

Family Medicine

Claims Data Snapshot

2023



This publication provides an analysis of aggregated data from clinically coded cases opened between 2012-2021 in which Family Medicine is identified as the primary responsible service.

Keep in mind...

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

Our data system, and analysis, rolls all claims/suits related to an individual patient event into one case for coding purposes. Therefore, a case may be made up of one or more individual claims/suits and multiple defendant types such as hospital, physician, and other healthcare professionals.

Cases that involve attorney representations at depositions, State Board actions, and general liability cases are not included.

This analysis is designed to provide insured doctors, healthcare professionals, hospitals, health systems, and associated risk management staff with detailed case data to assist them in purposefully focusing their risk management and patient safety efforts.

Key Points - Clinically Coded Data

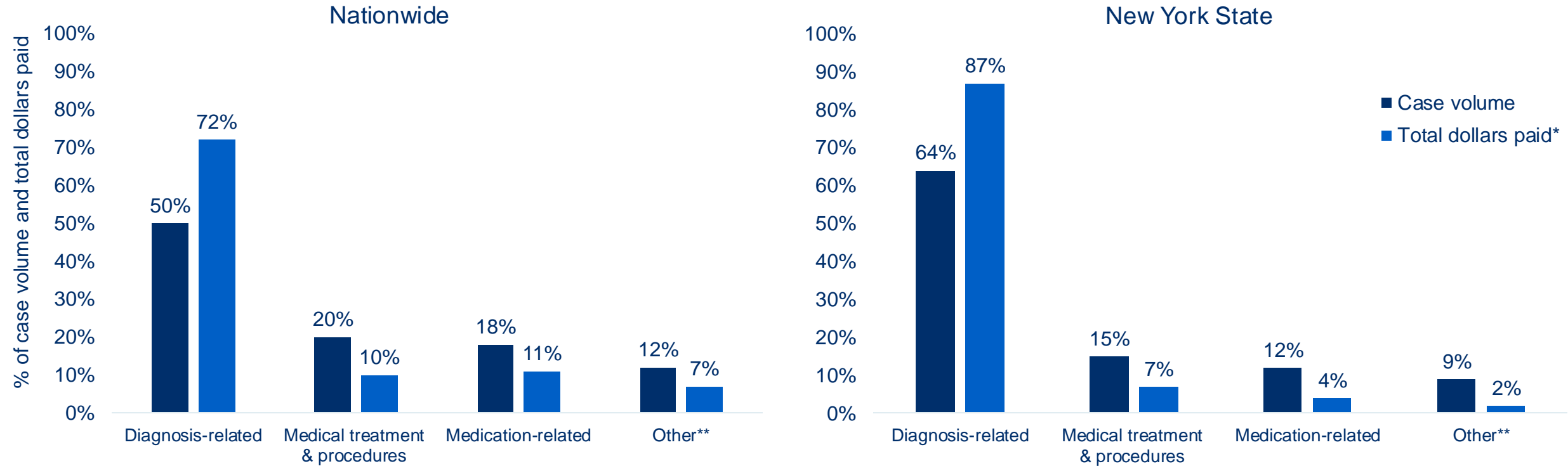
INTRODUCTION | **KEY POINTS** | GENERAL DATA ANALYSIS | CONTRIBUTING FACTORS | FOCUSED DATA ANALYSIS | CASE EXAMPLES | RISK MITIGATION

- **Throughout this analysis, nationwide Family Medicine case volume is reflected, with targeted focus on several New York State-specific data points.**
- **Diagnosis-related allegations** account for half of family medicine case volume and almost three-fourths of total dollars paid*. These most commonly reflect missed/delayed diagnoses of cancers and circulatory system diseases. **These cases commonly reflect breaks in the diagnostic process of care**, most often including inadequate assessment and evaluation of patient symptoms, a narrow diagnostic focus, delays or failures in ordering diagnostic testing, delays in obtaining consults or referrals, and sub-optimal communication among providers on the patient's care team.
- **Medical treatment allegations, which account for 20% of case volume**, are primarily related to issues with selection of the most appropriate treatment regimen for the patient, and appreciating and reconciling symptoms and test results.
- **Monitoring and managing patients' medication regimens account for three-fourths of all medication-related allegations.** Selection of the most appropriate medication for the patient's condition is a noted risk issue in narcotic cases, along with patient non-adherence to prescriptions. Issues with inadequate patient/family education about medication regimens is an often-noted factor across all medication types.
- **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, including inadequate assessments, are most common amongst cases with high clinical severity outcomes. Cases noting sub-optimal communication among members of the care team are among the most expensive to resolve.

Major Allegations & Financial Severity

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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.



