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SGH Grand Rounds - The Expanding Scope of Allied Health Professionals

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Thursday, April 9, 2020
12:30 p.m. - 1:30 p.m.

Educational Objectives:

- Review claims involving nurse practitioners and physician assistants
- Define the scope of practice for nurse practitioners and physician assistants in California
- Review the newest physician assistant regulations, SB 697
- Review case examples that emphasize risk prevention strategies for working with nurse practitioners and physician assistants

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Physician Assistant Regulations: SB 697

Summary of SB 697

- Repeals state law requirements for chart review or counter signature
- Repeals all references to delegation
- Allows for collaborative development of the practice agreement
- Repeals language designating PAs as agents of physicians, unless desired within the practice
- Removes requirements that physician be physically available to physician assistant for consultation
- PA cannot own more than 49% of a professional medical corporation
  (See Corp. Code, § 13401.5, subd. (a)(7).)

What is a practice agreement?

- Replaces delegation of services agreement
- A **written agreement** developed through collaboration among one or more physicians and surgeons (“physician”) and one or more physician assistants (PA)
- Defines medical services PA is authorized to perform and grants approval for physicians on the staff to supervise one or more PAs in an organized health care system (See BPC, § 3501, subd. (k).).

Practice agreement must include provisions addressing:

- ❑ Types of medical services a PA is authorized to perform
- ❑ Policies and procedure to ensure adequate supervision of PAs
- ❑ Methods for continuing evaluation of competency and qualifications of PAs
- ❑ The furnishing or ordering of drugs or devices by PA
- ❑ Any additional provisions agreed to by PA and supervising physician (See BPC, § 3502.3, subd. (a)(1).)
- ❑ Must be signed by PA and one or more physicians

What medical services is a PA authorized to perform?

- Those medical services described in the **practice agreement**
- Must also **have competency** to perform the medical services, and the education, training, and experience must have prepared the PA to render the services (See BPC, § 3502, subd. (a).)
- Order durable medical equipment
- For home health patients: approve, sign, modify or add to plan of treatment
- Perform exam and certify disability (in consultation with supervising physicians)

What about controlled substance?

- May furnish or order Schedule II through Schedule V controlled substances under California Uniform Controlled Substances Act that have been agreed upon in **practice agreement**, and consistent with PA's educational preparation and clinical competency
- To furnish drug or device, PA must have completed a course in pharmacology (sec. 1399.530 of Title 16 of Cal. Code of Reg as read on June 7, 2019. (See BPC, § 3502.1, subd. (e)(1).)
- PAs authorized through **practice agreement** to furnish Schedule II drugs must complete a controlled substance education course
- PA drug order must be treated in the same manner as a prescription of a supervising physician

Practice agreement authorizing PA to order or furnish drug or device shall specify all of the following:

- Which PA or PAs may furnish or order a drug or device
- Which drugs or devices may be furnished or ordered
- Under what circumstances a drug or device will be furnished
- The extent of physician supervision
- Method of periodic review of PA's competence, including peer review
- Review of the practice agreement (BPC, § 3502.1, subd. (b)(1); and
- If practice agreement authorizes PA to furnish Schedule II controlled substance, it shall address the diagnosis of the illness, injury, or condition for which the PA may furnish the Schedule II drugs (See BPC, § 3502.1, subd. (b)(2).)

Supervision requirements

- Removes requirement that each episode of care for a patient identify the physician responsible for the supervision of the PA
- Unless the practice agreement requires it, supervising physician no longer must review or countersign the medical records of a patient treated by PA
- Supervising physician must provide adequate supervision of a PA as agreed to in **practice agreement**
- Supervising physician need not be physically present while PA provides medical services but must be available by telephone or other electronic communication method at the time PA examines the patient (See BPC, § 3501, subd. (f)(1)(A)-(B).)

Supervision requirements (continued)

- Supervision means that a physician oversees and accepts responsibility for the medical services provided by the PA (See BPC, § 3501, subd. (f)(1).)
- PA must be supervised by a physician who has privileges to practice in that hospital
- Except as provided in Business and Professions Code section 3502.5 (state of war or emergency), a physician shall not supervise more than four physician assistants at any one time
- The Medical Board of California may restrict a physician and surgeon from supervising specific types of PAs including, those PAs practicing outside the field of specialty of physician (See BPC, § 3516.)

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Nurse Practitioner Scope of Practice

Practice authority

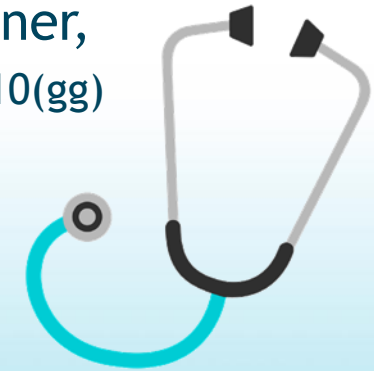
- Nurse practitioners must have **a standardized procedure or protocol** in place that must be developed and approved by the supervising physician Cal. Bus & Prof Code §2836.1.
- The NP does not have an additional scope of practice beyond the usual RN scope and must rely on standardized procedures for authorization to **perform overlapping medical functions** (CCR Section 1485)

