MedPro Group
a Berkshire Hathaway company

PEACE OF MIND | EXPERTISE | CHOICE | THE MEDPRO GROUP DIFFERENCE

Data Insight:

Learning From the High Dollar Cases

Introduction

- This publication contains an analysis of the aggregated data from MedPro Group's cases closing between 2008-2017 with indemnity payments greater than or equal to $1,000,000.
- Our data system, and analysis, rolls all claims/suits related to an individual patient event into one case for coding purposes. Therefore, a case may be made up of one or more individual claims/suits and multiple defendant types such as hospital, physician, or ancillary providers.
  - Cases that involve attorney representations at depositions, State Board actions, and general liability cases are not included.
- This analysis is designed to provide insured doctors, healthcare professionals, hospitals, health systems, and associated risk management staff with detailed case data to assist them in purposefully focusing their risk management and patient safety efforts.

Highlights: the $1,000,000+ cases….

- …account for one out of every 48 indemnity-paid cases closes. Diagnostic, surgical, obstetrical and anesthesia allegations combined drive 81% of this case volume.
- …resemble other cases, with similar distribution of allegations and locations; however…
  - they more frequently include some key breakdowns in the process of care, including the failure to act on, or share, readily available information, abide by established policies and procedures, effectively track test results, and meet supervision requirements.
- …are largely similar to all other cases* with regards to specific diagnoses and surgical procedures; however…
  - they include a larger volume of spinal surgical procedures and diagnoses of intra-spinal abscess;
  - and, 93% involve a high clinical severity patient injury (30% of which are death), compared to 47% high severity for all cases (45% of which are death).
- …arise across all regions of the U.S., but are more frequently seen in the eastern half. They affect all specialties, but disproportionately involve obstetrical issues.

Major allegation categories

	OB-Related Treatment	Anesthesia-Related Treatment	Diagnosis-Related	Surgical Treatment
# of cases that close with ≥ $1M indemnity	1 in 12	1 in 25	1 in 32	1 in 67
	And in comparison, the…			
…overall % of cases with ≥ $1M indemnity	19%	9%	34%	19%
…% of all cases (paid and not paid)	5%	5%	23%	27%

NOTE: Multiple allegation types can be assigned to each case; however, only one “major” allegation is assigned that best characterizes the essence of the case.

Data source: MedPro Group closed cases, 2008-2017; >/= $1M indemnity paid

Major allegation categories: key takeaways

Only 1 in 67 cases associated with surgical treatment closes with a ≥ $1M indemnity, compared to 1 in 12 cases associated with OB-related treatment. However, both represent the same overall percentage of cases with ≥ $1M indemnity (19%).

Further, surgical treatment allegations represent 27% of all cases (paid and not paid), while OB-related treatment allegations represent only 5% of all cases.

Data source: MedPro Group closed cases, 2008-2017, >/= $1M indemnity paid

Additional key points by allegation

OB-related treatment

- Improper management of pregnancy and/or the delivery, including delay in treatment of fetal distress

Anesthesia-related treatment

- Improper management of patients under anesthesia

Diagnosis-related

- Diagnostic error resulting from inadequate assessments and follow-up failures

Surgical treatment

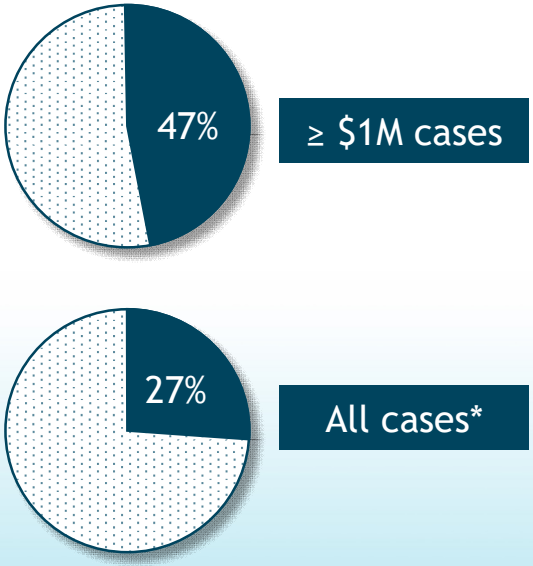
- Improper management of surgical patients, particularly postoperatively

