Mitigating OB Risk: Insight into new challenges

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Objectives

• Discuss trends, their impact and ways to mitigate

• Discuss common claims in Obstetrics and Risk Mitigation.

• Describe clinical situations where enhanced physician-patient shared decision making can improve patient safety.

• Review current material morbidity ad mortality rates, the racial disparities that exist, and effects of Maternity Care Deserts
COPIC Claims with Paid Indemnity – Top 3 Specialties (2019-2023)

- OB/GYN: $28,031,242
- Emergency Med: $22,754,008
- Radiology: $19,447,729
92% of Total Incurred $ Arise From the Top 20% of Claims (Aggregate)
92% of Total Incurred $ Arise From the Top 20% of Claims (Specialty by Specialty)
Common OB Claims

Management of Pregnancy

• Failure to monitor high risk conditions leading to failed or delayed diagnosis

• Failure to follow recommendations from other HCP

• Failure to communicate and document shared decision making/ informed consent/ refusal
Risk Mitigation: Pregnancy

Utilize and document thorough shared decision-making

Informed consent/refusal

TOLAC

Water Births

Birth Plans

Refer as appropriate
Common OB Claims

Management of Labor and Delivery

Failure to identify or act on non-reassuring FHR tracing

Mismanagement of Pitocin

Shoulder Dystocia and Operative Vaginal Delivery

Failure to recognize and timely respond to OB emergency (Hemorrhage, Hypertension, Sepsis, VTE/PE)
Fetal Monitoring

2017 study on 37,000 low and high-risk patients using continuous FHR monitoring vs. intermittent auscultation:

No statistically significant differences were noted for the following newborn/childhood outcomes:

- Acidemia
- APGAR scores < 4 at 5 minutes
- NICU admissions
- Hypoxic-Ischemic encephalopathy (HIE)
- Perinatal mortality
- Neurodevelopment impairment at ≥ 12 months of age
- Cerebral Palsy

Has Fetal Monitoring improved neonatal outcomes?
Five common mistakes in FHR monitoring

- Delayed use of internal monitors
- Confusing the maternal and fetal heart rates
- Not monitoring the fetus during placement of epidural
- Not monitoring the fetus in the OR
- Failure to identify abnormal FHR or act on abnormal FHR tracing
Risk Mitigation: Labor and Delivery

Prevention: education, protocols, simulations, audits of past cases for improvement opportunities, resource analysis

Implement interdisciplinary fetal monitor training

Implement a perinatal committee of various staff members/providers

Implement Maternal Early Warning System

Implement policies for Pitocin management

Utilize ACOG Practice guidelines for Operative Vaginal Deliveries and Shoulder Dystocia

Anticipate the unexpected: Drill high risk scenarios
Risk Mitigation Labor and Delivery: OB Emergency

Denial leads to delay
Widely available resources

**Perinatal Quality Improvement Collaborative**

**Safety Bundles: Alliance for Innovation on Maternal Health**

www.saferbirth.org

**CMQCC**
California Maternal Quality Care Collaborative

**ALSO**
Advanced Life Support in Obstetrics

**American Academy of Family Physicians**

COPIC
Better Medicine • Better Lives
Unexpected Outcome

- Obtain Cord gases/placental preservation. Who initiates??
- Debrief with family/Stay in contact
- Risk management notification. Track events for educational opportunities/lessons learned
- Early reporting to Insurance carrier
- Reportable event? Was equipment involved??
- Debrief with staff. ?RCA  **Lock the chart**
- Documentation: Physician: Narrative note, thought process. Assure alignment of notes
CDC Maternal Morbidity

Maternal morbidity per 100,000 births

- Overall
- White Non-Hispanic
- Black Non-Hispanic

COVID-19 Pandemic

<table>
<thead>
<tr>
<th>Year</th>
<th>Overall</th>
<th>White Non-Hispanic</th>
<th>Black Non-Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>17.4</td>
<td>17.4</td>
<td>17.4</td>
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<tr>
<td>2019</td>
<td>20.1</td>
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<tr>
<td>2020</td>
<td>23.8</td>
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<tr>
<td>2021</td>
<td>32.9</td>
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<tr>
<td>2022</td>
<td>22.3</td>
<td>22.3</td>
<td>22.3</td>
</tr>
</tbody>
</table>
Is this data accurate??

