Medical Hospitalist

Claims Data Snapshot

2023

MedPro Group

MLMIC
MLMIC Insurance Company
a Berkshire Hathaway company

Introduction

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 Medical Hospitalist 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.

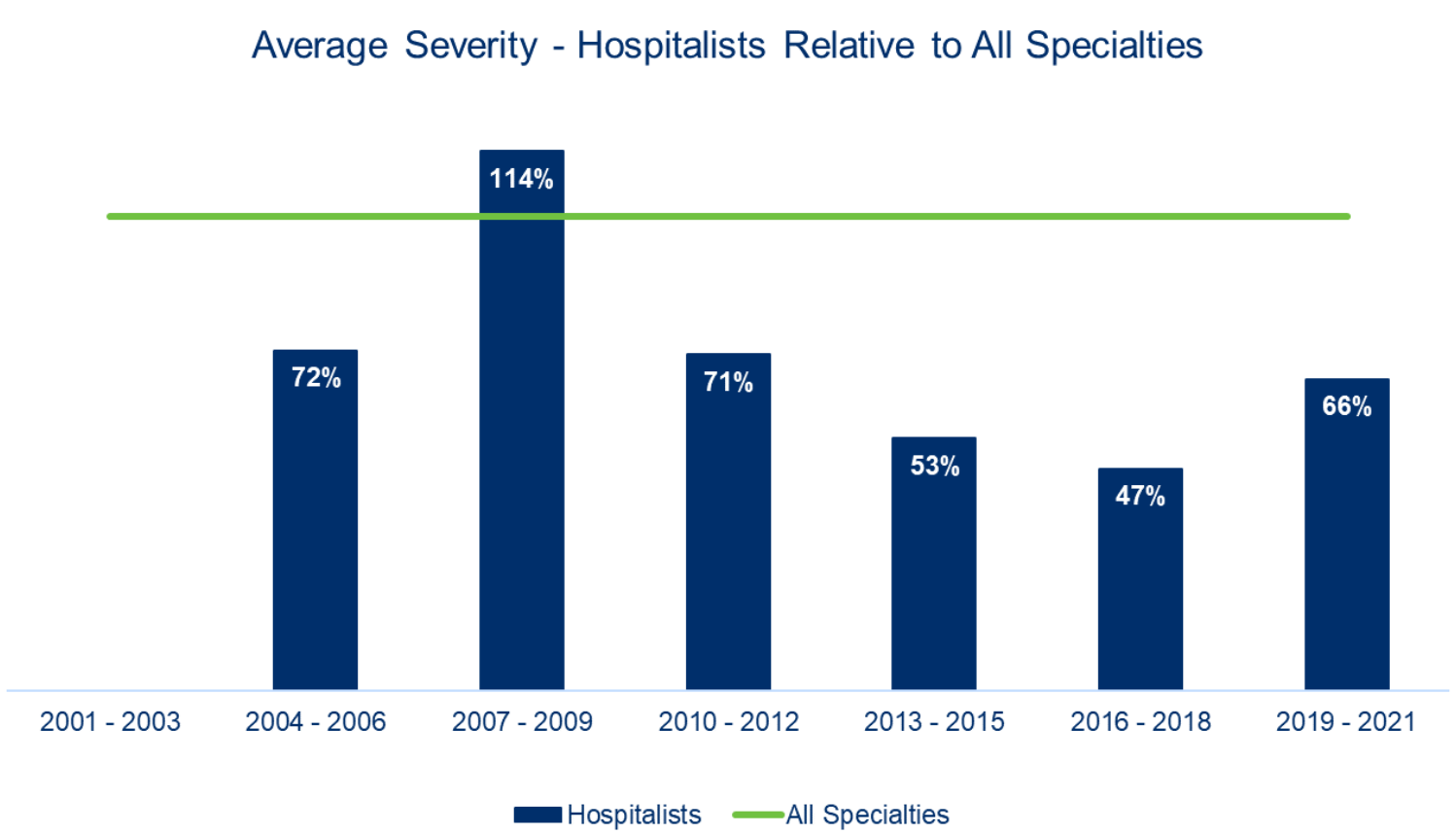
Severity Tier	Low Frequency	Medium Frequency	High Frequency
High	Hematology/Oncology, Pathology, Pediatrics	Anesthesiology, Neurology	Emergency Medicine, Neurosurgery, OB/GYN
Medium	Family Medicine, Nephrology, Physiatry, Urgent Care	Cardiology, ENT, Gastroenterology, Internal Medicine	Cardiovascular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

Frequency Tier

Source: MedPro Group Physician & Surgeon Claim Experience & Analysis

Specialty trends – Hospitalists

Hospitalists have a lower financial severity per case and a higher claim frequency compared to all specialties.



