October 2020

COVERYS

A CALL FOR ACTION

Insights From a Decade of Malpractice Claims

WHY HAVEN'T WE MADE MORE PROGRESS?

This review of 10 years of medical malpractice claims makes us ask an obvious question: Why haven't we made more progress to improve patient safety? We continue to see high numbers of claims in largely the same areas. In some ways, this report is a call for action to make a greater—and more effective—investment in a safer healthcare delivery model.

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Recognizing Ann Burke, RN, CPHRM, CPPS

In July, after 25 years of service, Ann Burke retired from Coverys. Ann was an instrumental member and leader of our risk management team. She contributed her expertise to this report and countless other reports and articles. Ann was passionate about patient safety and assisting the healthcare providers we serve. We wish her all the best in her retirement.

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SECTION

Despite Patient Safety Initiatives, Adverse Outcomes Continue

TWENTY YEARS AFTER *TO ERR IS HUMAN*

To Err Is Human transformed healthcare as we know it.[1] The 1999 report by the Institute of Medicine served as a major catalyst for innovation that is still playing out today. It launched initiatives that brought words and phrases to healthcare that were revolutionary for their time—and held great promise as avenues for change: team training, high-reliability, human factors engineering, Lean and Six Sigma, systems thinking, simulation, and just culture. It also clarified the core importance of seeing patients as partners in care. Despite widespread adoption and commitment to these strategies, myriad challenges to improved patient safety continue to surface.

This report explores how efforts in the decade following the 10-year anniversary of *To Err Is Human* have not delivered optimal results. It raises vital questions and renewed areas of focus, not just for Coverys but for the healthcare industry at large.

IMPROVEMENT HAS NOT HAPPENED QUICKLY ENOUGH

Change is not happening as quickly and collectively as it needs to. Our data shows improvement in select areas such as increased patient engagement, flattened hierarchies and the ability for staff at all levels to raise concerns, increased teamwork, and better sharing of information. However, many areas remain largely unchanged.

DATA INFORMS CHANGE

Data provides a glimpse into our past to inform the future. We see promise in a decade's worth of data and embrace decision-making based on robust data analysis. The ability to parse and examine claims and event data from many angles enables us to understand trends, reveal fresh insights, and make recommendations to help improve patient safety.

DATA USED IN THIS REPORT

The data in this report is derived from 11,907 events pertaining to 20,211 closed claims at Coverys across a 10-year period from 2010 to 2019. An event represents all parties involved during a patient episode of care where a claim is made against at least one of the healthcare providers. A claim refers to individual claims made against each specific healthcare provider and facility involved in the patient episode of care.

Analysis of 2010-2019 data at an event level represents a milestone for Coverys. The breakdown provides risk managers, clinicians, and healthcare executives a unique view into factors that lead to claims and how to proactively reduce conditions that result in patient harm and financial risk. It provides a foundation for a national-level examination into risk management issues and causation factors.

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NOW IS THE TIME TO TAKE ACTION

We must all step up to the challenge of examining data that reveals where action can be taken and use the knowledge to engage teams in the important work of care improvement and risk reduction. We encourage organizations to use Coverys' data and insights to analyze their own healthcare settings and data. This data complements the metrics that healthcare organizations are already collecting to expand thinking, pivot, prioritize, and then act. Our high-level analysis is offered to leaders to examine similar occurrences in their own organizations and motivate the data-driven changes needed to realize goals.

This report is sobering, yet motivating. Improvement efforts, including legislation, regulation, strong leadership, and collective efforts are not showing a dramatic impact on what we refer to as "the tip of the iceberg"—malpractice claims. Some would argue that preventing liability is perhaps the most challenging aspect of performance improvement, but we believe otherwise. With focused attention on the vulnerabilities that are at the root of the "worst of the worst" cases, proactive steps to create a safer, more reliable healthcare environment can help prevent these outcomes.

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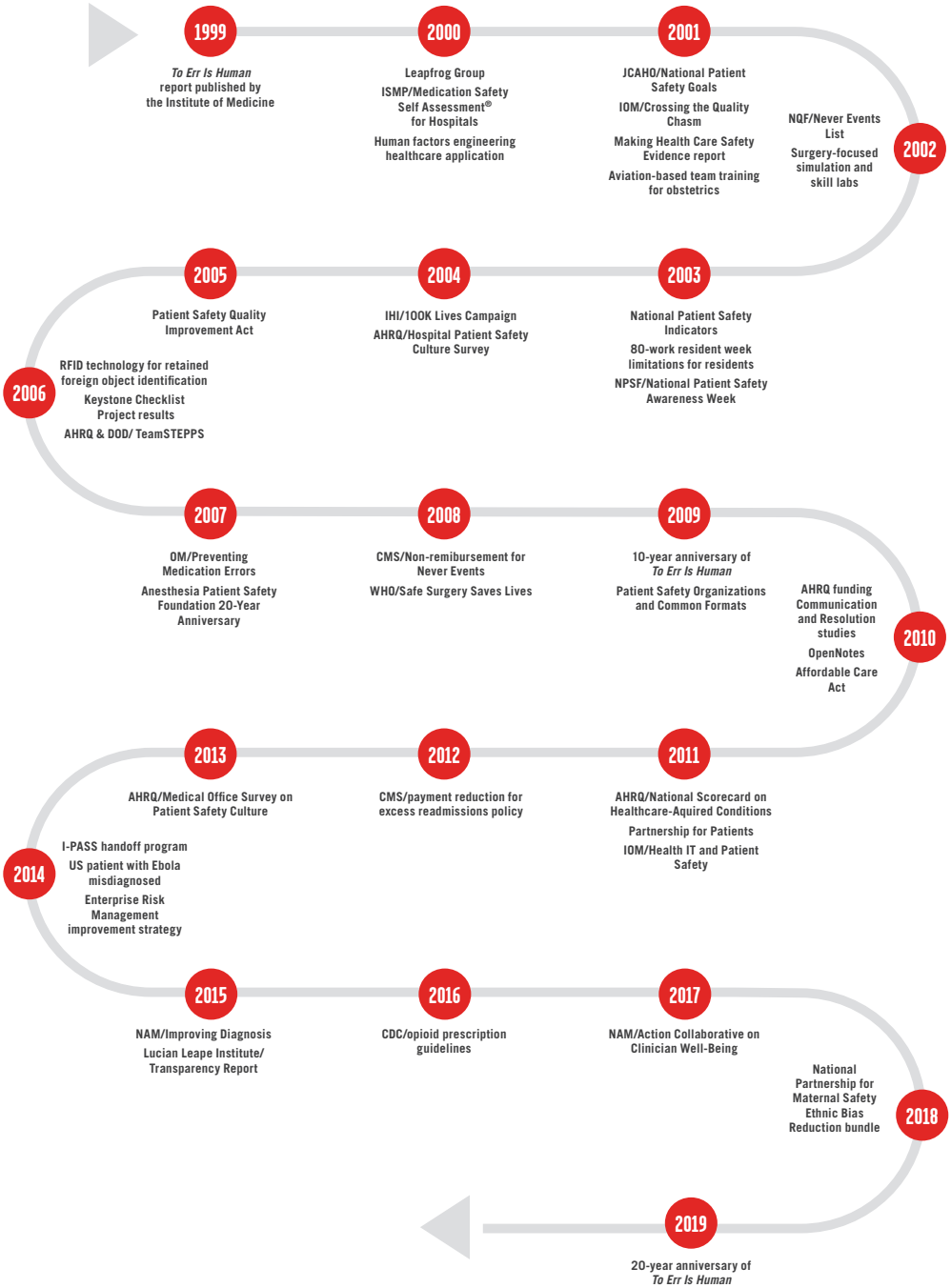
TO ERR IS HUMAN

Despite concerted efforts to improve patient safety over the past 20 years, patients continue to experience high-severity injury outcomes. This report documents how efforts in the decade following the 10-year anniversary of *To Err Is Human* have not delivered optimal results. It raises vital questions and renewed areas of focus.

Twenty Years of Patient Safety Efforts



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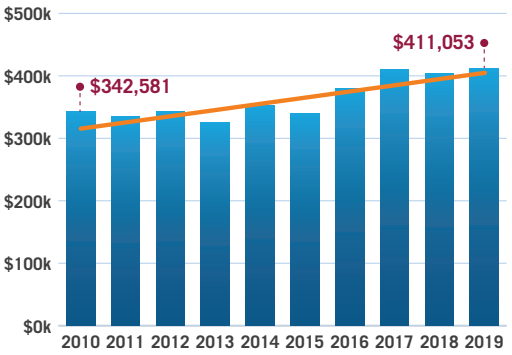
SECTION II | Physician Claims Trends

This glimpse into general claims trends shows that change has been fairly stagnant over the past decade. Patients continue to experience high-severity injury outcomes and clinicians and organizations are seeing increasingly high financial payouts. This section shares data on key claims trends.

INDEMNITY AND EXPENSES

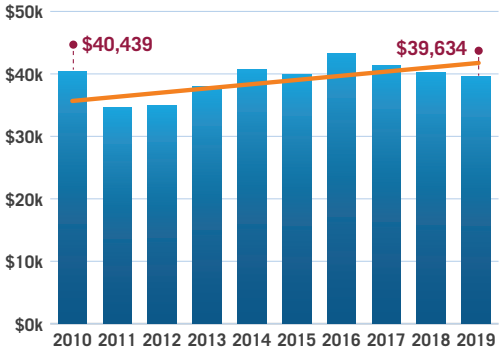
Despite lower claim rates, average indemnity and expenses are trending upward.

Average Indemnity Paid



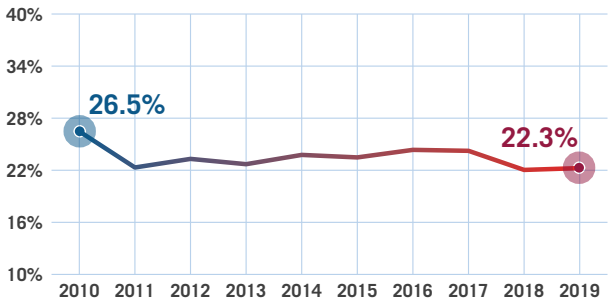
N = 20,111 claims closed between 2010-2019 involving a physician.

Average Expense to Defend Claim



N = 20,111 claims closed between 2010-2019 involving a physician.

Claims Closed With Indemnity Payment



N = 20,111 claims closed between 2010-2019 involving a physician.

The overall Closed With Indemnity Payment rate is essentially flat, averaging slightly over 23%.

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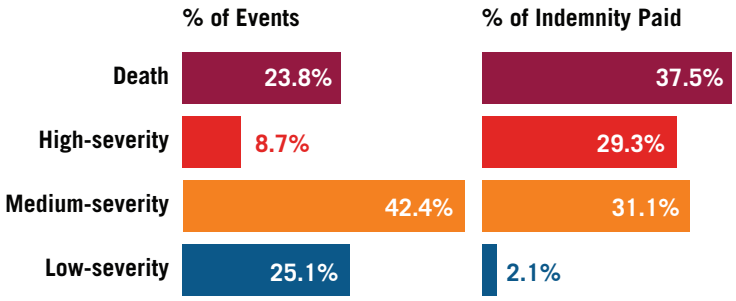
INJURY SEVERITY

Patients exhibit complex conditions that need to be managed in an increasingly complex environment. New technology and equipment should make life easier for providers and facilities, but they have also brought new challenges. Despite significant innovations over the past decade, the negative and lasting impact of injuries has remained fairly constant.

Percent of Events by Injury Severity



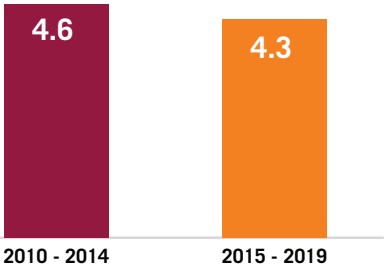
N = 11,907 events closed between 2010-2019 involving a physician.

Events involving high-severity injuries and death account for 33% of claims with little variability in the distribution from year to year.

PHYSICIAN NUMBERS

Claims Rate per 100 Physicians

The overall claims rate is trending **downward**.



4.4 Average Claims per 100 Physicians

Obstetrics and surgery have the highest claims rates; however, surgery claims are trending downward.

