Missed and Delayed Colorectal Cancer Diagnoses May Be Attributed to Process-of-Care Failures in Primary Care Clinicians’ Workup

New study in The Joint Commission Journal on Quality and Patient Safety shows 71 percent of patients experienced at least one process-of-care failure

(OAK BROOK, Illinois, January 4, 2017) – Diagnostic errors result in significant illness or death, affecting millions of patients each year. Missed and delayed colorectal cancer diagnoses represent a major share of medical malpractice claims. However, little is known about how often primary care clinicians followed recommended practice guidelines for patients experiencing rectal bleeding—a potential sign of colon cancer—including obtaining a family history, performing a physical exam and ordering laboratory tests.

A new study published in the January 2017 issue of The Joint Commission Journal on Quality and Patient Safety examines how the quality of primary care clinicians’ workup, procedures or tests performed to arrive at diagnosis can delay diagnoses of colorectal cancer. The full article and issue are available without charge at jointcommissionjournal.com.

For the study, Saul N. Weingart, MD, MPP, PhD, chief medical officer, Tufts Medical Center, and co-authors used billing codes to identify 438 patients with rectal bleeding, hemorrhoids and blood in the stool at 10 adult primary care practices in Boston. Physician reviewers assessed processes of care, overall quality of care and measures that could have reduced or prevented a delayed workup.

Reviewers judged the overall quality of care to be good or excellent in 77 percent of the cases. However, 71 percent of patients experienced at least one process-of-care failure in the workup of rectal bleeding. Clinicians failed to obtain an adequate family history in 38 percent of cases, conduct a proper physical exam in 23 percent and order laboratory tests in 16 percent. When a primary clinician did not order or perform tests, or make follow-up plans, reviewers were more likely to give a poor or fair rating.
In all, the reviewers estimated that 128 delays in workup could have been reduced or prevented through educating practitioners and creating office-based systems to ensure adequate history taking, physical examination and processes for ordering, performing and interpreting diagnostic tests.

An accompanying editorial by Hardeep Singh, MD, MPH, chief of Health Policy, Quality and Informatics, U.S. Department of Veterans Affairs Center for Innovations in Quality, Effectiveness and Safety, outlines two areas to address missed and delayed diagnoses: better recognition of key red flags in electronic health records (EHRs) by capturing essential data in a more “structured” way, and the use of EHR data for patient safety measurement and improvement.

“It is now time for patient safety professionals to harness EHR capabilities, use trigger-based monitoring and surveillance tools to reduce delays in primary care, and build ‘backup systems’ to catch abnormalities that might have been missed,” Singh concluded.

Also featured in the January 2017 issue:

- “Continuity and Change at The Joint Commission Journal on Quality and Patient Safety”
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Note for editors
The article is "Delayed Workup of Rectal Bleeding in Adult Primary Care: Examining Process-of-Care Failures," by Saul N. Weingart, MD, MPP, PhD; Elena M. Stoffel, MD, MPH; Daniel C. Chung, MD; Thomas D. Sequist, MD, MPH; Ruth I. Lederman,

**The Joint Commission Journal on Quality and Patient Safety**

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