

• A DOSE OF INSIGHT®

HIDDEN IN PLAIN SIGHT

Exposing the Drivers of Diagnostic Error

A Three-Part Series:

Part Two: Office-Based Practice

AUGUST | 2025



COVERYS



Q: In the past year, has your office practice:

- ☐ Received a patient complaint that you missed a significant diagnosis?
- ☐ Discovered there was a failure to follow up on a patient test or consult?
- ☐ Been surprised by a patient complaint or notice of a pending lawsuit after losing contact with the patient?

If so, you're not alone. These are some of the most common scenarios that can alert you to diagnostic error in office-based practices.

This white paper is the second of a three-part series exploring diagnostic challenges in three different care settings. Our first paper addressed diagnosis-related issues in the emergency department.¹ In this edition, we investigate diagnostic errors or omissions during office-based care. A future report will explore diagnostic risks for inpatients and their clinical teams.

In this paper you will learn:

- How often diagnostic errors occur, and in which settings and services, based on data from closed malpractice events.*
- Key factors that lead to error in the office-based practice, and which diagnoses are most likely to be missed.
- Recommendations to help reduce diagnostic error in office-based practices.
- How to identify key vulnerabilities in your practice with a brief self-assessment.

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*Coverys® evaluated 6,009 events that closed between January 1, 2020 and December 31, 2024, and identified 294 specific events where a diagnostic error in an office-based practice was alleged. Unless otherwise indicated, statistics and information in this publication were derived from this proprietary data.

COVERYS



DATA METHODOLOGY

Medical malpractice claims data trends provide insights that warn of risks that could be contributing to patient harm, claims, and looming lawsuits.

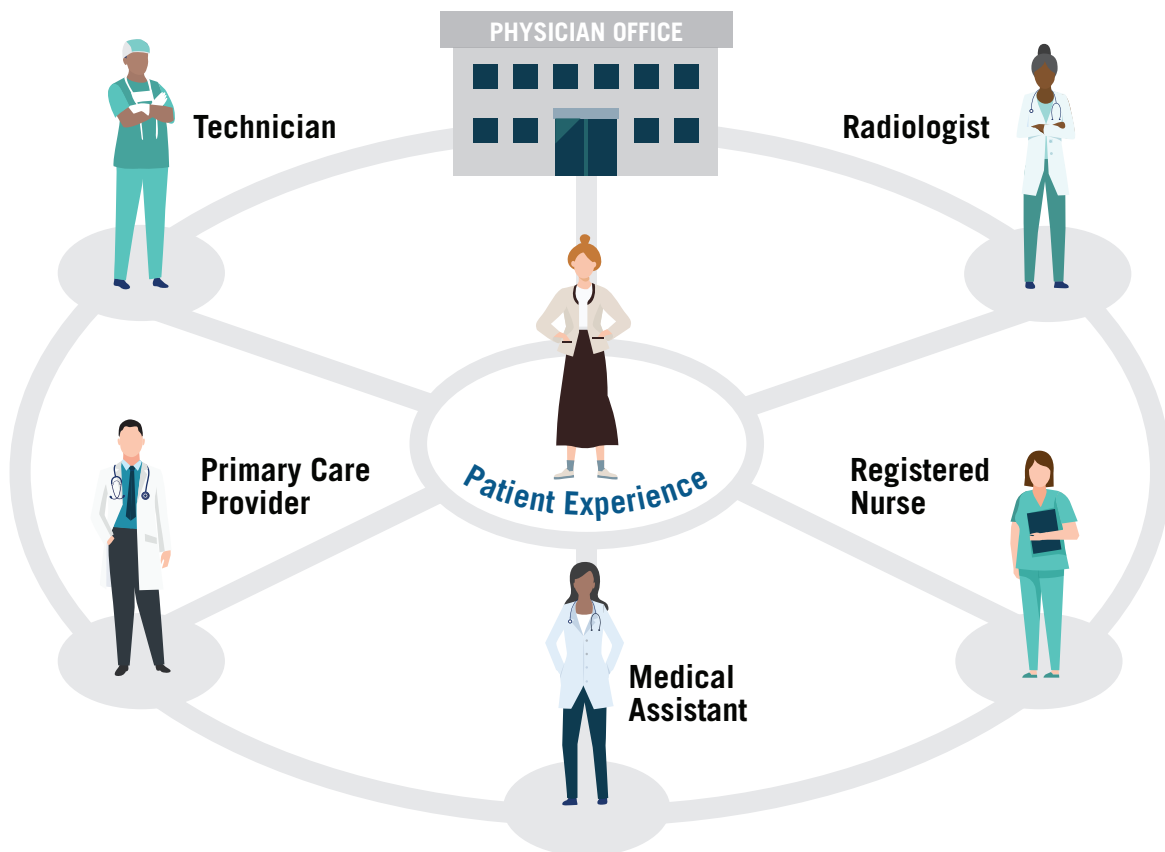
Using a proprietary coding taxonomy, our team of expert clinical coders captures key data elements as they relate to the patient's experience across or within the clinical care process.

Cases are coded at the “event” level, meaning all associated claims and suits are grouped into a single event. This approach provides a complete picture of the patient care journey, including all relevant care providers—both those “named” in the event (defendants in a claim) and those who played a role but may not be named (staff involved).

By capturing multiple data points across time and providers, we are able to tell a comprehensive story of the patient's care.

These insights can be critical in identifying and mitigating risks before they happen, and learning from them can assist in improving patient safety.