Frequency Tier
High
Medium
Low

Source: MedPro Group Physician & Surgeon Claim Experience & Analysis

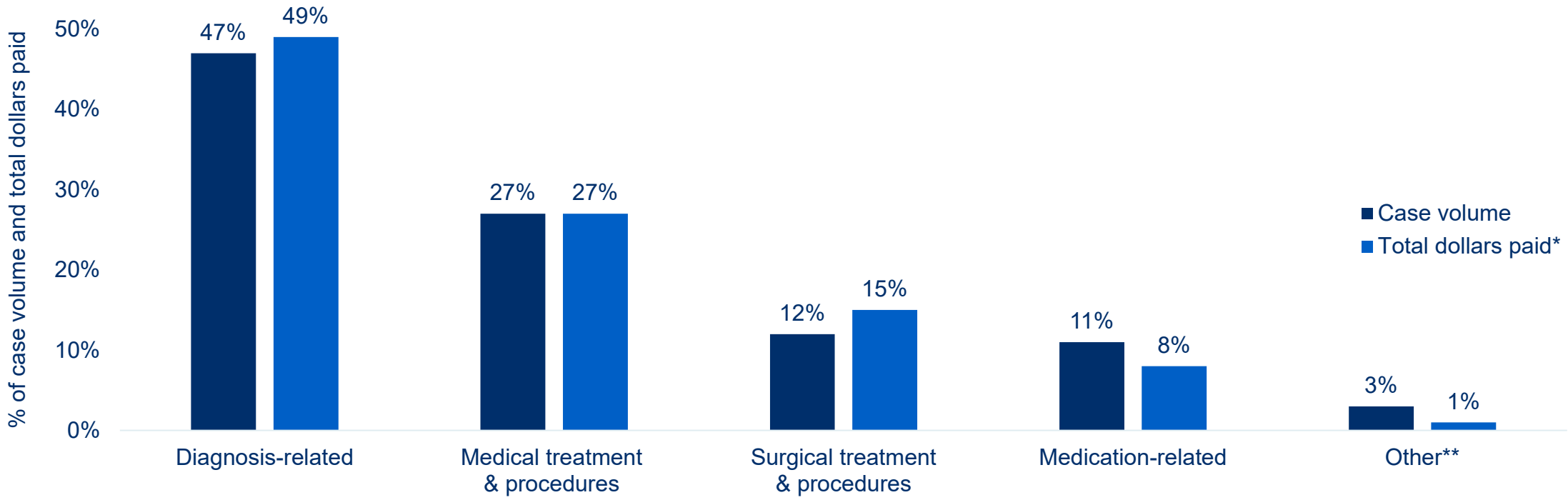
Key Points - Clinically Coded Data

- **Diagnosis-related allegations** account for almost half (47%) of Medical Hospitalist case volume and half (49%) of total dollars paid*. These most commonly reflect missed/delayed diagnoses of cardiac disease, strokes, central nervous system infections and lower gastrointestinal disorders. **These cases commonly reflect breaks in the diagnostic process of care**, most often including inadequate assessment and evaluation of patient symptoms, a narrow diagnostic focus, delays or failures in ordering diagnostic testing, delays in obtaining consults or referrals, and sub-optimal communication among providers on the patient's care team.
- **Medical and surgical patient management allegations** encompass a variety of conditions, including medication-related complications, post-operative infections and other complications, impending respiratory and cardiac failures, and strokes. These cases most often reflect issues with selection of the most appropriate course of treatment for the patient, and appreciating and reconciling symptoms and test results. While complications of procedures may have been the result of procedural error, the failure to timely recognize and/or monitor/manage the issue prevents the opportunity for early mitigation of the risk of serious adverse outcome.
- **Monitoring and managing patients' medication regimens account for over half (57%) of all medication-related allegations.** These most commonly involve anticoagulants, cardiovascular medications, antibiotics and narcotics. Selection of the most appropriate medication for the patient's condition is one of the most frequently noted risk issues in medication cases. Issues reflecting patient non-adherence to prescriptions are sometimes impacted by inadequate patient/family education of the importance of prescription adherence. Inadequate patient monitoring, and suboptimal communication about medication regimens across the patient's care team are also commonly noted risk issues.
- **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, communication, and clinical environment factors,** specifically inadequate patient assessment processes and a narrow diagnostic focus, team communication failures, and events occurring during weekend/holiday/night shifts, **are key drivers of both clinical and financial Medical Hospitalist case severity.**

MedPro Group + MLMIC cases opened 2012-2021, Medical Hospitalist as responsible service (N=368); *Total dollars paid = expense + indemnity

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, Medical Hospitalist as responsible service (N=368); *Total dollars paid = expense + indemnity; **Other includes allegations for which no significant case volume exists

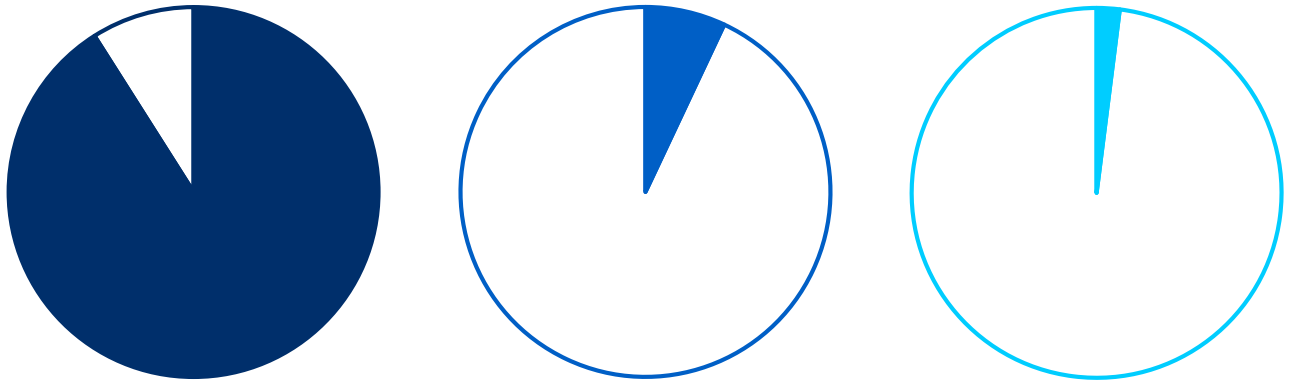
Clinical Severity*

Clinical Severity Categories	Sub-categories	% of case volume
LOW	Emotional Injury Only	3%
	Temporary Insignificant Injury	
MEDIUM	Temporary Minor Injury	14%
	Temporary Major Injury	
	Permanent Minor Injury	
HIGH	Significant Permanent Injury	83%
	Major Permanent Injury	
	Grave Injury	
	Death	

Typically, the higher the clinical severity, the higher the indemnity payments are, and the more frequently payment occurs.

