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HOW PROVIDERS CAN MAKE URGENT CARE SAFER FOR PATIENTS

Part 2: Factors Behind Increases in Urgent Care Claims

We believe the trend of increasing claims in urgent care settings is influenced by both an increased relative rate of incidents and claims, and an increased volume of patients who visit urgent care facilities. It's important for physicians and other medical providers/staff to be aware of the risks unique to urgent care facilities and to examine how the diversity of resources, disparity in patient expectations, and the differences in provider training can affect their facilities.

1. DISPARITY IN PATIENT EXPECTATIONS

The expectations of patients who present to urgent care facilities are all different. Claims are filed when the expectations of the patient or their family are widely different from that of the providers and facility. In urgent care, beyond the chief complaint, it's important to ask the patient (or when applicable their parents, caregivers, or friends of family who are present):

- "What do you think this is?"
- "What are you most worried about by this?"

The chief concern needs to be addressed at least as thoroughly as the chief complaint. The issue of patient expectations can be a huge factor in the likelihood of a subsequent malpractice action even when the medical care provided is later found to meet the standard of care. We have seen claims arise in the following circumstances:

- **When existing patients of the primary care office are seen in extended hours by practitioners whom the patient has previously seen in the primary care setting.** This area becomes risky when the current chart or pertinent medical information is unavailable. Prescribing errors can occur. We've also seen errors that occur when the extended hours physician fails to address a significant issue that was in progress of work-up. When it was not addressed, the patient perceives the issue to be less important.
- **When patients who had not previously visited the facility present for minor, episodic care and expect only this type of care.** They identify another physician who is actively serving as their primary care physician. Because of the congruency in expectations, this scenario does not present any unique risks as long as the patient understands that primary, preventive or ongoing care will be provided by the identified primary care physician.
- **Patients who have no primary care physician and recurrently visit the facility for episodic, acute care.** These patients may view the providers of the facility as their primary care physician. This scenario is the most risky— particularly if the provider fails to diagnose malignancies.
- **Patients with acutely urgent or conditions who have chosen to present to the facility for issues of cost, convenience of location, or minimal waiting times.**

2. DIVERSITY OF RESOURCES

In most jurisdictions, because there is no single definition, licensure, or accreditation required to operate an "urgent care" facility, they possess a diversity of resources. Urgent care facilities vary from a hospital-based facility with resources similar to an emergency department to a freestanding clinic in strip mall that employs a nonclinical receptionist and a provider—having the ability to do little more than strep screens and urinalysis. Variables can include:

- The experience, training, and turnover rate of the support staff.
- The availability of consultants and laboratory diagnostic services.
- The availability of diagnostic imaging services and access to radiologist consultation.
- Access to and working relationships with existing emergency departments—including any communication problems that exist between the parties.

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FAILURE TO DIAGNOSE: THE COMMON PRESENTATIONS THAT RESULT IN CLAIMS

The risky presentations that urgent care facilities face closely mirror those of emergency medicine. While emergency department physicians clearly perform more invasive procedures on higher acuity patients, both settings provide a risk of failure to diagnose or delay in diagnosis. Our data for emergency medicine shows high frequency and severity of claims resulting from the failure to timely diagnose the following conditions:

>>HEADS

Atypical presentations of stroke are now the leading delayed diagnosis in urgent care and emergency departments. A timely diagnosis of a posterior circulation event, or a posterior circulation dissection, or a brainstem lesion can be pivotal in the time to intervention and ultimate outcome. Even though the catastrophic outcome may be due to the disease process itself—not to any act of omission on the part of the physician—the allegation of substandard care provided to the patient with a resultant brain injury can be difficult to defend. A detailed and documented neurologic exam including the brainstem and posterior circulation functions is critical to the defense, especially when definitive imaging tests are delayed or unavailable. Specific claims have been made for cerebral aneurysm, cerebral bleed, cerebral thrombosis, subdural hematoma, epidural hematoma, sagittal sinus thrombosis, meningitis, and herpetic encephalitis.

>>OCCULT TRAUMA

The mechanism of injury should be actively sought, considered and communicated to radiology to help evaluate potential significant trauma, particularly in the head, spine and great vessels. To avoid missing significant findings, a system should be in place to ensure that the radiologist overread of any imaging study is documented and reviewed in a timely fashion.

>>SEVERE INFECTIOUS DISEASE

Our emergency medicine data indicate that the allegation of delay in diagnosis of severe infectious disease such as sepsis, severe pneumonia, ruptured appendicitis, perforated or ischemic bowel, meningitis and encephalitis can lead to catastrophic outcomes and potential claims even when it would have been very difficult to predict the catastrophic outcome. It's important to pay particular attention to sometimes subtle signs and symptoms such as unexplained tachycardia or relative hypotension, very high or very low white blood cell counts, illness out of proportion to expectation, rapid progression of deterioration, or failure to improve as expected. If referral, admission or consultation is not the chosen action plan in this setting, close monitoring and follow-up can be crucial to providing the provider with a second chance to make this difficult diagnosis in a timely fashion.

>>HEARTS

The failure to diagnosis an impending acute coronary event such as myocardial infarction or acute coronary syndrome can lead to fatal arrhythmia, cardiac arrest or significant loss of cardiac function. A high index of suspicion is necessary because atypical presentations can be common, especially in women and/or the elderly. Seeking early consultation and/or referring to an emergency department, a chest pain track, or admitting a patient may be warranted. Risk factors should be solicited, documented and respected as elevating the potential for the need to consider a cardiac cause. Normal EKGs do not rule out cardiac sources in otherwise high or intermediate risk patients. Gastrointestinal cocktails should never be used as a diagnostic challenge to try to rule out a cardiac source.

>>ABDOMINAL PAIN

Abdominal pain is a frequent presenting complaint. It can be difficult to diagnose a surgical abdomen, particularly in the young and the elderly who often present atypically. Document the time of onset and duration; complete vital signs, including level of pain; thoroughly examine the abdomen; address pain out of proportion to the exam; and discuss the differential diagnosis. Also, the diagnosis should not be "gastroenteritis" when the presentation is truly undifferentiated abdominal pain. Provide specific follow-up instructions and schedule a repeat examination within 24 to 48 hours (sooner for the young or elderly and other high-risk patients). Communicate clearly and document this discussion. "Follow-up prn" is not adequate instruction.

>>MALIGNANCY

Failure to diagnose malignancy claims generally arise when the delay is at least six months and usually longer (as such, a single visit generally is not the single causative event in that delay). The exception to this statement is when the physician fails to communicate to the patient or treating physician an incidental abnormality seen on imaging study that was done to rule out a different disease. The bigger risk is when a patient presents repeatedly to an urgent care facility or a patient views the urgent care facility as providing him/her with comprehensive and preventive primary care. The repeated visits, including phone contacts and medication refills, might create patient expectations that prove to be problematic in defending against the need to have adequately worked up a persistent problem that ultimately proved to be a malignancy, such as colorectal cancer.