

Emergency Medicine

Claims Data Snapshot

2023



Introduction

INTRODUCTION | KEY POINTS | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION

This publication begins with insight into frequency and financial severity profiles by specialty. Then follows an analysis of aggregated data from clinically coded cases opened between 2012-2021 in which Emergency Medicine is identified as the primary responsible service.

Keep in mind...

A clinically coded malpractice case 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.

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, and other healthcare professionals.

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.

Specialty benchmarking

Specialties have different frequency and financial severity profiles which combine to produce differing risk levels.

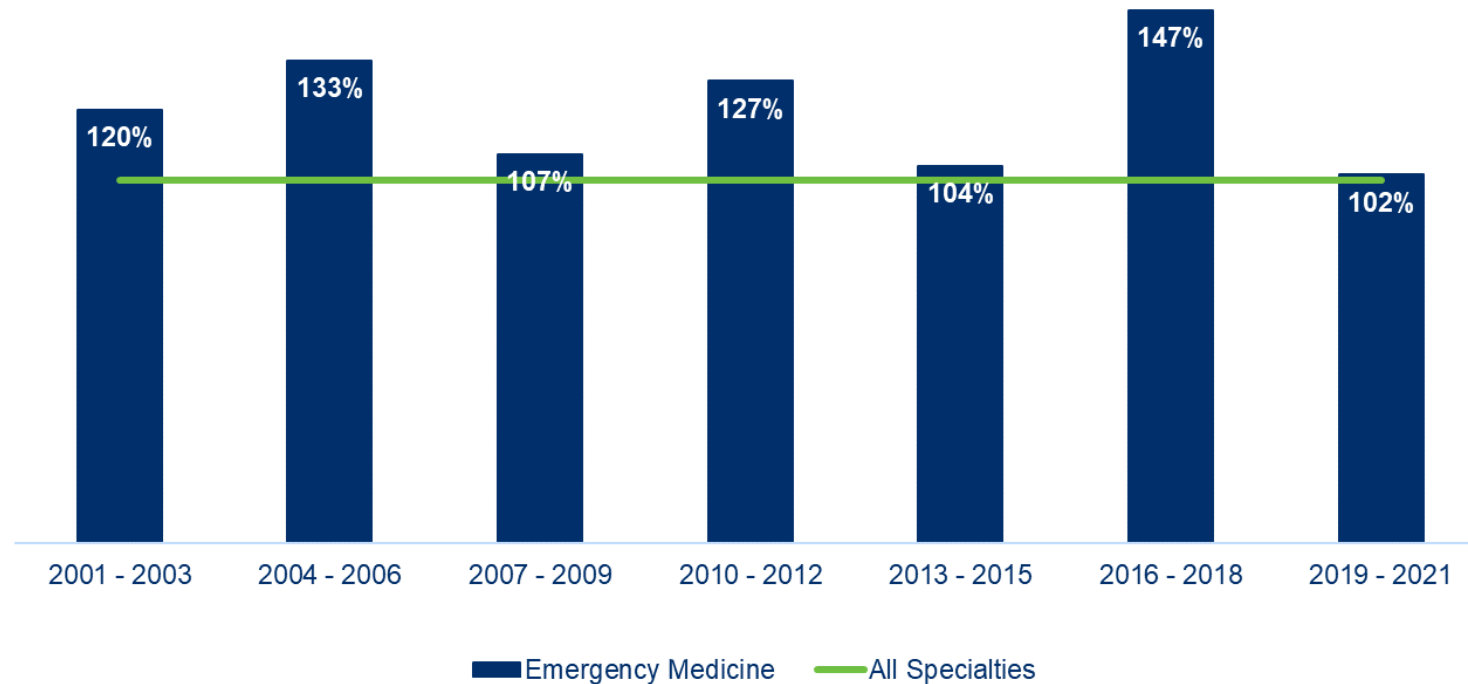
Severity Tier	High	Hematology/Oncology, Pathology, Pediatrics	Anesthesiology, Neurology	Emergency Medicine, Neurosurgery, OB/GYN
	Medium	Family Medicine, Nephrology, Physiatry, Urgent Care	Cardiology, ENT, Gastroenterology, Internal Medicine	Cardiovascular Surgery, General Surgery, Orthopedic Surgery, Radiology, Urology
	Low	Allergy, Dermatology, Occupational Medicine, Psychiatry, Rheumatology	Ophthalmology, Plastic Surgery, Pulmonology	Hospitalists
		Low	Medium	High
		Frequency Tier		

Specialty trends – Emergency Medicine

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Emergency Medicine has a higher financial severity per case and a higher claim frequency compared to all specialties.