Prescriptive authority

- NP may furnish drugs and devices within the NP's area of practice
- Drugs or devices furnished by NP must be ordered in accordance with the policies and protocols set forth in the agreement with the supervising physician
- Physician involvement is required when the NP is furnishing Schedule II or III controlled substances, and a patient-specific protocol is required. Cal. Bus. & Prof. Code §2836.1

Nurse Practitioner as a primary care provider

- NPs are recognized in state policy as primary care providers
- Primary care provider means a person responsible for coordinating and providing primary care to members, within the scope of their license to practice, for initiating referrals and for maintaining continuity of care
- A primary care provider may be a primary care physician or non-physician medical practitioner including a nurse practitioner, certified nurse midwife or physician assistant. 22 CCR §53810(gg)



Supervision of NP

- Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include:
  - Collaboration on the development of the **standardized procedure**
  - Approval of the standardized procedure, and
  - Availability by telephonic contact at the time the patient is being examined by the nurse practitioner.
  - For furnishing purposes, the physician may supervise a maximum of no more than four (4) NPs at one time (BPC 2836.1)

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Data Insight:

Cases Involving Physician Assistants and Nurse Practitioners

Introduction

- This publication contains an analysis of the aggregated data from MedPro Group's **cases closing between 2009-2018 with an indicator of a Physician Assistant (PA) or Nurse Practitioner (NP) involvement in the case.**
- 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, or ancillary providers.
  - 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.
  - A comparison to other physician cases is provided for perspective.

Highlights: PA/NP cases

- Involve PAs or NPs who played a contributing role in the patient's outcome.
  - Cases are representative of approximately **10% of all physician and hospital cases**.
  - **Two-thirds involve outpatients** (includes all outpatient settings and ED).
  - Of the total, **56% involve PAs and 44% involve NPs.**
- When compared to physician/hospital cases they:
  - Result in slightly higher frequency of clinically severe patient outcomes.
  - Result in similar frequency, and payment size, of indemnity payments.
- More likely to involve:
  - Diagnostic related, office-based claims;
  - General medicine, Orthopedic, and Emergency specialties; and,
  - Communication, credentialing, training and supervision contributing risk factors.

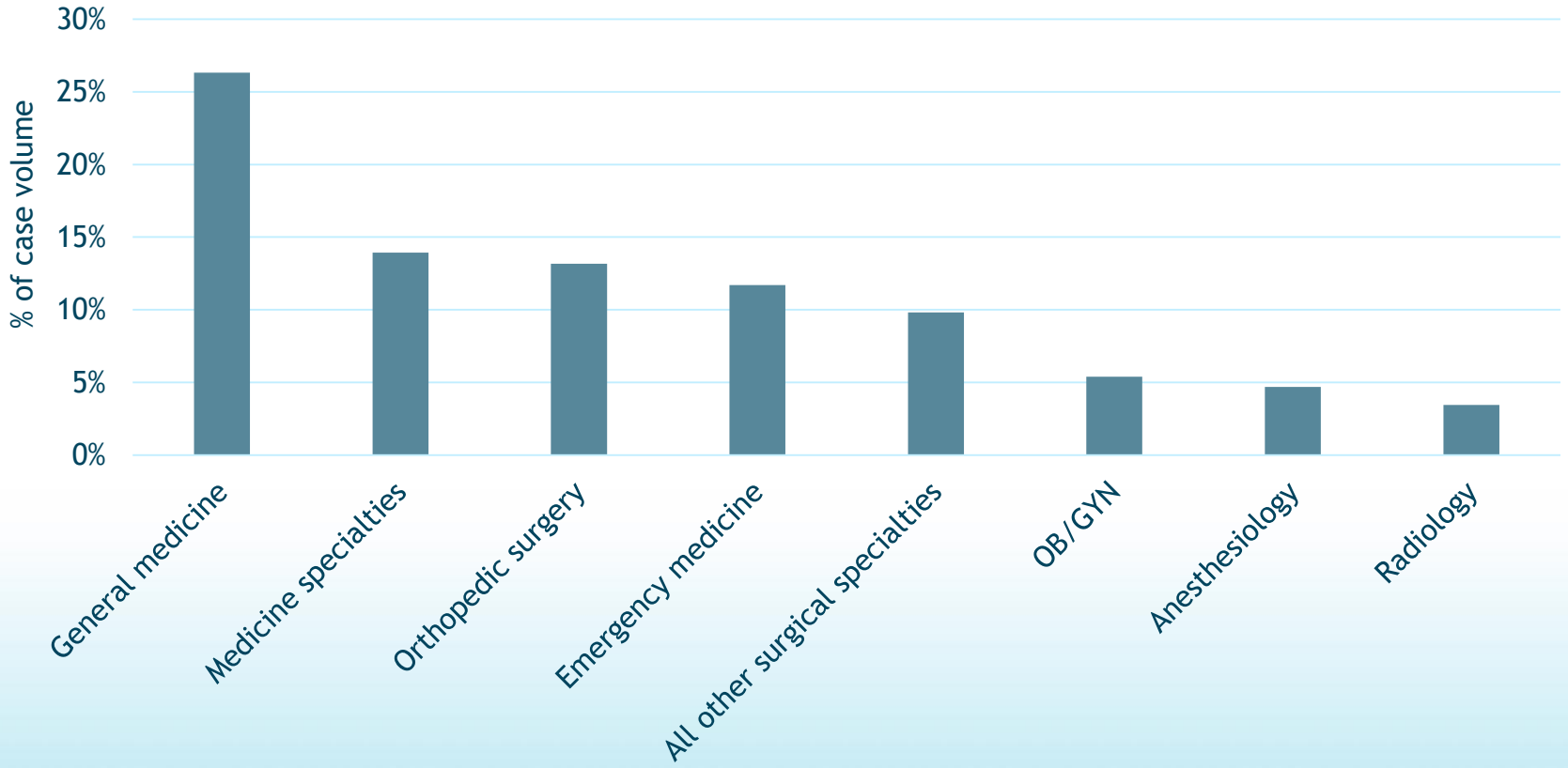
Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome

Primary responsible services

A malpractice claim 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.

