Physicians' Reciprocal Insurers

*Historical Medical Malpractice Claims Analysis**

ABC Health System

December 2014

Privileged and Confidential

Physicians' Reciprocal Insurers

* ***Information valued as of 12/31/14***
PL_Mature Claims-Made Policy Period 8/1/06 to 11/1/14
GL_Occurrence Policy 8/1/08 to 8/1/12

ABC Health System

Executive Summary

PRI continuously strives to deliver value added services and resources to meet the needs and expectations of our clients. Accordingly, the Department of Hospital and Special Programs has incorporated the quality management perspective into our array of risk management programs and services. It is our objective to reduce claims and promote quality care by mitigating potential risks for the insured and its patient population.

This historical malpractice claims analysis is based on the facility loss run as of July 31st 2014. This draft is for informational purposes only and includes the following indicators for professional and general liability claims:

- Claims per year and by description category
- Claims costs based on the total incurred amount
- Total incurred based on description category
- Observations and Comments
- Publicly reported data per industry benchmarks and national quality measures

In addition to noted observations, the data herein may be indicative of patterns or trends. It includes recommendations for improvement based on clinical expertise and evidence-based practice. A majority of claims were attributed to surgical and procedural complications, the 'other' category (see footnote page 2), diagnosis failures/ treatment related issues and ulcers. Therefore, suggestions include review and reeducation of fall prevention protocols, proper documentation of ulcers and emergency department related cases, and engaging staff in prevention programs, trainings and education to mitigate risk and bolster strategies in defense of cases related to these occurrences.

Highlights

- 85% of all Professional Liability claims are attributed to surgical and procedural complications, diagnosis failures and/or treatment related issues, which includes the emergency and obstetric departments.
- 76% of the Professional Liability total incurred losses were attributed to diagnosis failures and treatment related issues in the emergency department, obstetric related issues, surgical and procedural complications, and ulcers.
- Current average Professional Liability severity based on open and closed claims with an associated cost = *$138,882.86.*
- Current average General Liability severity based on open and closed claims with an associated cost = *$48,813.65:*

Additional Information

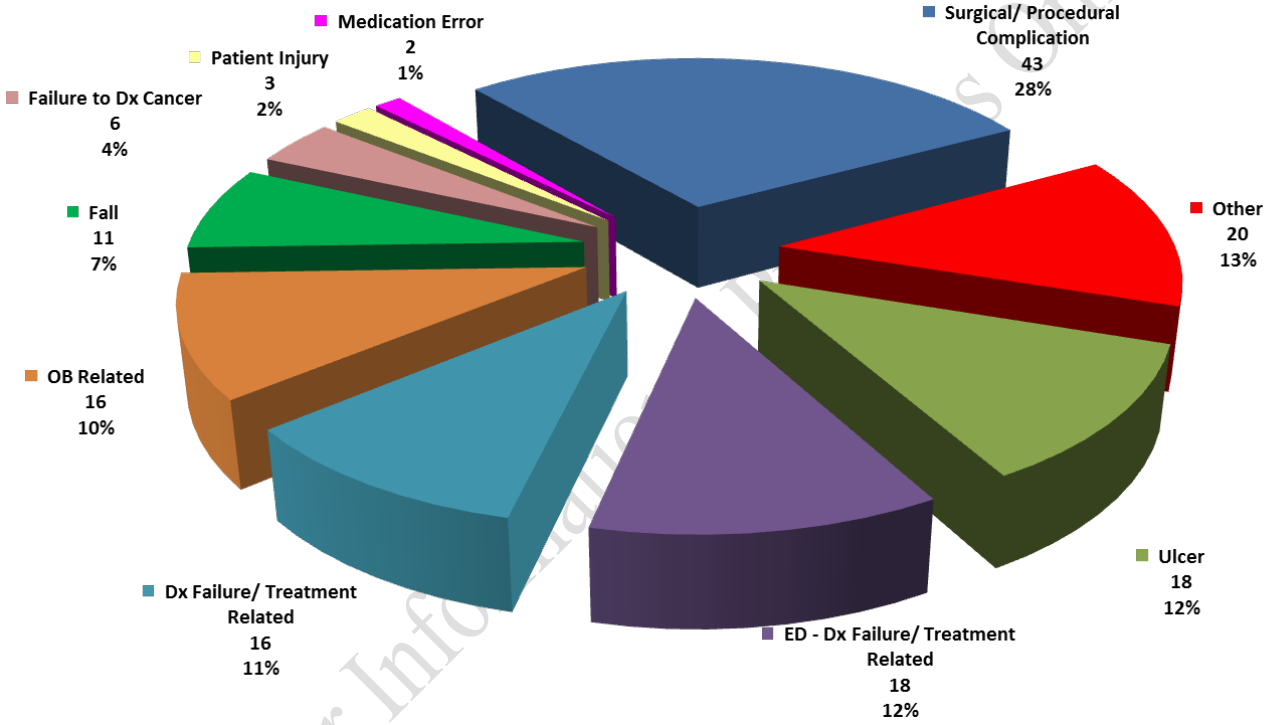
This report was compiled by Ely Jacobs, Manager of Quality Initiatives for PRI's Hospitals and Special Programs Department. If you have any questions, requests or would prefer a formal presentation, he can be reached at 516-277-4064 or via email at e.jacobs@medmal.com.