Data source: MedPro Group closed cases, 2008-2017, >/= $1M indemnity paid

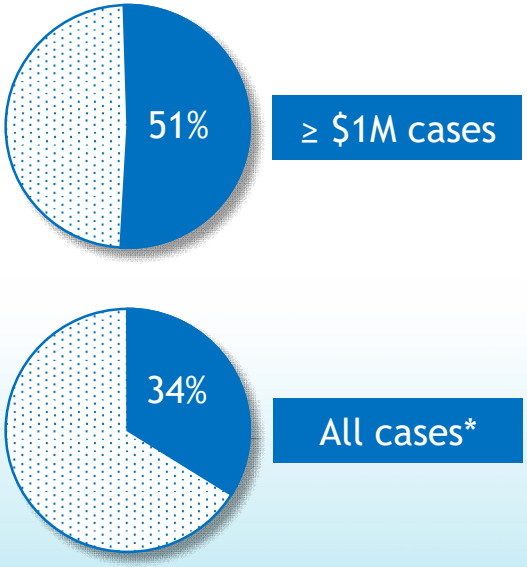
Management issues drive three major allegations

Patient management, rather than procedural performance, is a more frequent factor in the ≥ $1M cases. These charts show the percentage of total management-related cases by allegation category.

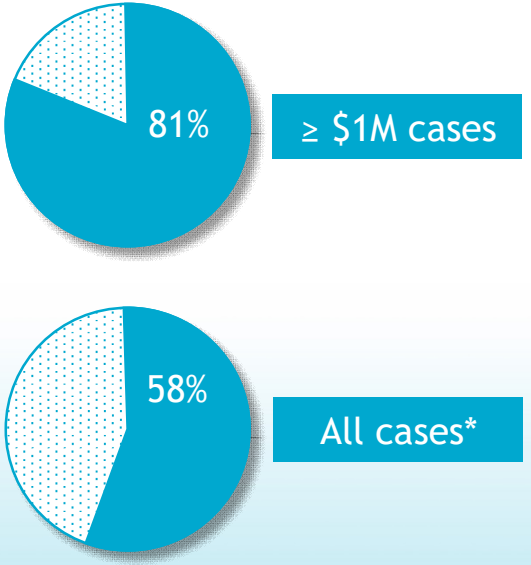
Anesthesia-Related
(physiological monitoring)



Surgical Treatment
(postsurgical complication management)



OB-Related
(pregnancy and L&D management)



Data source: MedPro Group closed cases, 2008-2017, ≥ $1M indemnity paid; *all cases = paid & not paid