Within the coding taxonomy, PAs and NPs are not identified as the primary responsible service; instead, the specialty under which they practice is identified, giving insight into the wide scope of specialties who utilize the services of these advanced practice providers.

Most frequent responsible service types

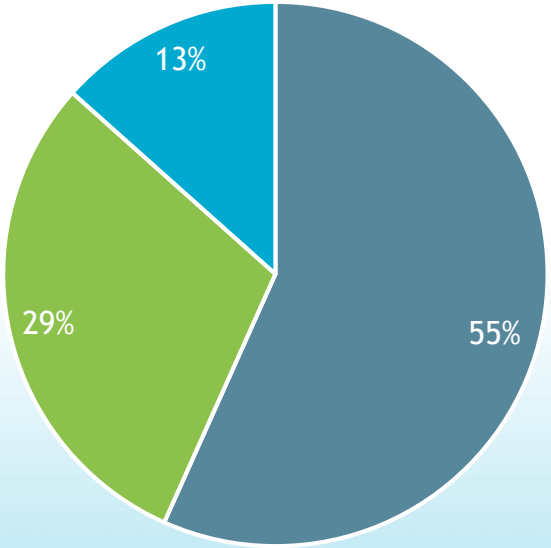


Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome

Claimant type – a comparison

PA & NP cases are noted less often in the inpatient setting.

