Psychiatry

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 Psychiatry 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.

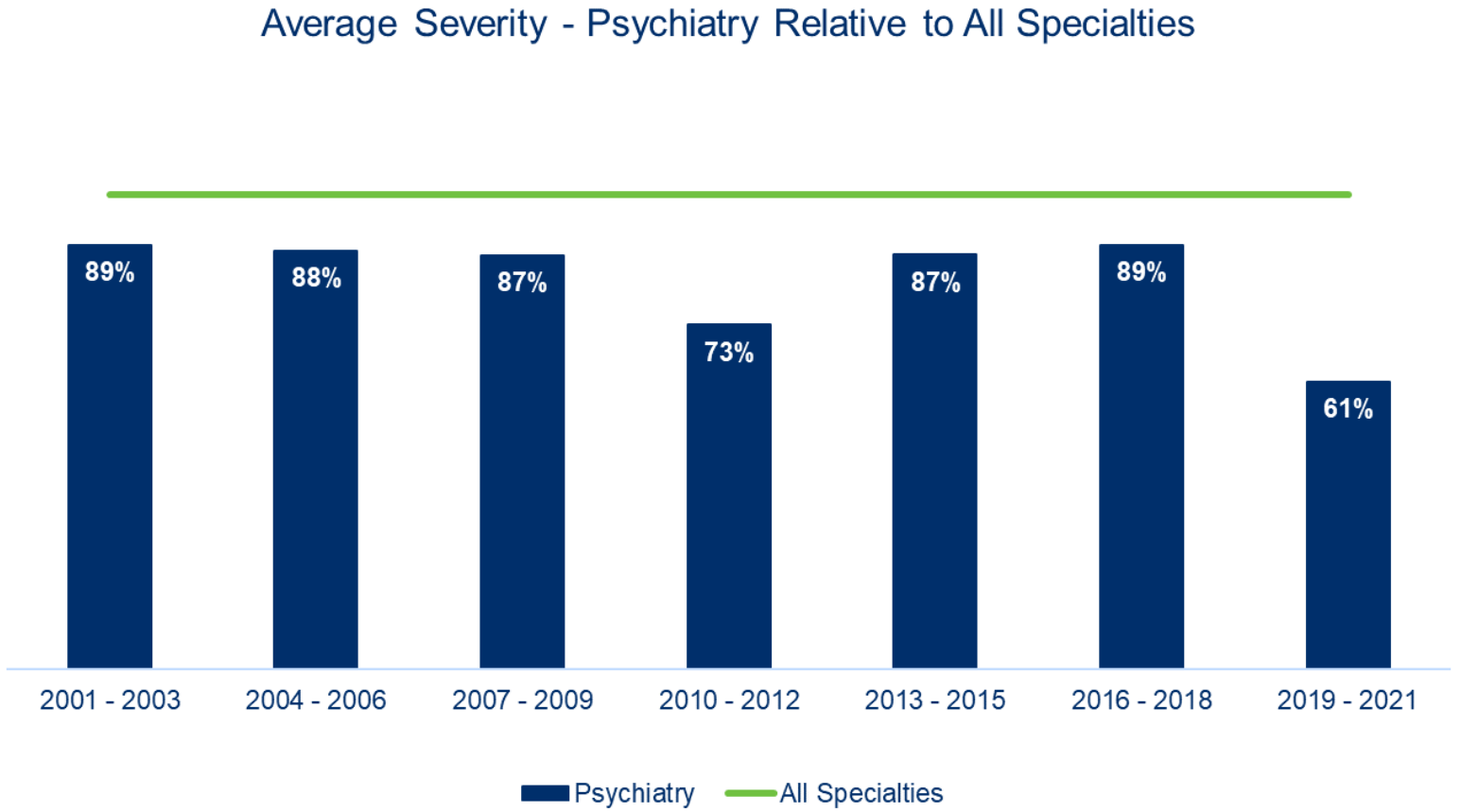
Severity Tier	Low Frequency	Medium Frequency	High Frequency
High	Hematology/Oncology, Pathology, Pediatrics	Anesthesiology, Neurology	Emergency Medicine, Neurosurgery, OB/GYN
Medium	Family Medicine, Nephrology, Physiatry, Urgent Care	Cardiology, ENT, Gastroenterology, Internal Medicine	Cardiovascular 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 – Psychiatry

Psychiatry has a lower financial severity per case and a lower claim frequency compared to all specialties.