MLMIC + MedPro Group cases opened 2012-2021, Family Medicine as responsible service; Nationwide N=1194, New York State N=186; *Total dollars paid = expense + indemnity; **Other includes allegations for which no significant case volume exists

Clinical Severity*

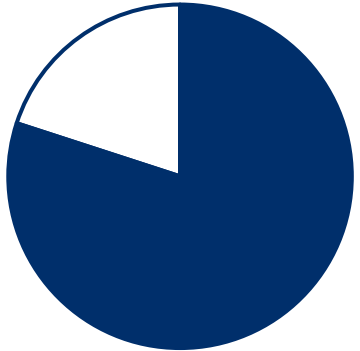
Clinical Severity Categories	Sub-categories	% of Nationwide case volume	% of New York State case volume
LOW	Emotional Injury Only	9%	6%
	Temporary Insignificant Injury		
MEDIUM	Temporary Minor Injury	27%	31%
	Temporary Major Injury		
	Permanent Minor Injury		
HIGH	Significant Permanent Injury	64%	63%
	Major Permanent Injury		
	Grave Injury		
	Death		

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

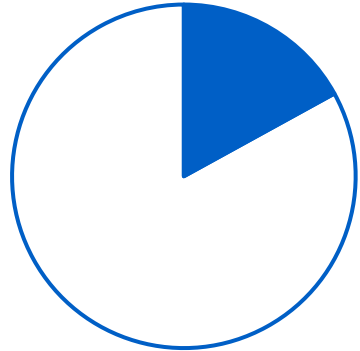
MLMIC + MedPro Group cases opened 2012-2021, Family Medicine as responsible service; Nationwide N=1194, New York State N=186; *Severity codes reflect National Association of Insurance Commissioners (NAIC) injury severity scale

Claimant Type & Location

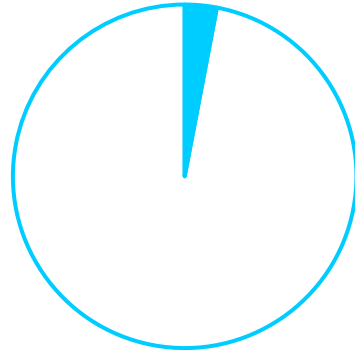
Nationwide



Ambulatory
80%



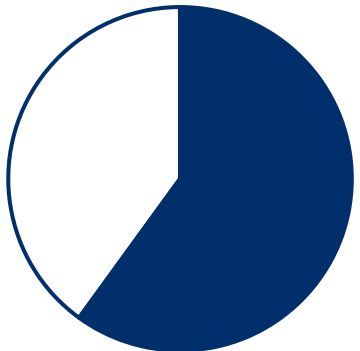
Inpatient
17%



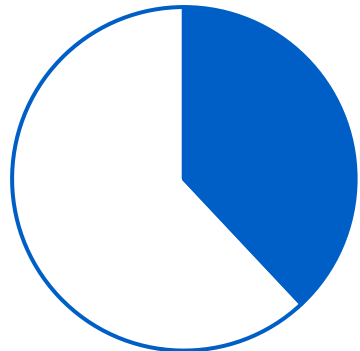
Emergency
3%

Top locations	% of case volume
Office/clinic	75%
Patient room (includes ICU & extended care/skilled nursing)	13%
Emergency	2%
Labor & delivery	2%

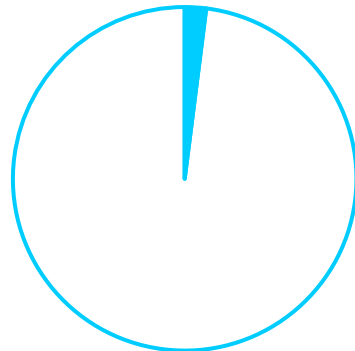
New York State



Ambulatory
60%



Inpatient
38%



Emergency
2%

Top locations	% of case volume
Office/clinic	74%
Patient room (includes ICU & extended care/skilled nursing)	13%
Emergency/Urgent Care	7%
Labor & delivery	1%

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.”