PA/NP

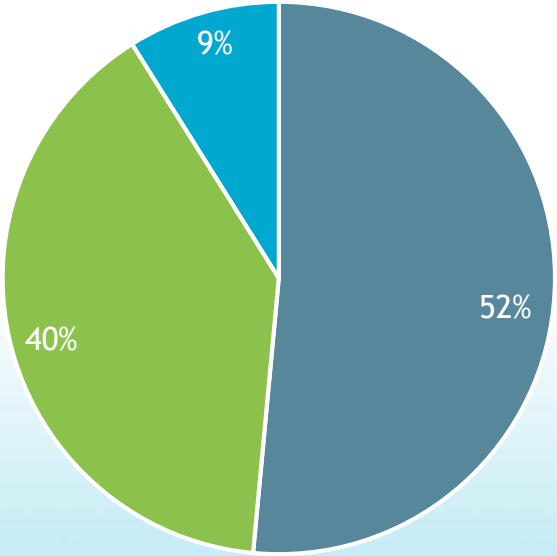


Outpatient

Inpatient

Emergency department

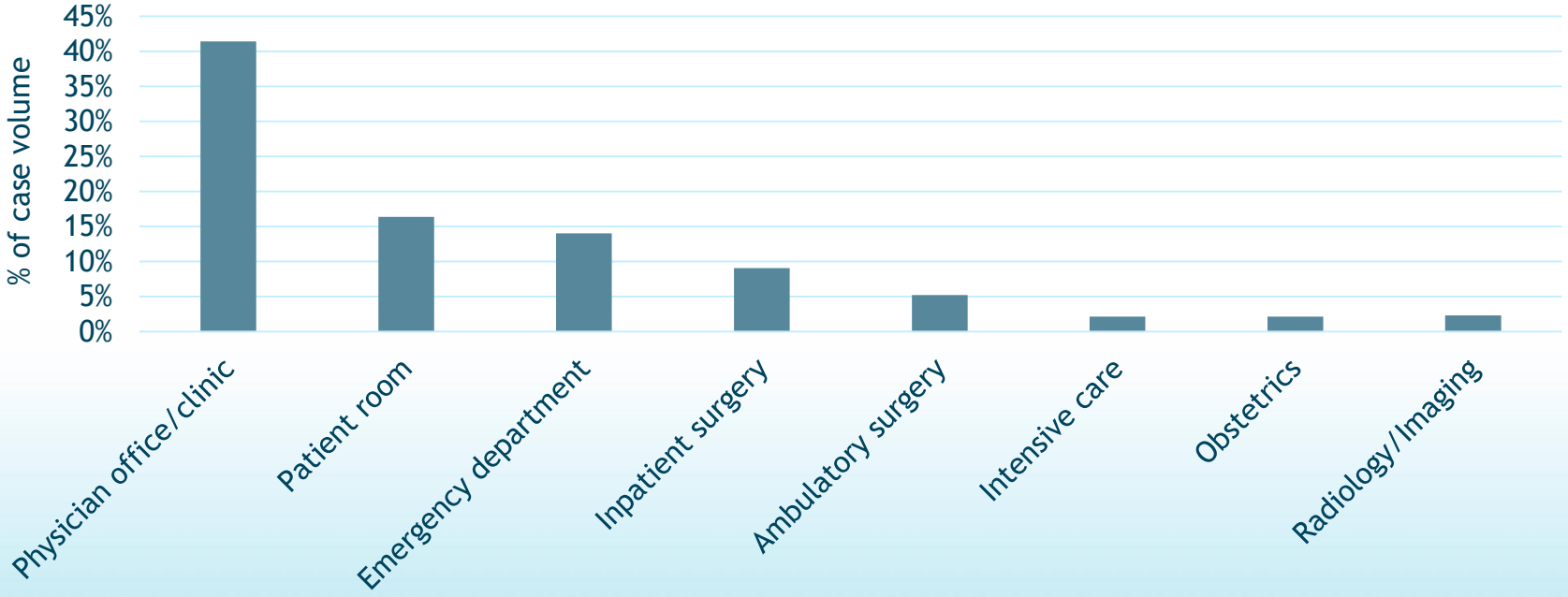
All physician



Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome; any totals not = to 100% are a result of rounding

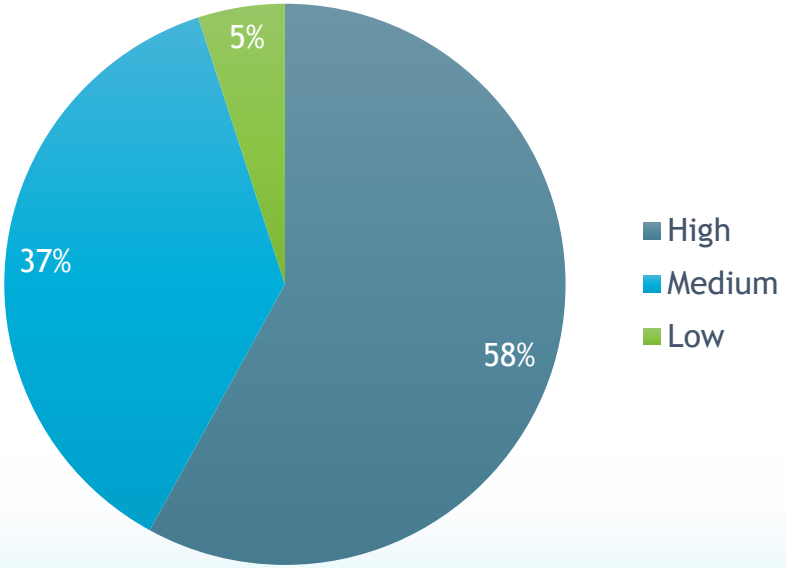
Specific location of the event

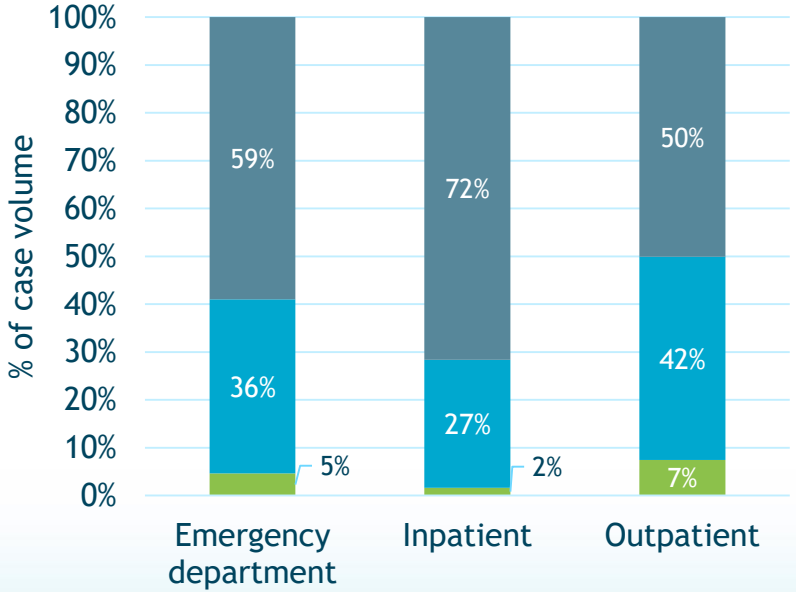
The majority of cases arise in the office setting. Of note, there has been a slight upwards trend in the number of cases arising in an inpatient setting across the most recent 5 years (2014-2018) of this analysis.



Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome

Clinical severity*





PA & NP cases involve a high clinical severity patient injury slightly more often than do all physician cases (53%). Like the PA & NP cases, a larger percentage of all high severity physician cases arise in the ED & inpatient settings.

Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome; *NAIC rating scale; any totals not = to 100% are a result of rounding

Allegations

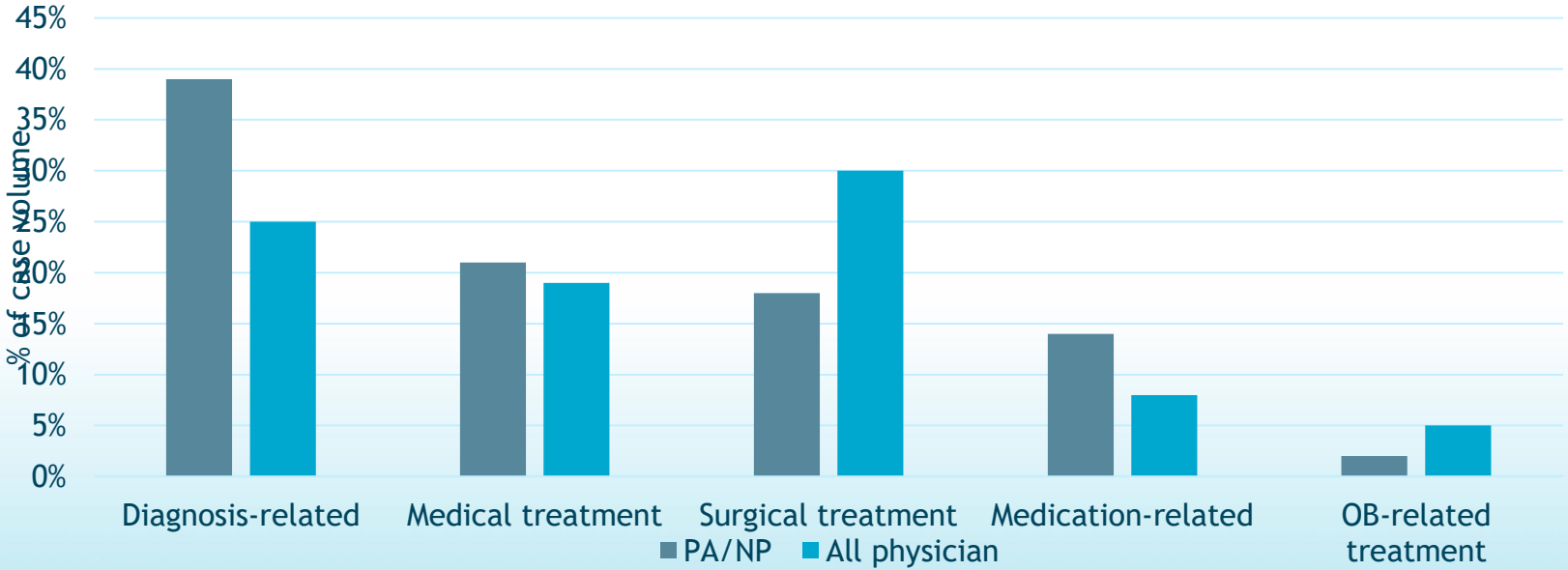
Multiple allegation types can be assigned to each case; however, only one “major” allegation is assigned that best characterizes the essence of the case. Within the coding taxonomy, each allegation category is comprised of several sub-categories.

Cases involving PAs and NPs are primarily diagnosis-related; these and medication-related cases seen more frequently when compared to all physician cases.

Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome

Major allegation categories – a comparison

Notable differences between PA & NP cases:
PAs are more often involved in surgical allegations than NPs (23%, 12%, respectively).
NPs are more often involved in medication-related allegations than PAs (16%, 11%, respectively).



Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome

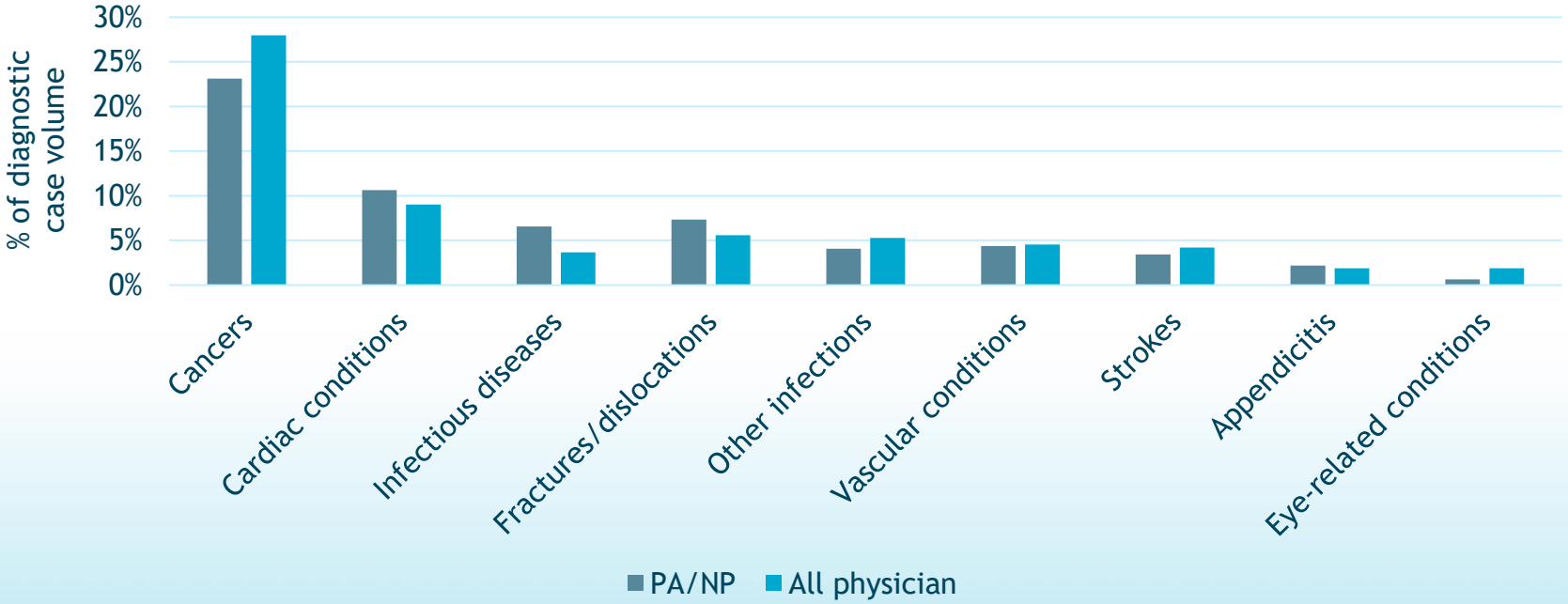
Most frequent allegations* – by claimant type