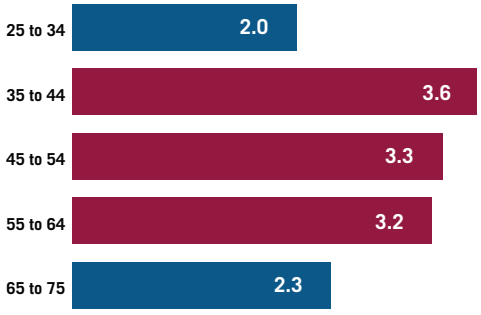
N = 236,213 physicians and 10,421 open claims between 2007-2016.

PHYSICIAN AGE

Analyzing claims rates by age groups requires lining up the incident date with the age of the person at the time of the event. To get a full experience of the claims, we went back four years and then analyzed data from the 10-year period 2007 to 2016.

Claims Rate by Age per 100 Physicians

2007–2016



Surgeons aged 35–44 have the highest claim rates overall

12.2 Claims per 100 Physicians

N = 90,489 claims opened between 2007-2016 involving a physician.

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SECTION III | Physician Claims Trends By Specialty

Demands on physicians are burdensome and widely known. Burnout is widespread and rising. Factors include the influence of health information technology, production pressures, and overall reduction in workplace satisfaction. These influences are persistent despite efforts from the National Academy of Medicine and many local initiatives to provide resources to help physicians deliver safe, effective care and stay healthy. Our data shows these efforts are not necessarily having the desired impact. One exception is anesthesiology, which serves as an example of how data can be used to drive change.

DEMANDS ON PHYSICIANS ARE BURDENSOME

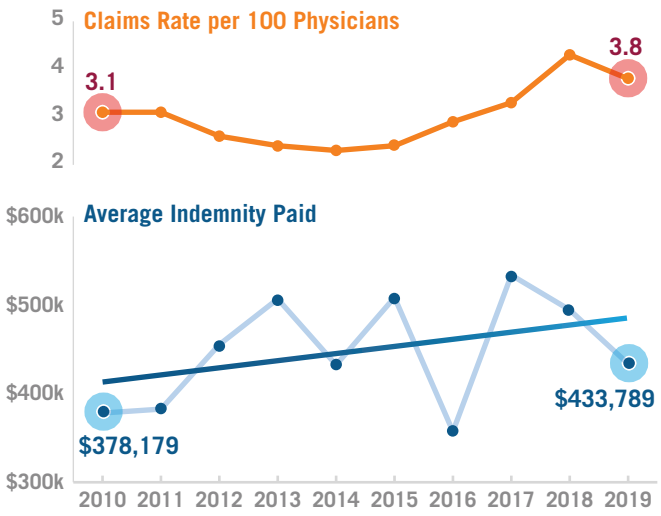
TOP SPECIALTY ANALYSIS

Physician practice over time has become increasingly specialized. There are currently about 120 specialties and sub-specialties populating the physician ranks.[2] This section examines the claim experiences of top specialties and a selection of medical sub-specialists.

GENERAL MEDICINE

- The claims rate for general medicine (Coverys' largest insured base) has trended upward due to higher claims counts in recent years, including a spike in 2018.
- Average gross paid indemnity per claim increased, with a 10-year average of approximately $449,000.
- The number of claims with indemnity paid have remained relatively flat, averaging 23% over the 10-year period. Average expenses are also relatively flat despite significant yearly variations.

General Medicine Trends



Claims Rate: N = 9,935 physicians between 2010-2019.
Indemnity: N = 586 closed claims with indemnity paid between 2010-2019.

23%
Average rate of claims with indemnity paid

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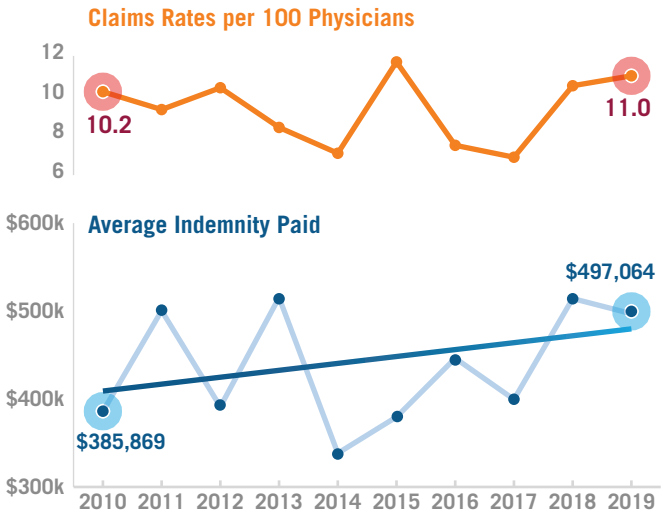
OBSTETRICS

- Claims frequency increased slightly from an average of 9.1 claims per 100 physicians in the first five years to 9.5 in the last half of the 10-year period.
- The highest rate of obstetric claims are experienced by physicians in the 35–44 age range.
- Both average indemnity and expenses are increasing with average indemnity per claim over 10 years at $435,447.
- The rate of claims with indemnity paid was 32% across the 10-year period, which is basically flat but higher than for other types of claims.

Average indemnity paid and expenses are increasing.

32%
Average rate of claims with indemnity paid

Obstetric Trends



Claims Rate: N = 2,797 physicians between 2010-2019.
Indemnity: N = 1,207 claims closed with with indemnity paid between 2010-2019.

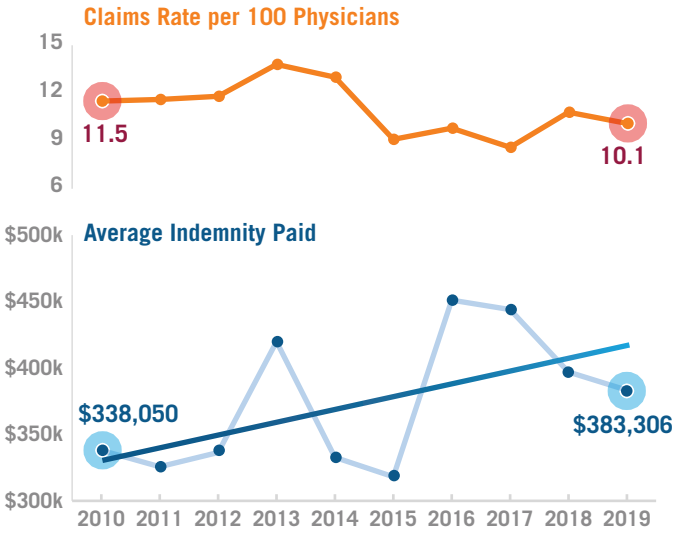
SURGERY

- The claims rate per 100 surgeons is on a downward trend, with an average of 12.4 claims per 100 physicians during 2010 to 2014. This lowered to 9.7 from 2015 to 2019.
- The highest claims rates are attributed to physicians 35 to 44 years of age.
- Indemnity payouts for surgery claims are increasing, as are expenses.
- The rate of claims with indemnity paid was 25%.

Surgery claims are trending downward

25%
Average rate of claims with indemnity paid

Surgery Trends



Claims Rate: N = 26,279 physicians between 2010-2019.
Indemnity: N = 3,485 closed claims with indemnity paid between 2010-2019.

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SURGICAL SPECIALTIES BREAKDOWN

The claims rate for neurosurgeons is high but trending downward. Neurosurgeons also constitute the highest percent of physicians with more than one claim.

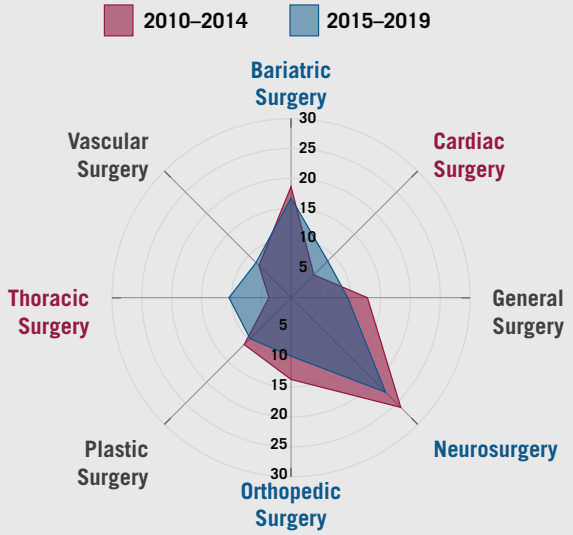
Bariatric claims are the second highest in frequency with only a slight decrease in the past five-year period.

The orthopedic surgery claims rate is on a slight downward trend due to fewer-than-average claims in 2015–2017.

Thoracic surgery claims are on an upward trend with spikes in 2017 and 2019 due to a higher-than-average claim count.

Cardiac surgery claims have also increased.

Surgical Specialties: Claim Rate per 100 Physicians



N = 21,886 events closed between 2010-2019 involving surgery.

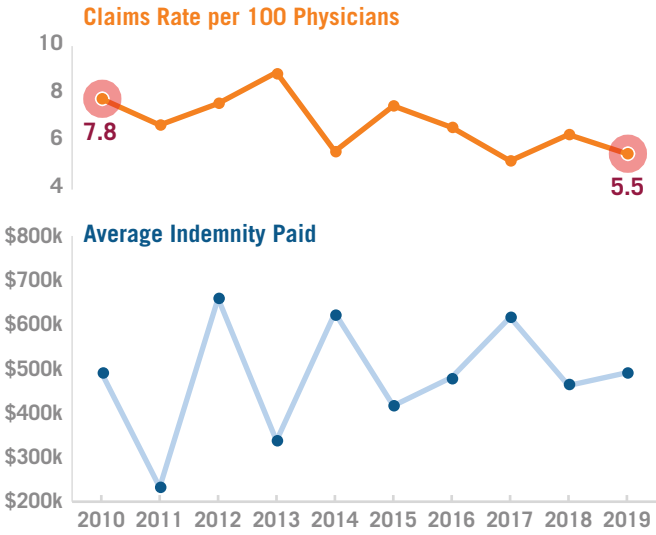
RADIOLOGY

- The claims rates for radiologists are decreasing.
- Radiologists tend to be sued less frequently after age 54.
- Average expenses and indemnity payouts for radiologists have increased.
- The rate of claims with indemnity paid was 27%.

The claims rates for radiologists are decreasing

27%
Average rate of claims with indemnity paid

Radiology Trends



Claims Rate: N = 12,601 physicians between 2010-2019.
Indemnity: N = 1,078 closed claims with indemnity paid between 2010-2019.

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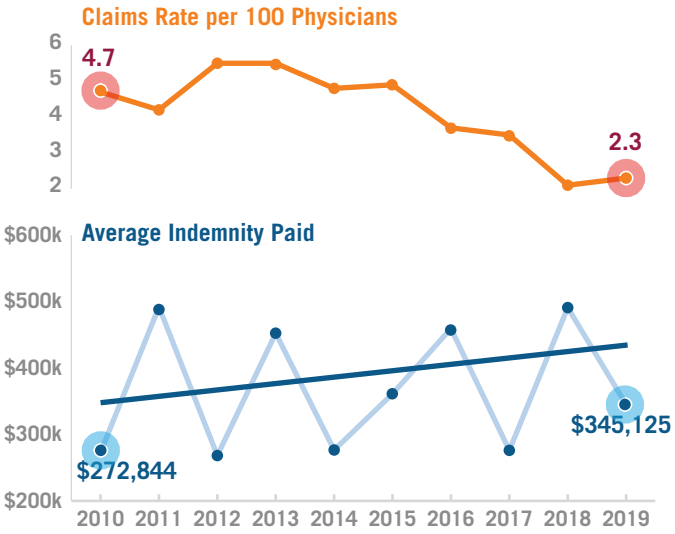
ANESTHESIOLOGY

The practice of anesthesia is now highly data-driven, and claims are declining. A focus on simulation training, human factors engineering, and evidence-based decision-making has resulted in improvements.

- The overall claims rate was reduced significantly from an average of 4.9 claims per 100 physicians in the first five years analyzed to 3.2 per 100 in the last five years.
- Anesthesiologists aged 55 to 64 have a higher rate of claims than other age groups.
- Although average indemnity and expense payments have been increasing, indemnity payouts have varied considerably from year to year.
- The average rate of claims with indemnity paid was 21%.