MedPro Group + MLMIC cases opened 2012-2021, Medical Hospitalist as responsible service (N=368); *Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

Claimant Type & Location



Inpatient
91%

Emergency
7%

Ambulatory
2%

Top Locations	% of case volume
Patient room	76%
ICU	10%
Emergency department	7%

MedPro Group + MLMIC cases opened 2012-2021, Medical Hospitalist as responsible service (N=368)

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."

CRICO Strategies. (2020). The Power to Predict: Leveraging Medical Malpractice Data to Reduce Patient Harm and Financial Loss. Retrieved from https://www.candello.com/Insights/Candello-Reports/Power-to-Predict.

Contributing Factors

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.

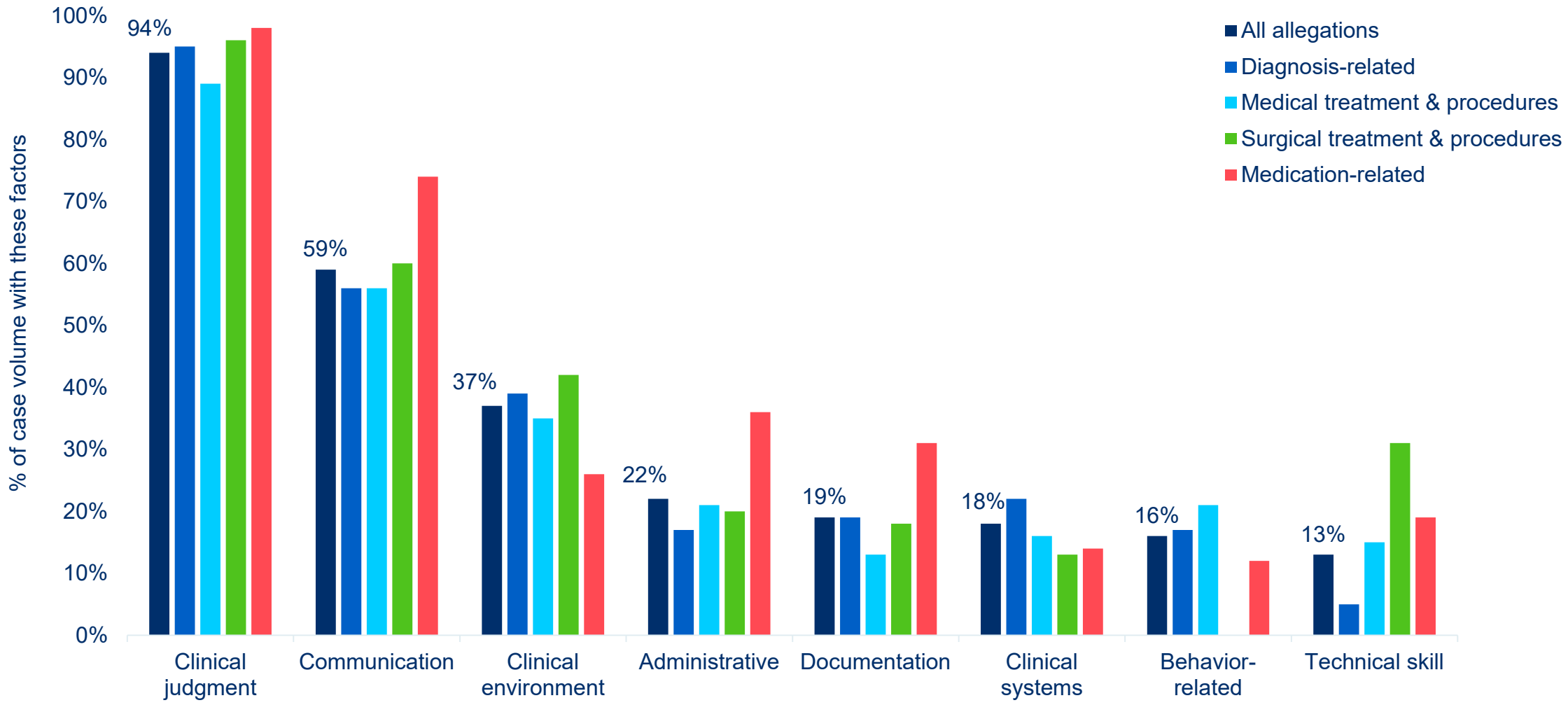
Multiple factors are identified in each case because generally, there is not just one issue that leads to these cases, but rather a combination of issues.