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



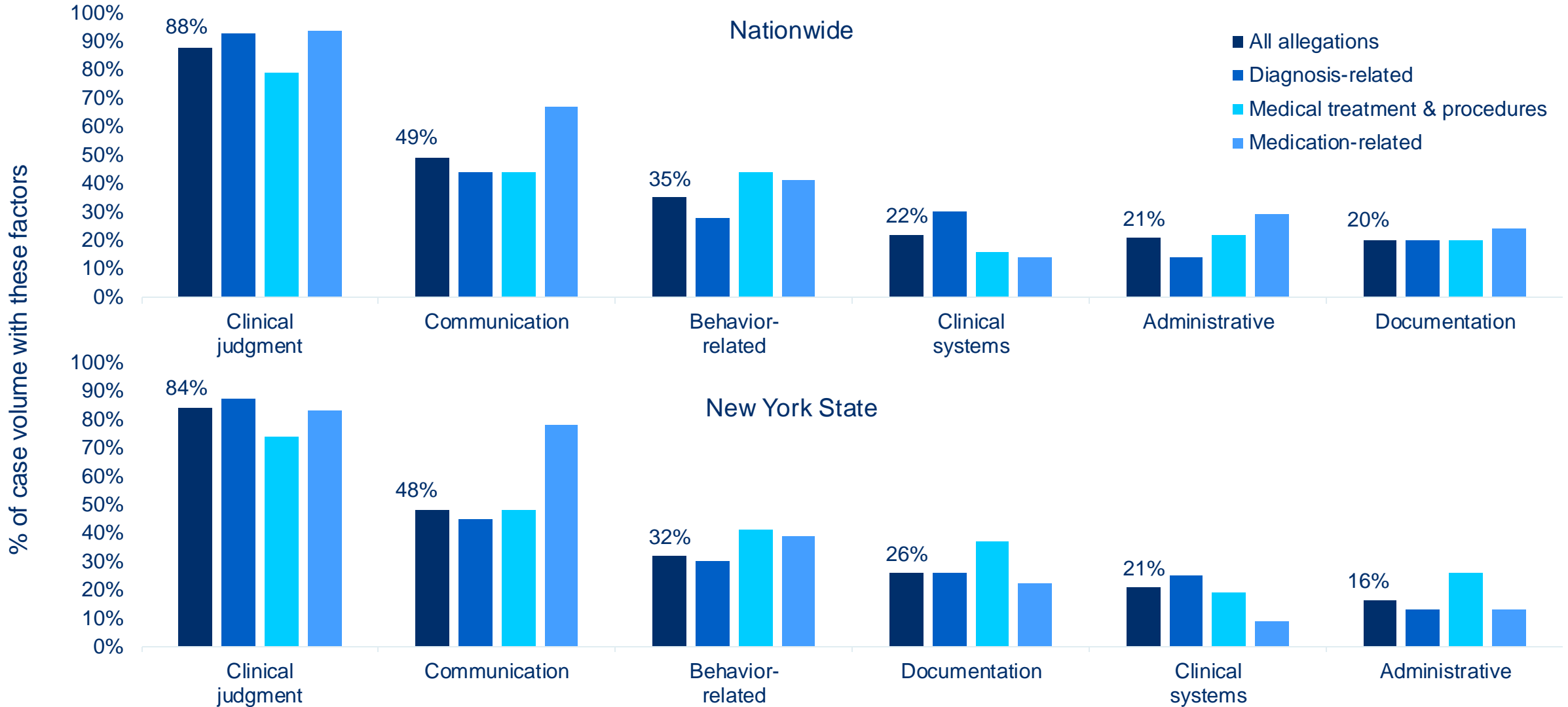
Technical skill

Contributing Factor Category Definitions

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

Administrative	Factors related to medical records (other than documentation), reporting, staff education and training, ethics, policy/protocols
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, diagnostic decision making, 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

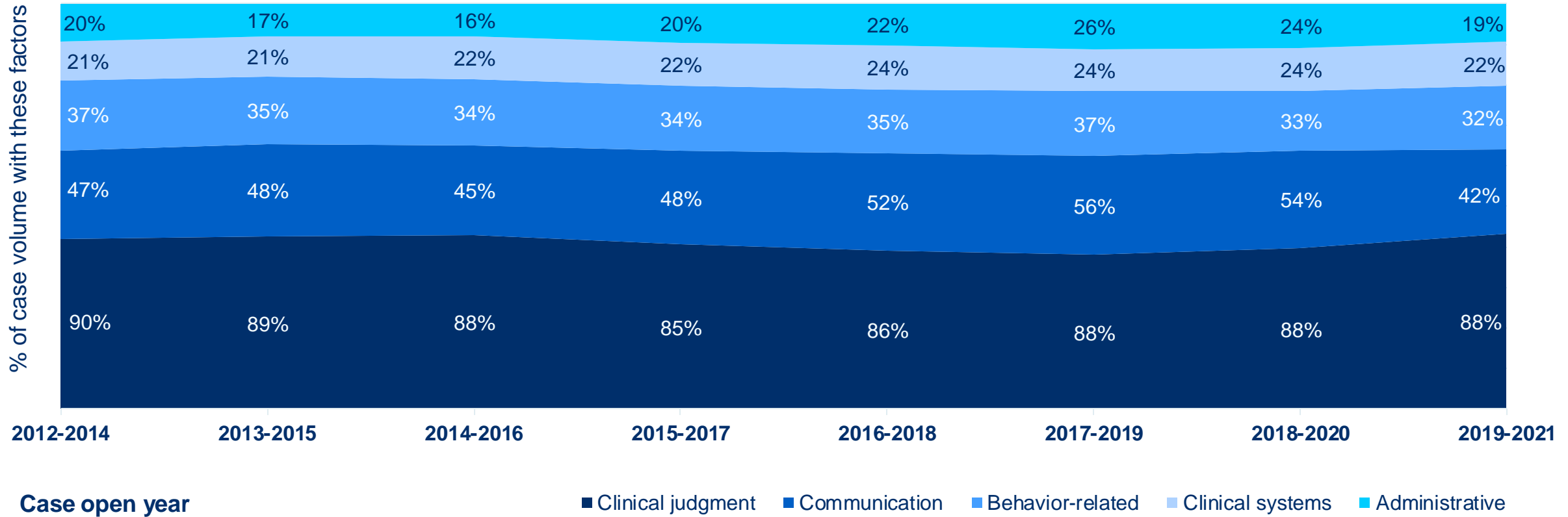
Most Common Contributing Factor Categories by Allegation



MLMIC + MedPro Group cases opened 2012-2021, Family Medicine as responsible service; Nationwide N=1194, New York State N=186; More than one factor per case, therefore totals >100%