A focus on simulation training, human factors engineering, and evidence-based decision-making has resulted in improvements.

Anesthesiology Trends



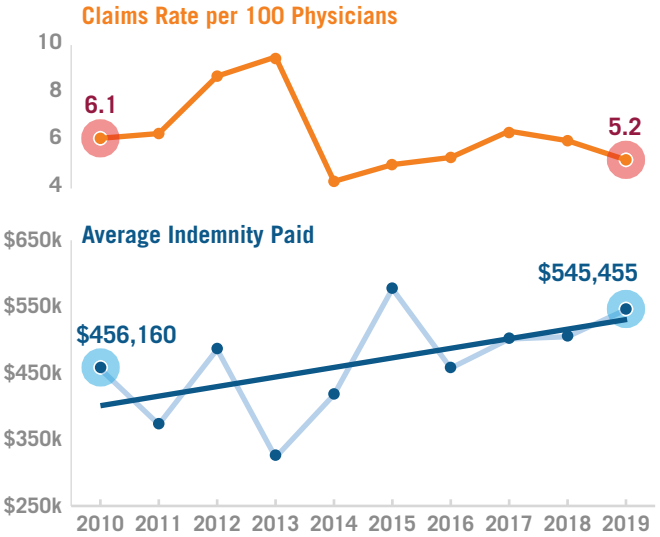
Claims Rate: N = 9,935 physicians between 2010-2019.
Indemnity: N = 586 claims closed with indemnity paid between 2010-2019.

EMERGENCY MEDICINE

- The claims rate is declining for emergency medicine physicians.
- The claims rate for emergency physicians aged 45 and older decreased significantly.
- The rate of claims with indemnity paid was 20% over 10 years with a significant decline in 2019 to 15%.
- Average indemnity and expenses increased with average claims expenses slightly more than $41,000 over the 10-year period.

20%
Average rate of claims with indemnity paid

Emergency Medicine Trends



Claims Rate: N = 12,157 physicians between 2010-2019.
Indemnity: N = 1,064 claims closed with indemnity paid between 2010-2019.

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MEDICAL SUB-SPECIALTIES BREAKDOWN

All sub-specialties show some decline in claims rates in the latter five years except for pulmonary disease physicians, who are experiencing a slight increase.

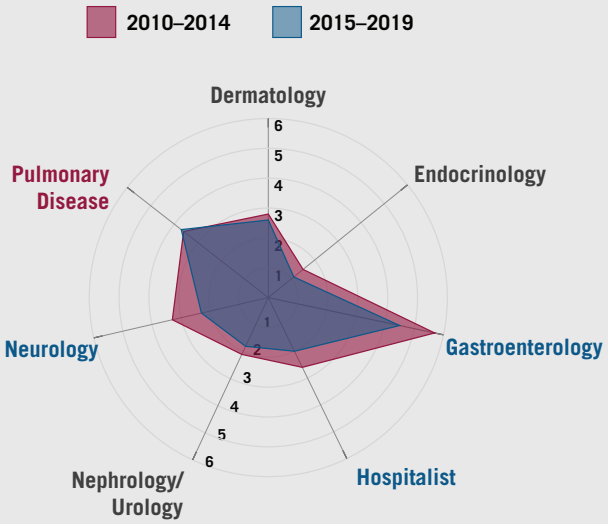
Average indemnity is approximately $449,000 and the claims with indemnity paid rate averages 21%, both essentially flat while expenses are increasing.

The gastroenterology claims rate is markedly higher than for other medical sub-specialties. It is encouraging that these rates have decreased in the latter five-year period.

The neurology claims rate is on a downward trend due to a fairly stable claim count.

The claims rate for hospitalists is also down due to an increasing physician count yet a stable claim count over the past five years.

Medical Sub-Specialties: Claims Rate per 100 Physicians



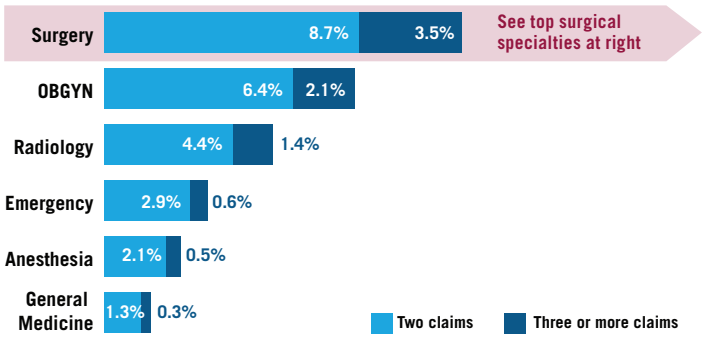
N = 1,511 events closed between 2010-2019 involving medical sub-specialties.

PHYSICIANS WITH MULTIPLE CLAIMS

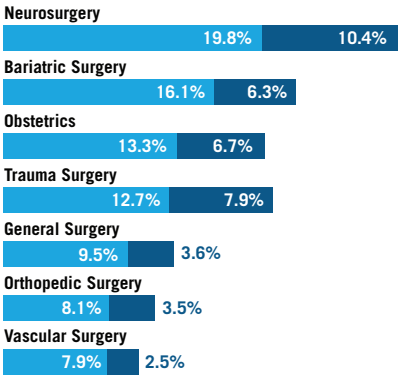
Physicians that experience more than one claim during a given time period represent a unique subset of defendants. These charts show the percentage of physicians who had more than one claim during our 10-year evaluation period. Surgery and obstetrics comprise the highest percentage of specialists with multiple claims.

63%
of surgical claims involve a surgeon with multiple claims

Top Specialties With Multiple Claims



Top Surgical Specialties With Multiple Claims



Top Specialties: N = 38,044 claims closed between 2010-2019 involving a physician.
Surgical Specialties: N = 4,818 claims closed between 2010-2019 involving surgery.

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SECTION IV | Top Claims Trends

There is always the potential for risk when delivering or receiving medical care. Often these risks remain largely invisible until a patient experiences a poor outcome. Efforts to learn from missteps through peer review, incident reporting, and patient safety organization work have been ongoing for more than 20 years, with the goal of proactively reducing risk. Yet, when the root causes of these problems either are not well understood or appropriately prioritized, many of the issues we see in malpractice-related events cannot be dealt with in an impactful way.

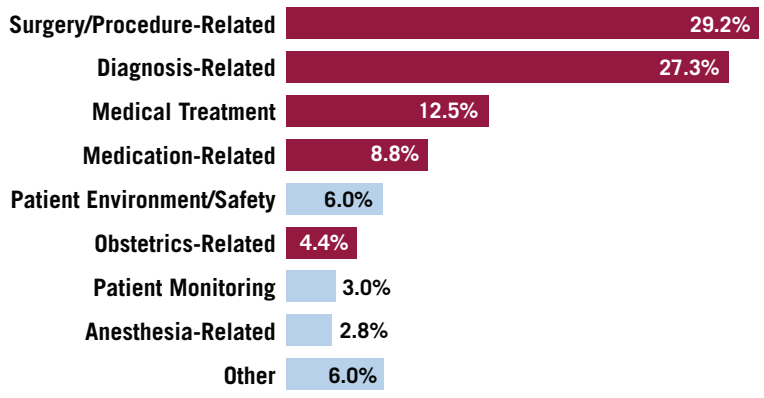
RISKS OFTEN REMAIN LARGELY INVISIBLE

We see slight modifications in the claims data and improvements in diagnosis that are promising. However, given the outcomes stemming from missed and delayed diagnosis scenarios—and the resultant higher-than-average payouts, there is more to be done. In this section, we focus on what can be learned from events in our key data-driven target areas: surgery, diagnosis, medical treatment, medication, and obstetrics.

TOP ALLEGATIONS

Surgery/procedure-related allegations are the most frequent in our data, followed closely by diagnosis-related allegations. Diagnosis-related allegations are the costliest. Surgery/procedure and diagnosis-related allegations combined account for 57% of allegations and 59% of indemnity paid. It follows that if focused attention is paid to significant—and sustained—improvement in those two categories alone, it could have a major positive impact on improved patient safety and could result in fewer malpractice claims.

Top Allegation Types



N = 11,907 events closed between 2010-2019.

Surgery/procedure- and diagnosis-related allegations combined account for **57%** of allegations and **59%** of indemnity paid

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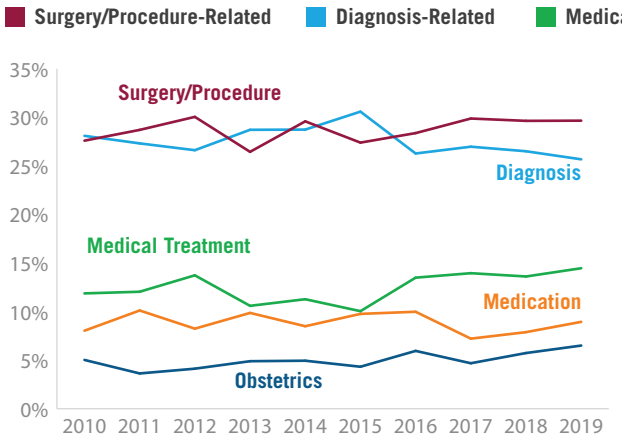
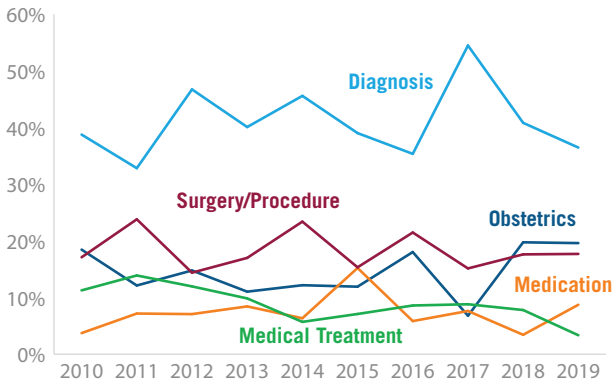
Top Five Allegation Categories Over Time

Event Rate
Top 5 Allegation Types



Closed With Indemnity Paid
Top 5 Allegation Types



N = 11,907 events closed between 2010-2019.

SURGERY/PROCEDURE-RELATED EVENTS

Surgical care is inherently risky, and when things go wrong, is a common basis for malpractice claims. Despite widely distributed guidance, checklists, team training, and simulation aimed at reducing their prevalence, events continue to occur involving retained foreign bodies, wrong-site procedures, and less-than-optimal team performance. Fatigue, hierarchy, and distractions still affect experienced surgeons' decision-making, technical ability, and team leadership skills. Surgery events have the second-highest total indemnity (18%). Average gross paid indemnity for surgery/procedure-related events was $374,449.

Surgery/procedure-related events are the most common allegation category. Surgery performance issues accounted for 78% of events and 72% of indemnity paid. Performance-related issues, specifically technical skill, predominate in these events.

Surgery/ procedure-related events are the most common allegation category.

Top Five Allegations – Surgery/Procedure

	Performance	Retained Object	Unnecessary Surgeries	Wrong Side/Site/ Patient	Delay in Surgery
% of Events	78.2%	7.1%	3.5%	3.4%	2.7%
% of Indemnity	71.7%	4.3%	6.0%	2.2%	6.6%

N = 3,428 events closed between 2010-2019 involving a surgery/procedure.

Surgery performance issues accounted for **78%** of events and **72%** of indemnity paid

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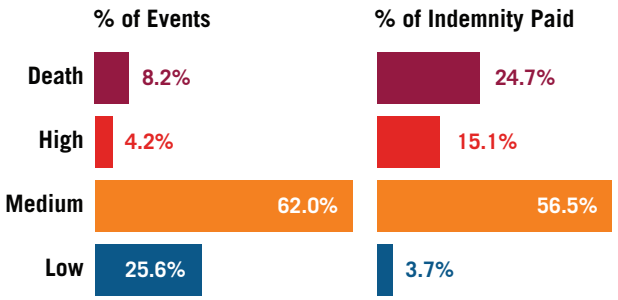
INJURY SEVERITY – SURGERY/PROCEDURE



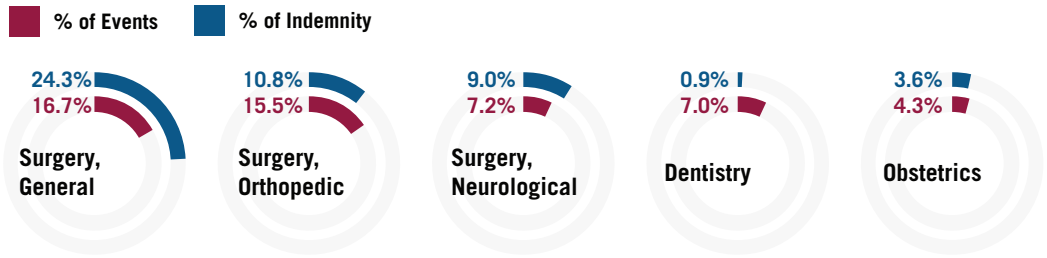
N = 3,428 events closed between 2010-2019 involving a surgery/procedure.