***PROFESSIONAL LIABILITY*:**

I. Claims Per Year

This indicator breaks out the claims by Description Category, Year the Policy was in effect and Year in which the loss occurred.

- 154 cases total: 74 Open; 80 Closed.
- Top 3 categories accounting for nearly 64% of all cases were attributed to surgical and procedural complications, the 'other' category[1], diagnosis failures/ treatment related issues in the ED and ulcers.
- OB cases resulted in Erb's Palsy, infant demise, IV infiltration, improper delivery, brain damage and infant lacerations during delivery.



[1] 'Other' category includes cases involving alleged assault, sexual trauma, a doctor's suspension due to incompetency, a workers' compensation claim and alleged unlawful discrimination and slander.

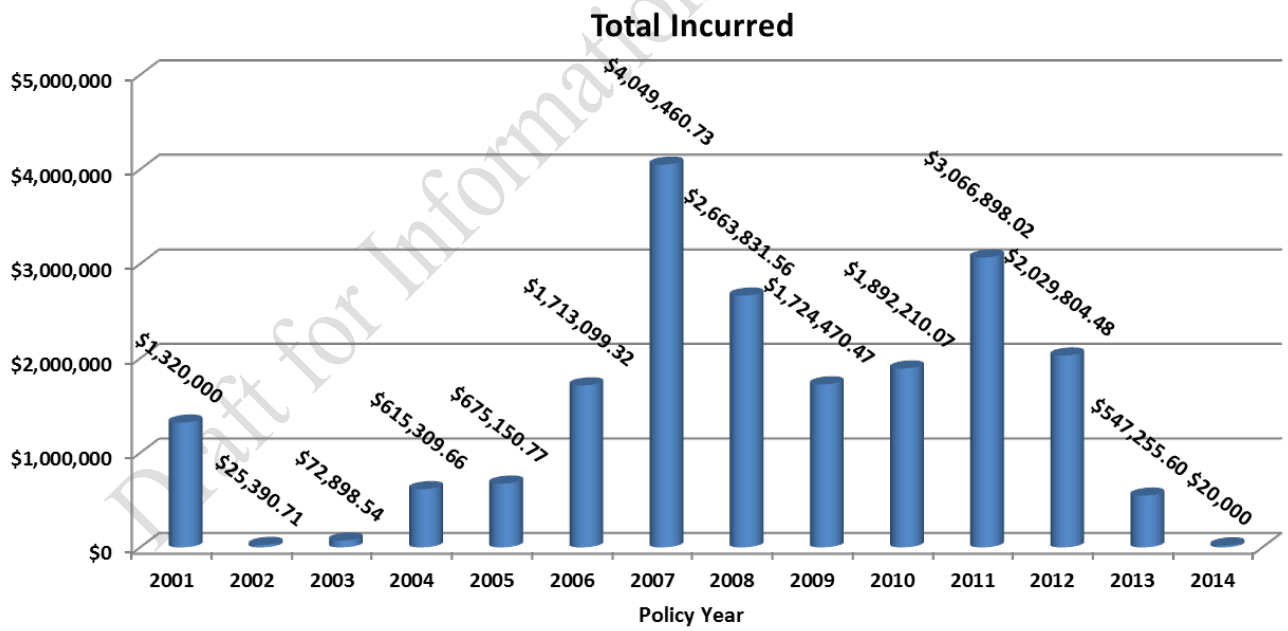
II. Claims by Incurred Cost

The total incurred losses inclusive of indemnity, expenses and reserves by **A.** Policy and **B.** Loss year.

- The average incurred cost based on non-zero[2] closed claims *only* was $127,155.83.
- Closed Claims (80) accounted for $9,282,375.68 or 45% of the total incurred.
- No Ded/SIR Indemnity Payments to date.

A.

Policy Year	ALAE[3] Reserves	ALAE Payments	Ded/SIR Indemnity Reserves	Indemnity Reserves	Indemnity Payments	Total Incurred	*Total Incurred as % of Grand Total*
2006	$29,630.94	$1,240,512.10	$0	$345,000	$2,070,000	$3,685,143.04	***18%***
2007	$21,472.61	$625,537.20	$0	$10,001	$840,000	$1,497,010.81	***7%***
2008	$61,956.47	$794,780.53	$0	$1,010,001	$2,355,000	$4,221,738	***21%***
2009	$75,828.20	$499,796.81	$0	$610,003	$1,100,000	$2,285,628.01	***11%***
2010	$115,467.86	$497,744.37	$0	$675,006	$175,000	$1,463,218.23	***7%***
2011	$177,541.40	$419,063.41	$0	$2,730,003	$107,500	$3,434,107.81	***17%***
2012	$207,684.69	$285,769.68	$0	$2,465,013	$75,000	$3,033,467.37	***15%***
2013	$93,467.38	$11,995.28	$690,004	$0	$0	$795,466.66	***4%***
Grand Total	**$783,049.55**	**$4,375,199.38**	**$690,004**	**$7,845,027**	**$6,722,500**	**$20,415,779.93**	***100%***