Frequency Tier
High
Medium
Low

Source: MedPro Group Physician & Surgeon Claim Experience & Analysis

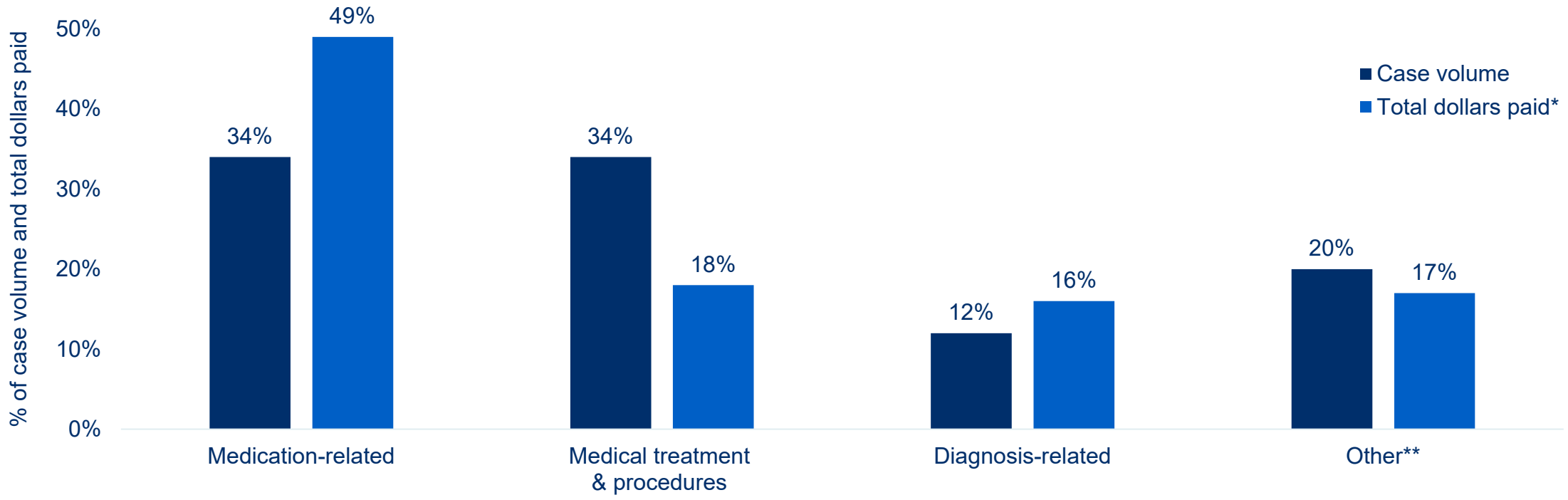
Key Points - Clinically Coded Data

- **The monitoring and management of patients' medication regimens account for 34% of all Psychiatry case volume, and almost half of total dollars paid.*** Inadequate monitoring of the effects of medication regimens, decision-making as to the most appropriate medication for the patient's condition, and suboptimal patient/family education about the risks of the medication are commonly identified risk issues.
- **Medical treatment allegations, which account for another 34% of case volume,** commonly reflect issues with selection of the most appropriate course of treatment for the patient, and appreciating and reconciling symptoms and test results.
- **Diagnosis-related allegations** account for 12% of Psychiatry case volume. These most commonly reflect missed/delayed diagnoses of behavioral disorders, and warning signs of patient tendency toward suicide or other self-inflicted injury **These cases commonly reflect breaks in the diagnostic process of care**, most often in the initial diagnostic phase, including inadequate assessment and evaluation of patient symptoms, a narrow diagnostic focus, and delays or failures in ordering diagnostic testing.
- **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 and selection/monitoring of medication regimens, and a narrow diagnostic focus are key drivers of both clinical and financial Psychiatry case severity.

MedPro Group + MLMIC cases opened 2012-2021, Psychiatry as responsible service (N=308); *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, Psychiatry as responsible service (N=308); *Total dollars paid = expense + indemnity; **Other includes allegations for which no significant case volume exists

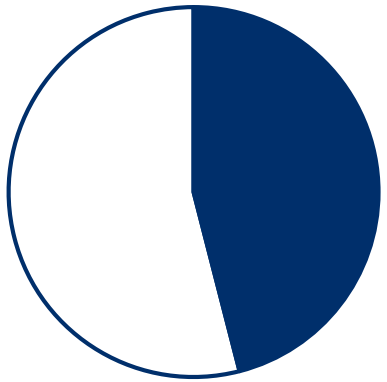
Clinical Severity*

Clinical Severity Categories	Sub-categories	% of case volume
LOW	Emotional Injury Only	35%
	Temporary Insignificant Injury	
MEDIUM	Temporary Minor Injury	24%
	Temporary Major Injury	
	Permanent Minor Injury	
HIGH	Significant Permanent Injury	41%
	Major Permanent Injury	
	Grave Injury	
	Death	