Administrative | Behavior-related | Clinical environment | Clinical judgment | Clinical systems | Communication | Documentation | Supervision | Technical skill

Contributing Factor Category Definitions

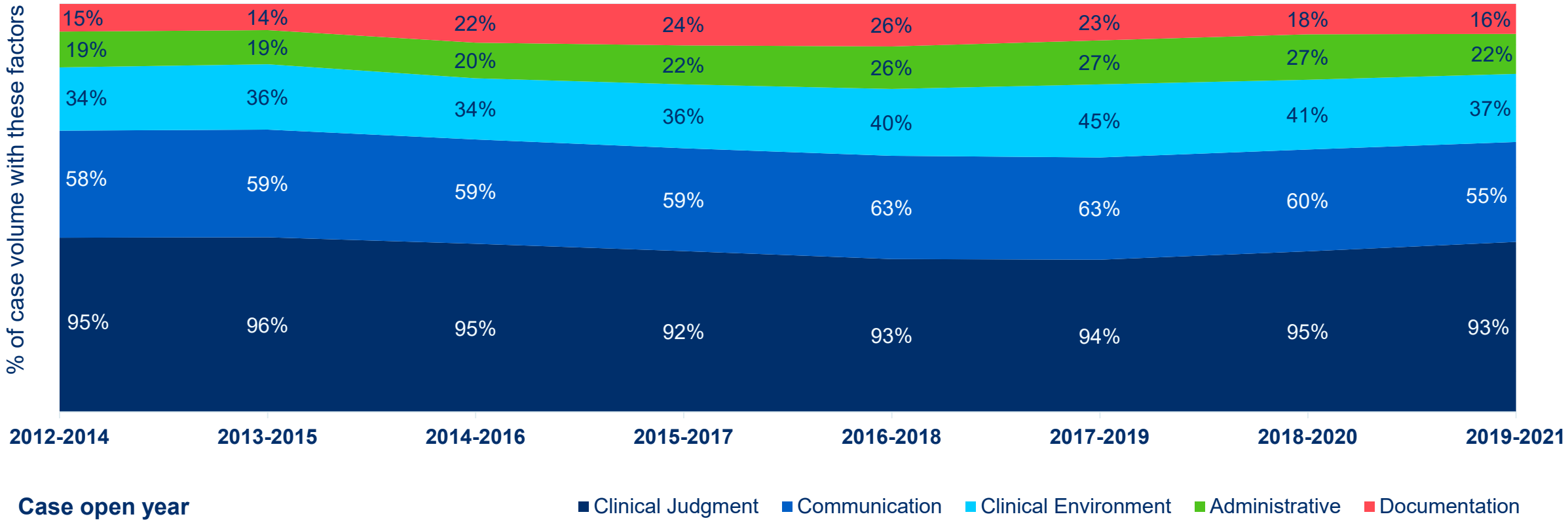
Administrative	Factors related to medical records (other than documentation), reporting, staff, ethics, policy/protocols, regulatory
Behavior-related	Factors related to patient nonadherence to treatment or behavior that offsets care; also provider behavior including breach of confidentiality or sexual 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-radiology
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, Medical Hospitalist as responsible service (N=368); 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.

MedPro Group + MLMIC cases opened 2012-2021, Medical Hospitalist as responsible service (N=368); More than one factor per case, therefore totals >100%

Focus on Most Common Drivers of Clinical and Financial Severity

Factors associated with high clinical severity outcomes	**(CJ) failure to appreciate/reconcile signs/symptoms/test results (51%)**	**% of high severity case volume**
	(CO) suboptimal communication among providers about patient condition (36%)	
	(CJ) failure/delay in ordering diagnostic test (33%)	
	(CJ) failure/delay in obtaining consult/referral (29%)	
	(CJ) narrow diagnostic focus – failure to establish differential diagnosis (26%)	
Factors associated with the costliest indemnity payments	**(CE) weekends/holidays (49%)**	**% more expensive than the average indemnity payment***
	(CJ) failure/delay in ordering diagnostic test (41%)	
	(CE) night shifts (23%)	
	(CJ) failure to appreciate/reconcile sign/symptom/test result (22%)	
	(CJ) inadequate patient assessments – history & physical (20%)	

Clinical judgment and communication factors, specifically inadequate patient assessment processes and a narrow diagnostic focus, team communication failures, and events occurring during weekend/holiday/night shifts are key drivers of both clinical and financial Medical Hospitalist case severity.

AD: administrative; BR: behavior-related; CE: clinical environment; CJ: clinical judgment; CO: communication; CS: clinical systems; DO: documentation; SU: supervision; TS: technical skill
MedPro Group + MLMIC cases opened 2012-2021, Medical Hospitalist as responsible service (N=368); More than one factor per case, therefore totals >100%; *limited to factors associated with >/= 15 cases

Focus on Diagnosis-Related Allegations

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

Cardiac disease
(12%)

Including cardiac infections, infarctions and pulmonary emboli

Cerebrovascular disease
(9%)

Strokes

Central nervous system infections
(9%)

Primarily intra-spinal abscess, meningitis

Digestive system
(9%)

Primarily appendicitis, infections and intestinal obstructions

MedPro Group + MLMIC cases opened 2012-2021, Medical Hospitalist as responsible service (N=368); *as a percentage of all diagnosis-related allegations