Average Severity - Emergency Medicine Relative to All Specialties



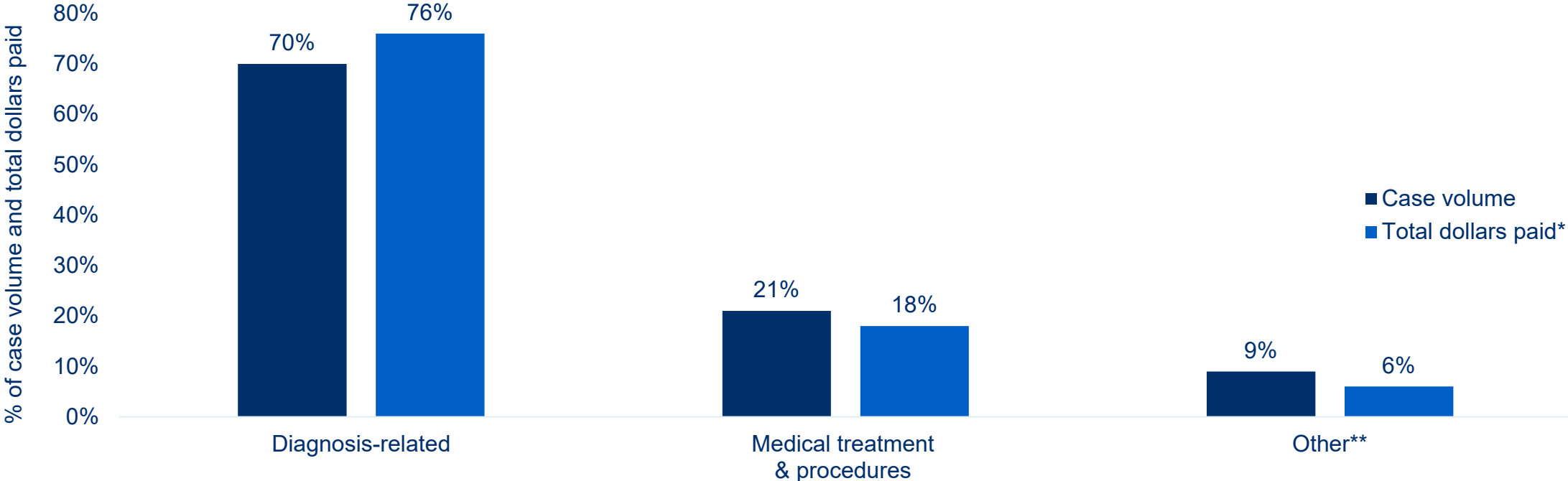
Key Points - Clinically Coded Data

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- **Diagnosis-related allegations** account for 70% of Emergency Medicine case volume and three-fourths of total dollars paid*. Diagnoses most commonly noted include myocardial infarctions, strokes, and fractures, along with spinal cord injuries, infections and gastrointestinal disorders. These cases **commonly reflect breaks all along the diagnostic process of care continuum, but most often during the initial diagnostic process phase** of patient assessments, establishment of differential diagnoses and ordering of diagnostic testing.
- **Medical treatment cases reflect triage processes issues and inadequate re-assessment/monitoring of patients admitted but not yet transferred to inpatient units.** Procedural performance cases, including intubations, setting of fractures, and wound care, often are the result of poor procedural technique, and can be impacted by delayed recognition of complications.
- **Contributing factors, which are multi-layered issues or failures in the process of care that appear to have contributed to the patient's outcome,** and/or to the initiation of the case, provide valuable insight into risk mitigation opportunities. Clinical judgment factors, specifically inadequate patient assessment processes – some resulting in premature discharge from care, and a narrow diagnostic focus, and suboptimal communication, documentation and supervision of advanced practice providers are key drivers of both clinical and financial Emergency Medicine case severity.

Major Allegations & Financial Severity

Each case reflects one major allegation category. Categories are designed to enable the grouping and analysis of similar cases and to drive focused risk mitigation efforts. The coding taxonomy includes detailed allegation sub-categories; insight into these is noted later in this report.



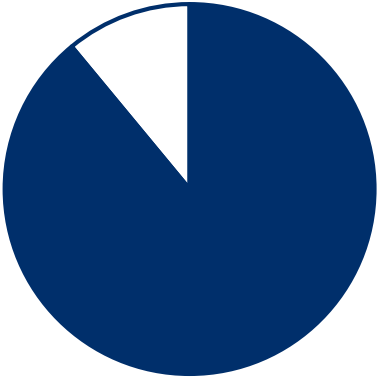
MedPro Group + MLMIC cases opened 2012-2021, Emergency Medicine as responsible (N=1629); *Total dollars paid = expense + indemnity; **Other includes allegations for which no significant case volume exists

Clinical Severity*

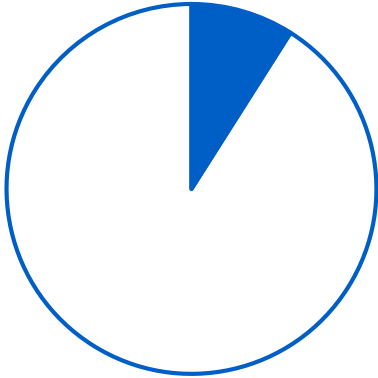
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Clinical Severity Categories	Sub-categories	% of case volume	Typically, the higher the clinical severity, the higher the indemnity payments are, and the more frequently payment occurs.
LOW	Emotional Injury Only	6%	
	Temporary Insignificant Injury		
MEDIUM	Temporary Minor Injury	29%	
	Temporary Major Injury		
	Permanent Minor Injury		
HIGH	Significant Permanent Injury	65%	
	Major Permanent Injury		
	Grave Injury		
	Death		