LOCATION – SURGERY/PROCEDURE

As expected, most indemnity payments result from events that occur in the operating rooms of hospitals and outpatient facilities. We see 66% of events occur in surgery and 17% in the physician office, before dropping to 3% in clinics and emergency departments, and finally, 2% in the patient's hospital room.

TREATMENT AREA – SURGERY/PROCEDURE

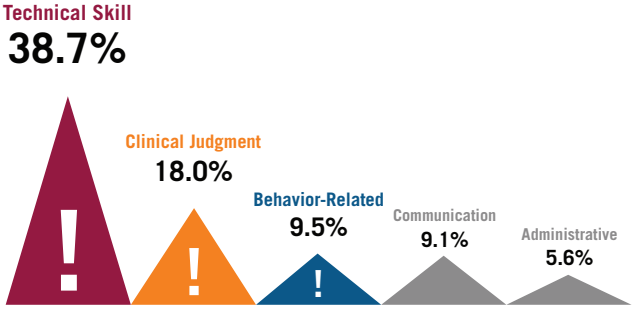
General surgery and orthopedic surgery specialties account for 17% and 16% of events respectively, and 24% and 11% of indemnity paid.



N = 3,428 events closed between 2010-2019 involving a surgery/procedure.

TOP RISK MANAGEMENT ISSUES – SURGERY/PROCEDURE

Technical skill, clinical judgment, and behavior-related allegations surface as the top risk management categories. The recurring themes of patient assessment and diagnosis of clinical condition are two of the sub-factors comprising clinical judgment.



Technical Skill

- **51%** Unexpected technical problem
- **27%** Clinical judgment, flawed decision-making
- **12%** Inadequate skills
- **11%** Presence of retained object

Clinical Judgment

- **35%** Selection and management of therapy
- **30%** Patient assessment/diagnosis of clinical condition
- **22%** Patient monitoring

Behavior-Related

- **46%** Patient unhappy with results
- **40%** Non-compliant patient

N = 3,428 events closed with a risk management issue between 2010-2019 (events may have more than one risk issue).

EVENT IN CONTEXT: Failure To Remove Denture Results in Patient Harm

A 55-year-old female patient was admitted to the ICU with an acute cerebral infarct. The presence of upper and lower dentures was documented on the **pre-transesophageal echocardiogram (TEE)** anesthesia history and assessment form. A **cardiologist** performed the TEE at the bedside while an **anesthesiologist** administered anesthesia. A **nurse** also assisted at bedside.

Post procedure, the patient became restless and hypertensive and notified her nurses that her lower partial denture was missing. Chest X-rays were taken the morning after the TEE and again two days later with **no abnormalities reported**. The patient subsequently developed throat pain, increased difficulty in swallowing, and a persistent sensation of a lump in her throat. **Her providers attributed these symptoms to her cerebral infarct**. The patient's speech therapist made **repeated recommendations for a barium swallow study**, but the test was never ordered.

The patient underwent placement of a feeding tube into her abdomen due to her eventual inability to swallow food. She was subsequently **discharged home** and presented to another hospital several weeks later with worsening throat pain. A modified barium swallow revealed a foreign body consistent with a denture, wedged in her throat. She required a tracheotomy for removal of the foreign body which was subsequently confirmed to be her denture.

During the investigation, the nurse said that she **did not complete the pre-procedure checklist** because the procedure was performed at the bedside. The patient alleged that all her providers failed to remove her denture prior to her TEE. As a result, the TEE instrumentation displaced her denture and caused it to become lodged in her throat, which necessitated two additional surgical procedures (PEG tube placement and the tracheotomy).

3% of surgery events involved a cardiac procedure.

RISK RECOMMENDATIONS:

- Define the roles and responsibilities of all members of the procedural team.
- Conduct routine medical record audits to ensure all providers are discharging their responsibilities before, during, and after procedures.
- Consider conducting a Root Cause Analysis for unanticipated outcomes.

4% of surgery events involved risk issues related to testing.

RISK RECOMMENDATIONS:

- Provide access to decision support tools for healthcare personnel to rule out/rule in potential diagnoses.
- Recommend a second over-read by a different radiologist if the patient continues to experience worsening symptoms.
- Recommend consultation with a specialist when a patient has persistent or worsening symptoms.

9% of surgery events involved risk issues related to communication failure.

RISK RECOMMENDATIONS:

- Ensure all members of the care team discuss the patient's condition and are in agreement with the care plan.
- Define a method to escalate differences among care providers to an ultimate decision–maker.

4% of surgery events involved risk issues related to discharge.

RISK RECOMMENDATIONS:

- Define the patient status criteria that must be met prior to discharge and actions to take when the criteria is not met.
- Ensure the written discharge instructions describe actions to take for worsening symptoms and include contact information.

3% of surgery events involved a policy/ procedure issue.

RISK RECOMMENDATIONS:

- Document the intended procedure, type of anesthesia, and removal of dentures and other items on the preoperative checklist. Verify this was accomplished prior to a procedure or surgery by holding a "time out session," and encourage anyone to stop the line.

COVERYS

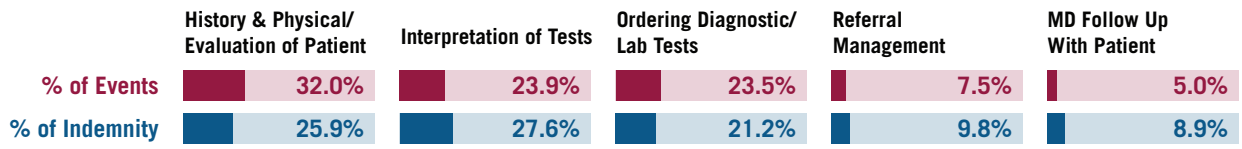
DIAGNOSIS-RELATED EVENTS

Diagnostic error is a primary contributor to healthcare-related patient harm.[3] Arriving at an accurate diagnosis is a process that can be derailed by bias, time pressure, and knowledge gaps—even for experienced diagnosticians. To help improve diagnostic safety, clinicians and organizations can learn from data to enhance the daily practice of care to ensure diagnoses are correct and acted upon without unnecessary delay.

ALLEGATION DETAIL – DIAGNOSIS

Three allegations, involving history & physical/evaluation of patient, interpretation of tests, and ordering diagnostic/lab tests, comprise 79% of events and 75% of indemnity payments, with allegations involving interpretation of tests being the costliest. In 2016, the number of diagnosis allegations dropped and remained below surgery allegations over the following four years. Diagnosis-related events have continued to trend slightly downward over the last five years but that movement is not statistically notable. The 10-year average indemnity payment for diagnostic-related events was $600,000, second only to obstetrical events.

Top Five Allegations – Diagnosis-Related Events



N = 3,291 events closed between 2010-2019 involving diagnosis.

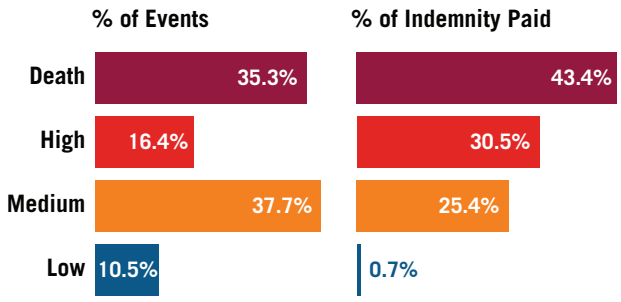
Three allegations, involving history & physical/evaluation of patient, interpretation of tests, and ordering diagnostic/lab tests, comprise 79% of events

INJURY SEVERITY – DIAGNOSIS

Death and high-severity injury constitute 52% of events and 74% of indemnity paid. High-severity injury and death allegations are mostly attributable to missed or delayed cancer diagnoses.

Death and high-severity injury constitute
52% of events and
74% of indemnity

Severity– Diagnosis-Related Events



N = 3,291 events closed between 2010-2019 involving diagnosis.

COVERYS

LOCATION – DIAGNOSIS

The majority of diagnosis-related events occurred in physician offices or emergency departments. In a trend that began well over 20 years ago, missed/delayed diagnoses have been far more prevalent in the outpatient and the emergency department settings—reflective of the shifts we have seen away from the inpatient setting.

Diagnosis – Top Five Locations

Physician Office

34.6% of Events | 42.6% of Indemnity

Emergency Room

24.9% of Events | 19.6% of Indemnity

X-ray

11.6% of Events | 10.8% of Indemnity

Patient Room

8.8% of Events | 6.3% of Indemnity

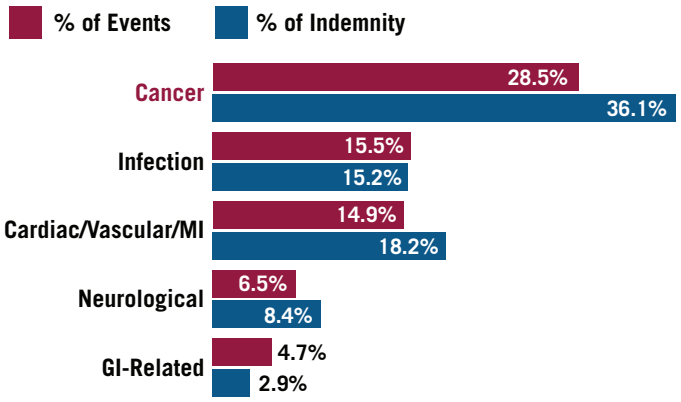
Laboratory

4.4% of Events | 6.4% of Indemnity

N = 3,291 events closed between 2010-2019 involving diagnosis.

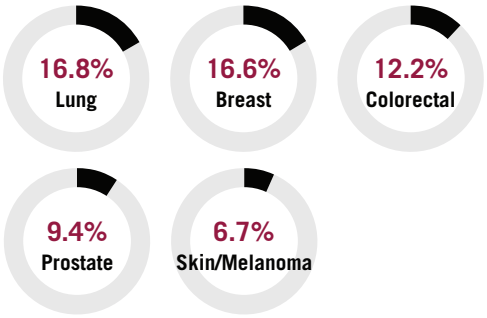
TOP CONDITIONS – DIAGNOSIS

The top missed or delayed diagnoses involve cancer, infection, and cardiac/vascular conditions. The top cancers for these events are lung, breast, and colorectal.



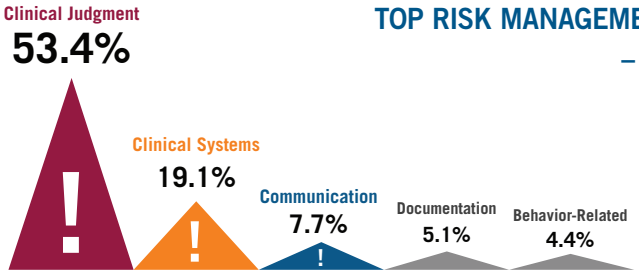
N = 3,291 events closed between 2010-2019 involving diagnosis.

Top Types of Cancer



TOP RISK MANAGEMENT ISSUES – DIAGNOSIS

Clinical judgment is consistently the most frequent risk issue, far higher than the next most frequent issue which is clinical systems. Both are trending higher. Communication ranks third at 8%.



Clinical Judgment

- 70% Patient assessment/diagnosis of clinical condition
- 13% Selection and management of therapy
- 12% Failure/delay in obtaining consult/referral

Clinical Systems

- 29% Failure/delay in reporting findings/revised findings
- 20% Failure/delay in scheduling/performing recommended test
- 19% Lack of/failure in system for patient care

Communication

- 65% Communication among providers
- 28% Communication between patient/family and providers
- 7% Telephone/email/fax-related issues

N = 3,291 events closed with a risk management issue between 2010-2019 (events may have more than one risk issue).