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

89%
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

19%
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

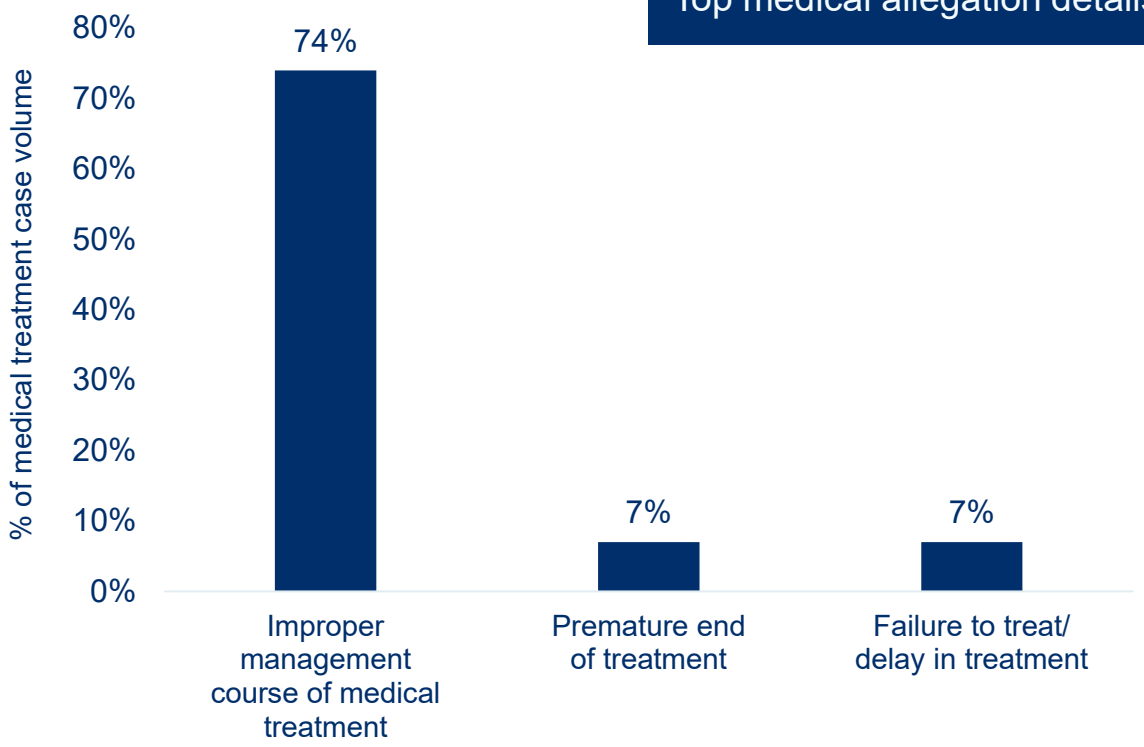
70%
of cases

- Physician follows-up with patient
- Referrals/Consults
- Patient information communicated among care team
- Patient compliance with follow-up plan

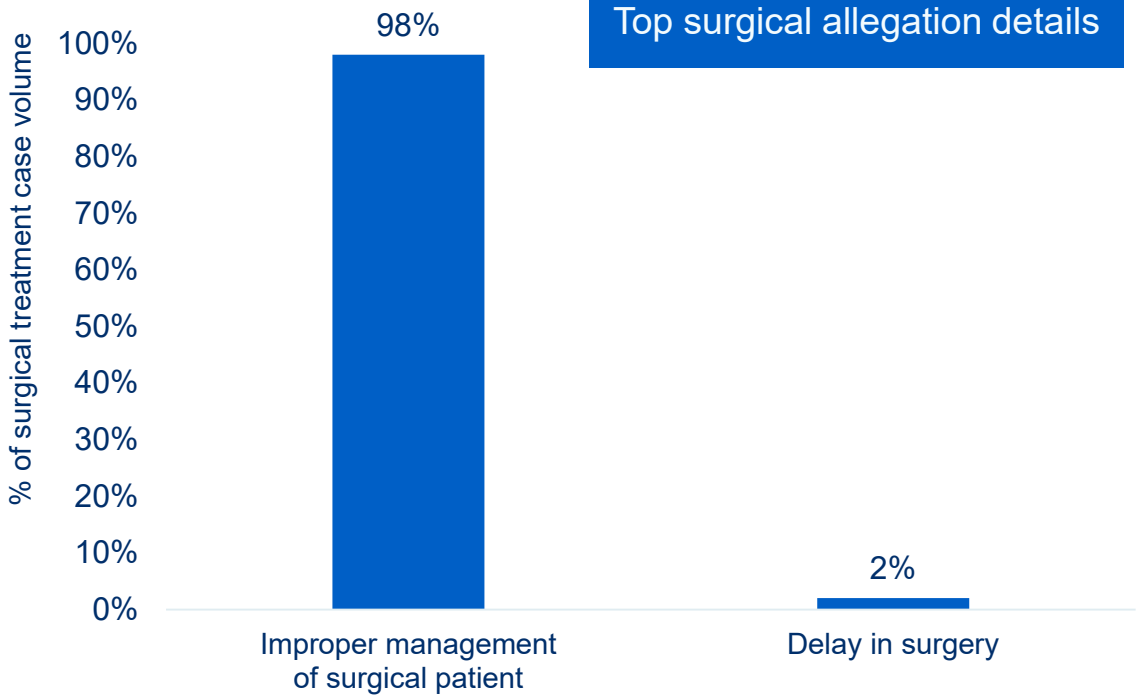
MedPro Group + MLMIC cases opened 2012-2021, Medical Hospitalist as responsible service (N=368); *each step reflects a combination of contributing factors; diagnostic process of care algorithm courtesy of Candello, a division of CRICO Strategies