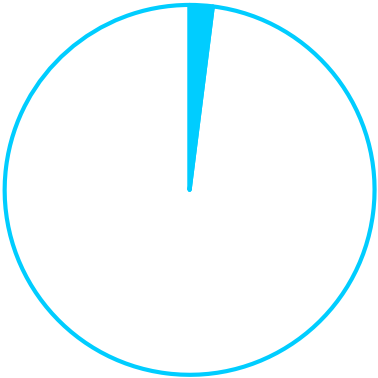
Claimant Type & Location



Emergency
89%



Ambulatory
9%



Inpatient
2%

Top Locations	% of case volume
Emergency department	93%
Walk-in/urgent care clinics	3%

Contributing Factors

“Contributing factors reflect both provider and patient issues. They denote breakdowns in technical skill, clinical judgment, communication, behavior, systems, environment, equipment/tools, and teamwork. The majority are relevant across clinical specialties, settings, and disciplines; thus, they identify opportunities for broad remediation.”

Despite best intentions, processes designed for safe patient outcomes can, and do, fail.

Contributing factors are multi-layered issues or failures in the process of care that appear to have contributed to the patient's outcome, and/or to the initiation of the case, or had a significant impact on case resolution.

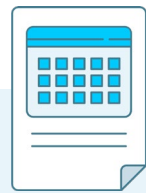
Multiple factors are identified in each case because generally, there is not just one issue that leads to these cases, but rather a combination of issues.