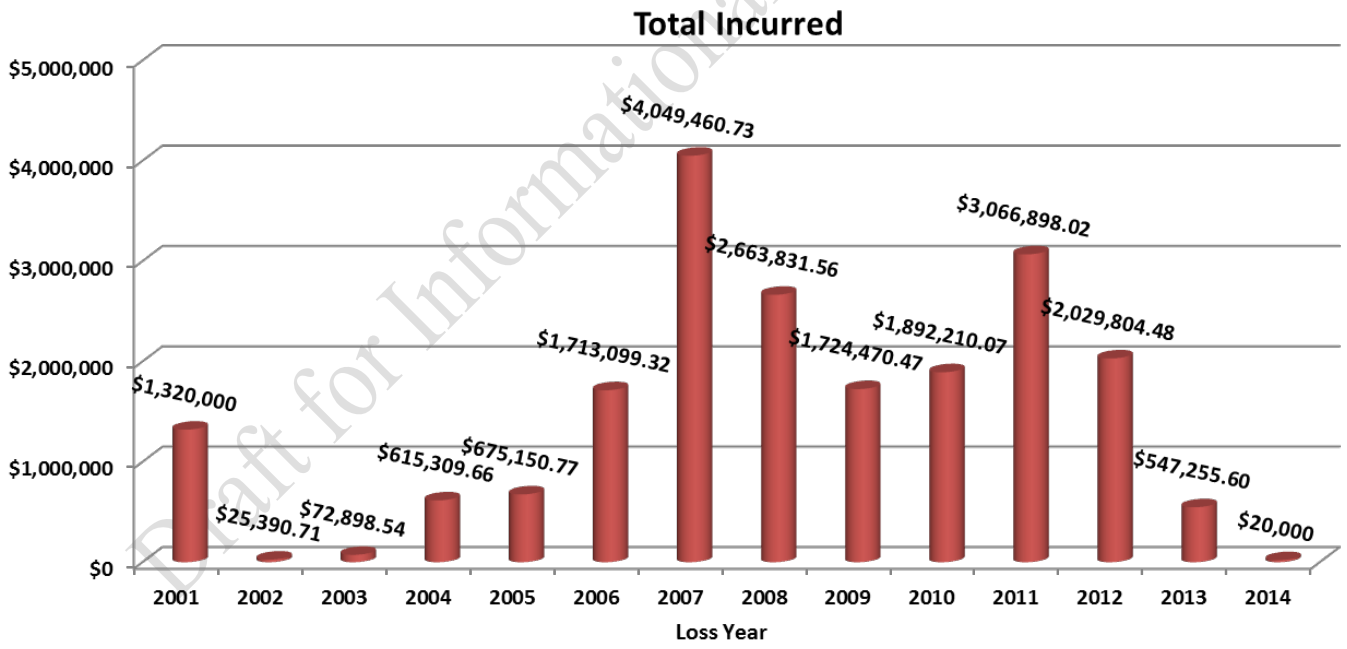


B.

[2] Claims with an associated cost due to expenses, indemnity payments and/ or reserves.

[3] Allocated Loss Adjustment Expense. ALAE refers to costs incurred in handling claims in addition to indemnity payments and reserves.

Loss Year	ALAE Reserves	ALAE Payments	Ded/SIR Indemnity Reserves	Indemnity Reserves	Indemnity Payments	Total Incurred	*Total Incurred as % of Grand Total*
2001	$41,705.82	$278,294.18	$0	$1,000,000	$0	$1,320,000	***6%***
2002	$0	$25,390.71	$0	$0	$0	$25,390.71	***0.1%***
2003	$0	$72,898.54	$0	$0	$0	$72,898.54	***0.4%***
2004	$0	$340,309.66	$0	$200,000	$75,000	$615,309.66	***3%***
2005	$43,751.26	$476,398.51	$0	$155,001	$0	$675,150.77	***3%***
2006	$7,352.29	$660,746.03	$0	$10,001	$1,035,000	$1,713,099.32	***8%***
2007	$66,701.33	$857,757.40	$0	$400,002	$2,725,000	$4,049,460.73	***20%***
2008	$21,064.43	$502,766.13	$0	$160,001	$1,980,000	$2,663,831.56	***13%***
2009	$84,538.65	$374,927.82	$0	$740,004	$525,000	$1,724,470.47	***8%***
2010	$157,622.24	$374,580.83	$0	$1,335,007	$25,000	$1,892,210.07	***9%***
2011	$194,441.95	$234,949.07	$180,002	$2,175,005	$282,500	$3,066,898.02	***15%***
2012	$119,918.36	$154,879.12	$180,002	$1,500,005	$75,000	$2,029,804.48	***10%***
2013	$35,953.22	$21,301.38	$320,000	$170,001	$0	$547,255.60	***3%***
2014	$10,000.00	$0	$10,000	$0	$0	$20,000	***0.1%***
Grand Total	**$783,049.55**	**$4,375,199.38**	**$690,004**	**$7,845,027**	**$6,722,500**	**$20,415,779.93**	***100%***