CAPTURING MULTIPLE DATA POINTS ACROSS TIME AND PROVIDERS ENSURES A COMPLETE PICTURE OF THE PATIENT'S CARE JOURNEY



DIAGNOSTIC ERROR



PAST INITIATIVES & PRESENT STATE

In 2015 the Institute of Medicine released their report “Improving Diagnosis in Healthcare.”² This report revealed that most patients experience at least one diagnostic error in their lifetime—sometimes with serious consequences. Prior to this report, diagnostic error was largely unappreciated as a major cause of medical error.

Over the years, many organizations such as the Leapfrog group,³ AHRQ⁴ and TJC⁵ have published guidelines, best practices, checklists, and road maps for reducing diagnostic error. Despite these ongoing efforts, the problem persists.

In the last several decades we have evolved in our understanding of medical error. We have shifted from focusing on whom to blame to understanding why errors and oversights occur. We now recognize that systems and human interactions with those systems are key drivers of diagnostic error, and malpractice data provides a unique lens into the understanding of those vulnerabilities. While high-level trends in malpractice events have remained relatively unchanged over time,⁶ we now have a better understanding of contributing risk factors and mitigation strategies to reduce diagnostic error.

Each department, service line, and setting in a healthcare organization is unique in terms of culture, communication, systems, and dynamics—and the factors that contribute to diagnostic error in each setting are unique as well.

In the first paper in this three-part series, we addressed diagnostic error in the fast-paced emergency department (ED) setting⁷ and why EDs are particularly vulnerable to diagnostic error. We explored how often diagnostic errors occur in the ED setting based on closed claims data, how they occur, and which diagnoses are most likely to be missed—in particular: infection, vascular, and orthopedic diagnoses. Based on that data, we provided risk recommendations to help reduce diagnostic errors in the ED. But the ED setting with its high-acuity patients, bustling pace, and uncontrolled patient flow, is not the biggest generator of malpractice claims.

In this paper, we turn our attention to the practice setting that generates the highest percentage of diagnostic error claims—office-based care. While the office setting can be busy and hectic, the pace is more structured, processes are more methodical, and acuity levels are often much lower than in the ED, resulting in a sense of less urgency. Unlike ED providers, office-based providers often have long-standing relationships with the patients they treat. As a result, providers in this setting are more familiar with their patients and the health challenges they face. The procedures performed in the office setting, unlike labor and delivery, surgery, and other care settings, can be less complex, less urgent, and require less monitoring. Yet, diagnostic error—especially in the primary care setting—is a persistent but underappreciated problem.



What is diagnostic error?

Diagnostic error is the failure to either establish an accurate and timely explanation of the patient's health problem(s) or communicate that explanation to the patient.

-National Academy of Medicine

DIAGNOSTIC ERROR



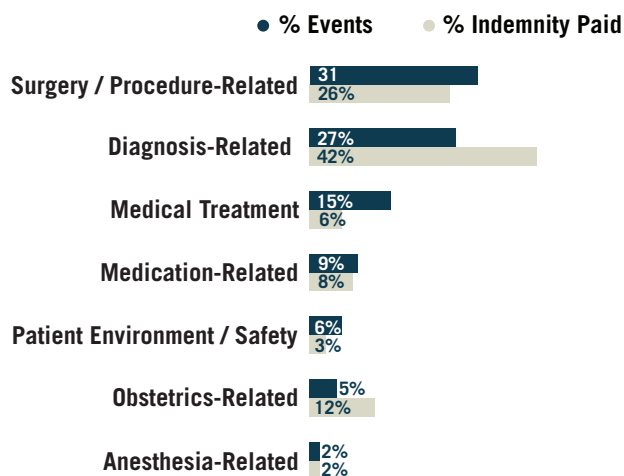
WHAT MALPRACTICE DATA REVEALS

Top Case Types

for all diagnosis-related claims/events

The Coverys team reviewed five years of closed medical malpractice events (2020 to 2024) and found that diagnostic error was the second most frequent allegation, accounting for 27% of events, and drove 42% of indemnity paid—the highest percentage of payments across all service settings.

TOP CASE TYPES FOR ALL EVENTS



N=6,009 events closed 2020-2024.

800,000

people in the U.S. are estimated to die or are disabled due to diagnostic errors each year.⁸

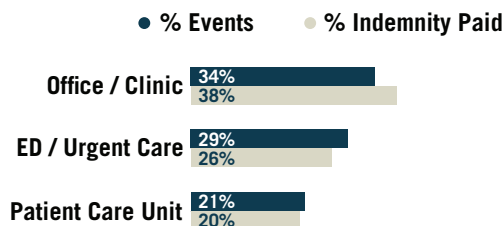
The discovery that a consequential diagnosis was missed can raise both dread and anger, often expressed as “How could you have missed this?”

Top Care Settings

for all diagnosis-related claims/events

Office-based settings account for the largest percentage of diagnosis-related events at 34% and the highest indemnity paid at 38%.

TOP CARE SETTINGS FOR ALL EVENTS



N=1,643 events with a diagnosis-related case type closed 2020-2024.

DIAGNOSTIC ERROR



DIAGNOSTIC ERROR IN THE OFFICE SETTING

Diagnosis involves the collection and analysis of data to arrive at a conclusion, discussions with the patient about that conclusion, and an appropriate treatment plan. There are multiple factors that can complicate the process for patients and providers.

It may take years for symptoms to be fully understood. The time and subtleties of (intentional) watchful waiting, patients hoping their symptoms go away, comorbidities, missed appointments, and numerous other factors further expose the process to missteps.

While what gets missed in the office setting includes diagnoses of cancers, fractures, and infections, the reasons why those diagnoses are missed are less diverse. Focusing on key vulnerabilities (page 9) and the most frequently missed diagnoses (page 7) can significantly reduce diagnostic error, patient harm, and the likelihood of a malpractice claim.