Administrative



Behavior-related



Clinical environment



Clinical judgment



Clinical systems



Communication



Documentation



Supervision



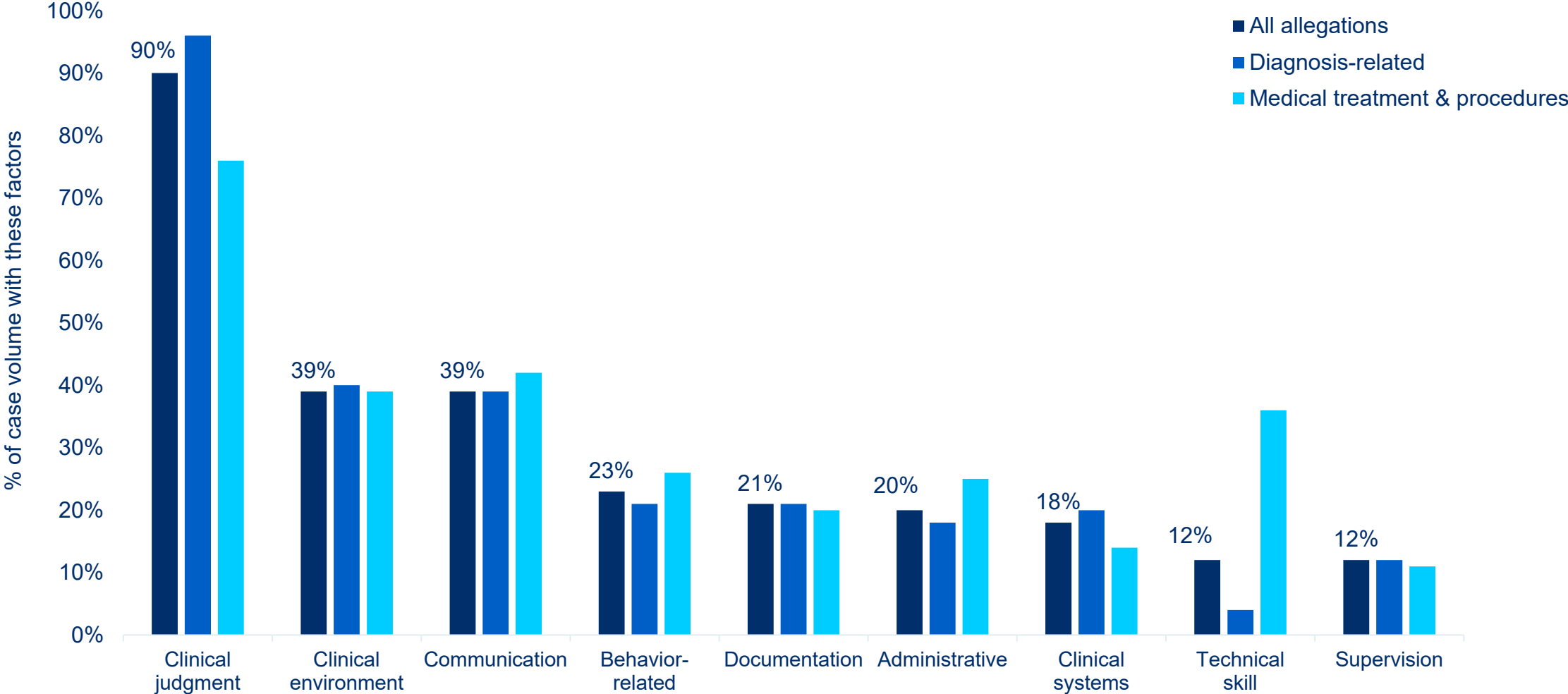
Technical skill

Contributing Factor Category Definitions

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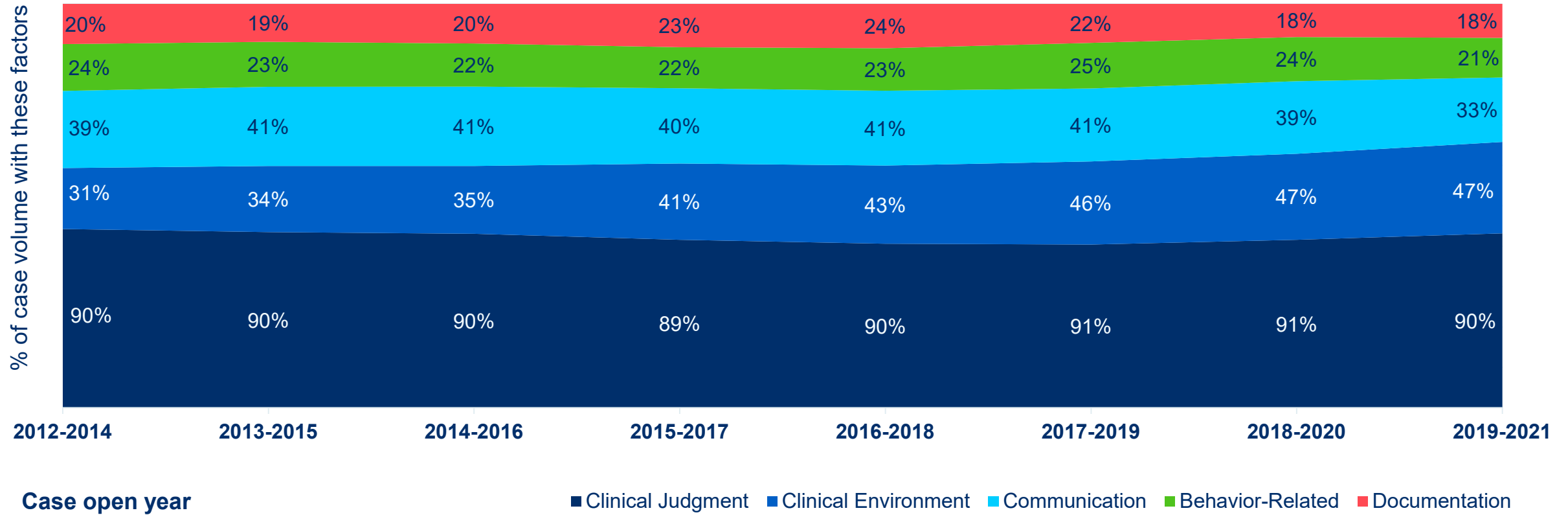
Administrative	Factors related to medical records (other than documentation), reporting, staff, ethics, policy/protocols, regulatory
Behavior-related	Factors related to patient nonadherence to treatment or behavior that offsets care; also provider behavior including breach of confidentiality or sexual misconduct
Clinical environment	Factors related to workflow, physical conditions and “off-hours” conditions (weekends/holidays/nights)
Clinical judgment	Factors related to patient assessment, selection and management of therapy, patient monitoring, failure/delay in obtaining a consult, failure to ensure patient safety (falls, burns, etc), choice of practice setting, failure to question/follow an order, practice beyond scope
Clinical systems	Factors related to coordination of care, failure/delay in ordering test, reporting findings, follow-up systems, patient identification, specimen handling, nosocomial infections
Communication	Factors related to communication among providers, between patient/family and providers, via electronic communication (texting, email, etc), and telehealth/tele-Emergency Medicine
Documentation	Factors related to mechanics, insufficiency, content
Supervision	Factors related to supervision of nursing, house staff, advanced practice clinicians
Technical skill	Factors related to improper use of equipment, medication errors, retained foreign bodies, technical performance of procedures

Most Common Contributing Factor Categories by Allegation



MedPro Group + MLMIC cases opened 2012-2021, Emergency Medicine as responsible service (N=1629); More than one factor per case, therefore totals >100%

Distribution of Top Five Factor Categories Over Time



While the distribution of these top (most common) factors across rolling three-year timeframes is relatively consistent, take note of even slight increases over time as indicators of emerging risk issues.