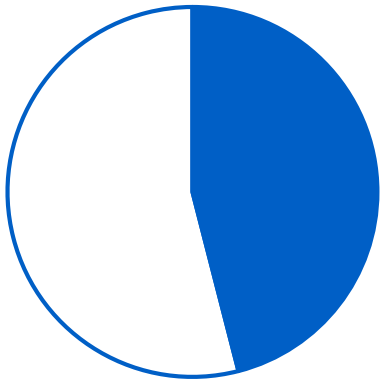
Typically, the higher the clinical severity, the higher the indemnity payments are, and the more frequently payment occurs.

MedPro Group + MLMIC cases opened 2012-2021, Psychiatry as responsible service (N=308); *Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

Claimant Type & Location



Ambulatory
46%



Inpatient
46%

Emergency
8%

Top Locations	% of case volume
Patient room	44%
Office/clinic	33%
Emergency department	7%

MedPro Group + MLMIC cases opened 2012-2021, Psychiatry as responsible service (N=308)

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.

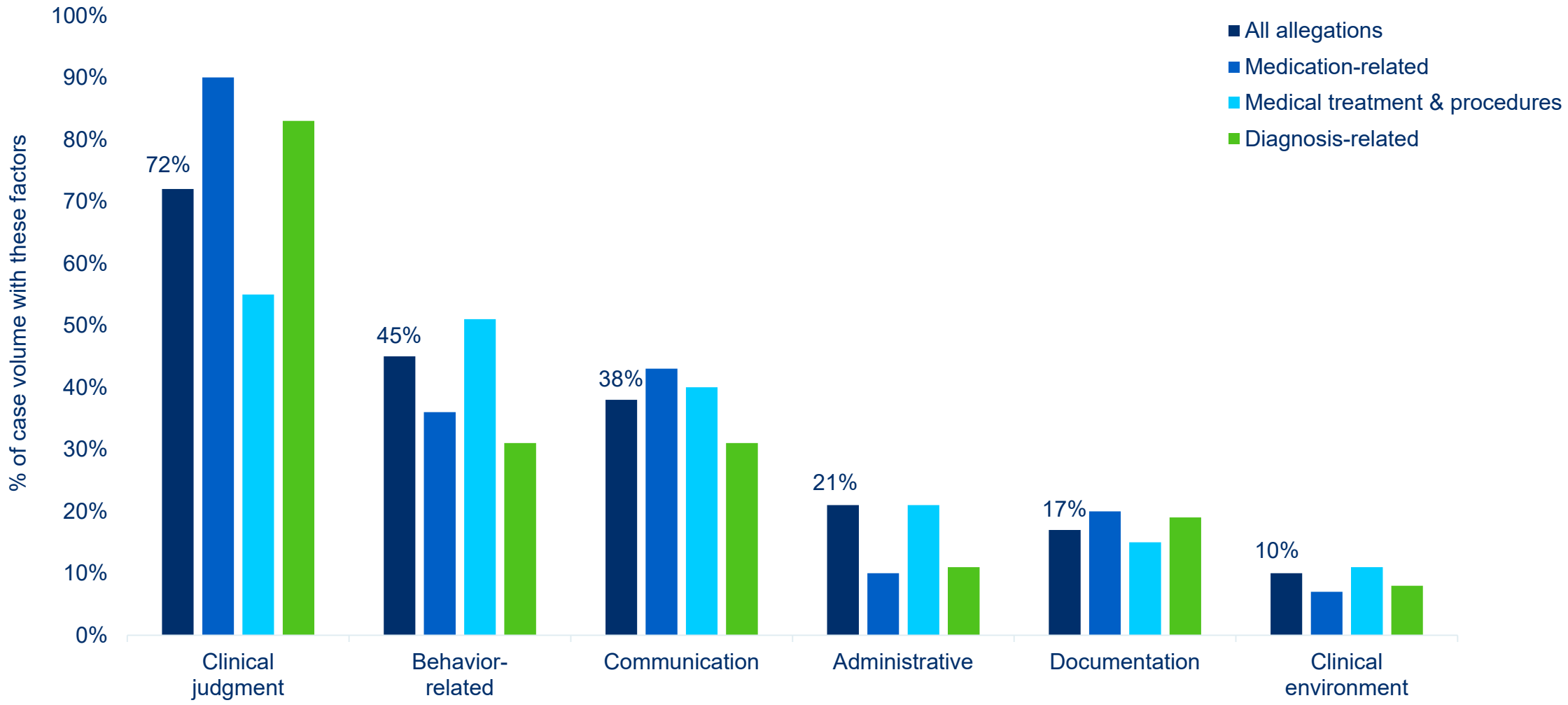
Multiple factors are identified in each case because generally, there is not just one issue that leads to these cases, but rather a combination of issues.