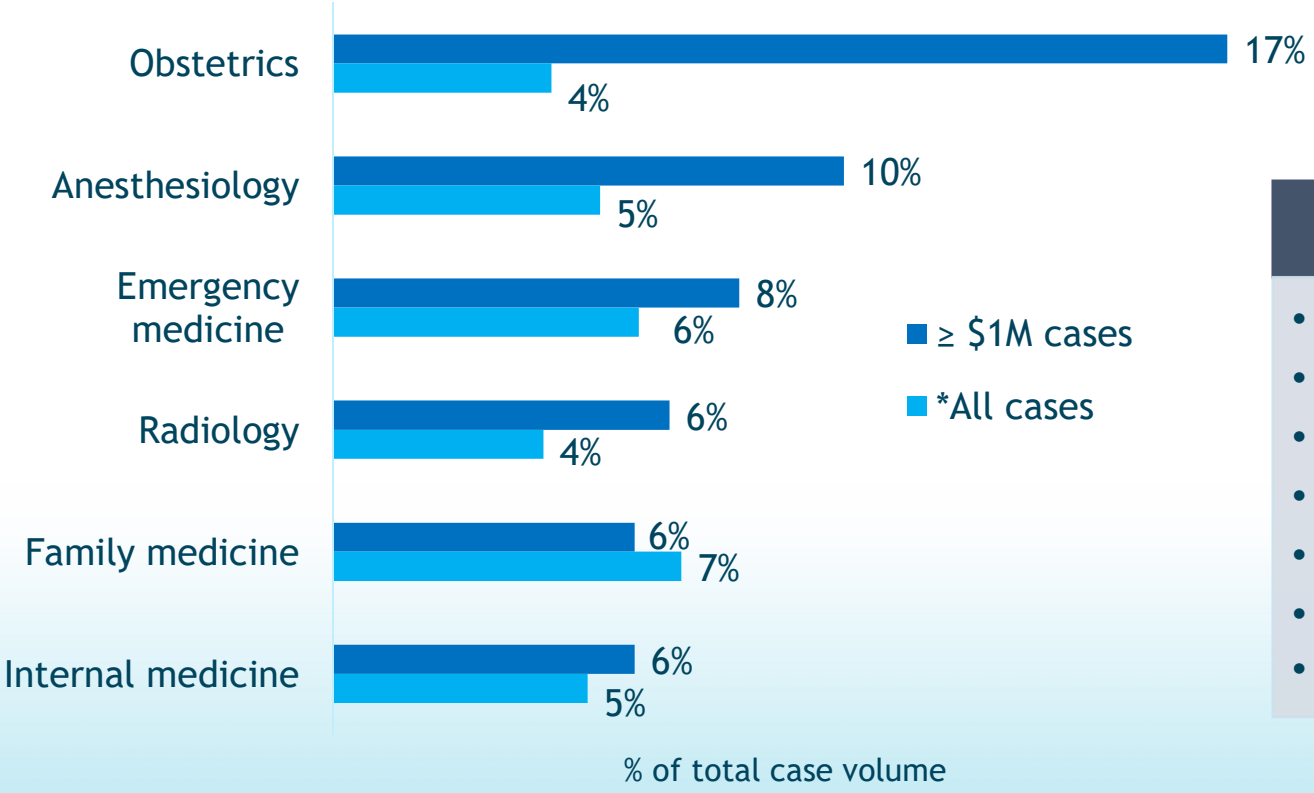
Primary responsible services

A malpractice claim can have more than one responsible service, but the “primary responsible service” is the specialty that is deemed to be most responsible for the resulting patient outcome.

As would be expected, anesthesiologists are most often noted in anesthesia allegations, surgical specialties in surgical allegations, and obstetricians in OB-related allegations. In the diagnostic cases, it is emergency medicine, family medicine, internal medicine, pediatrics, and radiology that account for the majority.