Focus on Most Common Drivers of Clinical and Financial Severity

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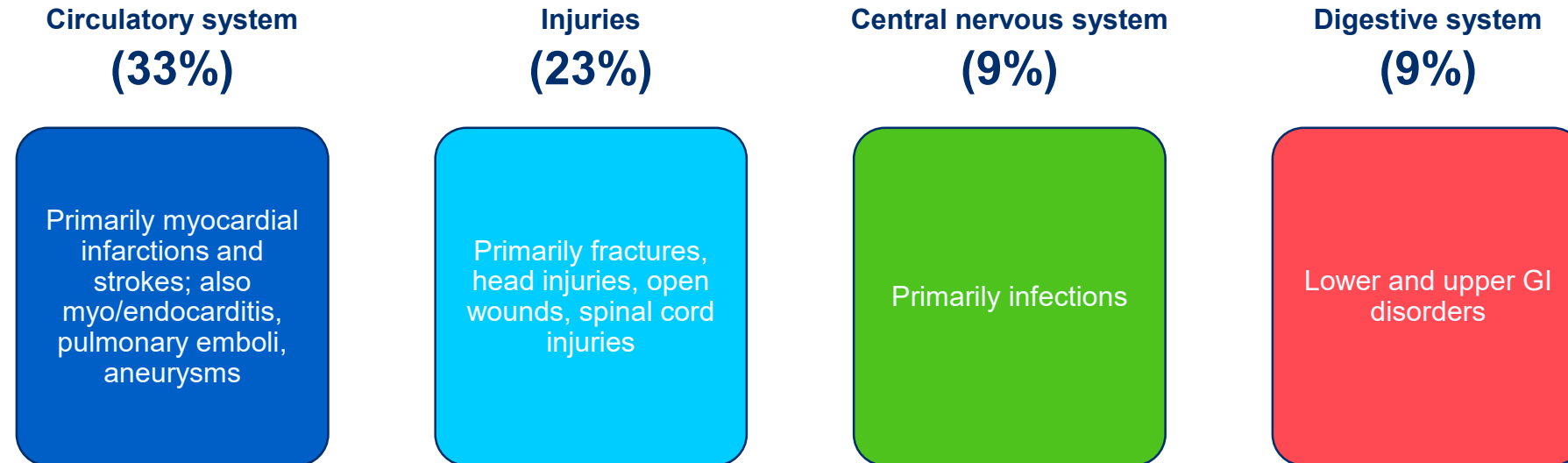
Factors associated with high clinical severity outcomes	(CJ) failure to appreciate/reconcile signs/symptoms/test results (48%)	% of high severity case volume
	(CJ) inadequate assessment resulting in premature discharge from care (43%)	
	(CJ) failure/delay in ordering diagnostic test (40%)	
	(CJ) narrow diagnostic focus – failure to establish differential diagnosis (34%)	
	(CJ) failure/delay in obtaining consult/referral (32%)	
Factors associated with the costliest indemnity payments	(SU) inadequate supervision of advanced practice providers (32%)	% more expensive than the average indemnity payment*
	(CJ) failure/delay in obtaining consult/referral (30%)	
	(CO) suboptimal communication among providers about patient condition (27%)	
	(CJ) narrow diagnostic focus – atypical presentation (21%)	
	(DO) insufficient documentation of clinical findings (18%)	

Clinical judgment factors, specifically inadequate patient assessment processes – some resulting in premature discharge from care, and a narrow diagnostic focus, and suboptimal communication, documentation and supervision are key drivers of both clinical and financial Emergency Medicine case severity.

Focus on Diagnosis-Related Allegations

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Diagnosis-related allegations encompass wrong diagnoses, failures/delays, and misdiagnoses. See below for the top diagnoses* noted in these cases.



Focus on Diagnosis-Related Allegations

Diagnosis-related allegations encompass wrong diagnoses, failures/delays, and misdiagnoses. Note the key opportunities to reduce diagnostic errors along the diagnostic process of care* below.

Phase 1

Initial diagnostic assessment 91% of cases	Patient notes problem & seeks care
	History & physical
	Patient assessed, symptoms evaluated
	Differential diagnosis established
	Diagnostic testing ordered

Phase 2

Testing and results processing 23% of cases	Performance of diagnostic tests
	Interpretation of diagnostic test results
	Test results transmitted to/received by ordering provider