Focus on Medical & Surgical Treatment Allegations

Top medical allegation details



Top surgical allegation details

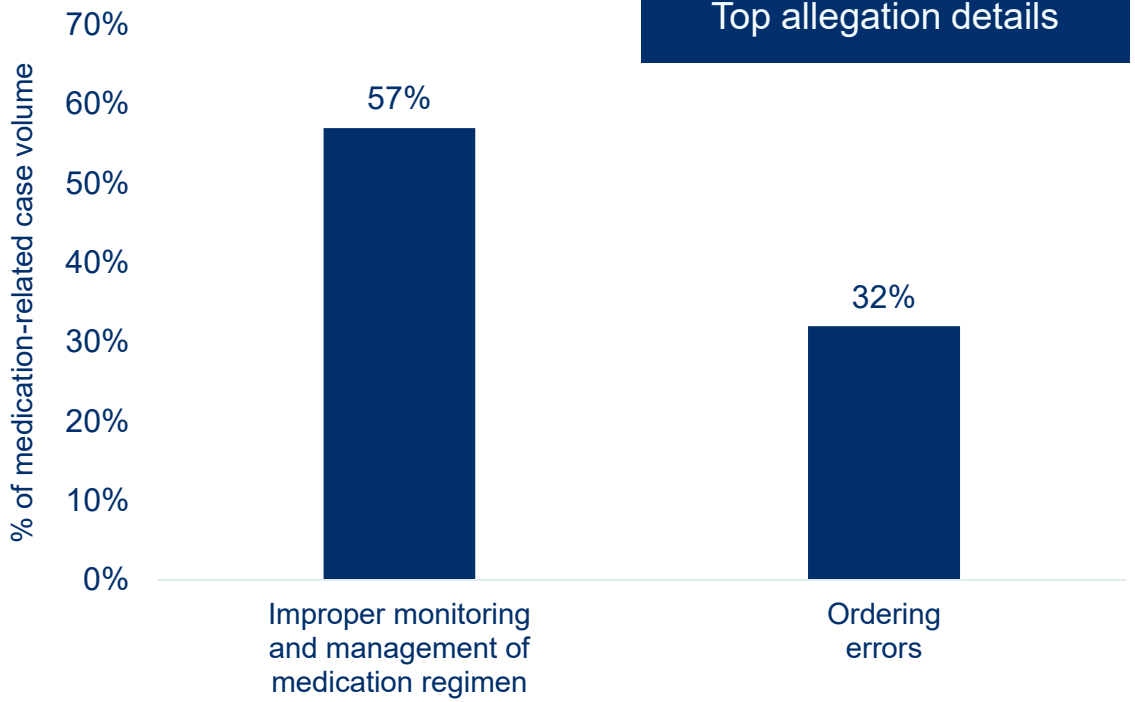


Medical and surgical patient management allegations encompass a variety of conditions, including medication-related complications, post-operative infections and other complications, impending respiratory and cardiac failures, and strokes. These cases most often reflect issues with selection of the most appropriate course of treatment for the patient, and appreciating and reconciling symptoms and test results. While complications of procedures may have been the result of procedural error, the failure to timely recognize and/or monitor/manage the issue prevents the opportunity for early mitigation of the risk of serious adverse outcome.

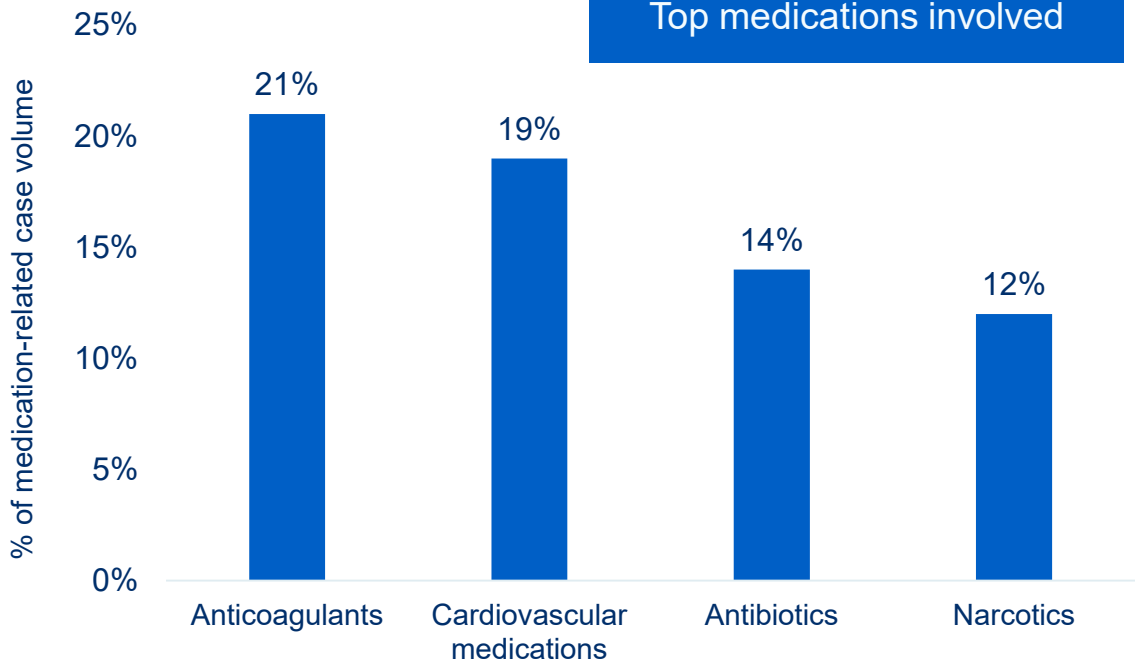
MedPro Group + MLMIC cases opened 2012-2021, Medical Hospitalist as responsible service (N=368)