Data source: MedPro Group closed cases, 2008-2017, >/= $1M indemnity paid

Top primary responsible services



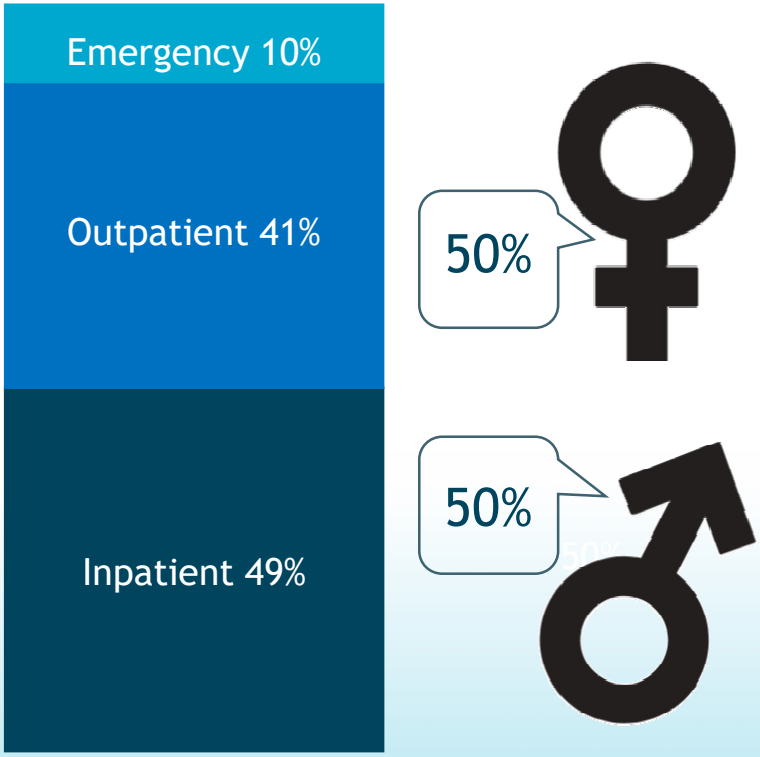
Followed by:

- Orthopedic surgery (5%/9%)
- General surgery (4%/5%)
- Nursing (3%/8%)
- Pediatrics (3%/1%)
- Gynecology (3%/4%)
- Neurology (2%/1%)
- Urology surgery (2%/2%)

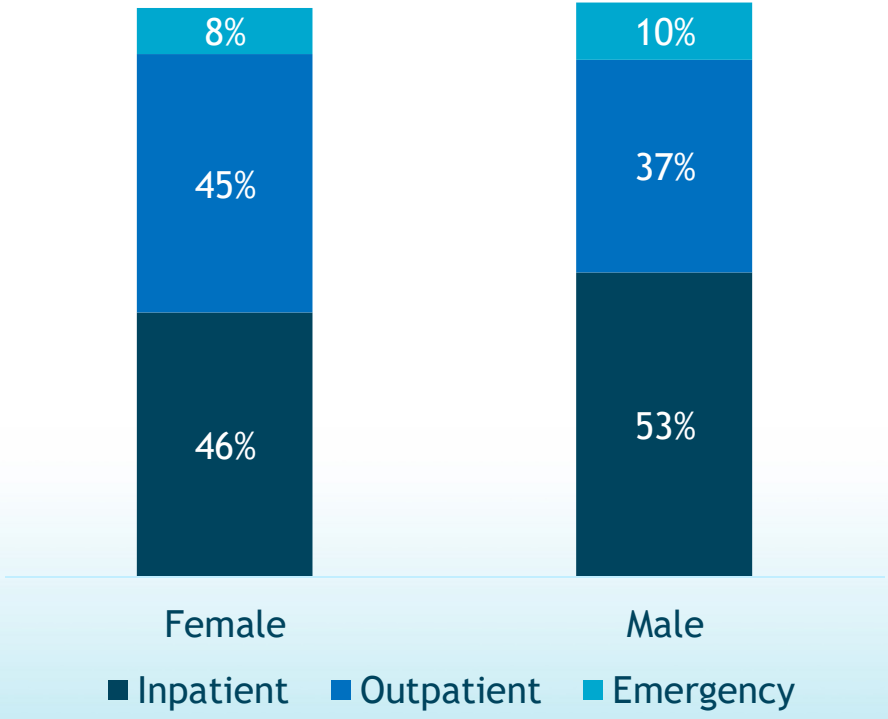
Data source: MedPro Group closed cases, 2008-2017, ≥ $1M indemnity paid; *all cases = paid & not paid

Healthcare setting and claimant gender

Overall for ≥ $1M Claims



Percentage of Claims Volume by Gender



Data source: MedPro Group closed cases, 2008-2017, >/= $1M indemnity paid

Location associated with allegations

	Labor & Delivery (L&D)	Emergency Department	Patient Room (including ICU)	Clinic/Office	Inpatient Surgical Suite/ Recovery
# of cases that close with ≥ $1M indemnity	1 in 12	1 in 36	1 in 39	1 in 51	1 in 52
	And in comparison, the…				
…% of all ≥ $1M indemnity cases that location represents	16%	10%	16%	25%	15%
…% of all cases (paid and not paid) that location represents	4%	8%	13%	27%	16%