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

Contributing Factor Category Definitions

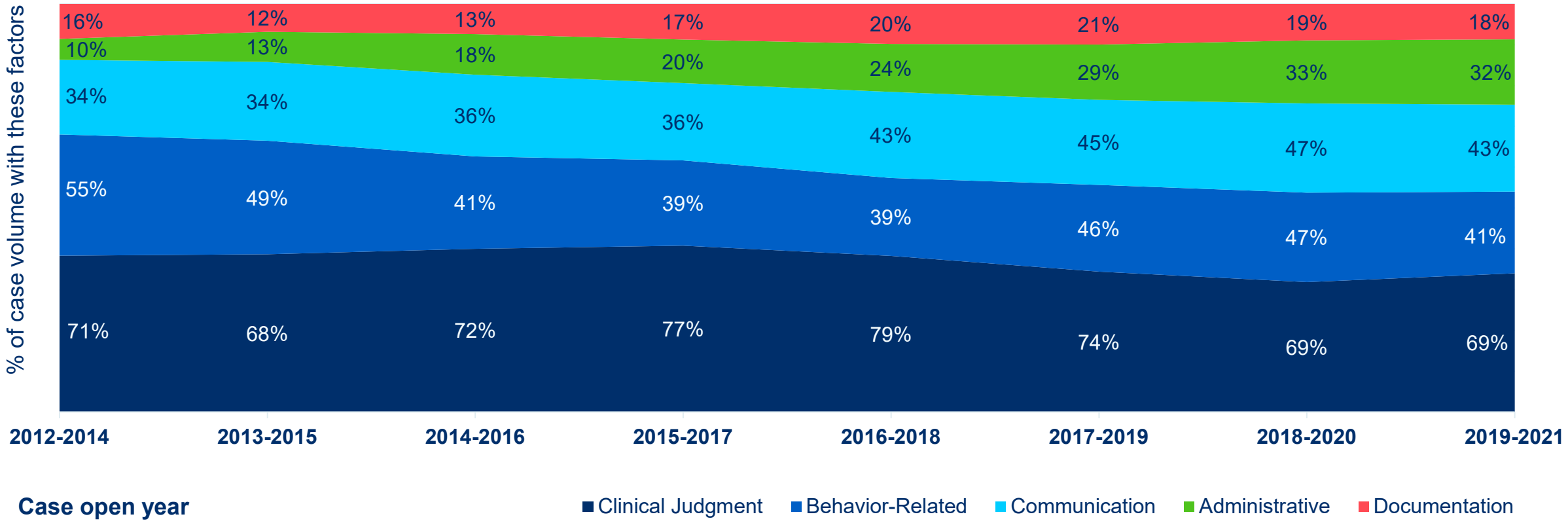
Administrative	Factors related to medical records (other than documentation), reporting, staff, ethics, policy/protocols, regulatory
Behavior-related	Factors related to patient nonadherence to treatment or behavior that offsets care; also provider behavior including breach of confidentiality or sexual 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, Psychiatry as responsible service (N=308); 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, Psychiatry as responsible service (N=308); 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 (37%)**	**% of high severity case volume**
	(CJ) selection/management of most appropriate medication (27%)	
	(CJ) inadequate monitoring of patient behavioral status (26%)	
	(CJ) inadequate assessment resulting in premature discharge from care (22%)	
	(CJ) inadequate monitoring of medication regimen (21%)	
Factors associated with the costliest indemnity payments	**(CJ) inadequate monitoring of medication regimen (76%)**	**% more expensive than the average indemnity payment***
	(CJ) failure to appreciate/reconcile signs/symptoms/test results (56%)	