- Are these deaths preventable

- With a maternal morbidity rate of How do we compare to other industrialized countries?
Racial disparity exists

Figure 2. Maternal mortality rate, by race and Hispanic origin: United States, 2021 and 2022

<table>
<thead>
<tr>
<th>Race</th>
<th>2021</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>16.8</td>
<td>13.2</td>
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<tr>
<td>Black</td>
<td>69.9</td>
<td>49.5</td>
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<tr>
<td>White</td>
<td>28.6</td>
<td>19.0</td>
</tr>
<tr>
<td>Hispanic</td>
<td>28.0</td>
<td>16.9</td>
</tr>
</tbody>
</table>

*Statistically significant decrease from previous year (p < 0.05).

1 Hispanic people may be of any race.

NOTE: Race groups are single race.


Age Matters

Figure 3. Maternal mortality rate, by age group: United States, 2021 and 2022

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2021</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Younger than 25</td>
<td>20.4</td>
<td>14.4</td>
</tr>
<tr>
<td>25–39</td>
<td>31.3</td>
<td>21.1</td>
</tr>
<tr>
<td>40 and older</td>
<td>138.5</td>
<td>87.1</td>
</tr>
</tbody>
</table>

*Statistically significant decrease from previous year (p < 0.05).

Pregnancy-related death: A death during or within one year of pregnancy, from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.

- Preeclampsia, Eclampsia, Hemorrhage, Suicide
- None of the pregnancy-related deaths occurred during pregnancy
  - 75% were within 42 days of the end of the pregnancy
  - 25% within 43 days to 1 year of the end of the pregnancy
- 100% were preventable
COMMITTEE RECOMMENDATIONS
The committee provided specific and feasible actions that, if implemented or altered, could prevent future deaths or poor outcomes.
Iowa policies to improve Maternal and Infant Healthcare

- **MEDICAID EXTENSION**
  - State has extended coverage for women to one year postpartum.

- **MEDICAID EXPANSION**
  - State has adopted this policy, which allows birthing people greater access to preventative care during pregnancy.

- **PAID FAMILY LEAVE**
  - State has required employers to provide a paid option while out on parental leave.

- **DOULA REIMBURSEMENT POLICY**
  - State Medicaid agency is actively reimbursing doula care.

- **MATERNAL MORTALITY REVIEW COMMITTEE (MMRC)**
  - State has a federally funded MMRC committee, which is recognized as essential to understanding and addressing the causes of maternal death.

- **FETAL AND INFANT MORTALITY REVIEW**
  - State has a Fetal and Infant Mortality Review team or teams to identify and review causes of death.

- **PERINATAL QUALITY COLLABORATIVE (PQC)**
  - State has a federally funded PQC to identify and improve quality care issues in maternal and infant healthcare.
Iowa's maternal death rate rises as birthing units close
Pregnancy: These patient live in your community until delivery and in emergency will come to the rural ED or CAH

- Two patients:
  - Medical Issue
  - Obstetrical Issue
- High risk patient from higher levels of care live in your community

Postpartum: 51% of maternal deaths occur in postpartum period when women have returned to their rural community

Red Flags for Cardiovascular Disease
- Shortness of breath at rest
- Chest pain at rest, with minimal exertion or ripping/tearing in quality
- Palpitations associated with near syncope
- Severe orthopnea
- Resting HR > 120 bpm
- Resting systolic BP > 150 or < 90

Other Signs and Symptoms
- Retiring RR > 25
- Oxygen saturation < 94%, with or without personal history of CVD
- Loud systolic murmur, diastolic murmur, 53, or 54
- Wheezing, crackles on lung exam
- Distended neck veins

Consider in your differential diagnosis:
- Myocardial infarction (including spontaneous coronary artery dissection), peripartum cardiomyopathy, congestive heart failure, arrhythmia, aortic dissection

Key Work-up
- EKG, BMP, chest X-ray, and Implanon

If testing is abnormal, CVD is a possible diagnosis:
- Obtain echocardiogram, consider transferring patient to obtain if not available at your facility
- Consult with cardiology and obstetrics or maternal-fetal medicine, if available
- Consider treatment and admission or transfer as clinically indicated

Treatment
Most medications for the treatment of cardiovascular emergencies do not have robust data surrounding their use in pregnancy and breastfeeding. These medications should not be withheld from a pregnant or breastfeeding patient in a life-threatening emergency if they are otherwise indicated. However, long-term use of certain medications should be avoided or may be contraindicated in pregnant or lactating patients; consult a pharmaceutical reference, obstetrics, or cardiology for further considerations.
Iowa Simulation Training Program

Obstetrics Simulation Training Program

Our Vision:
All hospitals in the state of Iowa will use best practices for maternal care.

Our Mission:
To impart knowledge, skills based on level-specific resources, and to create a self-sustaining, simulation-based education and communication teaching program.