In legal proceedings, early indicators such as a self-detected breast lump, rectal bleeding, or a lingering cough, can point an accusing finger at the clinicians who failed to appreciate “clear signals” and reach a timely diagnosis. But in the clinical context, understanding what conditions underlie those lumps, bleeds, and coughs is often nonlinear. Even experienced clinicians and fully engaged patients may have to pursue multiple possibilities as part of the diagnostic journey, wait to see if symptoms resolve or worsen, or agree to tests or specialty consults that add yet another layer of complexity.

Fortunately, in recent years, the dominant strategy for patient safety has shifted from a focus on the actions of an individual to a systems review, to ensure everyone has the right information at the right time so they can make the right decision to support the diagnosis.

Limited time and resources—as well as the complexity of human physiology and disease processes—are at the root of human and systemic errors. Clinicians and other practice staff regularly rely upon methods proven to prevent, recognize, or mitigate mistakes. In most circumstances, errors or omissions not immediately recognized or addressed are not crucial to the patient’s long-term health and slip from concern. But even “no harm” events often reveal vulnerabilities that may lead to an impactful, or worse, life-threatening delay in diagnosis and treatment.

Historically, many office-based settings lacked the structure and tools to foster a robust culture of safety. Root cause analyses and other forms of informative feedback that have proven effective in the inpatient environment were not routinely built into the clinical office setting. Many incorrect or missed diagnoses were not recognized until the patients had sought care outside the offices where they occurred. Often, the clinicians involved were unaware of the eventual findings until the patient—or a lawyer—asked **“How could you have missed this?”**

Focusing on key vulnerabilities and the most frequently missed diagnoses can significantly reduce the frequency of diagnostic error.

DIAGNOSTIC ERROR



INSIGHTS FROM OFFICE-BASED EVENTS

Coverys reviewed five years of closed medical malpractice claims—6,009 events closed from 2020-2024. Nearly one quarter (24%) of events involved office-based care. Of those 1,442 office-based care events, approximately 38% (552) involved an allegation of a missed, wrong, or delayed diagnosis.

Top Clinical Services

Specialties with the highest volume of office-based care—internal medicine and family medicine—are most frequently named as the service responsible for the patient's care at the time of the alleged diagnostic error, accounting for 41% of events and 45% of indemnity paid.

As a group, surgical specialties are the second most common service, accounting for 23% of events and 22% of indemnity paid.

Top Missed Diagnoses

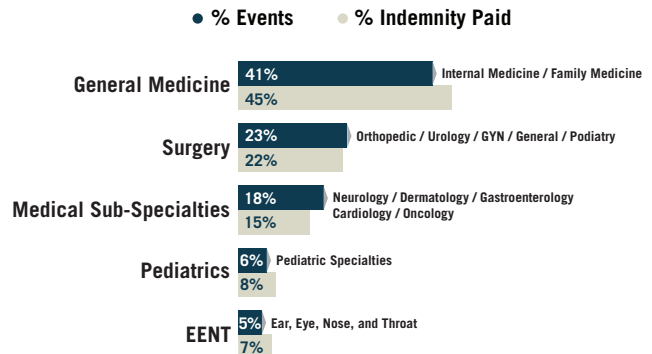
Nearly half (45%) of the events alleged a missed cancer diagnosis. Prostate, lung, breast, and colorectal cancers were the most common.

It is worth noting that—although the medical community regularly debates the efficacy of various screenings—the **top missed cancer types have all been promoted to the general population as “detectable.”**

Clinical Severity

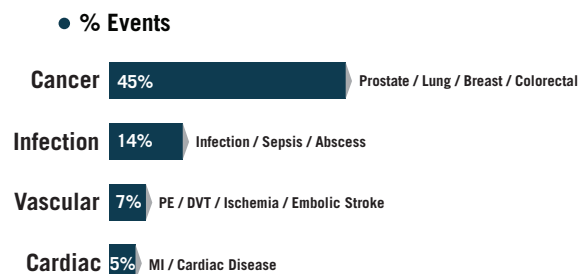
In one-third of the events, the patient died, with an additional 22% suffering a high-severity injury. Together, those tragic events accounted for 72% of the indemnity paid.

TOP CLINICAL SERVICES



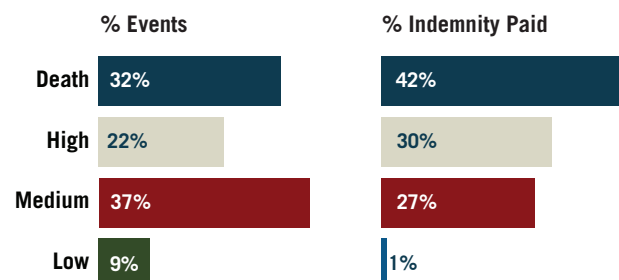
N=552 events with a diagnosis-related case type in the office-based setting closed 2020-2024.

TOP MISSED DIAGNOSES



N=1,126 final diagnoses on 552 events with a diagnosis-related case type in the office-based setting closed 2020-2024. An event can have more than one diagnosis.

CLINICAL SEVERITY



N=552 events with a diagnosis-related case type in the office-based setting closed 2020-2024. Injury severity based on National Association of Insurance Commissioners (NAIC) scale.

Indemnity Paid

More than half (53%) of the events were closed with an indemnity payment (via settlement or trial) with an average indemnity of \$661,000. This is more than twice the average indemnity paid on claims that were not diagnostic-related (\$323,000).



CASE SUMMARIES

Failure to document – A primary care provider recommended a patient with an abnormal EKG and chest pain to go directly to the ED but did not document the recommendation. The patient did not go to the ED and died of a MI the next day.