Focus on Medication-Related Allegations

Top allegation details



Top medications involved

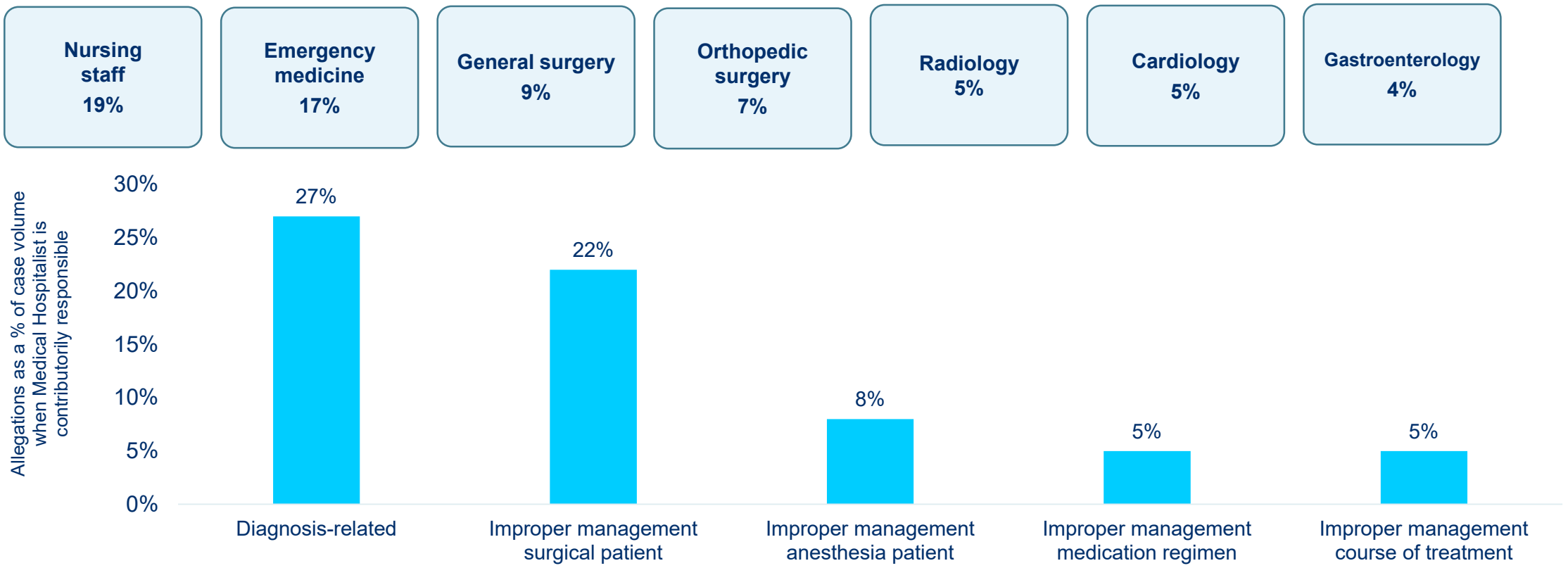


Selection of the most appropriate medication for the patient's condition is one of the most frequently noted risk issue in medication cases. Issues reflecting patient non-adherence to prescriptions are sometimes impacted by inadequate patient/family education of the importance of prescription adherence. Inadequate patient monitoring, and suboptimal communication about medication regimens across the patient's care team are also commonly noted risk issues.

MedPro Group + MLMIC cases opened 2012-2021, Medical Hospitalist as responsible service (N=368)

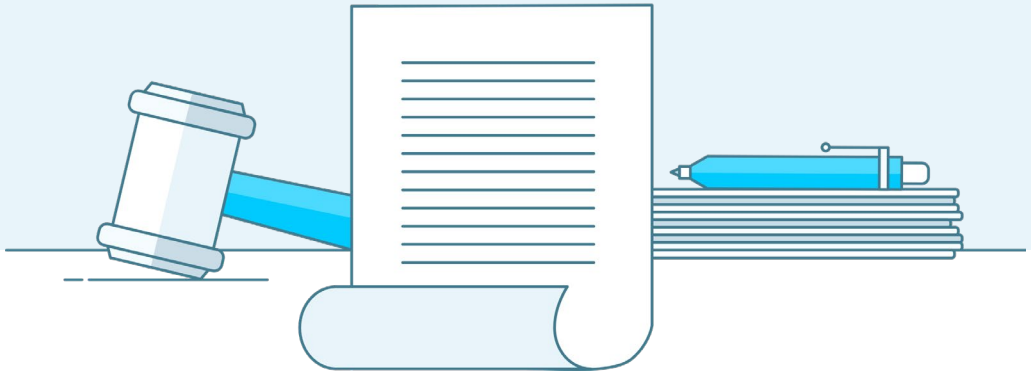
Contributorily Responsible

Although this analysis is focused on cases reflecting Medical Hospitalist as the primarily responsible service, another 461 cases identify Medical Hospitalist 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.



MedPro Group + MLMIC cases opened 2012-2021, Medical Hospitalist as contributorily responsible (N=461)

Case Examples



The following stories are reflective of the allegations and contributing risk factors which drive cases brought against Medical Hospitalists.

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

SETTLED

$1.4M

CONTRIBUTING FACTORS

Clinical environment

Night shift (11:30pm -7:30am)

Clinical judgment

Narrow diagnostic focus, including relying on previous provider's diagnosis

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

Failure/delay in ordering diagnostic testing

Failure/delay in obtaining consult/referral

Communication

Suboptimal communication among providers regarding patient's condition and failure to respond to call/text

DELAY IN DIAGNOSIS AND TREATMENT OF VOLVULUS

A female patient in her 40s presented to the Emergency Department (ED) with complaints of abdominal pain. CT scan of abdomen showed an enlarged pancreas and large paraesophageal hernia. **It was noted that a gastric volvulus could not be excluded; pancreatitis was also on the differential diagnosis list.** Plan was to transfer the patient to a facility for a higher level of care.