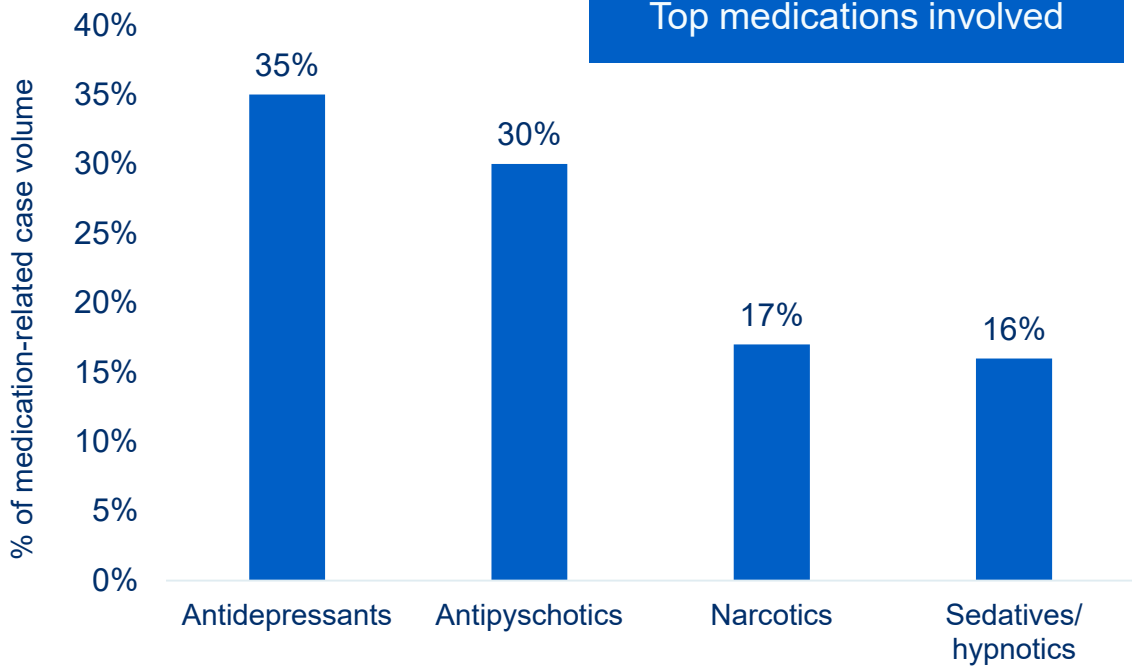
Clinical judgment factors, specifically inadequate patient assessment processes and selection/monitoring of medication regimens, and a narrow diagnostic focus are key drivers of both clinical and financial Psychiatry case severity.

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, Psychiatry as responsible service (N=308); More than one factor per case, therefore totals >100%; *limited to factors associated with >/= 15 cases