EVENT IN CONTEXT: Miscommunication Results in Delayed Lung Cancer Diagnosis

A 54-year-old male patient was a lifelong smoker with mild chronic obstructive pulmonary disease (COPD). His primary care provider was a **nurse practitioner (NP)** at a family practice office who saw him regularly for routine and acute care visits. During an annual visit, he reported continued smoking but denied shortness of breath, fatigue, or weight loss. Based on his history of smoking and COPD, the NP ordered a chest X-ray (CXR) that revealed a small nodule in the left lower lobe. The radiologist recommended a follow-up chest CT scan that showed a 1cm lesion with irregular borders that could have been suspicious for cancer. CT and PET scans were run and confirmed the presence of the lesion, suggested inflammation rather than a malignancy, and recommended a follow-up scan if a needle aspiration was not performed. Upon review of the test findings, the NP referred the patient to a thoracic surgeon to evaluate and manage the lesion.

27% of diagnosis-related issues involving NPs were related to test ordering.

- One claim per 200 NPs

The thoracic surgeon chose to monitor the patient with serial X-rays over the next six months that showed no change in the lesion. He noted in his records that the patient's lesion should continue to be evaluated with "periodic X-rays" that could be **monitored by the NP** who the patient saw every three months. The surgeon specifically documented, "It would be fine with me if she does them—otherwise he will be seen as necessary." A copy of the surgeon's note with the NP's handwritten initials and date of review was included in the patient's primary care record.

HANDOFF RISK RECOMMENDATIONS:

- Ensure that consultants clearly define plans for follow-up care that outline the types of tests needed to evaluate the condition, time frames to perform tests, and any changes in conditions that should prompt a referral.
- Review the records of other providers/consultants and clarify terms that do not provide specific times, intervals, and methods for continuing care.

POLICY RISK RECOMMENDATIONS:

- Conduct periodic review of policies to ensure they are based upon current evidence and are easily accessible to practitioners.
- Require documentation of any variances from practice policies.

The patient's care transitioned to the NP. Despite the surgeon's documented recommendation for periodic X-rays and that it was the NP's medical group's **policy to order yearly chest X-rays for smokers**, none were ordered until 2½ years later during a routine visit. At that time, the patient denied shortness of breath or difficulty breathing and indicated he had stopped smoking. The NP noted that the CXR was ordered to assess COPD with **no instructions to assess the status of the left lung nodule**. The CXR revealed a 5cm left lower lobe lesion suggestive of a primary lung cancer for which the patient was referred to an oncologist for cancer staging and treatment.

11% of risk management issues related to NPs involved inadequate follow-up.

RISK RECOMMENDATIONS:

- Document a plan of care for follow-up on known conditions that includes frequency of visits, tests to evaluate progress, and potential referrals for abnormal or significant changes in test results.
- Implement a test tracking process that addresses steps to follow for abnormal test results.

The patient underwent a lobectomy with pathology that confirmed the lesion was cancerous and no metastases to the lymph nodes. The patient also received adjuvant chemotherapy. **Earlier testing** may have recommended removal of the lesion which may have prevented it from progressing to cancer.

RISK RECOMMENDATION:

- The delay in testing may have been averted through internal peer review. Conduct ongoing internal peer review and provide feedback to all practitioners on strengths and opportunities to improve care.

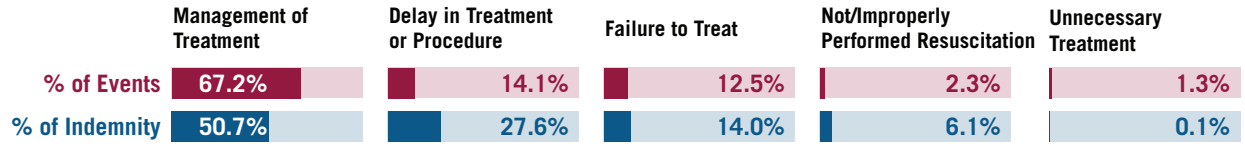
COVERYS

MEDICAL TREATMENT EVENTS

Medical treatment allegations refer to the non-surgical management and care of a patient to prevent or combat disease and disorders. Some examples include: radiation therapy, physical therapy, occupational therapy, and respiratory therapy.

Primary care and general medicine are areas of focus here. Care transitions and overall breakdown of team-based care are prevalent. Weaknesses in assessments result in subsequent treatment failures as indicated in the data exhibited below. Medical treatment is the third-most common allegation. Average indemnity paid was $442,000.

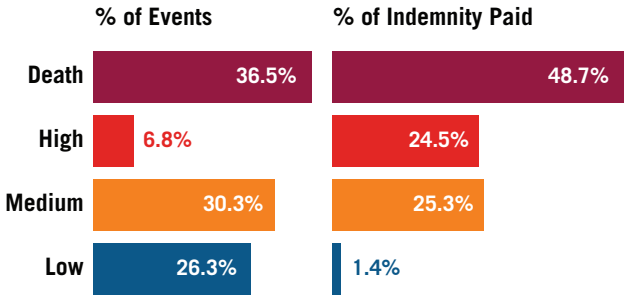
Top Five Allegations – Medical Treatment



N = 1,489 events closed between 2010-2019 involving medical treatment.

INJURY SEVERITY – MEDICAL TREATMENT

The high percentage of medical treatment events resulting in death is concerning. Death and high-severity injury cases are responsible for 43% of events and 73% of indemnity paid.



Death and high-severity injury are responsible for **43% of events** and **73% of indemnity**

N = 1,489 events closed between 2010-2019 involving medical treatment.

LOCATION – MEDICAL TREATMENT

Outpatient care accounts for 32% of medical treatment events and 41% of indemnity paid. Inpatient care accounts for 40% of events and 33% of indemnity. Inpatient events have been rising in the last five years while outpatient events have not been increasing as sharply. The increase in inpatient events is attributed to treatment of cardiac/vascular conditions, management of decubitus ulcers, wound management, and IV management.

Medical Treatment Events – Top Five Locations

Physician Office
23.8% of Events
35.2% of Indemnity

Emergency Room
20.1% of Events
20.9% of Indemnity

Patient Room
17.6% of Events
11.4% of Indemnity

Long Term/Extended Care
7.7% of Events
1.1% of Indemnity

Surgery
7.1% of Events
5.4% of Indemnity

N = 1,489 events closed between 2010-2019 involving medical treatment.

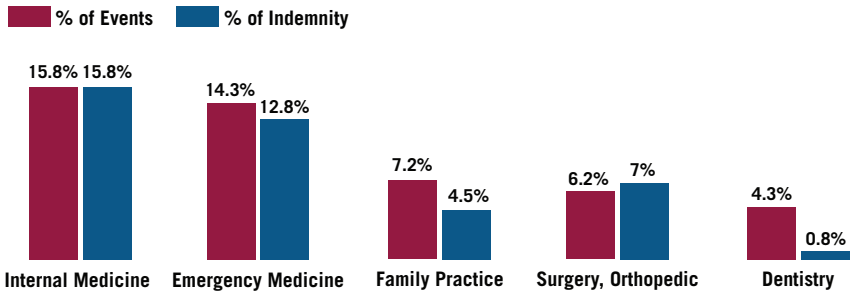
COVERYS

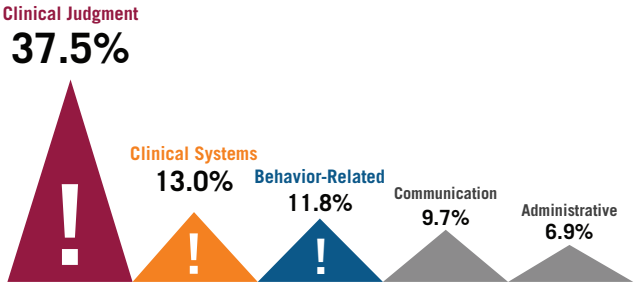
SPECIALTY – MEDICAL TREATMENT

Internal medicine and emergency medicine are the specialties most often cited in allegations related to medical treatment.

N = 1,489 events closed between 2010-2019 involving medical treatment.

Top Specialties – Medical Treatment





Clinical Judgment

- **39%** Selection and management of therapy
- **29%** Patient assessment/diagnosis of clinical condition
- **14%** Patient monitoring

Clinical Systems

- **48%** Lack of/failure in system for patient care
- **17%** Lack of/failure in patient follow-up system
- **16%** Failure to identify provider coordinating care

TOP RISK MANAGEMENT ISSUES – MEDICAL TREATMENT

Top risk management issues identified for medical treatment events are clinical judgment, clinical systems, behavior-related, and communication. Patient assessment problems and communication lapses are recurring themes throughout this report.

Behavior-Related

- **57%** Non-compliant patient
- **18%** Patient unhappy with results
- **15%** Inappropriate patient behavior

N = 1,489 events closed with a risk management issue between 2010-2019 (events may have more than one risk issue).

MEDICATION-RELATED EVENTS

Medication error related to the processes of ordering, dispensing, administering, monitoring, and managing medications is the fourth-highest allegation category among all events. This makes up 9% of all allegations and accounts for 7% of total indemnity payouts. Ordering medication and monitoring/management allegations combined account for 65% of all indemnity paid. Average indemnity paid over the 10-year span is approximately $327,500.

Top Five Allegations – Medication-Related Events

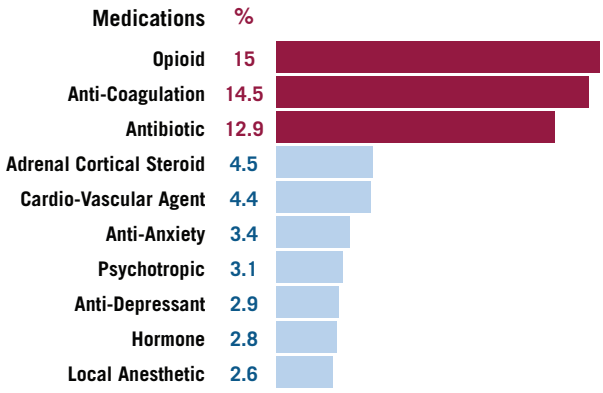
	Ordering Medication	Monitoring/ Management	Administration of Medication	Wrong Medication	Dispensing Error-Route, Dose, Pharmacy
% of Events	31.0%	29.6%	21.0%	12.5%	4.0%
% of Indemnity	27.0%	38.5%	22.5%	9.3%	1.6%

N = 1,061 events closed between 2010-2019 involving medication.

Ordering medication and monitoring/management allegations combined account for 65% of indemnity paid

COVERYS

Top Medications – Medication-Related Events



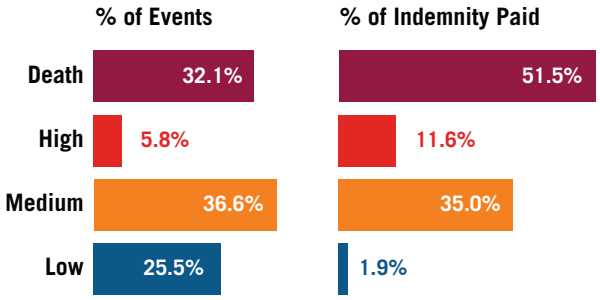
N = 1,061 events closed between 2010-2019 involving medication.

42% of medications administered were related to just three medications: opioids, anti-coagulants, or antibiotics

INJURY SEVERITY – MEDICATION

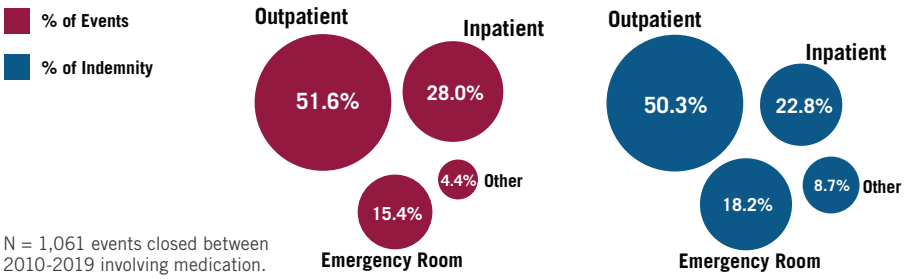
Events resulting in death and medium-severity injuries accounted for 87% of indemnity paid for medication-related events. Death is the costliest severity category (52% of all indemnity paid) for medication-related events, and events resulting in death accounted for 32% of all medication-related events. Medium severity was recorded for 37% of events, and contributed to 35% of the indemnity paid on medication-related cases.