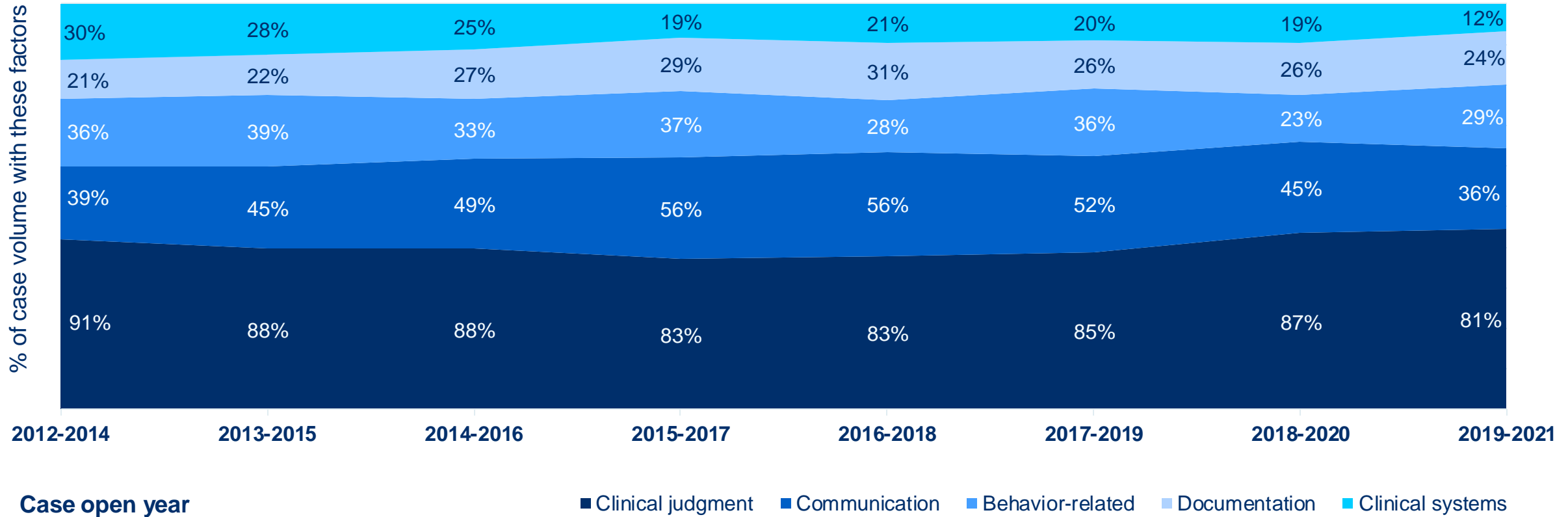
Nationwide: Distribution of Top Five Factor Categories Over Time

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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.

New York State: 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.

Over time in New York, we see a slight decrease in cases noting clinical judgment and behavior related issues, and a larger increase in cases noting clinical systems issues.*

MLMIC + MedPro Group cases opened 2012-2021, Family Medicine as responsible service; Nationwide N=1194, New York State N=186; More than one factor per case, therefore totals >100%; *Overall case volume is low in 2019-2021, therefore impacting volume of contributing factors

Nationwide: Focus on Most Common Drivers of Clinical & Financial Severity

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

Factors associated with high clinical severity outcomes	(CJ) failure to appreciate/reconcile signs/symptoms/test results (44%)	% of high severity case volume
	(CJ) failure/delay in obtaining consult/referral (41%)	
	(CJ) failure/delay in ordering diagnostic test (40%)	
	(CJ) failure to establish differential diagnosis (27%)	
	(CO) suboptimal communication among providers about patient condition (20%)	
Factors associated with the costliest indemnity payments	(CJ) failure/delay in ordering diagnostic test (30%)	% more expensive than the average indemnity payment*
	(CO) suboptimal communication among providers about patient condition (24%)	
	(CJ) lack of/inadequate assessment/history & physical (21%)	
	(CJ) failure to appreciate/reconcile signs/symptoms/test results (15%)	
	(CO) suboptimal communication among providers – failure to read record (12%)	

Clinical judgment and communication factors, specifically inadequate patient assessment processes, a narrow diagnostic focus, and team communication failures, are key drivers of both clinical and financial Family Medicine case severity.