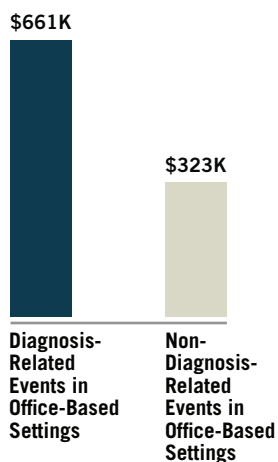
Failure to follow up on test results – A patient with advanced kidney disease died unexpectedly four days after a nephrology visit. An abnormal lab result was not communicated or acted upon prior to the patient's death.

Failure to ensure follow-up after declined imaging – A patient presented with right breast inflammation. An ultrasound was recommended but declined. There was no recommendation for a follow-up visit for reevaluation. The delay in follow-up resulted in the patient's death from breast cancer.

Failure to investigate persistent symptoms – A patient reported ongoing abdominal and back pain and changes in stool appearance at two separate internal medicine visits. The NP dismissed the abdominal/stool complaints and only treated the back pain. A year later, the patient was diagnosed with colon cancer.

Failure to communicate incidental findings – An incidental finding of a lung mass on a chest X-ray was not conveyed to the patient or the primary care provider thus no follow up care was in place. The patient was subsequently diagnosed with stage 3B lung cancer.

AVERAGE INDEMNITY PAID



N=552 events with a diagnosis-related case type in the office-based setting closed 2020-2024.

N=890 events excluding a diagnosis-related case type in the office-based setting closed 2020-2024



53%

of diagnostic-related events involving office-based care were closed with indemnity payment.

DIAGNOSTIC ERROR

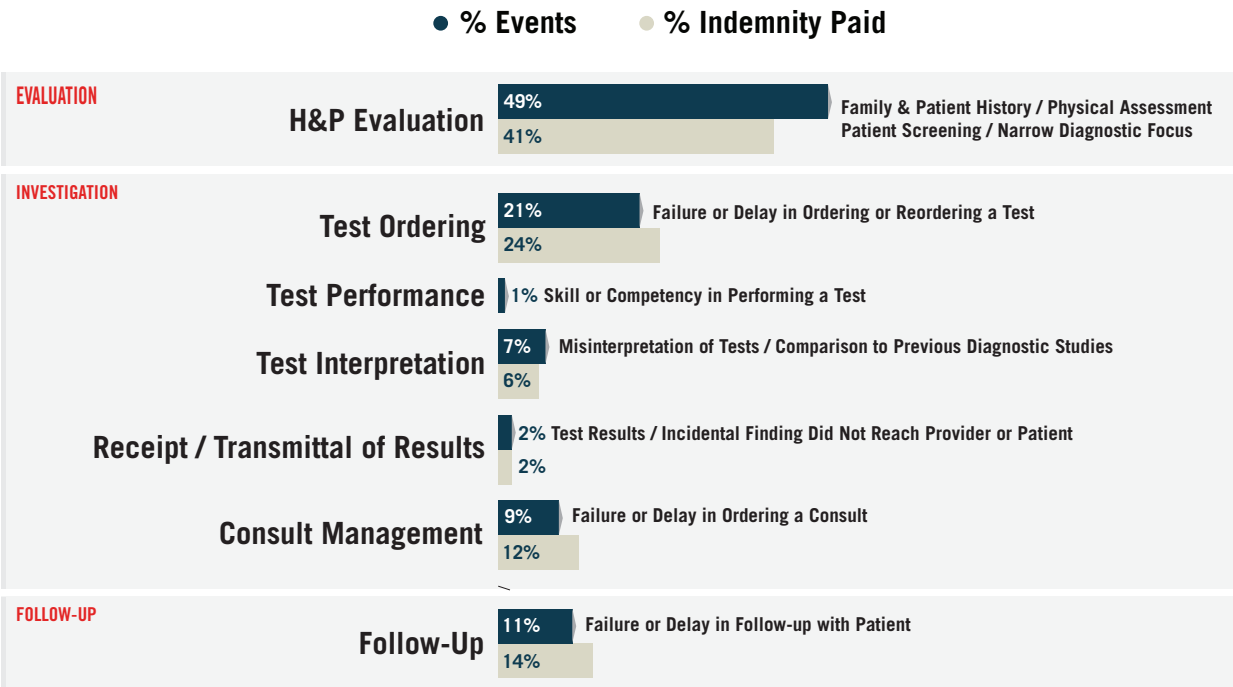


KEY VULNERABILITIES IN OFFICE-BASED PRACTICES

While an effective diagnostic process *acknowledges* uncertainty, the foundation of a broken diagnostic process is *unaddressed* uncertainty. The patient may be uncertain about symptoms or what health indicators they were told to watch for. The clinician may be uncertain about the patient’s history or their understanding of complex medical issues. Both may be uncertain about next steps. Consulting providers (including imaging and laboratory personnel) may be uncertain about why the patient is present.

Reaching a final diagnosis is a process—one that requires a systematic series of steps to determine the diagnosis or respond to uncertainty. When each step is conducted fully and effectively, clinicians and their patients should be confident that their diagnostic questions have been answered, and they can move forward, or that the issue is unresolved, and they need to continue addressing it.

KEY VULNERABILITIES IN THE PROCESS OF CARE



N=552 events with a diagnosis-related case type in the office-based setting closed 2020-2024.

More often than not, a single step or action in the process is not the sole reason for the diagnostic failure. Thirty percent of the diagnosis-related office-based malpractice events allege the clinical team failed to order an appropriate test (21%) or a specialty referral (9%). But these missed opportunities were frequently preceded by breakdowns during information gathering and patient evaluation—the history and physical.

