivered through an online course series, Dr. Finefrock uses multimedia videos to provide concrete examples that will help improve the patient experience.

In true TSG fashion, *PatientSET™* extends beyond online education to include a real-time 'checklist' for the provider (*PatientSET™* List) as well as an observational assessment tool (*PatientSET™* Assessment) to be used by a case manager to analyze the clinician's compliance with key behavior elements of the visit.

If you are interested in learning more about the new *PatientSET™* Program, please contact: Brant Roth at broth@thesullivangroup.com



NEW e-Learning Courses

Patient Safety & Risk Management

- ➔ 11 Simple Strategies to Prevent Medication Errors
- ➔ Communication Strategies to Improve Patient Safety in High-Risk Situations
- ➔ Essentials of Patient Safety
- ➔ Prevention of Medical Errors
- ➔ Technology Revolution: Improving Patient Safety, Reducing Liability

Hospital Medicine

- ➔ Anatomy of a Medical Negligence Lawsuit
- ➔ Myocardial Infarction Part 1
- ➔ Myocardial Infarction Part 2
- ➔ Pulmonary Embolism Part 1
- ➔ Pulmonary Embolism Part 2
- ➔ Risk & Safety Overview Part 1
- ➔ Sepsis
- ➔ Thoracic Aortic Dissection

Toxicology

- ➔ Gastrointestinal Decontamination in Toxic Ingestion
- ➔ Opiate Agonists & Antagonists

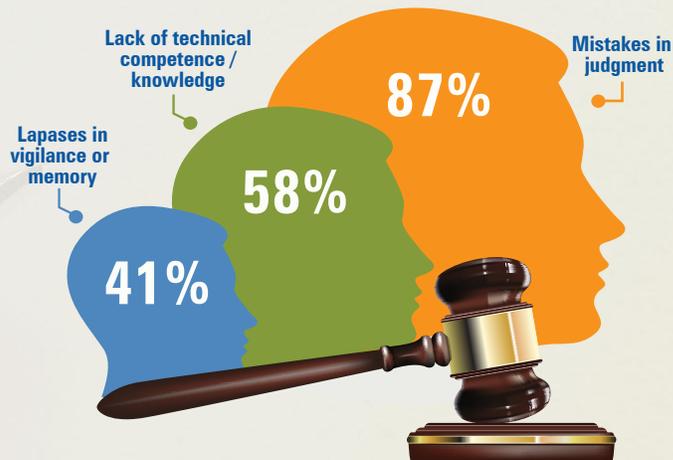
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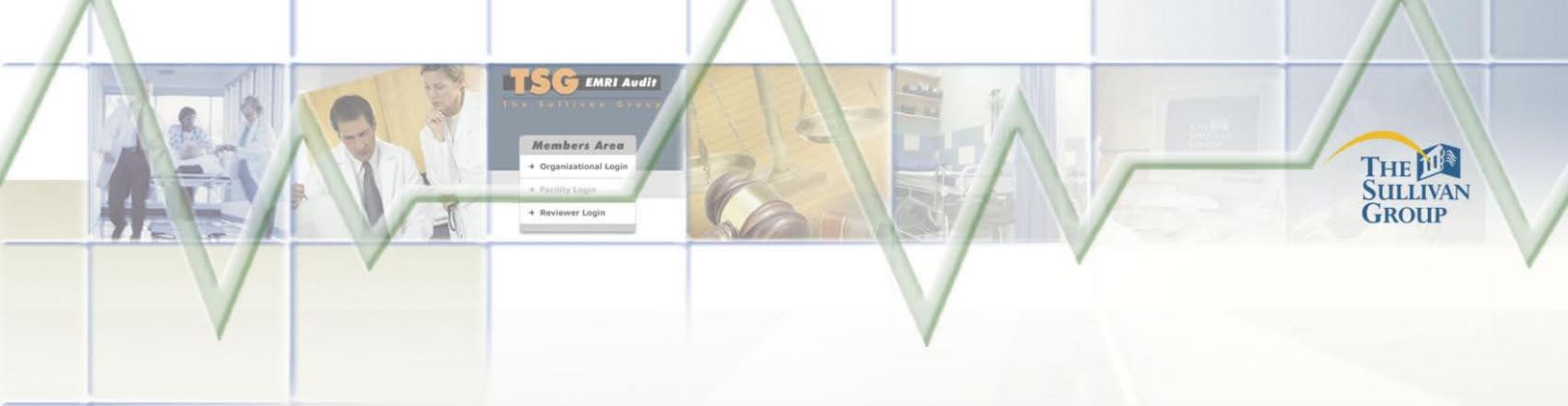
The Failure to Diagnose at 1,000 Feet

So now we know it is the 'failure to diagnose'; we know what we are failing to diagnose; we know the relevant anatomical high-risk areas; and we know some of the operative failures in the diagnostic process. Is that all we need to create our failsafe system? To create the malpractice proof ED? Not yet. The next issue is a critical aspect of this analysis.

In 2007, Kachalia et al. researched closed malpractice claims from four separate med mal insurance liability carriers for common denominators with a specific focus on missed and delayed diagnosis. The authors found that "Cognitive errors were involved in 96% of the cases." The breakdown is fascinating:

1. Mistakes in judgment in 87% of cases
2. Lack of technical competence or knowledge in 58% of cases
3. Lapses in vigilance or memory in 41% of cases





This is such a critical analysis, as it underscores the importance of an issue not often addressed in this type of analysis: **THE HUMAN CONDITION!** The point is we are only human. We forget stuff; sometimes critical issues at critical moments.