New York State: Focus on Most Common Drivers of Clinical & Financial Severity

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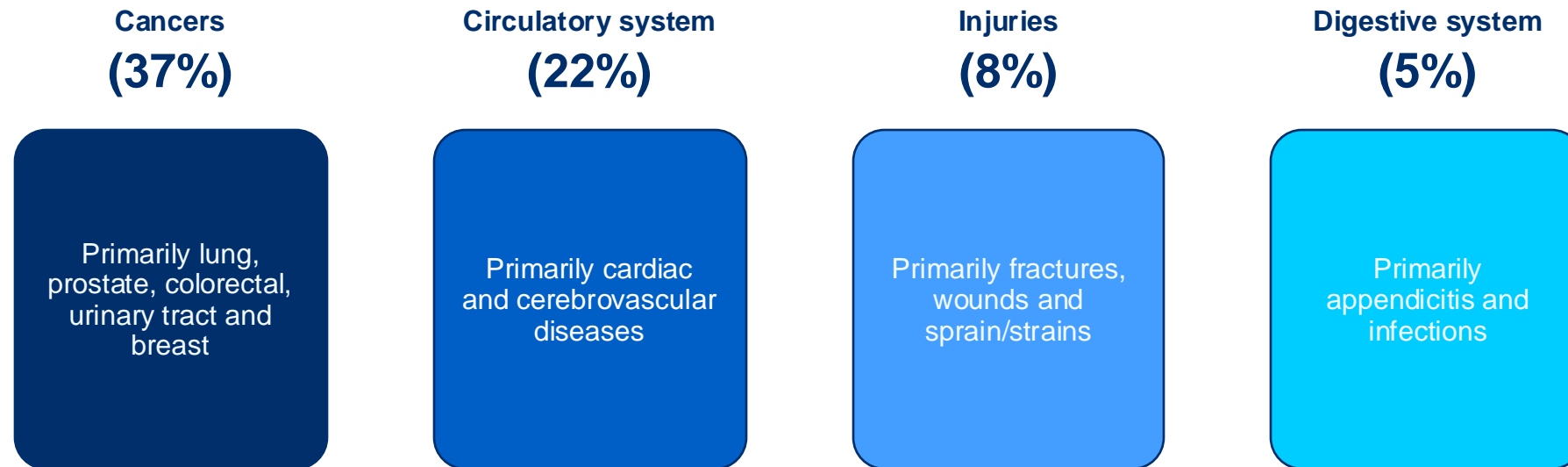
Factors associated with high clinical severity outcomes	(CJ) failure/delay in ordering diagnostic test (46%)	% of high severity case volume
	(CJ) failure to appreciate/reconcile signs/symptoms/test results (44%)	
	(CJ) failure/delay in obtaining consult/referral (29%)	
	(CJ) failure to establish differential diagnosis (24%)	
	(CJ) lack of/inadequate assessment/history & physical (21%)	
Factors associated with the costliest indemnity payments	(CJ) failure/delay in ordering diagnostic test (25%)	% more expensive than the average indemnity payment*
	(CJ) failure to appreciate/reconcile signs/symptoms/test results (12%)	
	(CJ) failure to establish differential diagnosis (7%)	

Clinical judgment factors, specifically inadequate patient assessment processes, a narrow diagnostic focus, and delays in ordering consults/referrals, are key drivers of both clinical and financial Family Medicine New York case severity, similar to the nationwide drivers.

Nationwide: Focus on Diagnosis-Related Allegations

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



Nationwide: Focus on Diagnosis-Related Allegations

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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 86% of cases	Patient notes problem & seeks care
	History & physical
	Patient assessed, symptoms evaluated
	Differential diagnosis established
	Diagnostic testing ordered

