

PROFESSION

Study details how primary care diagnoses get delayed

■ Health IT will not be enough to ensure that signals don't get crossed among primary care doctors, specialists and patients, experts say.

By KEVIN B. O'REILLY ([HTTP://WWW.AMEDNEWS.COM/APPS/PBCS.DLL/PERSONALIA?ID=KOREILLY](http://www.amednews.com/apps/pbcs.dll/personalia?id=koreilly)) amednews staff — Posted Aug. 26, 2013

Lack of care coordination, poor teamwork, miscommunication, patient no-shows and bureaucratic mix-ups are the leading factors contributing to months-long delays in diagnosis and treatment, said a review of 111 outpatient cases analyzed by the Veterans Affairs National Center on Patient Safety.

Researchers examined root-cause analysis reports done by the VA between 2005 and 2012 to find the reasons why outpatient care diagnosis and treatment gets delayed. Such delays — typically lasting about four months — are frustratingly common in office-based care and can be as harmful as misdiagnoses, said the study in the August issue of *Health Affairs*.

Because all VA medical centers and clinics use the integrated electronic health records system, the findings show that health information technology is insufficient to prevent delays in care, said Hardeep Singh, MD, MPH, the study's lead author. He also is chief of the Health Policy and Quality Program at the Houston VA Health Services Research and Development Center of Excellence.

“Even within the same system, which is fairly integrated and fairly closed in that most vets come back to VA, we're still finding communication and coordination issues,” Dr. Singh said. “This holds a lesson for the rest of the country as they are trying to become as interconnected as we are in the exchange of data between primary care providers and specialists.”

About a third of the care delays involved poor care coordination, such as when a patient needed follow-up care with a specialist but nothing was done about it. Three in 10 cases involved what researchers called “failure of team cognition.” An example of that is when a physician or another referring professional fails to flag a request for follow-up treatment as urgent and it consequently does not get acted on as quickly as it should.

“This team cognition concept is fairly new,” Dr. Singh said. “It has to do with the decision-making processes of a team rather than an individual. And that's what we're going to be doing more of as we move from a doctor-centered model of delivering care to a team-centered model. We've done a lot with teamwork training in the inpatient setting, but that hasn't happened yet on the outpatient side.”

That care team includes patients, who nearly 10% of the time contributed to delays by failing to show up for follow-up appointments, not following physician instructions or not seeking care in a timely fashion, the study said.

A survey released in May by medical liability insurer The Doctors Company found that 53% of patient-care sites reported scheduling follow-up appointments and referrals were their top risk-management problems.

Administrative mistakes also contribute to about 7% of delays, the *Health Affairs* study found. Examples include staff changes and inexperienced health professionals.

Growing focus on errors

This research comes on the heels of other recent research highlighting how errors in diagnosis occur. A systematic review of 34 studies found that failure to diagnose or delays in diagnosis were the most commonly cited reason for medical-liability claims in primary care. Heart attacks and cancer cases were the most commonly missed, said the

study, published July 18 in *BMJ Open*.

More than 100 thinking mistakes — called cognitive biases — have been found to affect physicians in practice, said a June 27 perspective piece in *The New England Journal of Medicine*. One example is settling on a diagnosis and sticking with it despite contradictory signs and symptoms.

Doctors get diagnoses wrong 10% to 15% of the time, said the article’s author, Pat Croskerry, MD, PhD. He is professor of emergency medicine and director of the Critical Thinking Program in the Division of Medical Education at Dalhousie University in Halifax, Nova Scotia, in Canada.

“Part of our program is coaching and teaching how decision-making actually works, what the models are that describe cognitive biases,” he said. “We show how they apply in clinical cases ... and show you how to fix those biases.”

One approach is a “forcing function,” Dr. Croskerry said. If physicians are aware that, for example, complaints from patients with mental illness tend to get discounted, they can consciously work to examine such patients even more carefully than others. He compared it with always putting one’s keys in the same place when arriving home — a way to avoid easily committed cognitive errors.

The topic of diagnostic mistakes has received an increasing amount of attention during the last decade, experts said. From Sept. 22-25, physicians and researchers from around the world will meet in Chicago for the Diagnostic Error in Medicine conference to develop ways to improve measurement and prevention of these medical mistakes.

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ADDITIONAL INFORMATION

5 ways to prevent diagnostic delays

These are the most common types of recommendations made in 111 root-cause analysis reports on delayed outpatient diagnosis and treatment:

- 1 **Staff training or education:** implementing new, additional or different training or education.
- 2 **Policy or procedure changes:** implementing, changing, developing, clarifying or reviewing a procedure, policy or process.
- 3 **Process changes:** standardizing protocols, clinical guidelines or order sets.
- 4 **Software or hardware changes:** installing new or modifying current software or hardware.
- 5 **Enhanced documentation or communication:** improving documentation of patient records or using and updating process and equipment manuals.

Source: “Root Cause Analysis Reports Help Identify Common Factors In Delayed Diagnosis And Treatment Of Outpatients,” *Health Affairs*, August ([link](#))

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EXTERNAL LINKS

“The epidemiology of malpractice claims in primary care: a systematic review,” *BMJ Open*, July 18 ([link: http://www.ncbi.nlm.nih.gov/pubmed/23869100](http://www.ncbi.nlm.nih.gov/pubmed/23869100))

“From Mindless to Mindful Practice — Cognitive Bias and Clinical Decision Making,” *The New England Journal of Medicine*, June 27 ([link: http://www.ncbi.nlm.nih.gov/pubmed/23802513](http://www.ncbi.nlm.nih.gov/pubmed/23802513))

“Root Cause Analysis Reports Help Identify Common Factors In Delayed Diagnosis And Treatment Of Outpatients,” *Health Affairs*, August ([link: http://content.healthaffairs.org/content/32/8/1368.abstract](http://content.healthaffairs.org/content/32/8/1368.abstract))

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