Focus on Medication-Related Allegations

Top allegation details

Top medications involved

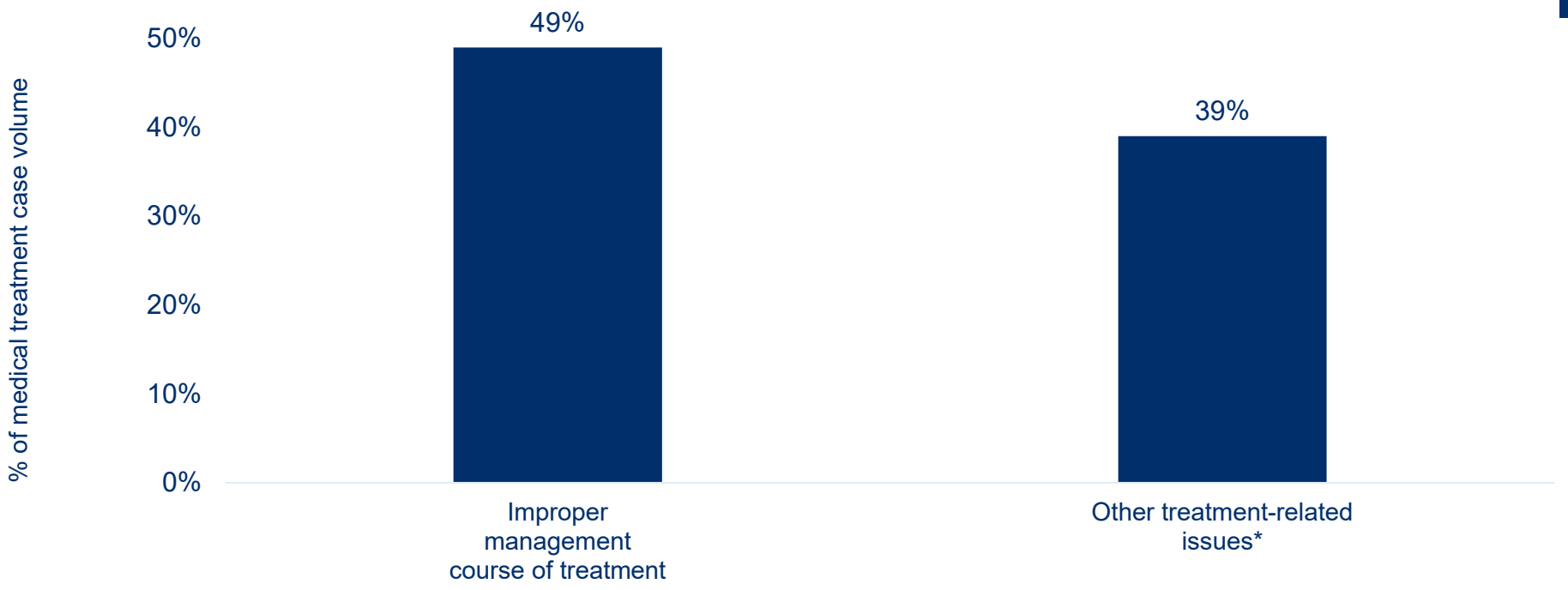


Inadequate monitoring of the effects of medication regimens, decision-making as to the most appropriate medication for the patient's condition, and suboptimal patient/family education about the risks of the medication are commonly identified risk issues.

MedPro Group + MLMIC cases opened 2012-2021, Psychiatry as responsible service (N=308)

Focus on Medical Treatment Allegations

Top allegation details

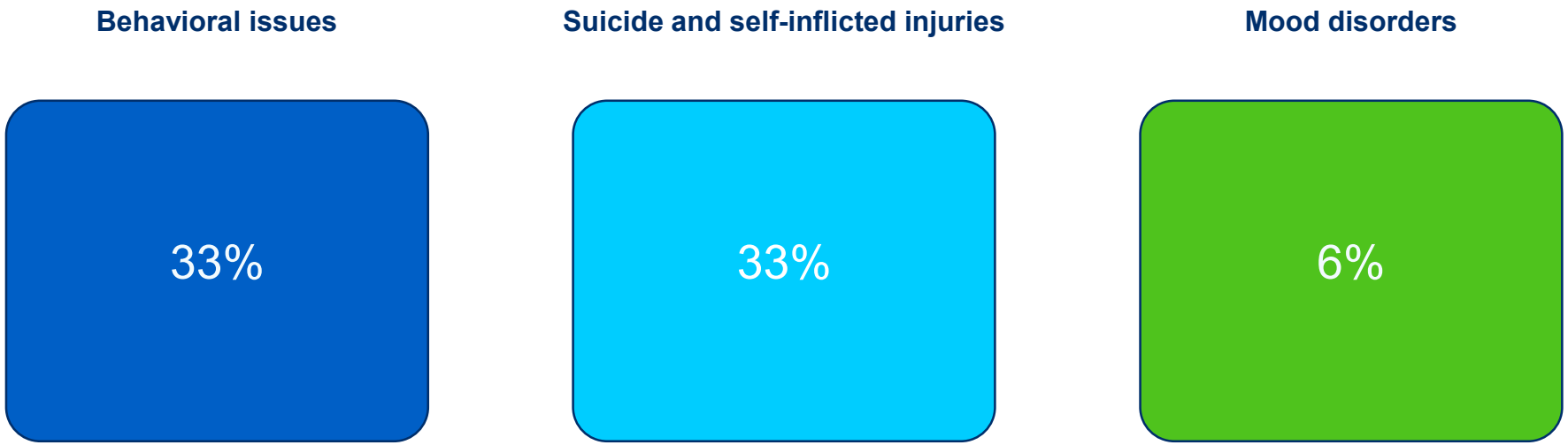


Medical management cases most often reflect issues with selection of the most appropriate course of treatment for the patient, and appreciating and reconciling symptoms and test results.

MedPro Group + MLMIC cases opened 2012-2021, Psychiatry as responsible service (N=308); *Includes cases involving premature end of treatment (abandonment)

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.



MedPro Group + MLMIC cases opened 2012-2021, Psychiatry as responsible service (N=308); *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