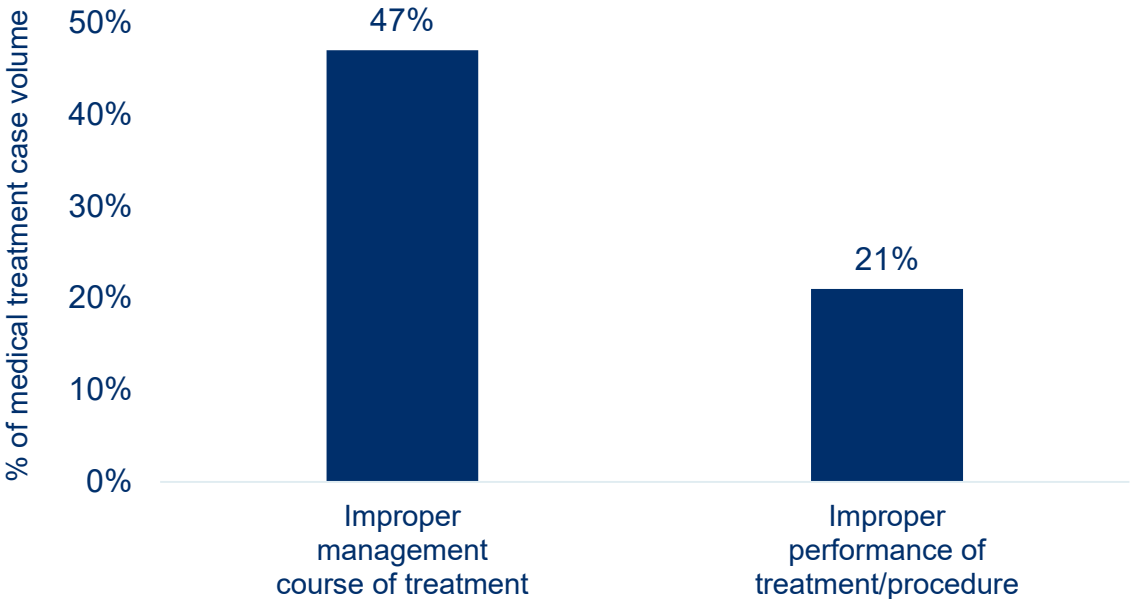
Phase 3

Follow-up and coordination 59% of cases	Physician follows-up with patient
	Referrals/Consults
	Patient information communicated among care team
	Patient compliance with follow-up plan

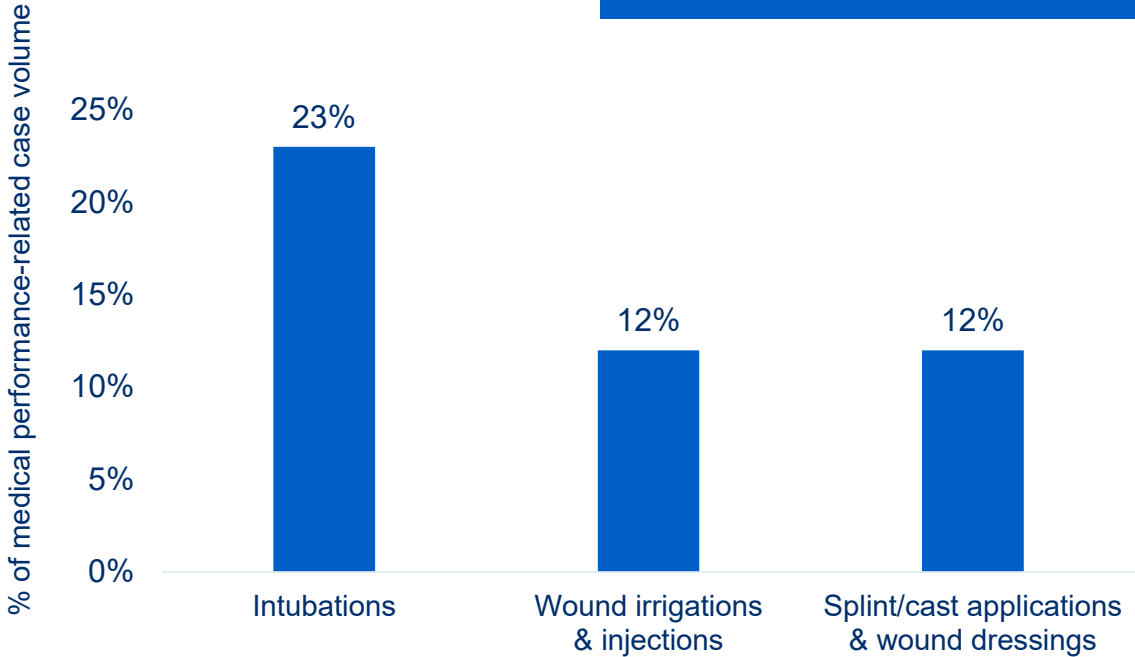
MedPro Group + MLMIC cases opened 2012-2021, Emergency Medicine as responsible service (N=1629); *each step reflects a combination of contributing factors; diagnostic process of care algorithm courtesy of Candello, a division of CRICO Strategies