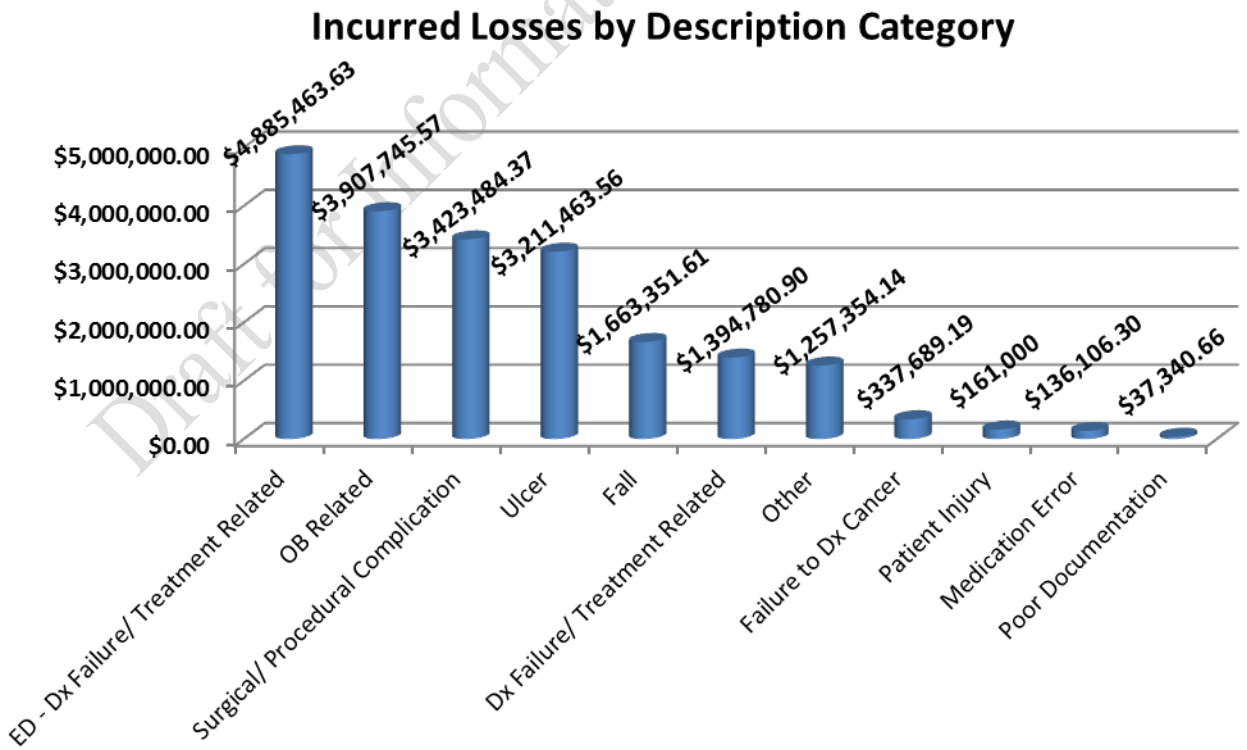


III. Description by Incurred Cost

The table below includes a breakdown of costs based on the description classifications of each case, followed by a graph illustrating the incurred losses for all descriptive categories.

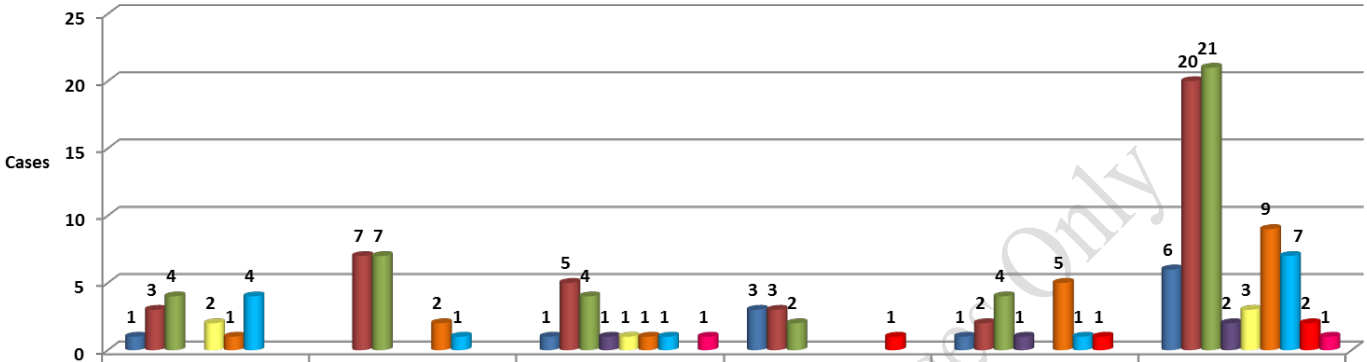
- No Ded/SIR Indemnity Payments to date.