Allegation category	Outpatient % of case volume	Emergency department % of case volume	Inpatient % of case volume
Diagnosis-related	40%	75%	22%
Medical treatment	23%	16%	17%
Medication-related	18%	5%	10%
Surgical treatment	13%	2%	36%
OB-related	1%	1%	6%

Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome; *accounting for >90% of all allegations by each claimant type

Focus on diagnosis-related allegations – the diagnoses

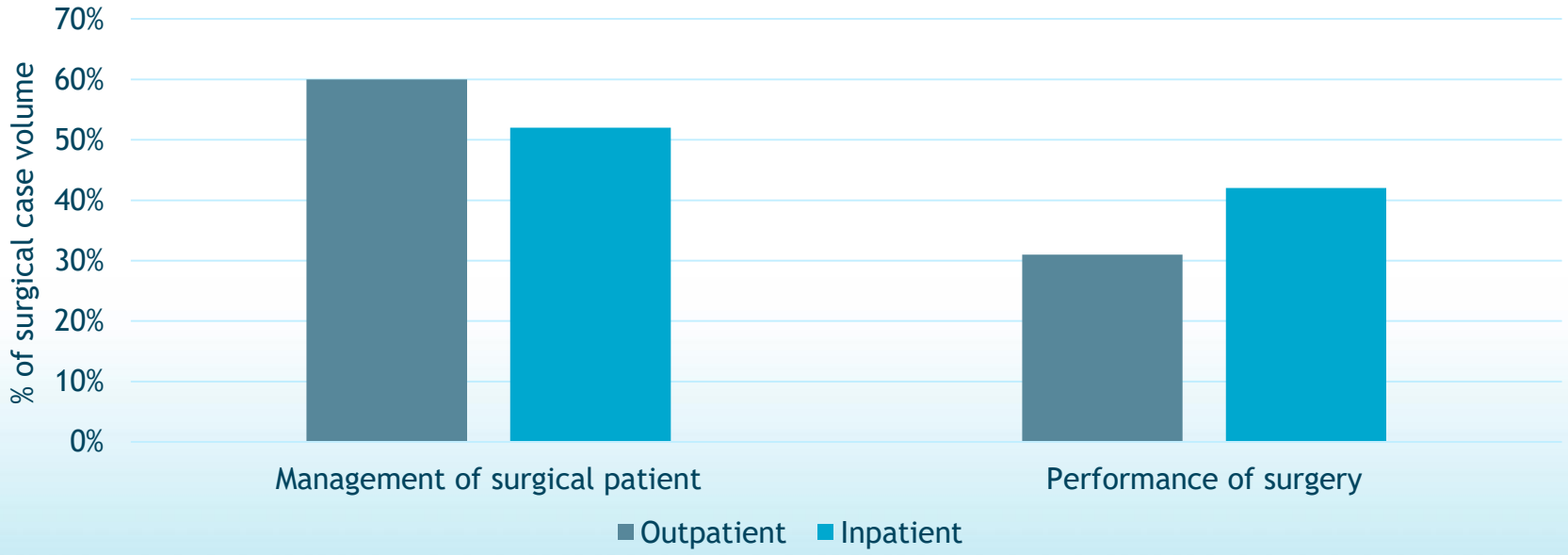
As with physician cases, missed/delayed/wrong diagnoses of cancer and cardiac conditions are the most frequent. Inadequate patient assessments and diagnostic decision-making are frequently noted risk issues.*



Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome; * to be addressed more fully on subsequent pages

Focus on surgical treatment allegations

PA/NP post-operative management of the patient is more often the issue, rather than circumstances involving the actual procedure. Inadequate provider to provider communication, failure to appreciate and recognize clinical signs and symptoms of complications, and improper education/training are recurring risk issues.*



Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome; * to be addressed more fully on subsequent pages