Focus on Medical Treatment Allegations

Top allegation details



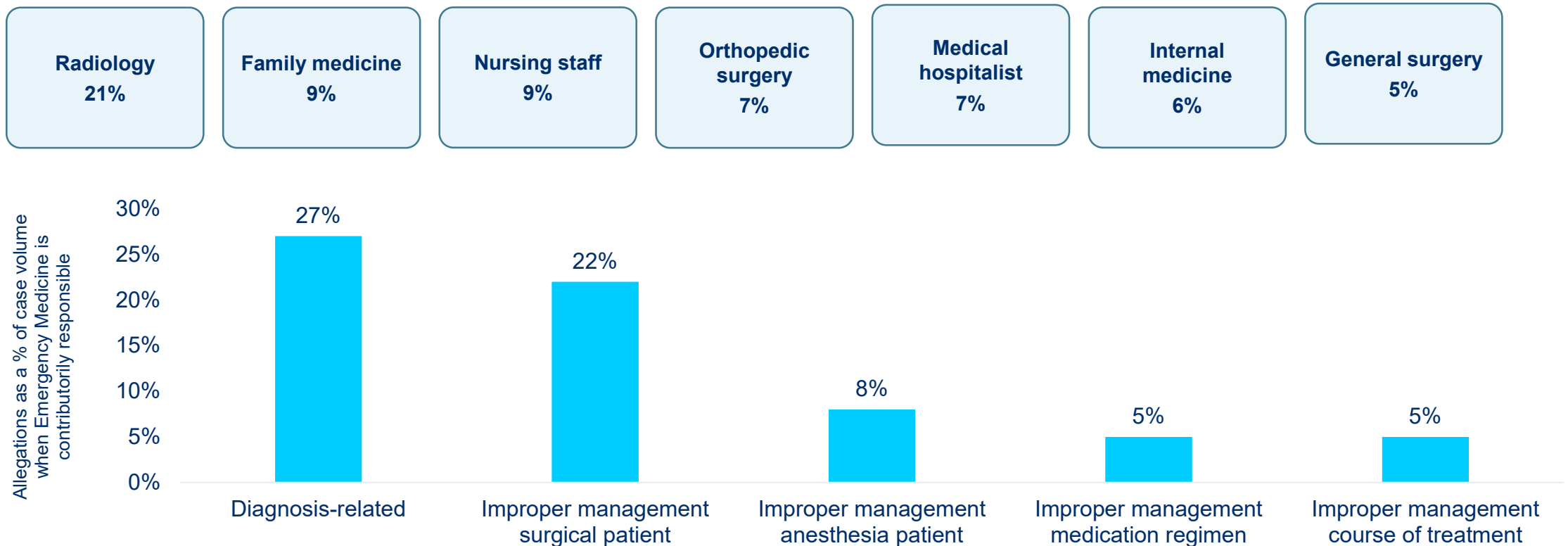
Top procedures involved



Medical treatment cases reflect triage processes issues and inadequate re-assessment/monitoring of patients admitted but not yet transferred to inpatient units. Procedural performance cases often are the result of poor procedural technique, and can be impacted by delayed recognition of complications.

Contributorily Responsible

Although this analysis is focused on cases reflecting Emergency Medicine as the primarily responsible service, another 908 cases identify Emergency Medicine as contributorily responsible. The primary services in these cases are varied, reflecting the myriad of providers who care for patients along the healthcare continuum. The most common primary services, and a comparison of top allegation categories, are shown below.





The following stories are reflective of the allegations and contributing risk factors which drive cases brought against Emergency Medicine providers.

We're relaying these true stories as lessons to build understanding of the challenges that you face in day-to-day practice. Learning from these events, we trust that you will take the necessary steps to either reinforce or implement best practices, as outlined in the section focused on risk mitigation strategies.

Case Examples

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SETTLED

\$800,000

CONTRIBUTING FACTORS

Clinical environment

Weekend/holiday

Clinical judgment

Patient assessment issues –
narrow diagnostic focus and
inadequate neuro exam

Failure to order diagnostic test

Failure to appreciate and
reconcile relevant
signs/symptoms/test results

Clinical systems

Failure/delay in scheduling
consult/referral

Communication

Suboptimal communication
among providers regarding
patient condition

DELAY IN DIAGNOSIS OF CAUDA EQUINA SYNDROME RESULTING IN PERMANENT URINARY RETENTION AND MOBILITY ISSUES

A female in her mid 20s with chronic lower back pain presented to her family practice physician (FP-A). At office visits on 1/15 and 2/1, her chief complaint was of worsening back pain. An x-ray of the lumbar spine was not concerning. She was referred to physical therapy (PT); first visit was 2/10. On 2/11, she called her FP-A's office with complaints of severe back pain radiating to the tailbone, vaginal numbness spreading to the buttocks, and inability to urinate. She was directed to the emergency department (ED); there she was seen by an **ED PA who noted symptoms but did not do a neurological exam**. The patient was able to produce a small urine sample which showed some bacteria. **She was diagnosed with a urinary tract infection, degenerative lumbar disc disease and was sent home** with steroids, Bactrim, and instructions to follow up with FP-A. **Cauda equina was not considered as a differential diagnosis and no MRI was ordered before discharge.**

On 2/12, FP-A received a request from the ED PA for an MRI. Process for obtaining an MRI was complex due to insurance requirements; the patient needed to be seen by her FP and a review of notes from 2/10 PT visit was required. **FP-A documented this on a Friday after staff had left, however he did not call the patient to arrange an appointment.** The patient left town for the holiday weekend, but called FP office on Sunday (2/14) and spoke with on-call FP-B, complaining of leg pain, perianal numbness, and no bowel movement for 4 days. **FP-B advised patient to take laxatives and follow up on return from vacation. No recommendation was made to go to the ED.** On Monday, FP-A communicated the need for priority MRI to staff. MRI was performed on Tuesday, revealing severe disc extrusion with narrowing thecal sac and displacement of nerve roots. The patient was immediately referred to a Neurologist. The Neurologist **considered the large L5-S1 disc herniation with cauda equina symptoms to be an emergent situation** and sent the patient to the ED. She was admitted for left sided microdiscectomy at L5-S1. Symptoms persisted post-operatively and a second surgery was required to remove disc fragments.