Description	ALAE Reserves	ALAE Payments	Ded/SIR Indemnity Reserves Outstand	Indemnity Reserves	Indemnity Payments	Total Incurred	*Total Incurred as % of Grand Total*
ED - Dx Failure/ Treatment Related	$98,554.16	$556,903.47	$30,001	$1,250,005	$2,950,000	$4,885,463.63	***24%***
OB Related	$120,638.75	$777,102.82	$20,002	$2,145,002	$845,000	$3,907,745.57	***19%***
Surgical/ Procedural Complication	$209,267.09	$1,202,203.28	$10,001	$780,013	$1,222,000	$3,423,484.37	***17%***
Ulcer	$181,470.18	$429,991.38	$160,000	$2,165,002	$275,000	$3,211,463.56	***16%***
Fall	$22,125	$218,726.61	$400,000	$325,000	$697,500	$1,663,351.61	***8%***
Dx Failure/ Treatment Related	$15,482.75	$471,297.15	$0	$310,001	$598,000	$1,394,780.90	***7%***
Other	$93,761.09	$443,590.05	$10,000	$635,003	$75,000	$1,257,354.14	***6%***
Failure to Dx Cancer	$16,708.17	$150,980.02	$10,000	$160,001	$0	$337,689.19	***2%***
Patient Injury	$25,042.36	$10,957.64	$50,000	$75,000	$0	$161,000	***1%***
Medication Error	$0	$76,106.30	$0	$0	$60,000	$136,106.30	***1%***
Poor Documentation	$0	$37,340.66	$0	$0	$0	$37,340.66	***0.2%***
Grand Total	**$783,049.55**	**$4,375,199.38**	**$690,004.00**	**$7,845,027.00**	**$6,722,500.00**	**$20,415,779.93**	***100%***

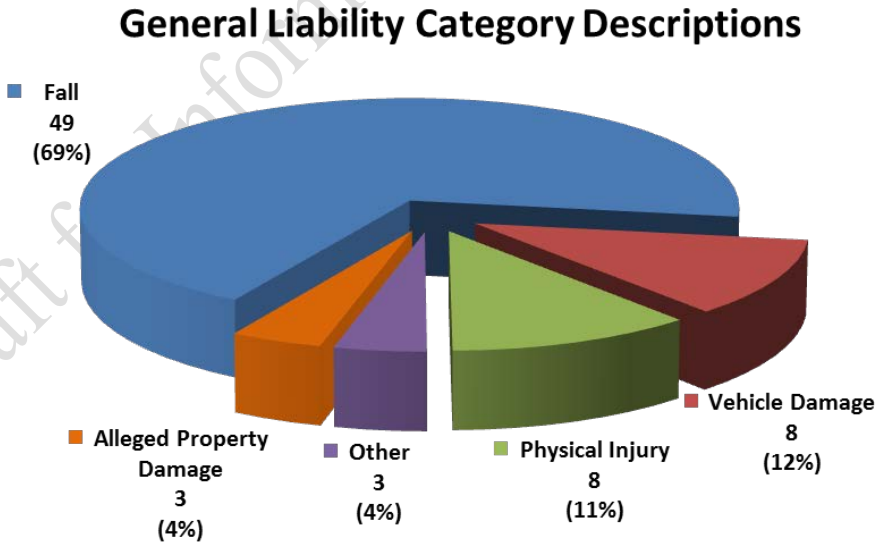


GENERAL LIABILITY:

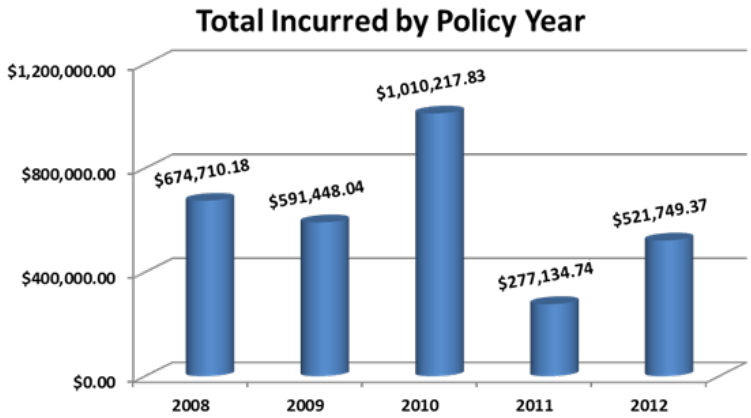
- 71 cases total: 33 Open. 38 Closed.
- The top three categories accounting for 92% of all claims are attributed to falls, vehicle damages and physical injuries. Falls and physical injury alone accounted for 99% of the total incurred losses.
- The 'Other' category includes a disorderly visitor and alleged stolen property.