Injury Severity – Medication-Related Events



N = 1,061 events closed between 2010-2019 involving medication.

Top Locations – Medication-Related Events



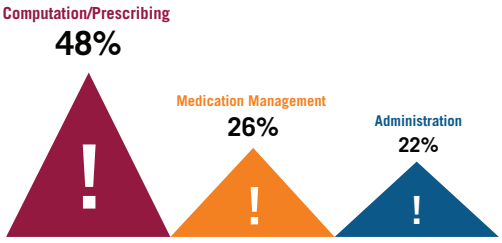
N = 1,061 events closed between 2010-2019 involving medication.

TOP LOCATIONS – MEDICATION

Outpatient events make up 52% of all medication-related events, and resulted in 50% of indemnity paid on medication-related cases. Poor or absent medication reconciliation as patients move across the care continuum is a contributing factor.

TOP RISK MANAGEMENT ISSUES – MEDICATION

The most common area of risk seen in medication-related events is in the computation/prescribing phase, followed by medication management, and then administration. In terms of the pain management process of care, prescribing and management are the two highest-risk phases. From a volume standpoint, screening/prescribing issues are more prevalent, making up almost half of all medication-related risk issues. Allergic reactions account for some medication management risks.



Computation/Prescribing Issues

- 34% Medication prescribing
- 11% Failure/delay in prescribing

Medication Management Issues

- 35% Selection and management of therapy
- 30% Patient assessment/diagnosis of clinical condition
- 22% Patient monitoring

N = 1,061 events closed with a risk management issue between 2010-2019 (events may have more than one risk issue).

EVENT IN CONTEXT: EHR Allergy Omission Results in Patient Death

A 66-year-old female with a history of **chronic obstructive pulmonary disease (COPD)** presented to the ER with complaints consistent with rib fractures and COPD exacerbation. She was admitted to the hospital under the care of a **hospitalist**. Her **Keflex (cephalexin)** allergy was documented in the electronic health record (EHR) and alternative medications were administered during her hospital stay.

Despite the patient's documented allergy, the hospitalist gave her a **prescription for Keflex** at discharge. She collapsed shortly after taking her first dose, was resuscitated by EMS, but remained unresponsive. EMS transported her to the hospital where staff determined she had suffered an **anoxic** brain injury and would likely remain in a vegetative state. **She died** shortly after the prognosis was made. The medical examiner listed the probable cause of death as an anoxic brain injury due to presumed anaphylaxis from cephalexin.

The **hospital's discharge protocol** prohibited handwritten prescriptions and required they be entered in the EHR for easy medication reconciliation. The hospitalist **violated the discharge protocol** in several ways. Violations included that the prescription was: 1) handwritten, 2) not entered into the EHR, and 3) not checked against the patient's documented allergies.

15% of medication-related events involved a patient with a comorbidity.

CO-MORBIDITY RECOMMENDATIONS:

- Identify and document patient co-morbidities.
- Require a medication reconciliation to avoid prescribing medications or doses that may exacerbate the patient's condition.

ALLERGY RECOMMENDATIONS:

- Outline the method to record allergies in the medical record and include a workaround if an electronic health record is used to accommodate for system failures.
- Describe how to access allergy information from electronic and workaround formats.
- Define individual responsibilities for each phase of the medication process of care—ordering, dispensing, administering and monitoring, and management—that provides multiple opportunities to prevent contraindicated medications from reaching the patient.

32% of medication-related events result in patient death.

4% of medication-related events involved issues related to violations of established protocols.

2.3 claims per 100 hospitalist physicians vs. 3.1 for primary care physicians.

HOSPITALIST RECOMMENDATIONS:

- Define the role and scope of the hospitalist, primary care, and consultant providers.
- Require the hospitalist to access prior patient records and consult the primary care provider and consultants for pertinent history, current treatments, and medications.
- Outline communication expectations among all providers particularly at transitions in care.
- Include a chain of command policy to address differences among providers regarding patient treatment.

26% of medication-related claims involved an antibiotic.

13% of medication-related events involved an antibiotic.

DISCHARGE RECOMMENDATIONS:

- Verify medication allergies.
- Require a discussion on generic and brand names of drugs prescribed, administration guidelines, expected results, potential untoward/adverse reactions, and recommended actions to take including whom to contact.
- Require patient "teach back" to evaluate and ensure patient understanding.
- Provide documentation guidelines, including documenting whether the patient received written discharge instructions.

COVERYS

OBSTETRICS EVENTS

Management of labor and delivery remain among the most vulnerable phases of obstetrical care. This has not changed in a meaningful way since the early 2000s. What has changed is the focus on the overall management of pregnancy, with a growing number of lawsuits finding their root in prenatal care.

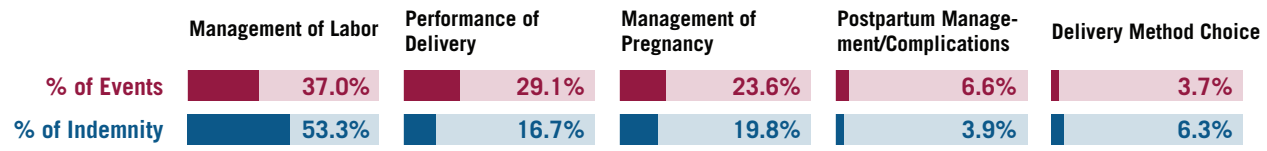
Obstetrics account for the highest average indemnity paid at approximately $915,000. The highest number of events and indemnity payments are linked to management of labor.

ALLEGATION DETAIL – OBSTETRICS

Management of labor remains the most frequent allegation in terms of frequency of events and indemnity paid. In the past, pregnancy-related allegations were largely focused on the management of active labor and delivery. In recent years, issues related to the overall management of pregnancy and postpartum complications have become more prevalent. Comorbidities (e.g., diabetes, obesity) are also more common today. Allegations related to the "choice of delivery method" are the lowest in frequency.

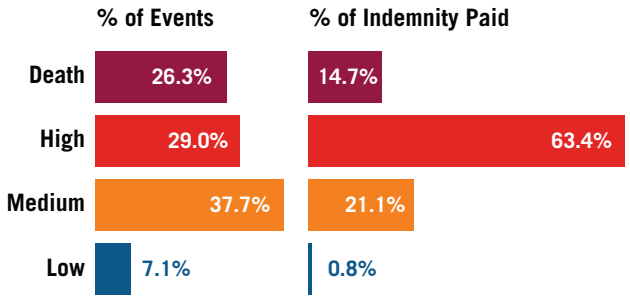
In recent years, issues related to the overall management of pregnancy and postpartum complications have become more prevalent

Top Five Allegations – Obstetrics



N = 594 events closed between 2010-2019 involving obstetrics.

INJURY SEVERITY – OBSTETRICS



N = 594 events closed between 2010-2019 involving obstetrics.

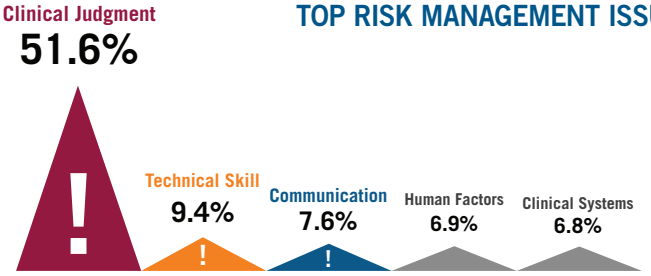
Death and high-severity injury accounted for 55% of events and 78% of indemnity

LOCATION – OBSTETRICS

Predictably, the labor and delivery unit accounted for 76% of events and 81% of indemnity while the physician office accounted for 13% of events and 13% of indemnity. The emergency department is a distant third with 4% of events and 1% of indemnity.

The labor and delivery unit accounted for 76% of events and 81% of indemnity

TOP RISK MANAGEMENT ISSUES – OBSTETRICS



Clinical Judgment

- **71%** Selection and management of therapy
- **12%** Patient monitoring
- **10%** Patient assessment/diagnosis of clinical condition

Technical Skill

- **60%** Unexpected delivery complications
- **17%** Flawed clinical judgment/ decision-making

Communication

- **65%** Communication among providers
- **25%** Communication between patient/family and providers
- **10%** Telephone/email/fax-related issues

N = 594 events closed with a risk management issue between 2010-2019 (events may have more than one risk issue).

EMERGENCY DEPARTMENT

Emergency departments (EDs) are often chaotic, stressful settings that test even the most resilient individuals and systems. It is incumbent on healthcare providers to understand the unique challenges of the ED and proactively design reliability into this care environment. We know the complexity here impacts teamwork, decision-making, task completion, and patient, provider, and family relationships.

ALLEGATION DETAIL – EMERGENCY DEPARTMENT

In the hospital ED, the top three allegations in terms of frequency of occurrence and severity are diagnosis-related, medical treatment, and medication-related. Diagnosis-related allegations account for 66% of indemnity paid. Combined medical treatment and medication-related allegations account for 26% of indemnity paid. Death and high-severity injury levels comprised 42% of events and 75% of total indemnity.

In the ED, diagnosis-related allegations are primarily focused on history and physical evaluation of the patient, ordering of tests, and interpretation of tests. The increasing presence of advanced practice providers in the ED may affect the rate of diagnosis-related claims. Medical treatment allegations include management of treatment, delay in treatment, and failure to treat. Medication-related allegations include ordering and administration of medications and wrong medications. Average indemnity payments for all ED events was $452,081. While most of these events involve emergency department physicians, other providers such as surgeons, radiologists, and general medicine physicians also get named on these events.

Top Five Allegations – Emergency Department

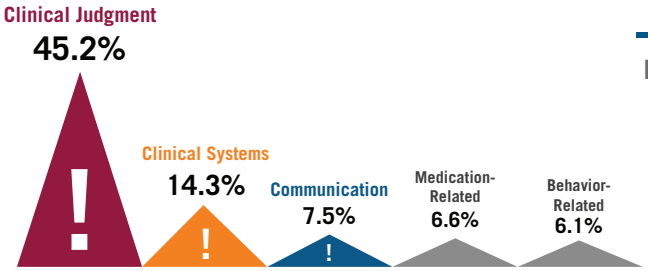
	Diagnosis-Related	Medical Treatment	Medication-Related	Surgery/ Procedure-Related	Patient Environment/ Safety
% of Events	52.7%	19.2%	10.3%	6.8%	2.8%
% of Indemnity	65.7%	14.8%	10.9%	3.1%	0.6%

N = 1,557 events closed between 2010-2019 involving care provided in the emergency department.

COVERYS

TOP RISK MANAGEMENT ISSUES – EMERGENCY DEPARTMENT

The top risk management issues relating to the ED are clinical judgment, clinical systems, and communication. Familiar themes—assessment, diagnosis, and communication—are again evident with emergency department events. There continues to be urgency in improving these elements in the fast-paced, high-pressure ED environment where there may be limited or no direct communication with the patient. A breakdown in clinical systems related to boarding issues, production pressures, and health information technology barriers interject weakness into ED care delivery.



Familiar themes—assessment, diagnosis, and communication—are again evident with emergency department events.

Clinical Judgment

- **57%** Patient assessment/diagnosis of clinical condition
- **20%** Selection and management of therapy
- **13%** Failure/delay in obtaining consult/referral

Clinical Systems

- **51%** Lack of/failure in system for patient care
- **22%** Failure/delay in reporting findings/revised findings
- **11%** Failure/delay in scheduling/performing recommended test

Communication

- **60%** Communication among providers
- **34%** Communication between patient/family and providers

N = 1,557 events closed with a risk management issue between 2010-2019 (events may have more than one risk issue).

COVERYS

SECTION V | Persistent Existing Risks

There is wide awareness of tenacious threats to healthcare and the tools and tactics in place to prevent them. Awareness, however, has not always translated into action. Fortunately, there is growing openness toward sharing stories, collecting data, and distributing knowledge to help address these threats. There is also continued interest from organizations and clinicians to examine their own claims data and adverse events to help reduce risk and improve patient care.