The biggest opportunity to address these ordering issues and ensure full and effective completion of the diagnostic process begins with more rigor during the initial assessment of the patient and their complaint. This may mean asking more questions (both parties) and understanding how assumptions and cognitive biases can undermine diagnostic accuracy.

A failure to consider a reasonable differential diagnosis and pursue the most serious of those possibilities—via testing or consultation—is often the crux of a malpractice claim. This does not mean that clinicians must order every test for every possible diagnosis. But when a clinician chooses not to pursue a reasonable differential diagnosis, their rationale for that decision should be discussed with the patient and documented.

Minimizing risk in the diagnostic process continues after testing, or a consultation is ordered and completed. All parties need to be informed of the results and what they mean going forward—even if that is not definitive—including monitoring, additional testing, or treatment.



30%

of diagnosis-related
office-based
malpractice events
allege the clinical
team failed to order
an appropriate test or
specialty referral.



Did you know?

Cognitive bias is recognized as a potential contributor to diagnostic error. One study⁸ found that cases involving indicators of bias were 69% more likely to close with indemnity payment and 10% more likely to result in severe injury.

Key definitions:

- **Anchoring bias:** The tendency to perceptually lock on to salient features of the patient's initial presentation too early in the diagnostic process.
- **Confirmation bias:** Looking for confirming evidence to support a diagnosis rather than disconfirming evidence to refute it.

DIAGNOSTIC ERROR



CANCER DIAGNOSES

Cancer accounts for 47% of alleged missed diagnoses in office-based settings.

While general medicine practices account for the greatest percent of these at 41%, surgical specialty practices account for 23%.

One of every three Americans will develop cancer in their lifetime,⁹ but making such diagnoses is one of the most significant challenges for a general medicine office practice.

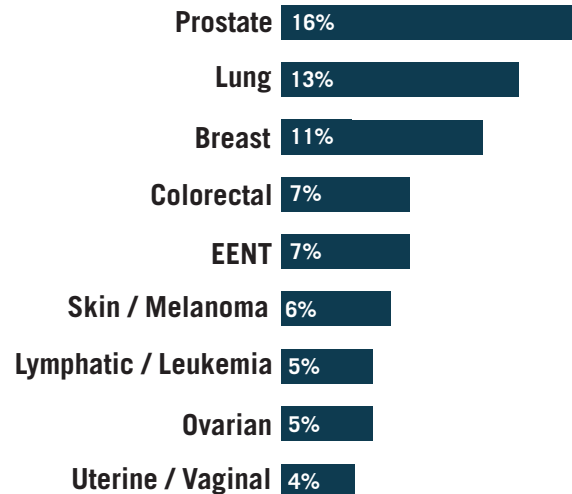
Patients with symptoms that may indicate cancer may not appear particularly sick, concerned, or eager to pursue dreaded news. Early-stage cancer symptoms can mimic more routine and benign conditions, or the patient may have more pressing health issues that they and the care team choose to focus on.

Patients who receive what they determine to be a delayed cancer diagnosis may look back in time to uncover missed opportunities for an earlier detection. Perhaps they had complaints not thoroughly pursued, reported a symptom that was not (or could not be) confirmed, or chose not to follow recommended testing/imaging because their clinician “didn’t seem too concerned.” They may even look back at prior results and find what is, with hindsight, clear evidence of their cancer.

Given these many challenges, what can an office-based clinical practice do to avoid being asked “*How could you have missed this?*”

TOP MISSED CANCER DIAGNOSES

• % Events



N=257 cancer related diagnoses out of 552 diagnosis-related events in the office-based setting closed 2020-2024.
An event can have more than one diagnosis.

Cancer accounts for 47%
of missed diagnosis allegations in office-based settings.

40

prostate cancer events
closed 2020-2024

73% of events

closed with an indemnity payment

\$749,000

average payment

Prostate Cancer

- 40 events closed 2020-2024
- 10 events resulted in death
- 22 events noted failure to order a diagnostic test (initial, or follow-up testing)
- 29 events (73%) closed with an indemnity payment
- \$749,000 average payment

About one in every eight American males will develop prostate cancer.¹⁰ Although the medical community continues to look for consensus on how to approach prostate cancer screening and treatment, it remains a high-profile health concern. Ethnicity and family history must be considered in discussions around PSA testing, and quality-of-life issues must be factored into treatment. Documentation is crucial, including the notation of all discussions about screening and treatment options (and the patient's informed refusal). If PSA testing has commenced, it is imperative to follow, discuss, and document the trajectory of results.

CASE SUMMARIES

Failure to document missed appointments and screening refusals complicated the defense of a failure-to-diagnose prostate cancer claim. The physician's testimony that they followed protocol could not be supported due to lack of documentation.

Failure to recognize and follow up on rising PSA levels led to a missed opportunity for early prostate cancer detection. A significant PSA increase (1.7 to 2.9) was not addressed or monitored over two years, and no related discussions were documented.

32

lung cancer events
closed 2020-2024

59% of events

closed with an indemnity payment

\$555,000

average payment

CASE SUMMARIES

Failure to follow up on abnormal chest X-ray findings in a long-term smoker with hemoptysis resulted in an 18-month delay in diagnosing lung cancer. Despite a radiologist's recommendation for a CT scan, no imaging was ordered or discussed during multiple visits.

Failure to act on radiology recommendations for a possible mediastinal mass led to a 13-month delay in diagnosing lung cancer. Although the PCP acknowledged the X-ray report advising follow up with a CT scan, the provider did not order follow up imaging despite subsequent visits until symptoms worsened and cancer was confirmed.