Phase 2

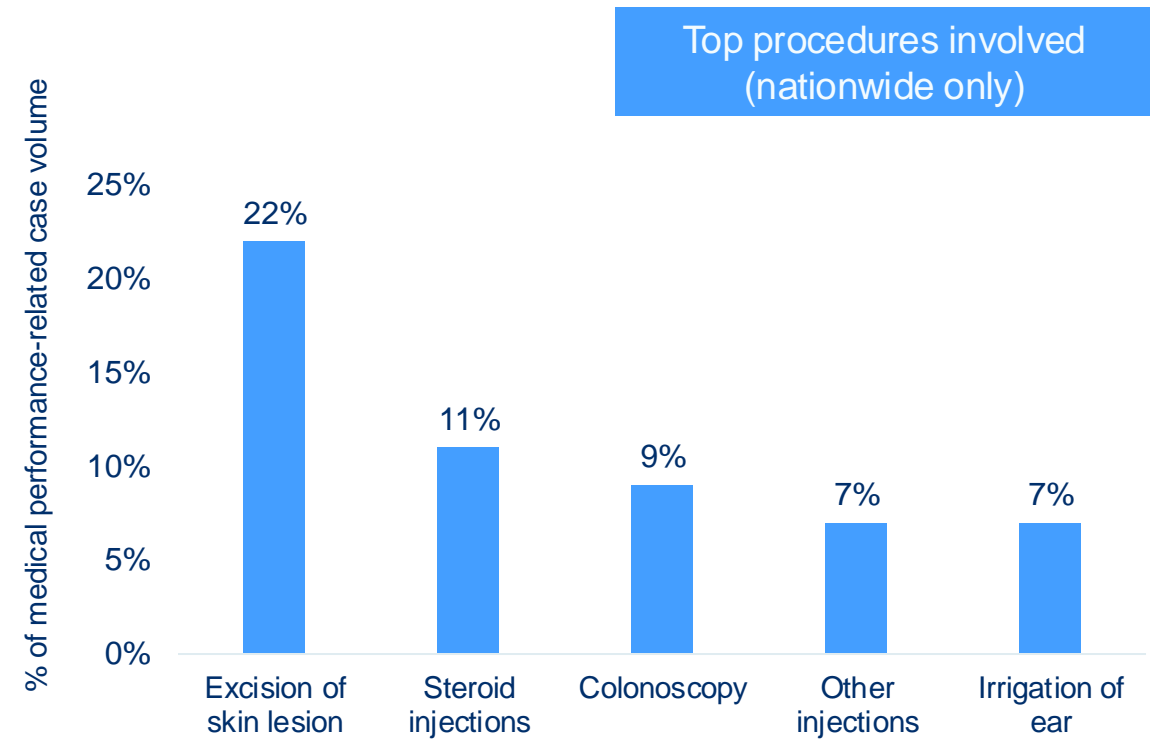
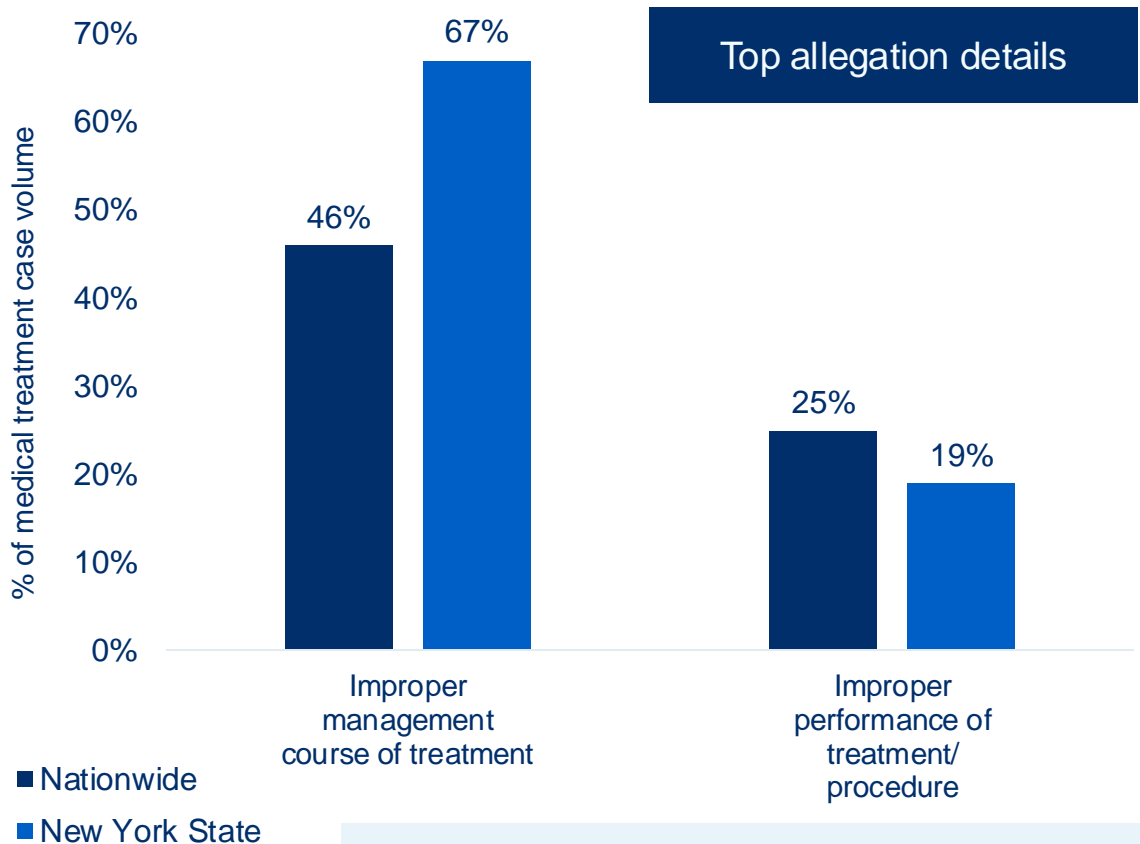
Testing and results processing 19% of cases	Performance of diagnostic tests
	Interpretation of diagnostic test results
	Test results transmitted to/received by ordering provider

Phase 3

Follow-up and coordination 75% of cases	Physician follows-up with patient
	Referrals/Consults
	Patient information communicated among care team
	Patient compliance with follow-up plan

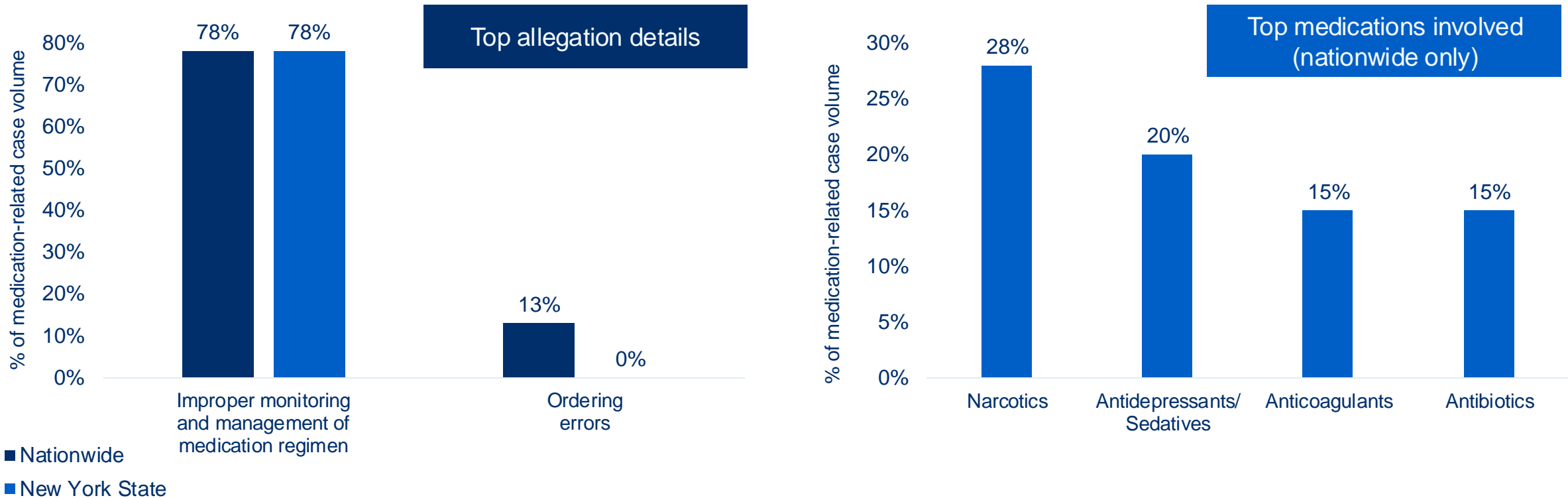
MLMIC + MedPro Group cases opened 2012-2021, Family Medicine as responsible service; Nationwide N=1194, New York State N=186; *each step reflects a combination of contributing factors; diagnostic process of care algorithm courtesy of Candello, a division of CRICO Strategies