	2008	2009	2010	2011	2012	Grand Total
Hospital 1	1		1	3	1	6
Hospital 2	3	7	5	3	2	20
Hospital 3	4	7	4	2	4	21
Hospital 4			1		1	2
Hospital 5	2		1			3
Nursing Home 1	1	2	1		5	9
Nursing Home 2	4	1	1		1	7
Nursing Home 3				1	1	2
Nursing Home 4			1			1



Policy Year - Facility	ALAE Reserves	ALAE Payments	Indemnity Reserves	Indemnity Payments	Total Incurred	*Total Incurred as % of Grand Total*
Hospital 1	$33,093.86	$38,332.84	$425,000.00	$42,000.00	$538,426.70	
Nursing Home 1	$3,312.48	$46,687.52	$75,000.00	$0.00	$125,000.00	
Hospital 2	$0.00	$1,740.78	$0.00	$4,455.26	$6,196.04	
Hospital 3	$739.95	$1,572.94	$0.00	$1,304.81	$3,617.70	
Hospital 4	$0.00	$1,383.59	$0.00	$0.00	$1,383.59	
Hospital 5	$0.00	$86.15	$0.00	$0.00	$86.15	
2008	**$37,146.29**	**$89,803.82**	**$500,000.00**	**$47,760.07**	**$674,710.18**	***22%***
Hospital 2	$2,302.71	$131,595.44	$75,000.00	$166,223.90	$375,122.05	
Hospital 1	$8,934.30	$96,324.97	$25,000.00	$45,000.00	$175,259.27	
Hospital 5	$2,539.37	$27,460.63	$5,000.00	$4,747.81	$39,747.81	
Hospital 3	$0.00	$735.95	$0.00	$582.96	$1,318.91	
2009	**$13,776.38**	**$256,116.99**	**$105,000.00**	**$216,554.67**	**$591,448.04**	***19%***
Hospital 2	$9,504.48	$80,495.52	$325,000.00	$5,000.00	$420,000.00	
Hospital 1	$27,735.56	$24,214.34	$250,000.00	$17,500.00	$319,449.90	
Nursing Home 1	$0.00	$2,115.05	$0.00	$145,000.00	$147,115.05	
Hospital 3	$0.00	$55,894.99	$25,000.00	$0.00	$80,894.99	
Nursing Home 2	$11,154.84	$18,845.16	$10,001.00	$0.00	$40,001.00	
Hospital 5	$0.00	$0.00	$0.00	$2,500.00	$2,500.00	
Hospital 4	$0.00	$0.00	$0.00	$256.89	$256.89	
Nursing Home 4	$0.00	$0.00	$0.00	$0.00	$0.00	
2010	**$48,394.88**	**$181,565.06**	**$610,001.00**	**$170,256.89**	**$1,010,217.83**	***33%***
Hospital 4	$811.19	$28,559.08	$152,500.00	$500.00	$182,370.27	
Hospital 2	$0.00	$14,387.43	$75,000.00	$2,777.04	$92,164.47	
Hospital 1	$500.00	$0.00	$1,000.00	$1,100.00	$2,600.00	
Nursing Home 3	$0.00	$0.00	$0.00	$0.00	$0.00	
2011	**$1,311.19**	**$42,946.51**	**$228,500.00**	**$4,377.04**	**$277,134.74**	***9%***
Hospital 5	$10,166.84	$5,933.16	$295,384.49	$0.00	$311,484.49	
Hospital 1	$13,000.00	$875.00	$51,000.00	$532.04	$65,407.04	
Hospital 3	$1,000.00	$0.00	$50,000.00	$0.00	$51,000.00	
Nursing Home 2	$7,467.00	$2,533.00	$25,000.00	$0.00	$35,000.00	
Nursing Home 3	$1,000.00	$0.00	$25,000.00	$0.00	$26,000.00	
Hospital 4	$10,000.00	$0.00	$10,000.00	$0.00	$20,000.00	
Hospital 2	$1,500.00	$0.00	$11,000.00	$357.84	$12,857.84	
2012	**$44,133.84**	**$9,341.16**	**$467,384.49**	**$889.88**	**$521,749.37**	***17%***
Grand Total	**$144,762.58**	**$579,773.54**	**$1,910,885.49**	**$439,838.55**	**$3,075,260.16**	***100%***