Upon arrival, the patient was admitted to the Hospitalist's service and was evaluated by a nurse practitioner at 3:30pm; she noted the abdomen to be tender and positive for bowel sounds. **Plan was to rule out volvulus, and a Gastrointestinal (Gastro) consult was planned**. A chest x-ray (CXR), interpreted by radiology at 6pm, showed an abnormal elevation of the left diaphragm. 20 minutes later, the patient's heartrate increased and oxygen saturations decreased to the 70s. A repeat CXR was obtained, and was read by the same Radiologist as showing a tear in the fundus of the stomach. Rapid response was called and at 7:30pm the patient was transferred to the ICU. **The Hospitalist ordered a CT scan (not STAT) to rule out a volvulus** and requested an endoscopy. The patient was also seen by Gastro who noted a nasogastric tube in place and a soft/non-tender abdomen. **Gastro requested a surgical consult for possible volvulus**.

At 8:30pm, the patient's blood pressure dropped and remained low overnight. **Attempts to contact Hospitalist were unsuccessful;** Gastro ordered a fluid bolus at 9:41pm. The patient remained unstable overnight, however, nursing staff did not attempt to contact the Hospitalist. **At 4am, the patient was significantly less responsive and efforts to contact Hospitalist at that point were unsuccessful.** The charge nurse did not call a rapid response but instead called the covering Intensivist at 4:30am. The Hospitalist returned calls at 5:20am and ordered a CT of the abdomen and a surgical consult. **CT showed a large amount of intraperitoneal free air as well as a large gastric volvulus. Signs of early peritonitis were also seen. Intra-operative findings included a perforation of the stomach. The patient ultimately required a gastrectomy** and suffered several post-operative complications requiring hospitalization for 7 months. The patient's gastrointestinal tract could not be successfully reconstructed.

Case Examples

SETTLED

$75,000

CONTRIBUTING FACTORS

Clinical judgment

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

Patient monitoring – of patient's physiological status and of medication effects

Communication

Suboptimal communication among providers regarding patient's condition

IMPROPER MANAGEMENT OF SURGICAL PATIENT RESULTING IN CARDIAC ARREST AND DEATH

A female in her late 70s, with a history of obstructive sleep apnea (OSA), presented to the Emergency Department (ED) after she fell and fractured her hip. An Orthopedic surgeon (Ortho) was consulted; repair surgery was scheduled for the next day. The patient was admitted by **Hospitalist A who noted that the patient used a CPAP machine at home**, **but Hospitalist A did not order one for the patient**. The patient **stayed overnight in ED without a CPAP machine** while awaiting a bed. The next morning, upon admission to the surgical floor, **Anesthesiologist A** (Anes A) **did a pre-operative evaluation, but did not note use of CPAP machine**. Anesthesiologist B (Anes B) monitored the patient during surgery, which went well with no complications. **Anes B noted patient's history and did not see an order for a CPAP** postoperatively in PACU. Patient's vital signs were stable in PACU; she was discharged to the surgical floor at 10pm. **No CPAP was ordered**. **Ortho ordered morphine for pain which was given at 10:45pm (can mask signs of OSA).** Patient was noted to be awake and stable at 11pm and again at midnight.

At 12:19am, the patient was bradycardic. Hospitalist B was contacted; he ordered Tylenol and Xanax which were given at 1am. **Hospitalist A ordered an additional dose of morphine**, which was given at 2:23am. Patient still had bradycardia at 4:12am, then went into cardiac arrest at 4:26am. Code was called and patient was resuscitated. Patient was intubated and transferred to the ICU where she arrested again. Cardiac evaluation found no pulmonary embolism. Her condition deteriorated, and her family opted for comfort measures only.

The family claimed that all involved providers failed to order a CPAP machine and/or did not ask family to provide patient's CPAP machine, resulting in the patient's cardiac arrest and death.

Expert reviewers could not support the failure to order a CPAP machine for the patient's use.

Risk Mitigation Strategies

- **Clinical judgment**
  - Be aware that inadequate patient assessment might be a result of cognitive biases, inadequate medical and family history taking, or inadequate sharing of information among providers. Recognize that delays in obtaining consults/referrals are one of the top driving factors behind diagnostic claims.
- **Communication**
  - Ensure efficiencies in the sharing and discussing of test results and consultative reports among other providers. Encourage verbal sharing of subtle changes which are not individually noteworthy when multiple providers are involved.
- **Clinical environment**
  - Recognize that weekend & night shifts can impact the timeliness of assessments, response to consult requests, and return of test results. Focus on eliminating any variation in processes during ‘off’ hours.
- **Clinical systems**
  - Focus on ‘closing the loop’ with regards to receiving, reporting and acting on test results, including incidental findings. Insist upon care coordination – determine which next steps belong to which provider.
- **Administrative**
  - Ensure that policies/procedures are well-constructed and that staff awareness & training is a priority.
- **Document.**
  - Discrepancies or gaps in the details/timing of care and clinical decision-making make it much more difficult to build a supportive framework for defense against potential malpractice cases.
- **Engage patients as active participants in their care.**
  - Consider the patient’s health literacy and other comprehension barriers. Recognize that patient satisfaction with treatment outcomes can be influenced by a thorough informed consent and education process.

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.