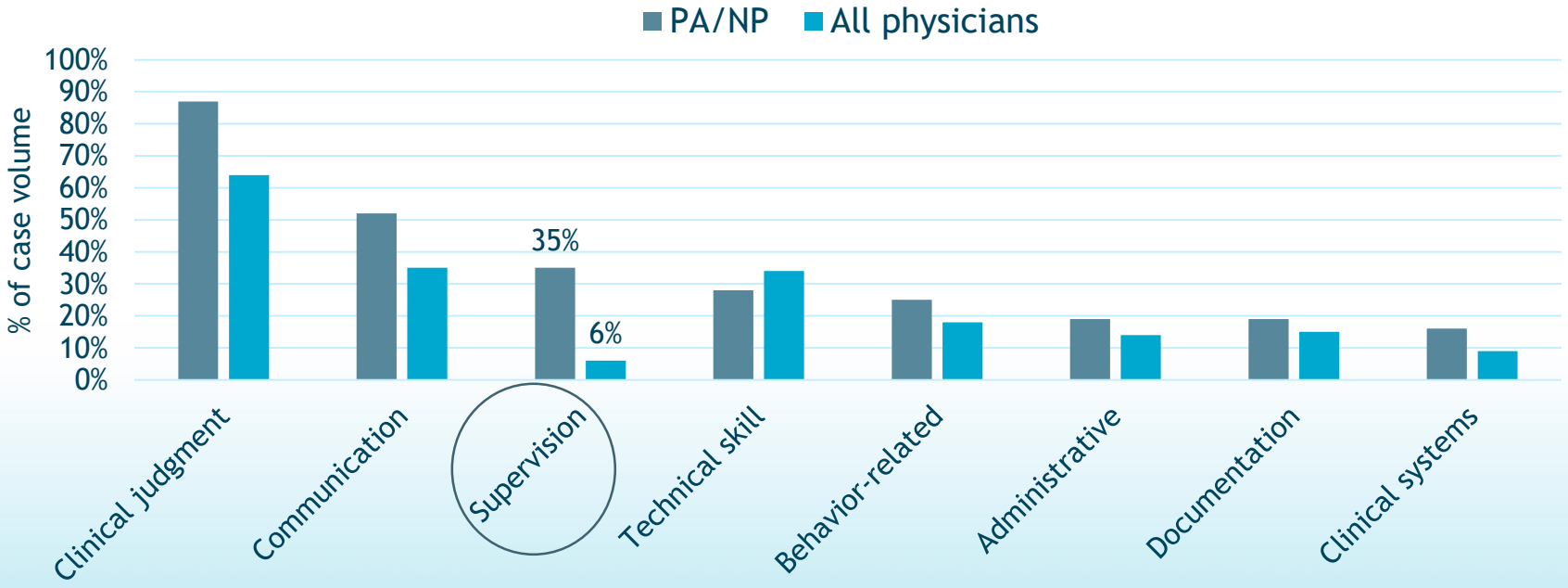
Contributing factors

Contributing factors are multi-layered issues or failures in the process of care that appear to have contributed to the patient outcome and/or to the initiation of the case. Generally there is not just one error that leads to these cases, but rather a combination of issues.

Most risk issues are found across all settings, although some are more prevalent in specific locations.

Contributing factors – a comparison

The prevalence of diagnosis-related allegations increases the volume of clinical judgment factors. Supervision (especially in outpatient settings) is noted in more than one-third of the PA/NP cases.



Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome; more than one issue is coded per case, therefore totals do not = 100%

Communication failures – a common theme

Insufficient communication with other providers, nurses ,and supervising physicians regarding relevant facts about the patient's care is a concern noted across all locations.

However, these issues are more prevalent in locations where multiple providers are more likely to be involved with a patient's care (inpatient and the emergency department).

Cases involving insufficient provider to provider communication tend to be more expensive to defend than cases without such issues.

Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome

Case example: Narrow diagnostic focus and failed communication

Patient	65 year old male presented to office with onset of shortness of breath & lightheadedness, & a history of diabetes, hypertension & smoking
Summary	Physician assistant (PA) ordered stat chest x-ray, read by radiologist as indicative of pneumonia and a widening of the mediastinum. Upon receipt of the results, the PA ordered cough medicine and an antibiotic to treat the pneumonia.
	PA recommended the patient follow up with a chest CT due to vascular abnormality seen on the x-ray, but the patient delayed due to not feeling well.
	One week later, the patient called to report persistent shortness of breath; PA ordered a dose of tapering steroids but did not ask the patient to come in to the office for evaluation and did not remind the patient that the CT had not yet been completed.
	Several days later, the patient obtained the chest CT. Results revealed bilateral pleural effusions, but the report was not called to the PA by the radiologist. The PA did not read the report until the next day when the patient's wife called to report more symptoms.
Outcome	The patient was sent to the ED where it was determined he had suffered a myocardial infarction and stroke.

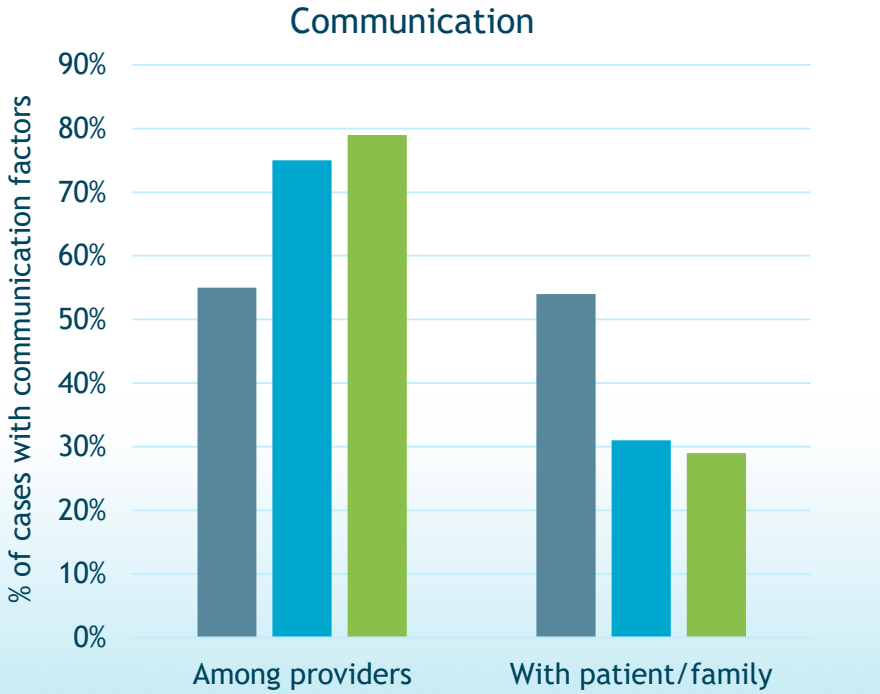
Contributing factors – important distinctions by claimant type