OBSERVATIONS & COMMENTS

- According to the World Health Organization (WHO) complications after inpatient surgery occur in up to 25% of all patients and that at least half of those complications are considered preventable. In order to face this head on some institutions have taken a multidisciplinary approach to the management of surgical care and have beefed up the surgical checklist (AORN model[4]) to include standards that follow the World Health Organization and the Joint Commission's Universal Protocol National Patient Safety Goals (NPSG[5]**)**. That model contemplates among a variety of factors, the key concerns for recovery and the management of the individual surgical patient.
- Some hospitals look at case frequency and results when accrediting its practitioners. Periodic reviews include the scope of privileges and the scope may be amended as appropriate to specific findings. Reappraisal of all privileges is also conducted any time a practitioner seeks to add to his or her delineated privileges. Institutions, when possible, assign staff (RN's, surgical technicians, and other allied health professionals) familiar with specific specialized and complicated cases to ensure staff knowledge, competency and proficiency. [6]
- The alleged failure to properly diagnose and treat on the units and in the ED is a common allegation cited in lawsuits. The failure to diagnose and promptly treat can complicate the patient's course of treatment and lead to a decline in condition, even death and this can lead to significant suits. Defense counsel have found that the best weapon to combat these allegations is the presence of proper documentation of what the physician did or not do in arriving at the diagnosis. Physician documentation of the differential diagnosis is noted to be key, as is the inclusion of the correct diagnosis and appropriate testing and consultations pertaining to the same, in determining how the doctor looked at and evaluated treatment determinations. Successful defense may hinge on correct, contemporaneous and precise documentation. It has proven to be a physician's and staffs first-line defense in combating allegations of negligence in an action alleging medical malpractice.
- ECRI Institute[7] reports that "studies suggest that an estimated 2% to 10% of hospital in-patients fall during a hospital stay."[8] Key recommendations on falls prevention include: "Developing and maintaining an interdisciplinary falls prevention team; develop, implement and modify as needed all falls reduction policies, procedures and tools; provide initial and ongoing falls reduction education programs for staff, nursing personnel and others; ensure patients are assessed and reassessed for falls risk; require pharmacy review of medication regimens; conduct environmental rounds frequently to reduce or eliminate risk for falls of patients, visitors and staff; communicate a patient's risk for falling to patient, family and staff; educate staff on how to appropriately respond to and report falls; identify falls incidents and develop strategies to identify and improve the falls program."
- Allegations of pressure ulcer formation and their progression continue to be potentially serious claims for hospitals and nursing homes. Some courts regard pressure ulcers as evidence of elder abuse and some lawsuits have resulted in multi-million dollar verdicts. Reimbursement may also be withheld for the costs of treating hospital acquired pressure ulcers creating a further incentive to properly assess and document any skin conditions present on admission.
- Institutions have engaged in extensive prevention programs and staff training and education to decrease occurrence and have engaged in strategies to bolster defense of decubitus ulcer cases. Proper assessment of patients (i.e. severity of illness, history of recent pressure ulcer, significant weight loss, oral eating problems, catheter and positioning device use), proper staging, documentation, implementation of preventive measures (i.e. nutritional interventions, use of disposable briefs, adequate RN and nurse's aides hours[9] and proper treatment techniques have all been positive factors in prevention and progression of decubitus ulcers. Communication about the risk of pressure ulcer formation is then communicated and discussed with the family and documented in the patient's medical record.

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[4] Association of periOperative Registered Nurses; http://www.aornjournal.org/

[5] http://www.jointcommission.org/standards_information/up.aspx

[6] Stanford Hospital and Clinics performs routine surveillance of surgical capacity, volume and results - it is 1 of the 10 essential team objectives for Safe Surgery utilized at the Hospital.

[7] Nonprofit organization dedicated to bringing the discipline of applied scientific research to discover which medical procedures, devices, drugs, and processes are best to improve patient care.

[8] Hendrich et al. "Validation"

[9] AHRQ (Agency for Healthcare Research & Quality) research suggests RN hours of .25 or more per resident per day, nurse's aides hours 2 hours or more per resident per day. LPN turnover rate of less than 25% are noted to be positive factors in prevention as well.

APPENDIX:
PUBLICLY REPORTED DATA

I. Certain data is available and publicly reported such as the quality measures listed on the Medicare.gov Hospital Compare site[10]. As noted earlier, a majority of the claims were due to surgical/ procedural complications as well as diagnosis failures and treatment related issues in the ED. Below are the scores for the timely and effective care measures under the 'Emergency Department Care'[11] and 'Surgical Complication'[12] sections of quality measures. The information below shows how quickly the hospital treats patients who come to the hospital emergency department, compared to the average for all U.S. hospitals. The second table lists another set of measures of serious complications that patients with Original Medicare experienced during a hospital stay. Two of the measures are from the Agency for Healthcare and Research Quality Patient Safety Indicators (AHRQ PSI).

Emergency Department Throughput - Quality Measure	ABC Hospital	NY Average	National Average	Data Collection Period
Average time patients spent in the emergency department (ED), before they were admitted to the hospital as an inpatient	380 Minutes*	378 Minutes	274 Minutes	10/1/2012 - 9/30/2013
Average time patients spent in the ED, after the doctor decided to admit them as an inpatient before leaving the ED for their inpatient room	225 Minutes*	154 Minutes	98 Minutes	10/1/2012 - 9/30/2013
Average time patients spent in the ED before being sent home	154 Minutes	156 Minutes	134 Minutes	10/1/2012 - 9/30/2013
Average time patients spent in the ED before they were seen by a healthcare professional	38 Minutes	35 Minutes	26 Minutes	10/1/2012 - 9/30/2013
Average time patients who came to the ED with broken bones had to wait before receiving pain medication	63 Minutes	61 Minutes	57 Minutes	10/1/2012 - 9/30/2013
Percentage of patients who left the ED before being seen	1%	2%	2%	1/1/2012 - 12/31/2012
Percentage of patients who came to the ED with stroke symptoms who received brain scan results w/in 45 min of arrival	Not Available^	55%	57%	10/1/2012 - 9/30/2013

**Data submitted based on a sample of cases/patients*

^too few cases/ patients to report

[10] http://www.medicare.gov/hospitalcompare/search.html

[11] Includes Medicare and Non-Medicare patients; Data comes from hospital medical records of their eligible patient.

[12] Original Medicare beneficiaries only; Non-Medicare patients and beneficiaries enrolled in Medicare managed care plans are also excluded from the data.