Data source: MedPro Group closed cases, 2008-2017, ≥ $1M indemnity paid

Location associated with allegations: key takeaways

Only 1 in 51 cases that closes with ≥ $1M indemnity is associated with the clinic/office setting compared to 1 in 12 cases associated with the L&D setting. However, the clinic/office setting represents 25% of all ≥ $1M indemnity cases and 27% of all cases (paid and not paid), while the L&D setting represents 16% of all ≥ $1M indemnity cases and only 4% of all cases.

Also of note, only 1 in 52 cases that closes with a ≥ $1M indemnity is associated with the inpatient surgical suite/recovery setting, but this setting represents 15% of all ≥ $1M indemnity cases and 16% of all cases.

Data source: MedPro Group closed cases, 2008-2017, >/= $1M indemnity paid

Additional key issues by location

Labor & delivery	Delays in treating fetal distress and mismanagement of labor
Emergency department	Diagnostic issues, including sepsis, cardiac conditions, and neurological conditions (trauma and CVA)
Patient room (including ICU)	Diagnostic issues (particularly in relation to vascular problems, cancers, and infections) and timely management of postoperative complications
Clinic/office	Diagnostic issues and management of pregnancy
Inpatient surgical suite/recovery	Performance of operative procedures (especially orthopaedic and abdominal) and anesthesia management

Data source: MedPro Group closed cases, 2008-2017, >/= $1M indemnity paid

Contributing factors

Contributing factors are issues or failures in the process of care that appear to have contributed to the patient outcome and/or to the initiation of the case.

Cases closing with ≥ $1M indemnity generally are complex, involve multiple providers, and remain open longer than other cases. As a result, more contributing factors often are noted in these cases.