AWARENESS HAS NOT ALWAYS TRANSLATED INTO ACTION

This section highlights claims data related to key existing risks that exhibit flat trends or in some instances are slightly increasing. These include: communication, retained foreign bodies, and hospital-acquired infections.

COMMUNICATION

ALLEGATION DETAILS

The top three allegation categories for communication risk are diagnosis-related, surgery/procedure-related, and medication-related. Within diagnosis-related events, the most common are history/physical and assessment of the patient, test interpretation, and ordering diagnostic/lab tests for cancer, cardiac/vascular, and infection conditions. Performance is the most frequent and costly communication issue in surgery allegations, especially for orthopedic and general surgery. Monitoring/management, ordering, and administration of medication are issues in medication-related allegations.

Top Five Allegations – Communication

	Diagnosis-Related	Surgery/ Procedure-Related	Medication-Related	Medical Treatment	Obstetrics-Related
% of Events	27.7%	27.4%	11.2%	11.0%	6.2%
% of Indemnity	32.8%	22.8%	6.6%	11.1%	12.6%

N = 1,413 events closed between 2010-2019 involving communication.

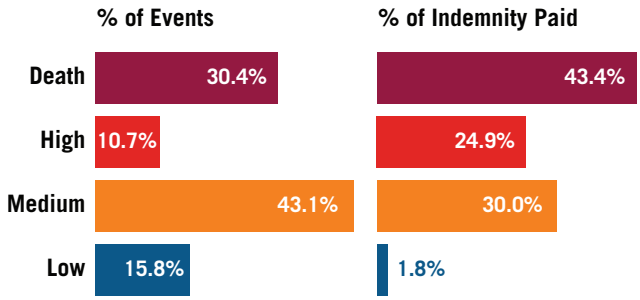
Within diagnosis-related events, the most common allegations are related to history/physical and assessment of the patient, test interpretation, and ordering diagnostic/lab tests for cancer, cardiac/vascular, and infection conditions.

COVERYS

INJURY SEVERITY – COMMUNICATION

Slightly more than 41% of events related to communication issues resulted in death or high injury severity.

41% of events resulted in death or high injury severity



N = 1,413 events closed between 2010-2019 involving communication.

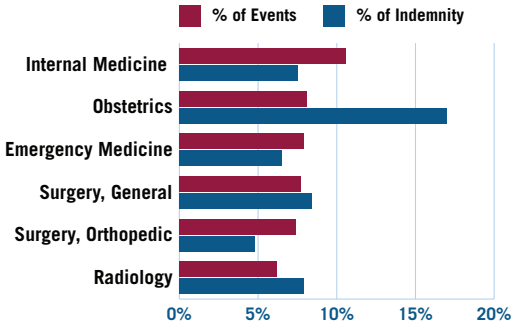
LOCATION – COMMUNICATION

28% of communication issues come from the physician office and **24%** from surgical settings

SPECIALTY – COMMUNICATION

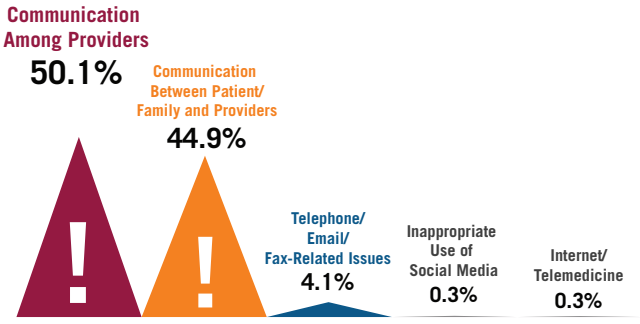
Communication risks among providers are seen in all treatment areas, although the most frequent are internal medicine and obstetrics. Emergency medicine and general surgery each account for 8% of events, and orthopedic surgery accounts for 7% of events.

Top Specialties Involved in Communication-Related Events



N = 1,413 events closed between 2010-2019 involving communication.

TOP RISK MANAGEMENT ISSUES – COMMUNICATION



Communication Among Providers

- **50%** Between physicians
- **27%** Between physician and RN
- **10%** Between physician and staff

Communication Between Patient/Family and Providers

- **44%** Inadequate informed consent for treatment options
- **38%** Communication between physician and patient (e.g., co-morbidity status, timeliness of surgical scheduling)
- **14%** Inadequate patient/family education

N = 1,061 events closed with a risk management issue between 2010-2019 (events may have more than one risk issue).

Much effort has been put into the design and implementation of standardized communication tools and handoff protocols over the past 10 years. However, the trends we are seeing indicate more work is needed in this area.

An area of communication emphasis over the last 20-30 years has been to enhance the informed consent process. New approaches include features in electronic health records, online learning, and increased patient engagement. Despite these efforts, consent-related issues are still prevalent and have continued to increase in the past 10 years.

COVERYS

RETAINED FOREIGN BODIES

Retained foreign bodies include sponges, needles, and equipment. The overall volume of retained foreign body events is low (228 events from 2010-2019), but average paid indemnity is increasing. Technology has been developed to help reduce this risk, but even this number of claims and suits begs the question of widespread adoption. Rigid adherence to counting, the use of X-rays, bar code technology, and small teams of surgical staff focused on preventing retained foreign bodies can help reduce this risk.

ALLEGATION DETAILS

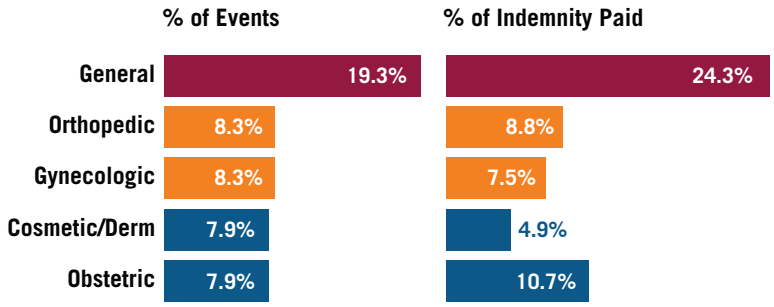
Most retained foreign body events and corresponding indemnity payments occur with surgery/procedure allegations. Some case-based examples include:

- **Instrument:** Retained surgical stapler. The disposable pieces of the stapler were not part of the instrument count. Hospital policy was changed due to this event.
- **Sponge:** Retained sponge. Although the instrument and sponge counts were indicated as correct, it was later discovered there was a miscount of sponges.
- **Hardware:** Guide wire inadvertently drilled and broke into the pelvis. Removal was deemed to potentially cause more damage than leaving in, so the hardware remained in place.
- **Uncounted surgical supplies:** Surgical towels left behind. These were not typically included in sponge, needle, or instrument counts.

INJURY SEVERITY – RETAINED FOREIGN BODIES

96% of retained foreign body events were medium to low severity

Top Five Surgery Types – Retained Foreign Body



N = 228 events closed between 2010-2019 involving a retained foreign body.

TOP RISK MANAGEMENT ISSUES – RETAINED FOREIGN BODIES

25% were administrative issues related to policies and procedure

21% were related to clinical judgment

12% were related to communication issues

RETAINED FOREIGN BODIES RISK RECOMMENDATIONS:

- **Identify procedures and patients** with a high potential for retained foreign bodies (FBs), for example: obese patients undergoing extensive abdominal surgery.
- **Define the responsibilities of the individual** tasked with tracking FBs to include tracking of sponges, towels, sharps, and equipment used during procedures. Assign these tasks to a specific individual on the team.
- **Limit distractions in the operating room** by prohibiting cellphones, music, visitors, and limiting conversations to those required during the procedure.
- **Implement assistive technology** to identify soft products such as sponges, packing, and towels.

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HOSPITAL-ACQUIRED INFECTIONS

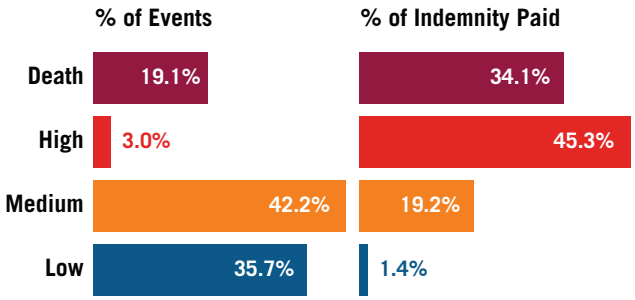
The number of hospital-acquired infection events, including methicillin-resistant staphylococcus aureus (MRSA), Clostridium difficile (c.diff), sepsis, etc., is low but rising slowly. Diagnosis-related allegations account for 80% of indemnity paid for hospital-acquired infections.

Diagnosis-related allegations account for 80% of indemnity paid for hospital-acquired infections

INJURY SEVERITY – HOSPITAL

While only 3% of events resulted in high-severity injury outcomes, the payouts on those cases were significant.

Injury Severity – Hospital-Acquired Infections



N = 234 events closed between 2010-2019 involving a hospital-acquired infection.

Hospital-Acquired Infections – Top Five Locations

Surgery

43.1% of Events | 2.8% of Indemnity

Physician Office

20.0% of Events | 25.2% of Indemnity

Emergency Room

15.0% of Events | 62.1% of Indemnity

Patient Room

13.1% of Events | 2.0% of Indemnity

Long Term/Extended Care

8.8% of Events | 7.9% of Indemnity

N = 234 events closed between 2010-2019 involving a hospital-acquired infection.

LOCATION – HOSPITAL

A low percentage of hospital-acquired infection events occur in the ED, but the associated indemnity is high. Conversely, a high percentage of events occur in the surgical setting, but indemnity paid is low.

COVERYS

SECTION VI | Emerging Risks

Malpractice data looks to the past and provides us with rich signals as to where patient care and provider exposure to claims remain vulnerable in today's healthcare settings. Areas of concern can be quickly prioritized if data shows issues that led to preventable adverse outcomes still exist. But concurrently, we must always keep our eye on emerging risks. Problem areas we see surfacing are related to new technology, novel procedures, and current events that are developing at a rapid pace. This section highlights emerging risks such as the growing use of urgent care and minute clinics, the ever-present electronic health record (EHR), and robotics.

WE MUST ALWAYS KEEP OUR EYE ON EMERGING RISKS

URGENT CARE

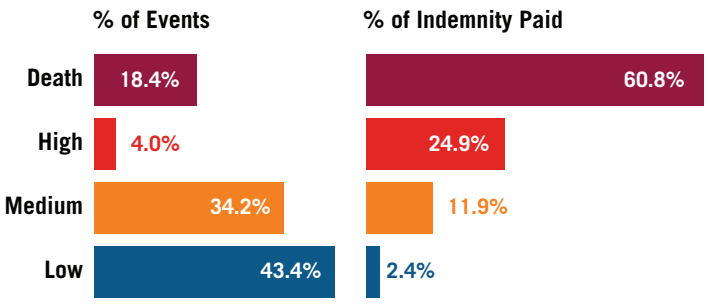
For the period covered in this report, urgent care or express care events are relatively new, comprising just 1% of closed event data and 1% of indemnity. Event counts and average indemnity paid are rising and are expected to grow over the next 10 years as the numbers of urgent care facilities expand.

ALLEGATION DETAIL

The most frequent and costly allegation for events occurring in an urgent care setting are diagnosis-related. Average indemnity for events in urgent care settings is rising, with large fluctuation from year to year.

INJURY SEVERITY – URGENT CARE

Most injuries are low or medium severity, but the combination of death and high-injury severity events accounts for 22% of events and is responsible for 86% of indemnity.



The combination of death and high-injury severity events accounts for **22%** of events and **86%** of indemnity

N = 76 events closed between 2010-2019 involving care provided in an urgent care setting.