When was your last newborn delivery complicated by shoulder dystocia? Do you remember ANY of the procedures to free the shoulder? First McRoberts, then suprapubic pressure; next try the Woods Screw maneuver and release the posterior arm. **Are you kidding! Get me an obstetrician!**

The point is whether it is the list of risk factors for pulmonary embolism, the extensor tendons of the hand, which dermatome is where, which deep tendon reflex goes with which level of the spine, or the most recent ACCF / AHA recommendations and risk stratification for management of STEMI, it is simply impossible to know or remember it all. Which begs the question: How do we do it without immediate access to key information, real-time during the patient encounter?

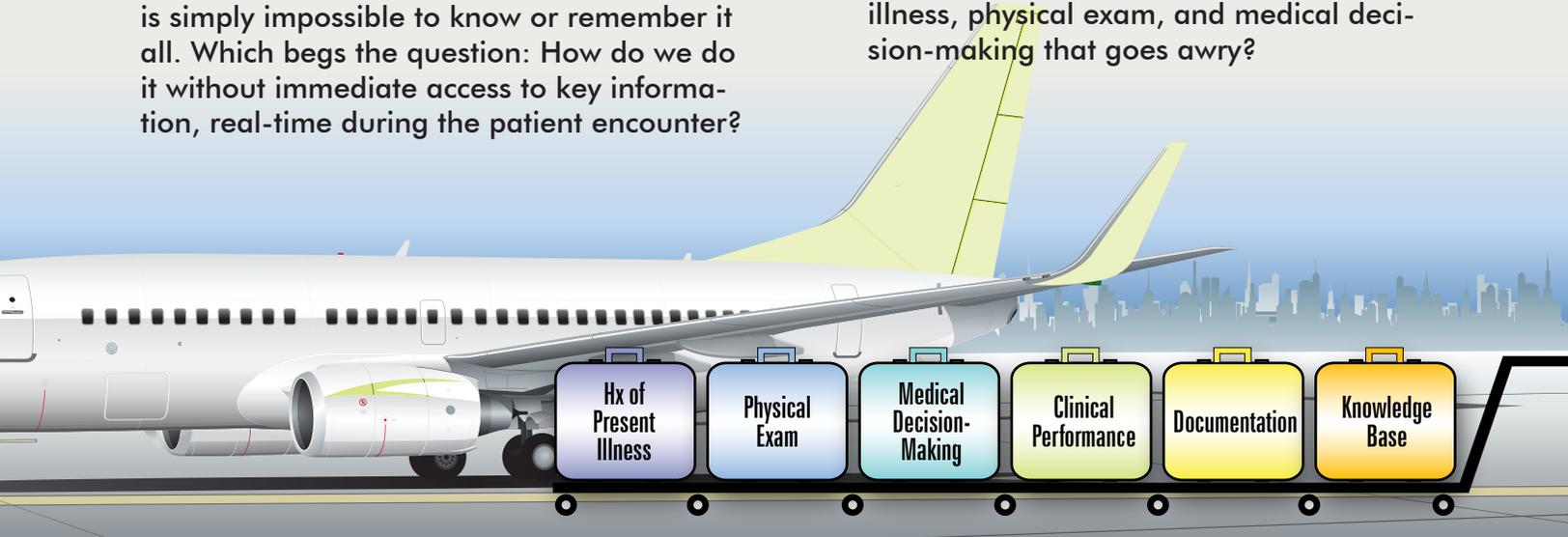
Answer: We don't. We typically do without. The result is Cognitive Errors related to knowledge base vigilance and memory.

So now we know it is the 'failure to diagnose'; we know what we are failing to diagnose; we know the relevant anatomical high-risk areas; we know some of the operative failures in the diagnostic process; and we now know that it is in significant part related to the HUMAN CONDITION.

The Failure to Diagnose – On the Ground

You thought we were finished? Well we are for now, or this newsletter will get so long you will stop reading it. The next step occurs at ground level; it takes all of the above and performs a granular analysis of practitioner clinical behavior.

- What is it exactly in the history of present illness, physical exam, and medical decision-making that goes awry?





- What clinical performance problems are at issue?
- What documentation is missing?
- What are we forgetting?
- What knowledge base is missing?

For that, look to our next newsletter. TSG has performed an analysis of over 170,000 high-risk patients with a specific focus on just



those issues, and we will present that data in the next newsletter. Once we have reached ground level in our search for the multiple causes of the failure to diagnose, we can then sort of 'white paper' our recommended solution for medical errors and adverse outcomes in the practice of emergency medicine. ■



Editor's Note: *I hope that this analysis rings true for you and that you have found it interesting and helpful; I also hope the cost of failure to diagnose claims has not unduly fanned the fires of paranoia. Most importantly, know that it is only through this granular analysis all the way from 20,000 feet to ground level and through immediate cause and effect that we can create a scalable system solution to medical errors and patient safety issues in the practice of emergency medicine. More on this in the next newsletter.*

Kachalia, et al. Missed and delayed diagnoses in the emergency department: A study of closed malpractice claims from 4 liability insurers. In the February 2007 *Annals of Emergency Medicine*; 49(2), pp. 196-205.

CRICO 2011 Annual Benchmarking Report. *Malpractice Risks in Emergency Medicine*.

PIAA Risk Management Review. *Emergency Medicine*; 2012.

As always, all thoughtful comments and questions are more than welcome!

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Thank You

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