Contributing factors

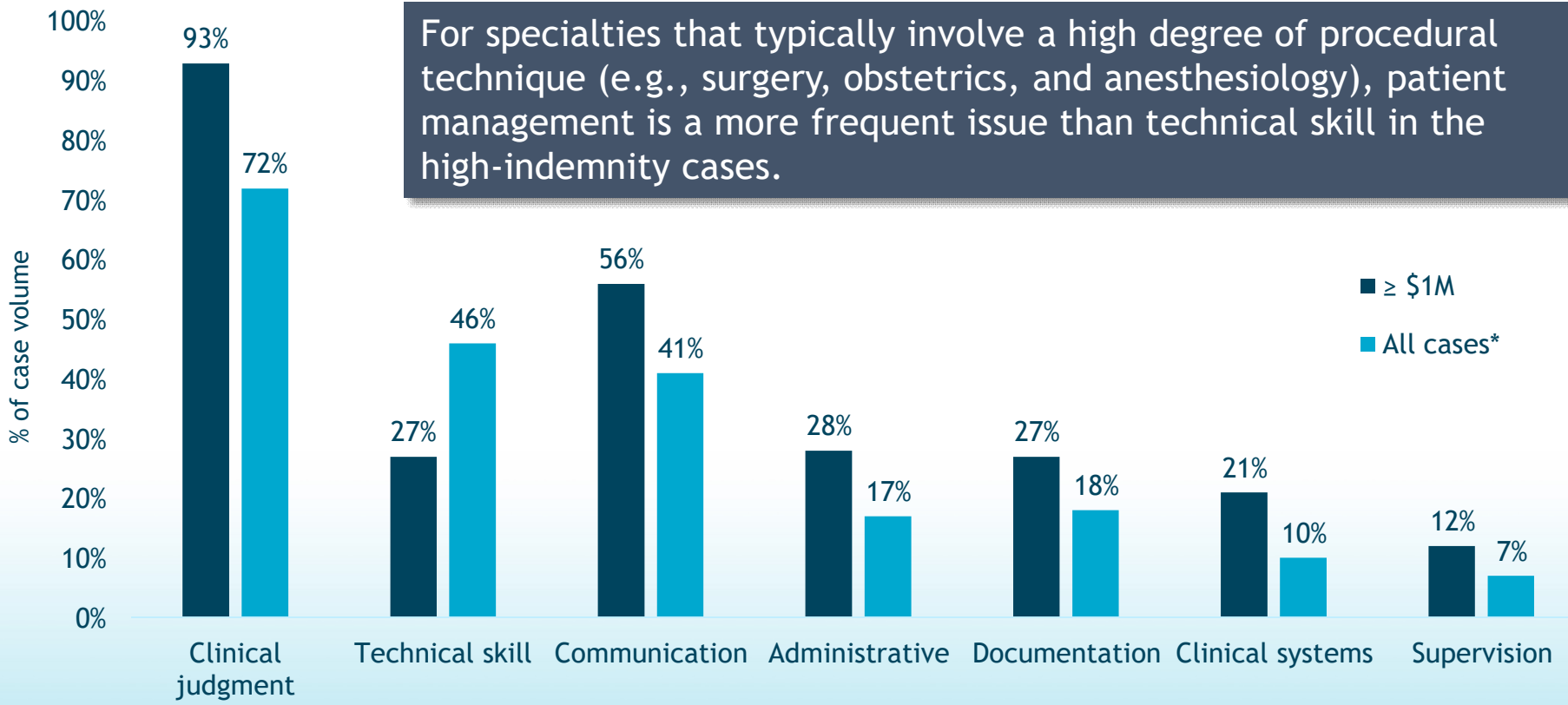
Specific issues occur more frequently in cases that close with ≥ $1M indemnity than in other cases, including:

- Communication failures among providers
- Failure to follow up with the patient to ensure tests are completed, test results are communicated to the patient, and the patient is engaged in ongoing care
- Failure to reconcile ALL signs, symptoms, and test results
- Lack of supervision for advanced practice providers and house staff
- Gaps in specialty physician coverage

Data source: MedPro Group closed cases, 2008-2017, >/= $1M indemnity paid

Top contributing factor categories

For specialties that typically involve a high degree of procedural technique (e.g., surgery, obstetrics, and anesthesiology), patient management is a more frequent issue than technical skill in the high-indemnity cases.



Data source: MedPro Group closed cases, 2008-2017, >/= $1M indemnity paid; *all cases = paid & not paid

Top contributing factors and sub-factors

Factor category	Sub-factor details
Clinical judgment	Failure to appreciate or reconcile patient symptoms or test results; further, judgment failures are exacerbated by poor communication with other providers. Noted across all case types, including assessment of fetal distress, diagnostic decision-making, and management of surgical complications. Encompasses failure to use available safety processes (e.g., time-outs, checklists, clinical decision tools), issues with provider bias, and failure to visualize the entire "patient picture."
Communication	Among providers: Failure to share knowledge about patient's condition resulting in an incomplete picture (which can lead to clinical judgment failures). Ineffective handoffs: Between departments in the inpatient setting, transfer of care among specialties, bedside reporting processes, and mismanaged handoffs between hospital discharge and primary care resumption.

Top contributing factors and sub-factors

Factor category	Sub-factor details
Administrative	Failure to follow policies and protocols for safe patient care. Insufficient specialty physician/surgeon coverage resulting in delayed treatment or reduced quality of care.
Documentation	Inadequate documentation of patient problem lists and the provider's clinical rationale for treatment/diagnostic considerations. Documentation issues contribute to communication lapses.
Clinical systems	Most frequently seen in the diagnostic cases and mainly related to follow-up issues. Most notably involves failures involving test completion and result notification.
Supervision	Inadequate supervision of house staff primarily. In diagnostic cases, involves inadequate supervision of advanced practice providers.