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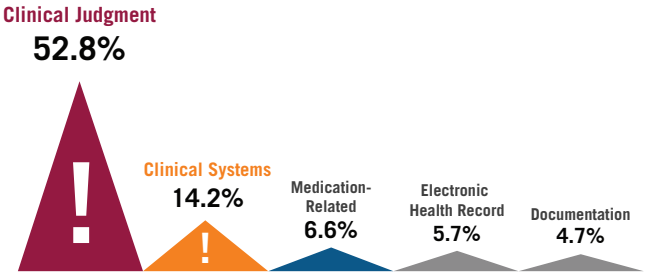
TOP RISK MANAGEMENT ISSUES – URGENT CARE

Issues related to patient assessment and diagnosis accounted for 77% of clinical judgment risks. Following are three examples:

- Patient seen in urgent care with flu-like symptoms and chest, jaw, and arm pain was tested and treated for influenza, discharged home, and died from a heart attack the next day. The physician assistant who treated the patient focused on diagnosing influenza and failed to consider patient history, risk factors, and a possible cardiac source of pain for this patient.
- Patient seen in urgent care by family practitioner and examined for chest congestion, shortness of breath, and fatigue. The physician listened to the patient's lungs, diagnosed pneumonia, and prescribed Albuterol and antibiotics prior to discharge. The physician did not consider the patient's recent foot surgery, her history of obesity, lack of mobility, and oral birth control history. The patient died a few days later from pulmonary embolism.
- Patient who had fallen presented to urgent care with complaints of wrist pain and swelling. At the time, the physician advised ice, rest, elevation, and nonsteroidal anti-inflammatory drugs. No imaging was performed. A month later, X-rays revealed an acute fracture of the distal radius with recommendations for surgery.



Clinical Judgment

77% Patient assessment/diagnosis of clinical condition

13% Selection and management of therapy

Clinical Systems

60% Lack of/failure in system for patient care

20% Failure/delay in scheduling/performing recommended test

N = 76 events closed with a risk management issue between 2010-2019 (events may have more than one risk issue).

ELECTRONIC HEALTH RECORDS

Diagnostic-related allegations comprise both the highest percentage of events as well as the highest indemnity payments in electronic health record-related (EHR) events. Total indemnity payout for diagnosis-related EHR events is $11 million more than for medication-related EHR events, which is the second-most financially severe allegation category.

Diagnostic-related allegations comprise both the highest percentage of EHR events as well as the highest indemnity payments

ALLEGATION DETAILS – EHR

	Diagnosis-Related	Medication-Related	Surgery/ Procedure-Related	Medical Treatment	Obstetrics-Related
% of Events	30.9%	21.4%	17.1%	10.0%	5.1%
% of Indemnity	33.7%	20.2%	11.5%	11.2%	8.5%

N = 350 events closed between 2010-2019 involving EHRs.

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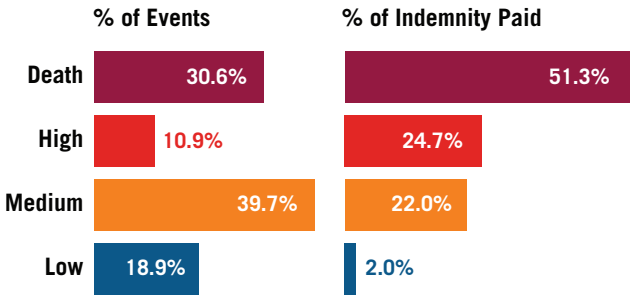
INJURY SEVERITY – EHR

The majority of EHR events were tied to medium-to-low severity injuries (59%). However, over half of the total indemnity dollars paid out on EHR events were attributed to events that resulted in death.



N = 350 events closed between 2010-2019 involving EHRs.

51%

of indemnity paid on EHR events were attributed to events that resulted in death

RISK MANAGEMENT – EHR

In theory, EHRs provide better data as well as a centralized capture of everything relevant to a patient's clinical profile. However, serious issues are evident. Users may be looking at the wrong dropdown, the wrong screen, the information might not have been updated, or the documentation was done on the wrong patient.

Documentation is the most common risk management subcategory for EHRs, making up 72% of all EHR-related risk issues. In practice, patient assessment questions do not necessarily follow the EHR interface prompts so some information may be missed. Other prevalent risk areas include system issues such as confusing system design and incorrect patient information due to a system conversion and general EHR usability. HIPAA security issues made up approximately 2% of all EHR-related risk management factors.

Documentation is by far the most common risk management subcategory, making up

72% of all EHR-related risk issues

TELEHEALTH

The COVID-19 pandemic has demonstrated the potential and importance of telehealth. The ability to conduct remote conversations and some level of examinations is critical during a crisis of this nature. We anticipate telehealth will grow exponentially. As the shift to telehealth continues, risk issues that may come to the surface include overreliance on technology, failure to appropriately document care, diagnosing clinical conditions without an in-person encounter, and lack of a traditional clinical evaluation.

ROBOTICS

Since 2011, we have recorded 58 robotics-related events with 36% resulting in indemnity payments. The average payment was approximately $230,000. Surgery/procedure-related allegations were by far the most common, with over $3 million in total indemnity payouts.

Of all robotics events, 84% are surgery/procedure-related allegations, specifically performance-related allegations (making up 52% of all allegations on robotics events). Seventeen percent of allegations on robotics events cited retained foreign bodies. Urological was the most common area of surgery followed by gastrointestinal. Urological and neurological procedures together made up 71% of all indemnity paid out for robotics events that involved surgical procedures. Technical skill risk issues make up 33% of all risk issues tied to robotics events and is the most common risk category.

Sixty-nine percent of all robotics-related events resulted in medium-severity injuries and contributed to almost half of all indemnity payments.

69% of

of robotics-related events resulted in medium-severity injuries

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ADVANCED PRACTICE PROVIDERS

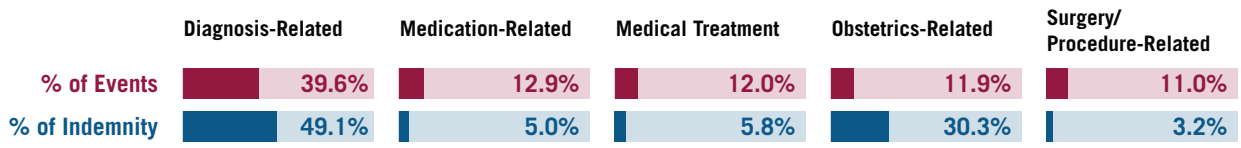
With the decreasing number of physicians, advanced practice providers (APPs) are assuming an increasingly central role in patient care which opens the door to increased opportunities for success and failure. APPs include nurse practitioners, physician assistants, certified nurse midwives, and certified registered nurse anesthetists.

From 2010-2019, there are relatively few events involving APPs, but the count is rising. That trend is expected to continue as the population of APPs grows. An examination of claims involving 690 of these providers gives us some insights into issues relevant to APPs.

ALLEGATIONS – APPs

Allegations are strongly diagnosis-related, specifically involving patient assessment and ordering of diagnostic or lab tests. Issues related to the patient assessment process are persistent across a range of APPs.

Top Five Allegations – APPs

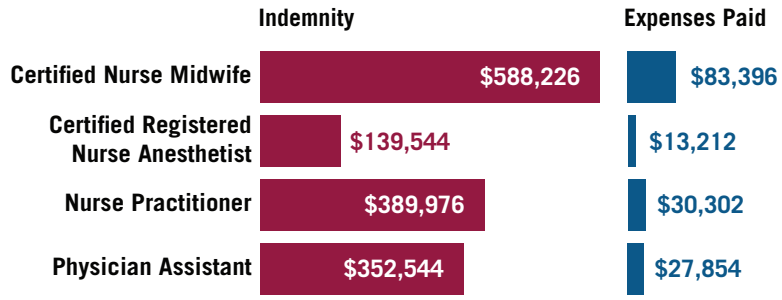


N = 690 claims closed between 2010-2019 that involved an advanced practice provider.

INDEMNITY & EXPENSES – APPs

Average indemnity paid for APP events was $440,116. Expenses are progressing upward and averaged $39,260. Rate of claims with indemnity paid was 25%.

Average Indemnity & Expenses Paid – APPs



N = 690 claims closed between 2010-2019 that involved an advanced practice provider.

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SECTION VII | No Time To Relax

Over the past two decades, there has been palpable effort and consensus on the need to reduce risk and improve patient care. Much of that work has been highly publicized and has held great promise; yet our malpractice data does not reveal collective success. Pressure is mounting to achieve improvement: financial, relational, and reputational. Expectations for change are high. In the midst of significant and complex issues that compete for your attention, it is vitally important not to relax your efforts to provide safe, high-quality care.

PRESSURE IS MOUNTING TO ACHIEVE IMPROVEMENT

The past 10 years have been challenging for an already overextended healthcare workforce. Rising litigation costs, higher severity claims, and more stringent reimbursement mandates put pressure on the bottom line. Continued challenges and crises (such as the COVID-19 pandemic, opioid epidemic, and natural disasters) in combination with less-than-optimal interoperability and design of health information systems, physician burnout, and loss of patient trust, have put front-line clinicians and staff under tremendous pressure. It is critical to engage beyond the day to day. A focus on the signals that actionable data provides can help develop and maintain initiatives and implement them in a way that can yield sustained results.

Our data suggests there are not significant overarching wins and improvements over the past 10 years. We see persistent risks that challenge safe, high-quality care on the frontline: challenges in communication, physical/history and assessment, and clinical judgment. If these issues are not addressed, patients will experience avoidable readmissions, clinicians will be sued, and providers will not get paid.

The good news is that influences in the broad expanse of healthcare are driving improvement. Good things are going on. What can be done to draw from that external energy to motivate change? Here's what healthcare leaders can do now:

- Make sure your staff know that their leaders are on board.
- Take advantage of tools that are available to generate, package, and learn from data—and use them to motivate action.
- Be alert to data signals that will inform the application of best practices to improve care.

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Questions to help HEALTHCARE EXECUTIVES innovate, design, and implement action toward improvement:	Questions for CLINICAL LEADERSHIP to motivate action toward improvement:
• How are you resourcing your organization to learn from failure? • How do you ensure learning happens and is applied widely from the board room to the frontline? • How are you partnering within your organization and the broader healthcare community to empower in-house leaders to achieve improvements? • How are you engaging decision-makers to commit to sustained improvement? • How do you demonstrate your responsibility and accountability to engage with front-line staff and patients if the momentum for improvement initiatives is lagging? • How are you tracking constant, emerging, and future operational, cultural, and clinical risks to prepare for them? • How are you ensuring the transparency needed to drive learning and improvement?	• Are existing tools to address ongoing challenges (such as use of surgical safety checklists or team training) fully embedded in our processes and culture? • What are the most frequent and highest-severity events impacting our patients? • Are there seemingly invisible issues contributing to poor patient outcomes? • What successful processes are already in place that we can leverage to improve patient outcomes?

IT CAN BE DONE: A SUCCESS STORY

The risk management leadership at a multi-hospital network asked Coverys to help them understand their organization's risk signals. Coverys worked with them on an analytics initiative to examine their malpractice data, identify causation factors driving historical claims, and identify relevant benchmarks.

When results were shared with senior leadership, the response was powerful. While the organization had systems in place to track patient safety events, the Coverys final analysis report provided insights formerly unavailable to the organization's decision-makers. The report identified root-cause drivers of clinical events, as well as a comparison of their experience against similar organizations. This motivated the leadership team to seek an understanding of how the historical data aligned with current clinical practice, which then led to a collaborative exchange of ideas that generated improvement actions.

The outcome of the engagement included several key next steps.

- Surgical and emergency department claims themes were provided to existing network-wide steering committees that were positioned to integrate the findings into their agenda. Current risks, specifically outlined by the Coverys report, were designed into the existing assessment tools and prioritized for action.
- Current systems expansions were outlined to enable clinical leadership to rapidly focus on high-severity events. Once implemented, these system changes will enable the healthcare system to better understand serious events at a deeper level.
- Risk education plans were designed through learnings generated by the report and are now available to all providers in the network.

As a result of the initiative, the health network's clinical leadership strengthened its ability to drive change across their organization while also offering individual providers opportunities to improve patient safety within their practice.

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CHANGE IS IN OUR REACH

The success story outlined above shows how today's healthcare providers can effectively identify and address risks specific to their organization. Malpractice is a lagging indicator of true improvement, and it may not always accurately depict where improvement has been made and where vulnerabilities continue to exist. Yet, to ignore the signals that it provides increases the odds that serious problems may recur. This data gives us unique perspectives into where vulnerabilities exist and provides sharp focus on where proactive, preventive steps can be taken to prevent adverse outcomes.

It is incumbent on us all to embrace data to meet the challenges of the next decade.

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