78%
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

6%
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

28%
of cases

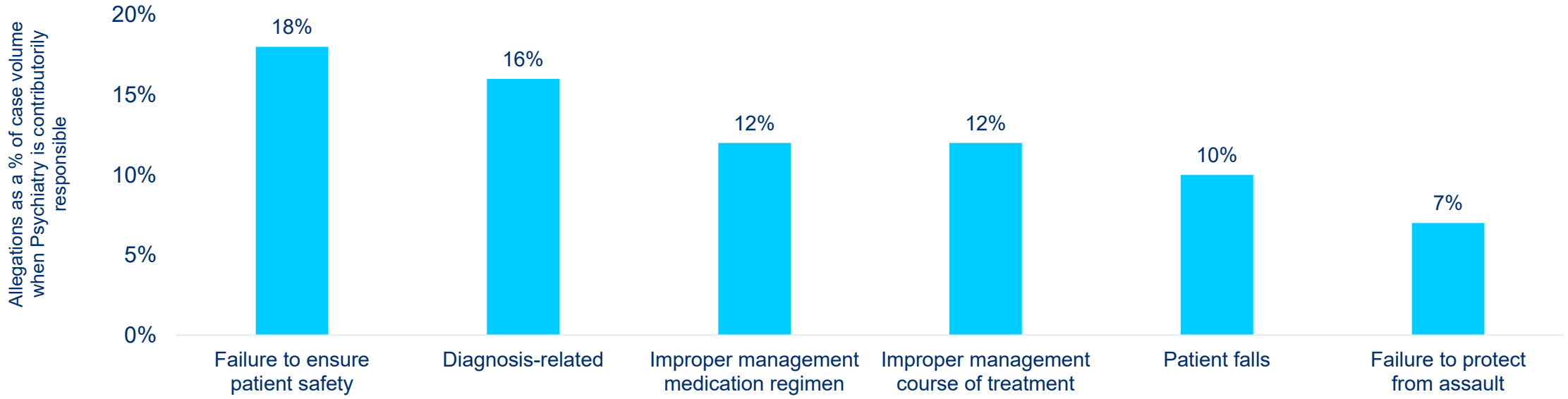
- Physician follows-up with patient
- Referrals/Consults
- Patient information communicated among care team
- Patient compliance with follow-up plan

MedPro Group + MLMIC cases opened 2012-2021, Psychiatry as responsible service (N=308); *each step reflects a combination of contributing factors; diagnostic process of care algorithm courtesy of Candello, a division of CRICO Strategies

Contributorily Responsible

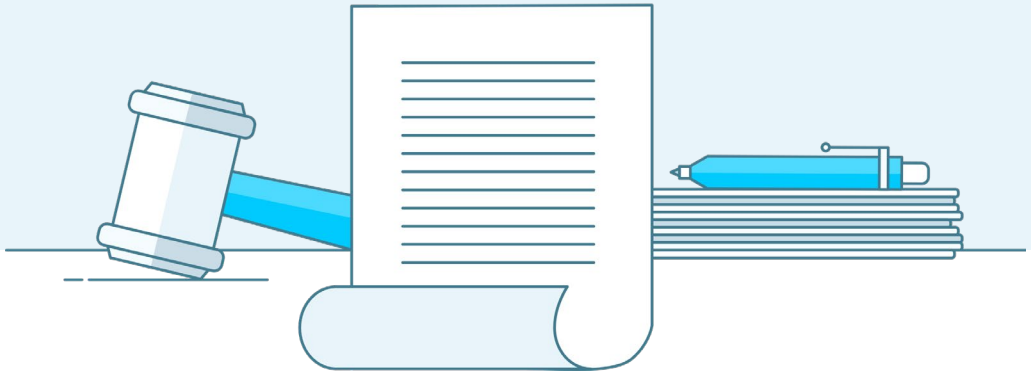
Although this analysis is focused on cases reflecting Psychiatry as the primarily responsible service, another 109 cases identify Psychiatry as contributorily responsible. The primary services in these cases are varied, reflecting the myriad of providers who care for patients along the healthcare continuum. The most common primary services, and a comparison of top allegation categories, are shown below.

Nursing staff	Internal medicine	Family medicine	Emergency medicine	Psychology	Pain medicine	Pediatrics
51%	10%	7%	6%	4%	3%	3%



MedPro Group + MLMIC cases opened 2012-2021, Psychiatry as contributorily responsible (N=109)

Case Examples



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

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

$200,000

CONTRIBUTING FACTORS

Behavior-related

Patient non-adherence with treatment regimen

Clinical judgment

Inadequate patient assessment

Communication

Patient education regarding follow up instructions

Lack of informed consent

Documentation

Lack of documentation regarding clinical rationale for treatment method

Supervision

Unlicensed receptionist relaying messages to patients

IMPROPER MANAGEMENT OF TREATMENT COURSE RESULTING IN SEVERE TARDIVE DYSKINESIA

A 50 year-old female patient, with a history significant for depression, alcohol and drug abuse, presented to her long-time Psychiatrist (Psych) with exacerbation of anxiety. Psych prescribed 20mg of an antipsychotic, marketed as effective for schizophrenia, bipolar disorder, and depression. Of note, **Psych rarely did physical examinations on this patient, or noted her clinical rationale for prescribing medications**, but for this, noted that the prescription was for anxiety and shakiness. Two weeks later, after a call from the patient, Psych increased the dosage to 40 mg, and two months later, after another call, to 60 mg. At that time, Psych referred patient to a Psychopharmacologist due to suspicions of serotonin syndrome (potentially life-threatening interaction of multiple medications), **but the patient did not comply, and Psych never followed up** with the patient regarding the referral. The **manufacturer of the antipsychotic recommended short duration usage and at the lowest dosage possible.**