Lung Cancer

- 32 events closed 2020-2024
- 26 events resulted in death
- 16 events noted failure to order a diagnostic test (initial, or follow-up testing)
- 19 events (59%) closed with an indemnity payment
- \$555,000 average payment

About one in every 17 or 18 Americans will develop lung cancer.¹¹ While tobacco use has dropped, a history of smoking remains a key risk factor and a trigger for screening. A prominent concern is appropriate follow up and communication after an incidental finding from a chest X-ray. Radiologists and primary care providers (PCPs) need to ensure patients are aware of such findings and next steps—even when the patient is undergoing care for a different concern (e.g., what prompted the X-ray). Repeated complaints of an unresolved cough are another red flag that may need further investigation of the possibility of lung cancer.

27

breast cancer events
closed 2020-2024

44% of events

closed with an indemnity payment

\$698,000

average payment

CASE SUMMARY

Failure to reassess a persistent breast mass led to a delayed diagnosis of stage 4 breast cancer. Despite an initial ultrasound showing no abnormalities, the mass remained on the problem list and was not re-evaluated during pregnancy or postpartum visits. When symptoms worsened, testing confirmed metastatic disease.

Breast Cancer

- 27 events closed 2020-2024
- 6 events resulted in death
- 11 events noted failure to order a diagnostic test (initial, or follow-up testing)
- 12 events (44%) closed with an indemnity payment
- \$698,000 average payment

About one in eight American females (and one in every 726 males) will develop breast cancer.¹² While clinicians may encounter patients who proactively report breast-related concerns, other patients may be unaware of their risk profile, or assume they are too young or too healthy to worry. The most important strategy to reduce the likelihood of a missed breast cancer allegation is closing the loop on complaints, imaging, and follow up, with thorough documentation of the discussions and plans for unresolved concerns.

19

colorectal cancer events
closed 2020-2024

63% of events

closed with an indemnity payment

\$750,000

average payment

Colorectal Cancer

- 19 events closed 2020-2024
- 8 events resulted in death
- 7 events noted failure to order a diagnostic test (initial, or follow-up testing)
- 12 events (63%) closed with an indemnity payment
- \$750,000 average payment

About one in every 25 Americans will develop colorectal cancer, with a recent increase among patients younger than 50 years old.¹³ Several factors may contribute to the failure to diagnose colorectal cancer including: patient embarrassment; the fact that rectal bleeding has a high likelihood of being caused by a benign condition; and that the most effective screening process is a colonoscopy which poses numerous hurdles.

For patients who present with a complaint of rectal bleeding, an assumption of hemorrhoids should only be made after engaging in a discussion that explores other risks (such as a family history of colon cancer) and diagnostic options. Within the subset of patients for whom a colonoscopy is recommended—and scheduled—ensuring they can and will comply with all the pre- and post-procedure requirements decreases the risk of a missed cancer diagnosis.

CASE SUMMARIES

Failure to inform the patient of a positive hemocult test and discuss associated risks resulted in delayed diagnosis of stage 4 colon cancer in a patient with severe diverticulosis.

Failure to follow up on a positive fecal occult blood test and ensure colonoscopy completion led to an 18-month delay in diagnosing metastatic colon cancer. Despite ongoing symptoms, providers attributed them to alcohol use and did not address prior abnormal test results.

DIAGNOSTIC ERROR



DIAGNOSIS IS A TEAM SPORT

A patient's visit to the physician office often involves nurse practitioners or physician assistants, along with registered nurses, technicians, and medical assistant staff. When a patient is sent outside the office for testing or a referral, administrative staff may be expected to handle tasks critical to the diagnostic process. With varying degrees of independence and role expansion, it is not uncommon for non-clinicians to have played a role in events that triggered an allegation of medical malpractice. Regardless of who is named, the consequences of a medical error are devastating to everyone on the healthcare team.

Every time another individual is added to the team involved in a patient's diagnosis—whether that is taking a history, conducting an exam, booking a test, receiving results, or managing patient communication—a layer of complexity is added and the opportunity for error expands. Allowing non-clinicians' duties to creep toward exercising clinical judgment is a risk that should be managed with policies and procedures that reflect appropriate scope of practice. Expecting a counterpart in a specialist's office to know why the patient was sent for evaluation without explicit communication is a risk. Having an undiagnosed patient seen by different providers on consecutive visits is a considerable risk.

In an effective patient-centered diagnostic process, everyone the patient communicates with—directly or indirectly—understands what needs to be shared with the team and the urgency of that need. An office-based practice must have a system that ensures critical information is conveyed and prioritized, that doesn't break down when someone on the team is out sick or on vacation, that doesn't rely on someone with no clinical expertise deciding whether a patient should come in or stay home, and that doesn't expose the diagnostician to the question, ***"How could you have missed this?"***



Coordination and communication among team members are critical to an effective, patient-centered diagnostic process.



CASE SUMMARIES

Failure to follow up on an incidental MRI finding led to delayed care and eventual kidney removal. The ordering rheumatologist did not act on the recommended endocrinology consult despite continued care.

Failure to recognize and escalate concerning foot symptoms resulted in delayed intervention and lower leg amputation. Office staff underappreciated signs of serious vascular compromise in an elderly patient post-injury.

Failure to properly handle a Pap smear led to a missed diagnosis of cervical dysplasia, which progressed to cervical cancer.

Failure to coordinate care among multiple providers led to delayed diagnosis of stage 4 prostate cancer in a high-risk patient. Miscommunication, missed appointments, and poor tracking of test results contributed to the outcome.