Focus on Medical Treatment Allegations



For both nationwide and New York State, procedural performance cases can be impacted by delayed recognition of complications, while 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.

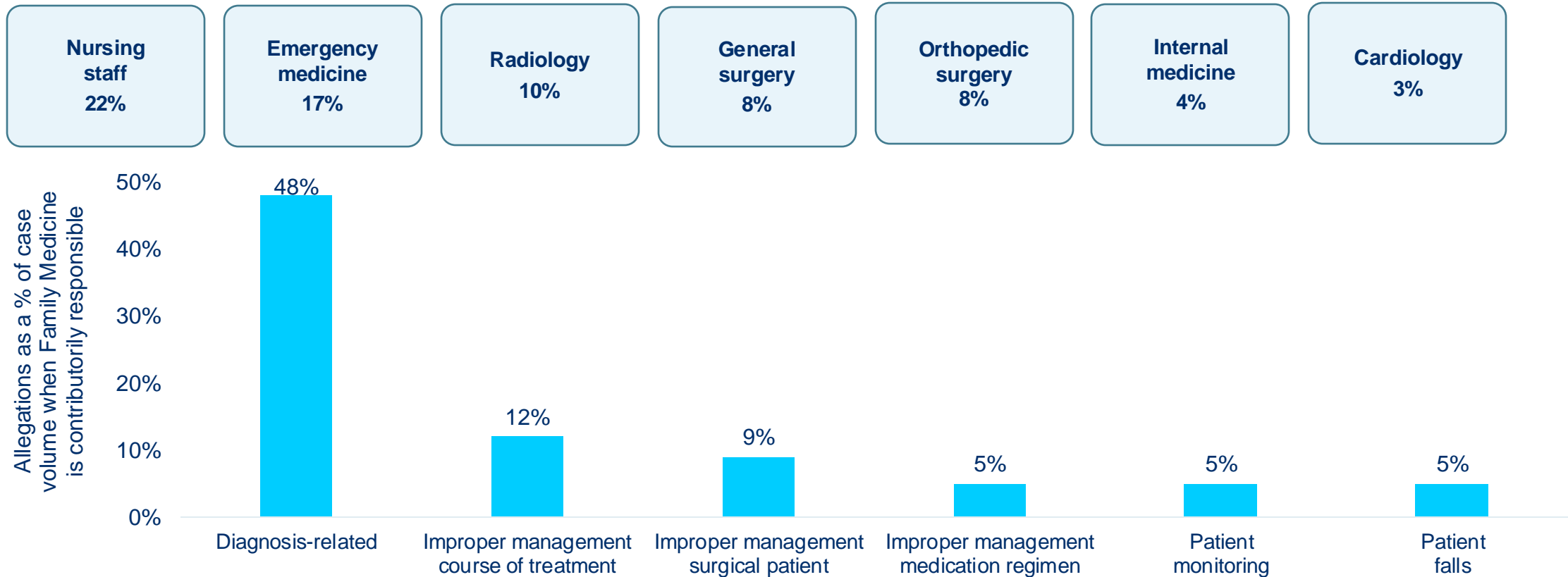
Focus on Medication-Related Allegations



For both nationwide and New York State, Selection of the most appropriate medication for the patient’s condition is a noted risk issue in narcotic cases, along with patient non-adherence to prescriptions. Issues with inadequate patient/family education about medication regimens is an often-noted factor across all medication types. Anticoagulant cases reflect a few instances of failures to restart/reorder and failures to identify which provider is coordinating anticoagulant regimens following a period of holding the medication (i.e. for surgery).

Nationwide: Contributorily Responsible

Although this analysis is focused on cases reflecting Family Medicine as the primarily responsible service, another 556 cases identify Family Medicine as contributorily responsible. The primary services in these cases are varied, reflecting the myriad of providers who care for patients along the healthcare continuum. The most common primary services, and a comparison of top allegation categories, are shown below.





