

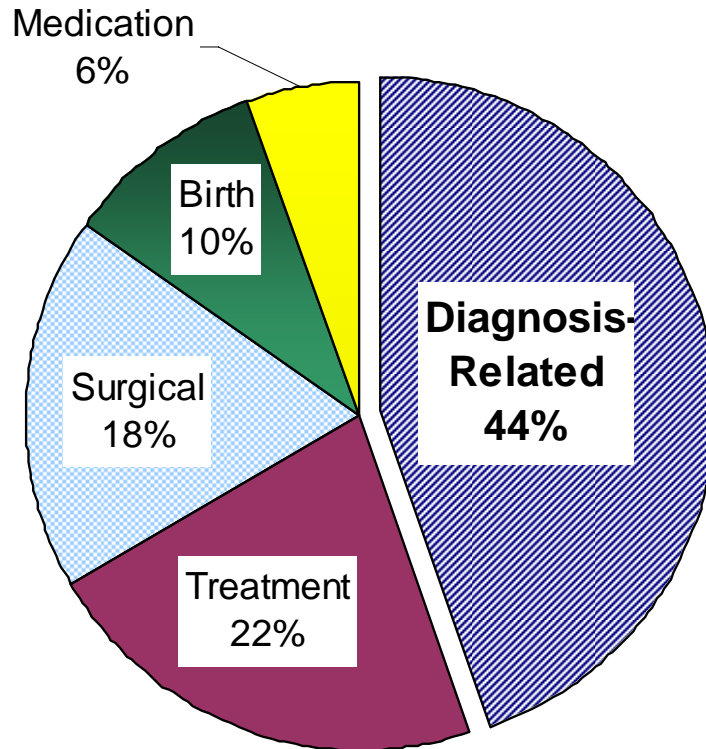


Genius diagnosticians make great stories, but they don't make great healthcare. The idea is to make (diagnosis) accuracy reliable not heroic "

Don Berwick MD . President and CEO of the Institute for Healthcare Improvement (IHI), Boston, MA.

Why now ?

DRIVER FOR ADOPTION at Kaiser Permanente : Diagnostic delays & failures – significant patient safety & medical-legal challenges



They represent the **most frequently** seen risk case type in our organization...

..... which account for medical-legal costs** of over **\$380 million from 2000 – 2004** (n= 856)

Risk cases that occurred between 1/1/2000 to 9/30/2005

Risk cases include: Sentinel Events/PCEs, Demands for Payment, and Legal Action Cases

** indemnity payouts + total legal costs

Source: PPL-RM

- ▷ HIGH RISK AREAS
- ▷ PATIENT SAFETY STRATEGIES
- ▷ CASE STUDIES
- ▷ EDUCATION / INTERVENTIONS
- ▷ RESEARCH RESOURCES

▷ **Diagnosis**

- Algorithms
- Cancer Screening Guidelines
- Case Studies
- FAQs
- Forms
- Health Screening
- Suicide Guidelines
- Tracking Abnormal Screening Tests
- Tracking Test Results

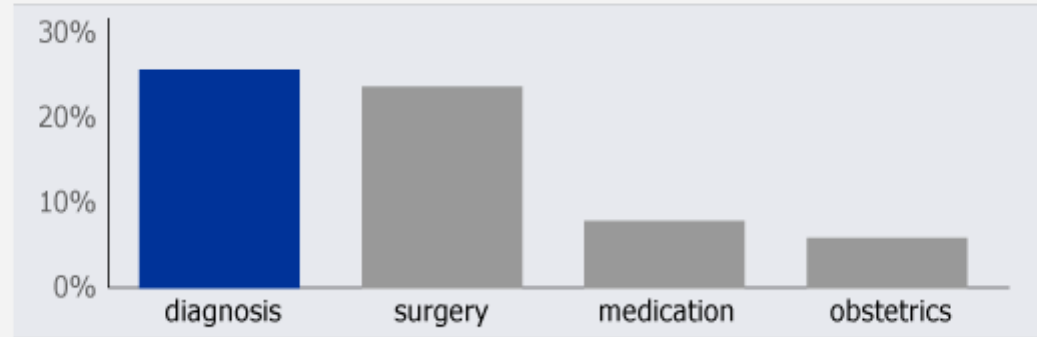
- ▷ Medication
- ▷ Obstetrics
- ▷ Surgery



Diagnosis

[Home](#) > [High Risk Areas](#) > [Diagnosis](#)

64% of claims come from these four high-risk areas.
percentage of all claims asserted 2002-2006, N=1,164 claims



Missed, delayed, or incorrect diagnoses account for approximately one-quarter of all malpractice cases naming CRICO-insured providers. Colorectal and breast cancer cases are the most common type filed. Address the highest risk diagnostic issues by using these algorithms, guides and information.