DIAGNOSTIC ERROR



SURGICAL SERVICES IN THE OFFICE-BASED SETTING

When general medicine clinicians refer patients with potential breast, prostate, or lung issues to the surgical services of a gynecologist, urologist, or pulmonologist, they, and their patients, presume the responsibility for the diagnostic process shifts to those surgical specialty providers. When those encounters fail to identify a subsequently diagnosed cancer or a post-operative complication, it is to these specialists who patients and their attorneys will direct the question, “*How could you have missed this?*”

Top Clinical Services

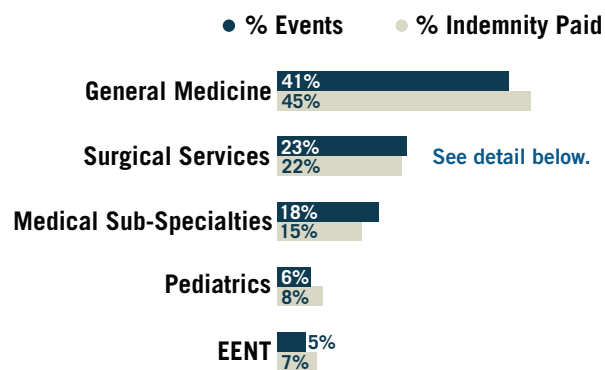
While only 23%, surgical services is the second highest contributor to allegations of diagnostic error occurred and accounted for 22% of the indemnity paid.

Top Surgical Services

Of all the office-based surgical events in this study, orthopedic is the service with the highest percentage of diagnosis-related events at 31%. These most frequently involved a pre-operative condition that was not addressed or a failure to identify an infection or other post-operative complication.

Cancer was the most frequently missed diagnosis for urology, gynecology, and general surgery.

TOP CLINICAL SERVICES



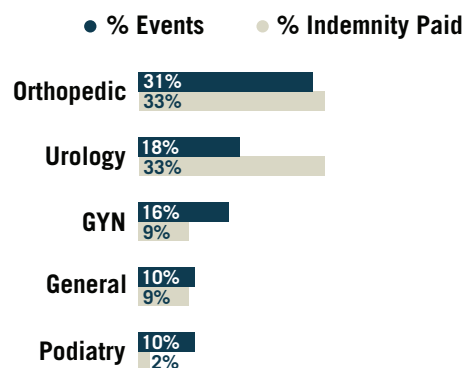
N=552 events with a diagnosis-related case type in the office-based setting closed 2020-2024.

CASE SUMMARIES

Failure to diagnose post-op infection following a partial knee replacement resulted in sepsis, kidney failure, and required a lengthy rehabilitation stay. The patient was placed on an antibiotic but did not receive appropriate instructions to report to the ED if symptoms worsened while waiting for a scheduled surgical revision.

Failure to appreciate an incidental finding of a suspicious mass in the course of orthopedic care resulted in delayed diagnosis of ovarian cancer. The patient, in her 50's, originally presented with hip pain. Imaging revealed a mass suspicious for ovarian cancer. The orthopedist took action on her osteoarthritis and femoral acetabular impingement findings but did not address the mass or refer to gynecology as recommended. The patient was ultimately diagnosed with stage 3 ovarian cancer.