- Iowa Statewide Mobile Simulation Team
- Postpartum Hemorrhage Recordings
- Simulation Materials
Trends

What’s happening in the MPL market in litigation?

➢ Effect of Tort Reform in Iowa
➢ Multi-defendant matters
➢ Prolonged lifecycle of matters
➢ Early Resolution Programs
➢ Organized plaintiff’s counsel bar

➢ Nuclear verdicts/High Damage Cases
➢ Changing Jury Pool
➢ Increase of Cyber matters
➢ Third-Party Litigation Funding
Nuclear Verdicts

The term “nuclear verdict” refers to any court award or settlement that is higher than expected, but legal experts officially define a “nuclear verdict” as one that exceeds $10 million.
$25M+ Med Mal Verdicts
2012-2023
National Data as of 1/5/2024
Top ten verdicts Each Year, 2010-2019

Comparison by Primary Injury

- Neuro: Birth: 37
- Neuro: Non-birth: 25
- Death: 9
- Paraplegia: 9
- Amputation: 8
- Internal Organ: 6
- Cardiac: 2
- Emotional Distress: 2
- Disfigurement: 1
- Vision: 1
Nuclear verdicts in Obstetrics

$40 million verdict in Central Illinois
A 19-year-old women and her parents have been awarded $40 million in medical malpractice suit over injuries the women suffered during her birth at Sarah Bush Lincoln Health Center.

$97,400,000 verdict in Iowa in 2022.
During the delivery, the forceps slipped off the baby’s head twice, which allegedly resulted in a skull fracture above the baby’s left ear that caused severe and permanent hypoxic brain injury.

$34,119,484.80 verdict in Missouri in 2021.
The plaintiff alleges she was given increasing amounts of Pitocin in labor, causing her contractions to become too frequent, depriving the baby of oxygen. The infant suffered brain damage, quadriplegia, and cerebral palsy
Importance of Tort reform

**TORT REFORM**

- **NONECONOMIC DAMAGES**
  - 28
  - $249,556

- **AVERAGE INDEMNITY**
  - $46,162

- **AVERAGE ALAE**
  - $49,910

- **INDEMNITY PAYMENTS**
  - 41% < $100,000
  - 25% $100,000-$249,999
  - 10% $250,000-$499,999
  - 10% $500,000-$999,999
  - 7% ≥ $1M

**NO TORT REFORM**

- **NONECONOMIC DAMAGES**
  - 23
  - $388,430

- **AVERAGE INDEMNITY**
  - $46,162

- **AVERAGE ALAE**
  - $49,910

- **INDEMNITY PAYMENTS**
  - 26% < $100,000
  - 19% $100,000-$249,999
  - 22% $250,000-$499,999
  - 19% $500,000-$999,999
  - 14% ≥ $1M
2023 Amendment Medical Malpractice Caps
Medical Malpractice Caps
Iowa Code 147.136A

The total amount recoverable in any civil action for noneconomic damages for personal injury or death, whether in tort, contract, or otherwise, against a health care provider for any occurrence resulting in injury or death of a patient regardless of the number of plaintiffs, derivative claims, theories of liability, or defendants in the civil action, shall not exceed two hundred fifty thousand dollars unless the jury determines that there is a substantial or permanent loss or impairment of a bodily function, substantial disfigurement, loss of pregnancy, or death, which warrants a finding that imposition of such a limitation would deprive the plaintiff of just compensation for the injuries sustained, in which case the amount recoverable shall not exceed one million dollars, or two million dollars if the civil action includes a hospital as defined in section 135B.1.
What do the changes mean

- **Total Non-Economic Damages:** What is recoverable under this new hard cap when both a hospital and another healthcare provider, such as a surgeon, are involved.
  
  - No matter the amount of defendants, as long as a hospital is involved, the maximum amount recoverable for non-economic damages is two million.
  - If a hospital is not a defendant, than the maximum amount is one million no matter the amount of defendants.
    - For example, if a hospital and two physicians are sued, the maximum amount recoverable for noneconomic damages would be $2M. If three physicians were sued, the maximum amount recoverable for noneconomic damages would be $1M. Due to this new language, we anticipate that lawsuits naming hospitals as defendants will increase.
  
  - It is worth noting that these limitations will increase by 2.1% starting on January 1, 2028 and each year thereafter.
Continue to be diligent in our early case/claim review

Push early reporting to carrier prior to patient retaining Plaintiff’s/Claimant’s counsel

Damage calculations inclusive of that knowledge

Consider Alternative Dispute Resolutions

So what does this mean?
Aggressive Defense

- Review of facts through evaluative processes
- Insured engagement
- Defense Team
- Trial success in 90% of cases taken to trial
Thank you! Questions?