The patient was left with permanent urinary retention and mobility issues. Subsequent providers critical of FP-A, FP-B and the initial ED PA who evaluated her.

Case Examples

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SETTLED

\$980,000

CONTRIBUTING FACTORS

Behavior related

Patient factors – positive drug abuse screening

Clinical judgment

Patient assessment – premature discharge

Failure to appreciate and reconcile relevant sign/symptom/test result

Failure/delay in ordering diagnostic test and consult

DELAY IN DIAGNOSIS RESULTING IN PARALYSIS, BOWEL/BLADDER INCONTINENCE, SEXUAL DYSFUNCTION AND SENSORY DYSFUNCTION

A female in her early 30s went to the emergency department (ED) with complaints of back and bilateral leg pain for two days which developed after swimming laps in the pool. She denied numbness, tingling, incontinence and spasms. However, an exam revealed muscle spasm and right rhomboid tenderness. At 3:16pm, the Nursing note revealed pain was a 6 out of 10. **No x-rays or labs were done.** Patient was given Percocet and discharged at 3:23pm.

Two days later, the patient returned to the ED with complaints of worsening back and bilateral leg pain and numbness. The ED physician and physician assistant evaluated her and concluded that she could be suffering from Guillain-Barre Syndrome as **she developed ascending paralysis while in the ED.** She was admitted under the care of the Hospitalist who consulted Infectious Disease and Neurology. Lab work revealed an elevated white blood cell count. **A drug abuse screen came back positive; the patient then admitted to taking her husband's narcotics.** The Neurologist diagnosed polyneuropathy with bilateral lower extremity weakness, and transferred the patient to another facility where she could undergo additional testing to rule out Guillain-Barre with thoracic/cervical cord compression.

CT of cervical and thoracic spine showed no evidence of acute fracture. However, the **lumbar spine images did reveal an acute fracture.** An MRI of the spine showed **a cervical to thoracic epidural fluid collection.** Patient underwent emergency spinal surgery.

Patient alleges that ED physician and physician assistant failed to diagnose and/or rule out the possibility of a cord compression and/or epidural abscess. Despite the emergency surgery, she sustained permanent paralysis from her breasts down.

- **Clinical judgment:**
 - Implement comprehensive test tracking and referral tracking procedures that include protocols for complete review of imaging studies, patient follow-up, and documentation.
 - Thoroughly screen patients for risk factors, atypical presentations, and associated symptoms to avoid a narrow diagnostic focus.
 - Utilize evidence-based guidelines for myocardial infarctions, strokes, etc. Consider the use of clinical decision support aids and group decision-making to support clinical reasoning.
- **Communication:**
 - Define and implement a detailed process for patient handoffs, including expectations for verbal and written communication. Audit for compliance with the policy.
 - Provide patients/caregivers with written and verbal instructions related to their treatment plans and follow-up care. Make sure written instructions are at an appropriate reading level.
- **Clinical environment:**
 - Be aware of how staffing levels/patterns during the overnight, weekend & holiday shifts can impact patient care.
- **Clinical systems:**
 - Focus on 'closing the loop' with regards to receiving, reporting and acting on test results, including incidental findings and test results received after discharge.
 - Use team drills and situational simulations to improve teamwork between all providers in the ED.
- **Documentation:**
 - Verify that documentation supports the clinical rationale for the diagnosis and treatment plan, including the inclusion/exclusion of differential diagnoses.
 - Adhere to processes for following up on radiology discrepancies and communicating & documenting test results received after discharge.

MedPro Group & MLMIC Data

MedPro and MLMIC are partnered with Candello, a national medical malpractice data collaborative and division of CRICO, the medical malpractice insurer for the Harvard-affiliated medical institutions.

Derived from the essence of the word candela, a unit of luminous intensity that emits a clear direction, Candello's best-in-class taxonomy, data, and tools provide unique insights into the clinical and financial risks that lead to harm and loss.

Using Candello's sophisticated coding taxonomy to code claims data, MedPro and MLMIC are better able to highlight the critical intersection between quality and patient safety and provide insights into minimizing losses and improving outcomes.

Leveraging our extensive claims data, we help our insureds stay aware of risk trends by specialty and across a variety of practice settings. Data analyses examine allegations and contributing factors, including human factors and healthcare system flaws that result in patient harm. Insight gained from claims data analyses also allows us to develop targeted programs and tools to help our insureds minimize risk.



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