Data source: MedPro Group closed cases, 2008-2017, >/= $1M indemnity paid

Frequency of sub-factors in ≥ $1M cases vs. other cases

Factor category	Sub-factor details	Frequency*
Clinical judgment	Failure to appreciate or reconcile patient symptoms or test results	+34%
Communication	Failed communication among providers	+60%
Administrative	Failure to follow policies and protocols for safe patient care	+20%
	Insufficient specialty physician/surgeon coverage resulting in delayed treatment or reduced quality of care	+69%
Clinical systems	Failures involving processes designed for safe patient care (test completion, result notification to providers and patients, and patient follow-up)	+104%
Supervision	Inadequate supervision of house staff and advanced practice providers	+118%

Data source: MedPro Group closed cases, 2008-2017, >/= $1M indemnity paid; * Factor is X% more frequent in ≥ $1M cases than in other cases.

Summary and recommendations

- In traditionally procedure-based care, the management of patients, both pre- and post- procedurally, is more often the issue than the procedural performance.
  - Ensure nurses and other providers communicate often and well, especially during handoffs.
  - Ensure staff is well trained to recognize known/expected complications, particularly in labor and delivery and post surgical units.
- Management of pregnancy, particularly related to genetics, is a growing concern.
  - Good informed consent discussions, documentation of informed refusal and tracking and follow-up of all testing performed during the pregnancy are imperative.
- Supervision of advanced practice providers and house staff is a frequently noted feature of these cases. Advanced practice providers continue to see an increase in the level of complexity in the patients they treat and supervision failures or inability to defend their competencies are more often noted in these cases.
  - Ensure that required supervision is a regular on-going activity.
  - It should include documented evaluation/measurement of competency.

Summary and recommendations, continued…

- Failure to reconcile all symptoms, signs and test results lead to under treatment and missed diagnoses.
  - Complex patient care requires effective care coordination, especially communicating verbally whenever possible to ensure critical information is not missed.
    - One piece of information by itself may not seem significant, but combined with other information can be very meaningful.
  - If verbal communication is not feasible, then ensure complete documentation in the medical record where it will be obvious to others.
- In office-based diagnostic cases, often the primary failure is a breakdown in the process of care intended to inform the patient of critical test results.
  - Establish a fail-safe tracking and follow-up system that guarantees patient notification of important information following consults or testing.
- Policies/procedures (P&Ps) are an important part of safe care, but only if followed.
  - Failure to follow your own P&Ps is very difficult to defend.
  - Ensure all caregivers are aware of the P&Ps

Resources with associated risk strategies: MedPro Group

- Clinical judgment & diagnostic errors:
  - Clinical Judgment in Diagnostic Errors: Let's Think About Thinking
  - Diagnostic Errors: Lessons Learned (On-demand webinar; CME available)
  - Reducing Diagnostic Errors in Emergency Medicine
  - Risk Factors That Contribute to Diagnostic Errors
- Clinical systems:
  - Addressing Clinical System Risk Factors
  - Test Result Communication Failures
- Communication:
  - Handoffs and Signouts
  - Communication in the Diagnostic Process
- Documentation:
  - Checklist: Documentation Essentials
- Supervision:
  - Checklist: Supervision of Advanced Practice Providers
- Surgical & anesthesia-related
  - Checklist: Risk Management Considerations in Surgical Practice
  - Managing Operating Room Distractions

More resources are available at www.medpro.com/dynamic-risk-tools

A note about MedPro Group data

MedPro Group has entered into a partnership with CRICO Strategies, a division of the Risk Management Foundation of the Harvard Medical Institutions. Using CRICO's sophisticated coding taxonomy to code claims data, MedPro Group is better able to identify clinical areas of risk vulnerability. All data in this report represent a snapshot of MedPro Group's experience with specialty-specific claims, including an analysis of risk factors that drive these claims.