[Expand All](#) / [Collapse All](#)

Algorithms

- [Breast Care Management Algorithm](#)
- [Colorectal Cancer Screening Algorithm](#)

CRICO/RMF is the patient safety and medical malpractice insurance company owned by and serving the Harvard medical community since 1976.

- 109 / 261 [42%] high severity cases alleged a missed or delayed diagnosis that impeded treatment &/or recovery
- 261 cases - nearly \$125 million in actual & potential losses. CRICO paid out 479K on average per case
- Missed, delayed, or incorrect diagnoses account for approximately 25% of all malpractice cases
- “ Physicians who overly rely on prior diagnoses, unconfirmed diagnoses, or intuition are especially susceptible to a narrow diagnostic focus that excludes appropriate tests and imaging study ”



Special Emphasis Notice (SEN): AHRQ Announces Interest in Research on Diagnostic Errors in Ambulatory Care Settings

Notice Number: NOT-HS-08-002

Key Dates

Release Date: October 25, 2007

" In 2008, AHRQ intends to get a better understanding of incidence, cost, determinants & strategies for preventing or mitigating diagnostic errors

Diagnostic error comprises a notable and costly fraction of all medical errors

Diagnostic error encompasses a broad array of factors including cognitive, systems, education, training, setting-of-care, disease-specific, and domain-specific issues. "

AHRQ puts spotlight on diagnosis error



Diagnostic Error in Medicine

"Diagnostic error comprises a notable and costly fraction of all medical errors and has resulted in devastating consequences for patients, families, and health care professionals."*

* Excerpted from: AHRQ Special Emphasis Notice

Purpose and Scope

The ultimate goal of this conference is to improve patient safety by reducing the likelihood of diagnostic error in medicine. Minimizing diagnostic error is an essential, although relatively neglected, aspect of patient safety. This conference aims to summarize the current state of the field by reviewing research in the clinical and cognitive sciences, and to catalyze emerging ideas on the educational and research agenda that should be implemented to minimize diagnostic error in the future. This is the first national conference dedicated specifically to diagnostic error in medicine. The conference is co-sponsored by the Agency for Healthcare Research and Quality and the American Medical Informatics Association. The conference is co-sponsored by AMIA and the Agency for Healthcare Research and Quality (with a grant to the University of Alabama at Birmingham).

Objectives

To summarize the current state of the field and approaches to reducing diagnostic errors
Thought leaders will be featured as speakers to review the current understanding of the extent of diagnostic



C1

New Ways to See: Innovative Tools to Improve Patient Care

*19th Annual National Forum on Quality
Improvement in Health Care*

*Maureen Bisognano
Executive Vice President and COO
Institute for Healthcare Improvement*

“You can put a little asterisk here. This is going to be like ‘I told you so’ because I bet, in this next year, we are going to see a huge focus across the US and around the world on diagnostic reliability...studies emerge that are all converging on the statistics show us we are not really good at making diagnoses - we think we are but we’re not.”

New Tools to “See” for Cognitive Errors

- Isabel (www.isabelhealthcare.com)
 - Developed in the UK by Jason Maude (in conjunction with physicians) after the near-fatal misdiagnosis of his three-year-old daughter Isabel
 - Symptoms are entered into a computer, and pattern recognition software queries current medical journals, textbooks, and databases such as the CDC’s. A list of differential diagnoses, bioterrorism diagnoses, and possible causative drugs is quickly produced to prompt the diagnostic process.
 - “Lessons Learned” section reviews pitfalls and errors associated with these diagnoses and symptoms.



“So diagnostic support, I think, is going to be a big focus for the year to come...if you want to get ahead of the game especially in terms of accreditation and payment, you might want to pick this tool up when you go back and start to think about the diagnostic process”

6. Diagnosis Support

- Why do we need this tool?
 - According to a 2003 *JAMA* review of autopsy studies, misdiagnoses occur between 8% and 24% of the time
 - A 2005 AHRQ study found that diagnosis errors far outnumber medication errors as a cause of claims¹
 - Almost 75 percent of all mortality attributable to patient safety incidents was caused in part by failure to diagnose and treat in time²

¹ Schiff G, Kim S, Abrams R et al. "Diagnosing Diagnosis Errors: Lessons from a Multi-institutional Collaborative Project." *Advances in Patient Safety*. 2005; 2: 255-278.

² HealthGrades Quality Study. "Patient Safety in American Hospitals." 2004

Diagnosis Support

- Cognitive reasons for misdiagnoses
 - A 2006 study showed that failures in judgment (79%), vigilance or memory (59%), and knowledge (48%) were the leading factors contributing to misdiagnoses.¹
 - An NPSF-funded Veterans Administration study found that premature closure (the failure to consider reasonable alternatives to an initial diagnosis) was the single most common cognitive factor.

¹ Gandhi T, Kachalia A, Thomas E et al. "Missed and delayed diagnoses in the ambulatory setting: a study of closed malpractice claims." *Annals of Internal Medicine*. 2006; 145(7): 488-496