Five months later, Psych prescribed a second antipsychotic, which the patient took for 2 days. At that point, the patient was admitted to a behavioral unit after making suicidal threats, and homicidal threats to her son. The inpatient treating Psychiatrist noted the patient's existing **medications were "not clinically indicated."**

After being discharged, the patient asked Psych to write a letter supporting her application for disability due to **tardive dyskinesia**, a disorder characterized by uncontrollable, repetitive movements of the face and other body parts.

The patient's malpractice action alleged improper prescription of medication resulting in severe tardive dyskinesia, and improper delegation of medical treatment to an unlicensed assistant.

Subsequent investigation revealed that Psych never saw or spoke with the patient during time she prescribed these drugs. **The patient would call and leave a request with the receptionist. Psych would respond via receptionist to patient.** Of note, there was **no evidence of informed consent** regarding the risks including tardive dyskinesia.

Case Examples

SETTLED

$150,000

CONTRIBUTING FACTORS

Clinical judgment

Failure to appreciate/reconcile relevant signs/symptoms

Selection/management of most appropriate medication

Failure to rescue

Failure to monitor medication affects, and patient's physiological status

Communication

Suboptimal communication among providers regarding patient's condition

IMPROPER MANAGEMENT OF MEDICATION REGIMEN RESULTING IN TOXICITY AND DEATH

A female in her late 20s voluntarily checked into a behavioral health facility for treatment of alcohol and morphine addition. The patient had a history of endometriosis, depression and substance abuse with prior detox admissions. A psychiatrist (Psych) examined the patient the next day and noted also suicidal ideation and a family history of substance abuse. **The patient's urine drug screening was positive for benzodiazepines.** Psych issued orders for 15-minute checks, vital signs every four hours and a clonazepam detox protocol. The patient reported taking anti-anxiety medications for panic attacks, sleep medication, and a history of several different antidepressants Patient also complained of pain relating to endometriosis, for which she was prescribed hydrocodone.

The patient was seen by Psych two days later, and again complained of severe endometriosis pain. **Psych changed the hydrocodone to morphine, and prescribed temazepam for sleep.** The next day, the patient reported her anxiety was under control, but she was still in pain from endometriosis. The next morning, the **patient woke up feeling "out of sorts", was highly tremulous, and couldn't eat.** Psych documented the need for a specialty medical consult. At 8pm, **the nurse noted patient was argumentative**. Patient's husband called the nurse, indicating that he felt that the patient was not getting the appropriate treatment. At 11pm, the nurse noted **patient had slowed movements and complained about the care she was getting**. Nurse suggested the patient was getting too much morphine and the patient became upset.

The every 15-minute checks were documented throughout that night, and the patient was noted to be asleep from 1:45am-5:15am. At 5:20am, a nursing assistant found the patient slumped over in bed and nonresponsive. A crash cart was brought in and 911 was called. CPR was given until EMS arrival at 5:30am. The patient was unable to be revived. **Autopsy listed the cause of death as combined morphine, clonazepam, and temazepam toxicity.**

Expert reviews were not supportive of Psych's prescribed medication regimen.

Risk Mitigation Strategies

- **Conduct an appropriate and thorough assessment of the patient.**
  - Update and review medical, medication, and family history at every visit to ensure the best decision-making.
  - Maintain problem lists.
- **Communicate with each other.**
  - Focus on care coordination if other specialties are involved, including next steps and determining who is responsible for the patient.
  - Give thorough and clear patient instructions.
- **Engage patients as active participants in their care.**
  - Consider the patient's health literacy and other comprehension barriers.
  - Recognize patterns of patient non-compliance, and focus on documentation of efforts made to encourage compliance and follow up with treatment.
- **Document.**
  - Verify that documentation supports the clinical rationale for the method of treatment.
  - Describe the rationale for inclusion/exclusion of differential diagnoses.
  - Timely document thorough, objective information about the results of patient assessments, education of the patient/family about treatment plans - including medication regimens, and any instances of patient nonadherence.
  - Thorough, consistent documentation in the chart enhances communication between providers and provides a supportive framework for defense of any subsequent malpractice case.

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.