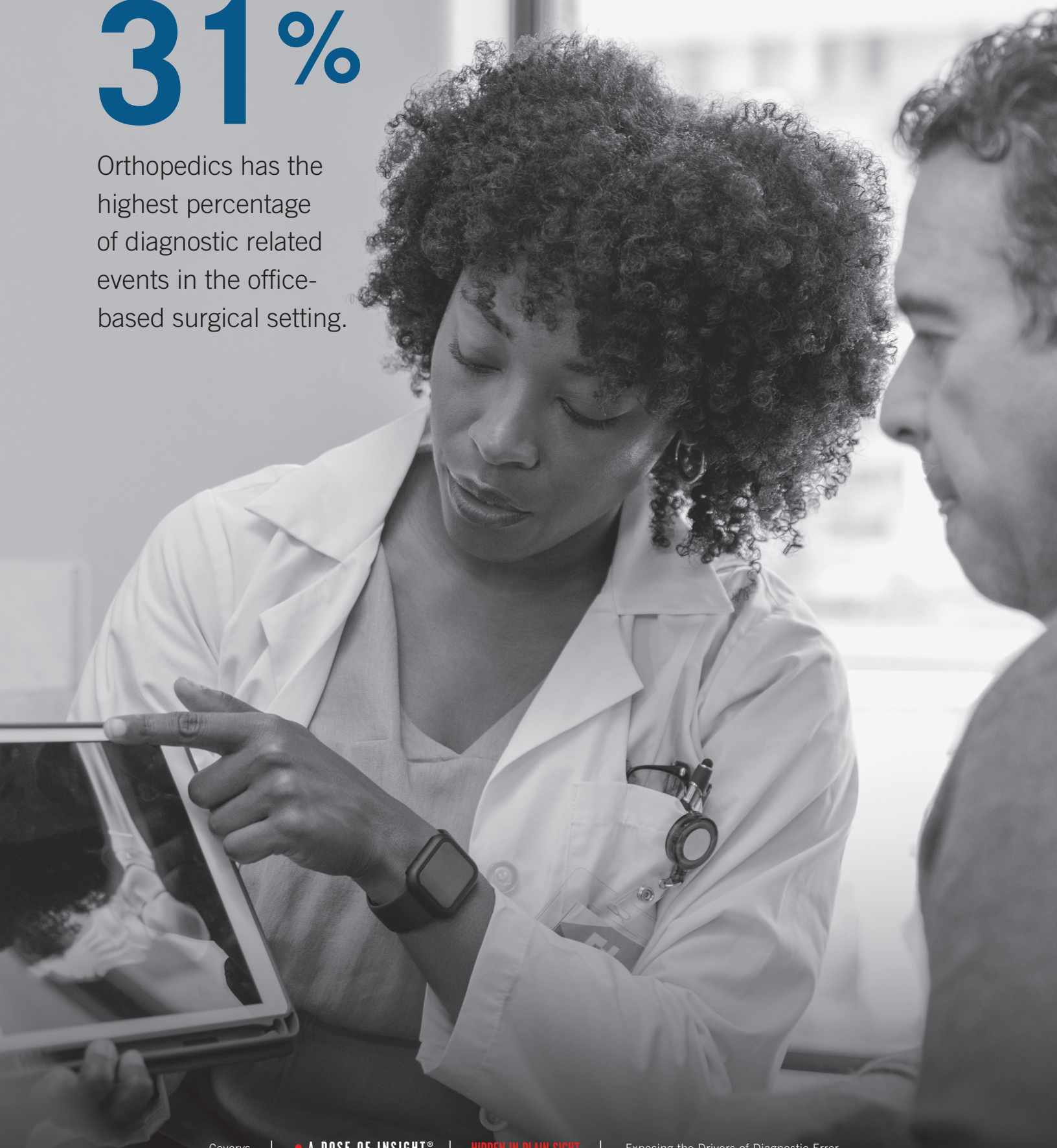
TOP SURGICAL SERVICES



N=126 diagnostic-related events in the MD office with a surgical clinical service closed 2020-2024.

31%

Orthopedics has the highest percentage of diagnostic related events in the office-based surgical setting.



SELF-ASSESSMENT TOOL



IDENTIFYING YOUR VULNERABILITIES

Our analysis of office-based malpractice events uncovered vulnerabilities that contribute to diagnostic error and harm. The following self-assessment identifies crucial best practices that address the contributing factors in our data. How consistently does your team follow the recommendations in each of the following areas?

History & Physical (H&P) and Test Ordering: Complete and timely information for full assessment.

Always Sometimes Unsure

- | | | | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Our H&P process requires gathering, updating, and documenting relevant clinical information and family history on every visit. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | We have a process to identify increased cancer risk among patients. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | We have access to and optimized the use of decision support tools to assist with test selection and ordering. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Our EHR provides automatic reminders regarding routine health screenings based on nationally accepted guidelines and are updated regularly. |

Diagnostic Processing and Differential: Robust differential diagnosis, free from cognitive bias.

- | | | | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | We have access to and have optimized the use of decision support tools to assist with the differential diagnostic process and documentation. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Our team has a process, such as a diagnostic time out , to ensure all data/input is reviewed and all possibilities/perspectives have been considered in events where diagnostic uncertainty exists. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Our team recognizes the potential for cognitive bias to limit the differential diagnosis and is comfortable raising concerns about such pitfalls as anchoring or confirmation bias. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Our team members operate within well-defined scope of practice parameters and utilize collaborative/supervisory agreements as appropriate. |

Test Tracking and Follow Up: Consistent reassessment and escalation for change/decline in status.

- | | | | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | We have a clear process to follow up on test results , including reporting results to patients and other care providers. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Our team has a well-defined process for following up on incidental findings . |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Test results are made available or communicated to the patient as soon as possible. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Our team has a robust process for initiating and following up on referrals . |

Documentation and Communication: Clearly expressed plan for follow-up communication/next steps.

- | | | | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Our team has a process in place to document patient refusal of recommended screening tests. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | We follow a standard process to document test results that include receipt, communication, and follow-up on test results. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | We set expectations for follow-up with patients by using health-literacy based communications . |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | We include the patient in the diagnostic process by engaging in shared decision-making and communicating diagnostic uncertainty. |

LEADING CHANGE



COVERYS DATA-INFORMED METHODOLOGY FOR ACTION

Using insights revealed by the self-assessment tool, your team can expose the hidden drivers of diagnostic error in your office-based practice and take action to eliminate them—this is the foundational methodology behind our data-driven approach.

Leading this change will involve identifying your organization's unique vulnerabilities and implementing new protocols. It will require the commitment of the entire care team to work together to implement solutions with consistent monitoring, continual adjustments, and ongoing vigilance.

While this effort won't be easy, it will be worthwhile. When you eliminate the drivers of diagnostic error, you will reduce the harm experienced by patients, their loved ones, and their care teams. You will also help mitigate the trend of exorbitant medical practice liability costs and thermonuclear verdicts—and their impact on the ever-increasing cost of healthcare.

Five Key Steps

1

RAISE AWARENESS

Share this report to educate your team on the prevalence of diagnostic error, its causes, and how it can be prevented.

2

KNOW YOUR DATA

Become a data sleuth. Ask for a review of your adverse event, patient experience, and culture safety data. Set measurable goals for improvement.

3

ENLIST AND ENGAGE

Develop champions to vigilantly lead change, continually improving your most vulnerable areas.

4

EVALUATE AND MONITOR

Stay on track, monitoring and sustaining best practices and holding teams accountable.

5

CONTINUOUSLY ADAPT

Continuously adapt your practices to address emerging exposures. Monitor metrics to avoid complacency.

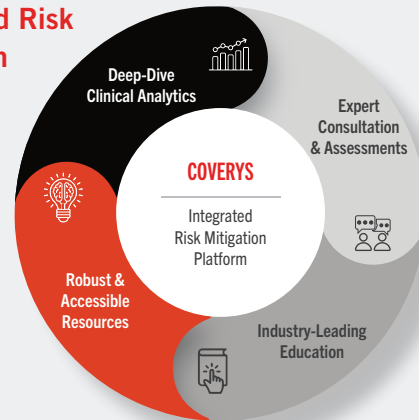
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Case scenarios and other patient examples shared in this publication are derived from actual malpractice claims with identifying details removed or altered to protect the anonymity of patients, families, healthcare providers, and healthcare organizations. The information in this report is intended to provide general guidelines for risk management. It is not intended as, nor should it be construed as, legal or medical advice.

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