Surgical Complications - Quality Measure	ABC Hospital	National Average	Data Collection Period
Rate of complications for hip/knee replacement patients*	No Different than U.S. National Rate	3.4%	7/1/2009 - 3/31/2012
Serious complications (AHRQ)	No Different than U.S. National Rate	0.61 per 1000 persons at risk	7/1/2010 - 6/30/2012
Deaths among patients with serious treatable complications after surgery (AHRQ)	Worse than U.S. National Rate	110.25 per 1,000 patient discharges	7/1/2010 - 6/30/2012
* risk-adjusted estimate of complications for patients electively admitted for the procedure; It is calculated by dividing the number of complications that occurred within 30 days of an eligible index admission by the number of eligible index admission nationally.			

II. This section is comprised of data from the AON Global Risk Consulting firm and the Physician Insurers Association of America (PIAA)[13].

A) The AON actuarial analysis includes benchmark[14] data for hospital professional liability (HPL) and is limited to the database of participants who submit data. It includes 118 health care systems nationwide and containing over 103,000 open and closed non-zero claims[15] for a period of 10 years (2003-2012). The participant base represents 28% of the total U.S. hospital industry. The study is designed as a hands-on tool to provide healthcare risk managers with a better understanding of their cost of risk compared to an industry benchmark.

B) PIAA is the insurance trade association representing domestic and international medical professional liability (MPL) insurance companies, risk retention groups, captives, trusts, and other entities. PIAA members insure more than two-thirds of America's private practicing physicians as well as dentists, nurses and nurse practitioners, and other healthcare providers and provide indemnification and other services to more than 400,000 healthcare professionals around the world. The PIAA data comes from its Data Sharing Project (DSP) that includes professional liability claims as submitted by DSP participants. Data reported consists only of physician professional liability claims and is based on *closed claims only* between 2003 and 2012.

A) Key Findings:

Hospital Professional Liability

- Frequency[16] of hospital professional liability claims is stable; no growth projected in the number of HPL claims experienced by health care organizations.
- Severity and Loss Rate[16] are limited to $2 million per occurrence and both have a projected annual growth rate of 2.5%.
- The projected average Severity or dollar amount of a claim (including indemnity and expenses) is $176,000.

[13] http://www.aon.com/default.jsp ; https://www.piaa.us/

[14] Benchmarks are actuarial estimates of ultimate claim costs for the year in which claims occurred. Claims experience is organized by occurrence year and actuarial techniques are used to estimate the total (or ultimate) number of claims for that year.

[15] Claims with an associated cost due to expenses, indemnity payments and/ or reserves.

[16] Frequency and Loss Rate estimates are per Occupied Bed Equivalent (OBE); occupied beds are calculated by multiplying the number of licensed beds by the average annual occupancy rate.

**Current average severity for ABC Hospital (based on Open and Closed non-zero claims) = $138,882.86*

- Projected 2014 hospital Loss Rate, or the annual amount per occupied bed expected to be paid to settle and/or defend professional liability claims is $2,940.
- AON also analyzed the HPL claims and exposure of the Emergency Department:
    - The exposure underlying the ED analysis is approximately 28.5 million ED visits annually with a projected loss rate of $6.16, or the annual amount per visit expected to be paid to settle and/or defend claims.
    - Approximately one in three ED claims results in an indemnity payment as this area is often the focal point of key risk management activities.
    - Overall claim frequency and indemnity claim frequency have remained relativity stable for Emergency Departments since 2006.

B) Key Findings:

- Type of institution where claims most frequently occurred was in a hospital, accounting for 60% of claims and 62% of indemnity.
- Obstetric and Gynecologic (Ob/Gyn) surgeons reported the highest number of paid claims (3681) and the highest total indemnity paid of $1,530,697,387.
- Neurosurgery reported the highest average indemnity of $439,146. Neurosurgery also had the highest percentage (21%) for indemnity payments between $500,000 and $999,999.
- Radiation therapy had the highest percentage (27%) for indemnity payments between $250,000 and $499,999.
- Average indemnity or money incurred in the resolution of a claim for the Emergency Medicine specialty (2003 – 2012) was $330,762.
- Most prevalent medical mishaps under the Emergency Medicine specialty include:
    - ✓ Diagnosis Errors - Failure to diagnose or an incorrect diagnosis
    - ✓ Improper Performance - An act performed by a physician resulted in a procedure which was done incorrectly.
    - ✓ Failure to Supervise or Monitor a Case - Failure to monitor the care of the patient or when the physician involved in patient care has neglected the management of the treatment or the condition of the patient.
    - ✓ Medication Errors - Medication problem or the failure to prescribe.
- Most prevalent medical mishaps under the Obstetric and Gynecologic Surgical specialty include:
    - ✓ Diagnosis Errors - Failure to diagnose or an incorrect diagnosis
    - ✓ Improper Performance - An act performed by a physician resulted in a procedure which was done incorrectly.
    - ✓ Failure to Supervise or Monitor a Case - Failure to monitor the care of the patient or when the physician involved in patient care has neglected the management of the treatment or the condition of the patient.
    - ✓ Delay in Performance - Physician defers testing or treatment of a patient.