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

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

Case Examples

SETTLED

\$1.5M

CONTRIBUTING FACTORS

Clinical judgment

Narrow diagnostic focus, including failure to appreciate/reconcile signs/symptoms/test results; failure/delay in ordering diagnostic testing; failure to obtain consult/referral; and relying on previous provider's diagnosis

FAILURE TO DIAGNOSE BLADDER CANCER RESULTING IN DEATH

A 51 year-old female with a history of frequent urinary tract infections (UTI), pyelonephritis, hypertension, hyperlipidemia and asthma presented to her long-time family medicine physician for a routine office visit. **She was found to have elevated creatinine levels, and renal insufficiency was diagnosed.** An ultrasound of her kidneys and a renal function panel were both within normal limits.

At a follow-up office visit one month later, she complained of discomfort with urination. A small amount of blood was noted in the urinalysis (UA); records are silent as to whether any treatment was provided. Three months later, she reported ongoing pain and burning with urination, along with frequent thirst. UA showed hematuria plus leukocytes and nitrates. She was treated for a UTI. A repeat UA one week later was better, but the urine cultures grew E. coli; antibiotics were continued. Seven months later she presented for an office visit. UA positive for leukocytes, and antibiotics were prescribed. Lab work revealed decreased renal function and a urine culture was again positive for E. coli. Two months later, patient was treated for “overactive bladder.” Eight months after that, she complained of urinary burning/frequency for two weeks and was treated with antibiotics.

She was not seen again for one year. At that time, **she was seen by the physician assistant, who noted the patient had a two month history of hematuria, frequent urination, foul smelling urine, lower back/pelvic pain, and passing golf ball sized blood clots when urinating. Antibiotics and analgesics were prescribed.** One month later, she reported the same symptoms to a second physician assistant and was again treated for a UTI.

She requested referral to a urologist. Subsequent CT and MRI results showed a **urinary bladder mass (squamous cell carcinoma) measuring 7.0 x 4.4 x 7.8 cm.** She underwent cystoscopy and tumor resection, but mass was unable to be completely resected due to size. Patient quickly developed metastatic disease and died three months later.

Case Examples

SETTLED

\$387,500

CONTRIBUTING FACTORS

Clinical judgment

Inadequate assessment related to history & physical; failure to order medication; selection of invasive procedure (despite incomplete pre-op clearance form); and failure/delay in obtaining consult/referral

Communication

Suboptimal communication among providers

Failure to establish clear lines of responsibility

Documentation

Insufficient related to clinical rationale, and incomplete pre-op form

IMPROPER MONITORING AND MANAGEMENT OF ANTICOAGULANT REGIMEN RESULTING IN STROKE

A 76 year-old male patient with a history of recently diagnosed Parkinson's disease, **chronic atrial fibrillation controlled with Coumadin**, congestive heart failure and multiple other co-morbidities (no hyper-coagulation history provided), moved and established care with a family medicine physician. The patient, who had not been under the care of a cardiologist before moving, **reported taking 81mg of aspirin daily and an unknown dose of Coumadin. The family medicine physician did not obtain the patient's previous medical records.**

One year later, the patient required eyelid surgery to treat uncontrolled ptosis. Pre-surgery, the patient was required to obtain clearance from the family medicine physician, via a pre-op form which included check boxes for yes or no responses **related to stopping Coumadin** seven days prior to surgery. **The physician left the boxes unchecked (abstained from giving opinion), but did sign off on medical clearance for surgery.**

The patient did stop Coumadin seven days prior to surgery; there were no specified directives as to when to resume Coumadin. **On the day after surgery, he developed slurred speech while at home and was diagnosed with occlusion in the left middle cerebral artery.** He was given tPA, which caused bleeding from eye incisions. He did undergo a successful thrombectomy. However, he sustained permanent brain damage resulting in persistent right-sided weakness and aphasia, and is now wheelchair-bound.

Expert review was critical of the family medicine physician for not ordering a Lovenox bridge, for at least a few days pre-operatively. The physician contended that the patient didn't disclose a comprehensive history related to hyper-coagulation and that the CHADS2 score (atrial fibrillation stroke risk) was used as part of the diagnostic clinical decision making process. From that score, the physician determined that the patient wasn't at high risk for perioperative stroke related to his underlying atrial fibrillation. **However the physician did not document the CHADS2 score, and didn't believe that a cardiology referral was warranted.** He deferred Coumadin management to the ophthalmologist.

Conduct an appropriate and thorough assessment of the patient.

- Understand patient complaints and concerns.
- Update and review medical and family history at every visit to ensure the best decision-making.
- Be alert to high-risk diagnoses, such as cancer, cardiac disease, stroke and infections.
- 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 that patient satisfaction with treatment outcomes can be influenced by a thorough informed consent and education process.

Document.

- 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.

Review office processes for test tracking, consults/referrals, appointment setting, and managing patient nonadherence.

Know (and adhere to) your supervision responsibility for advanced practice providers.

MLMIC & MedPro Group Data

MLMIC and MedPro Group 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, MLMIC and MedPro Group are better able to highlight the critical intersection between quality and patient safety and provide insights into minimizing losses and improving outcomes.

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



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