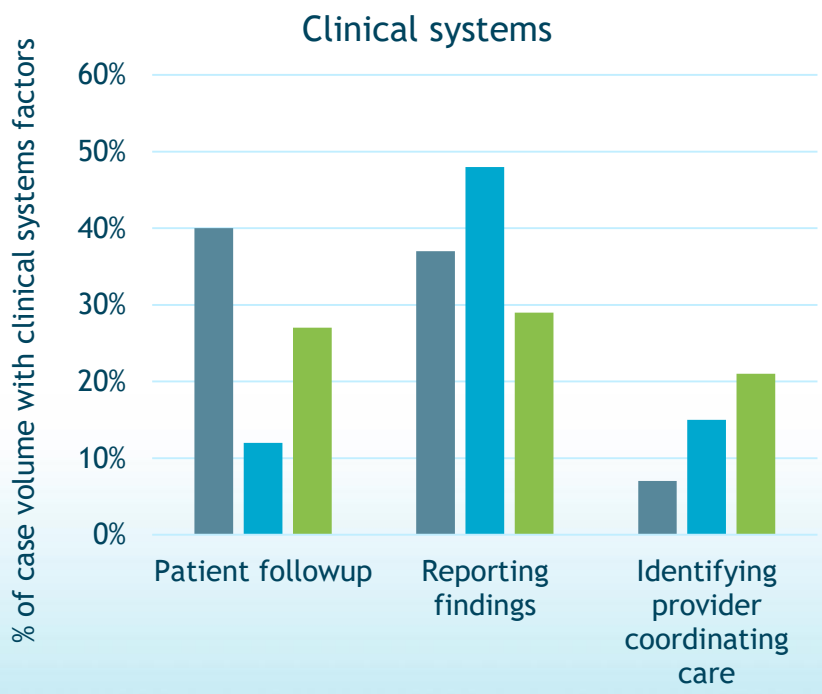
Outpatient	**Breaks in clinical systems** designed to ensure diagnostic findings are followed-up in a timely manner and reported to the patient; and, **Patient behavioral issues**, specifically those involving non-adherence to recommended treatment; can have a detrimental impact on outcomes.
Emergency department	**Breaks in clinical systems** designed to ensure that diagnostic findings are reported to the provider and to the patient; this process is often complicated **by diagnostic test results** which are not returned until after the patient has been discharged.
Inpatient	**Inconsistent coordination of care** amongst providers; and, **Inadequate patient monitoring** for evolving signs and symptoms.

Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome

Contributing factors – important distinctions by claimant type

Outpatient | Emergency department | Inpatient





Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome

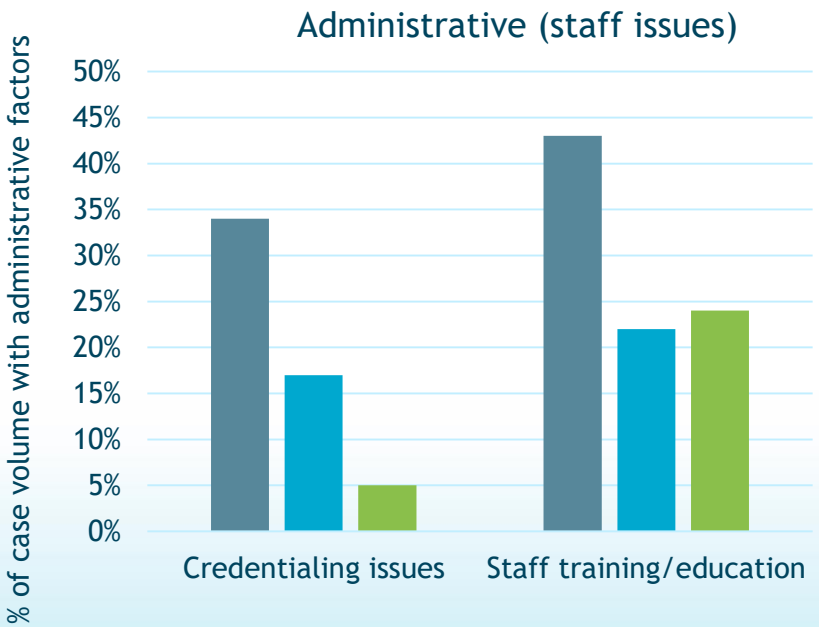
Contributing factors – additional distinctions by claimant type

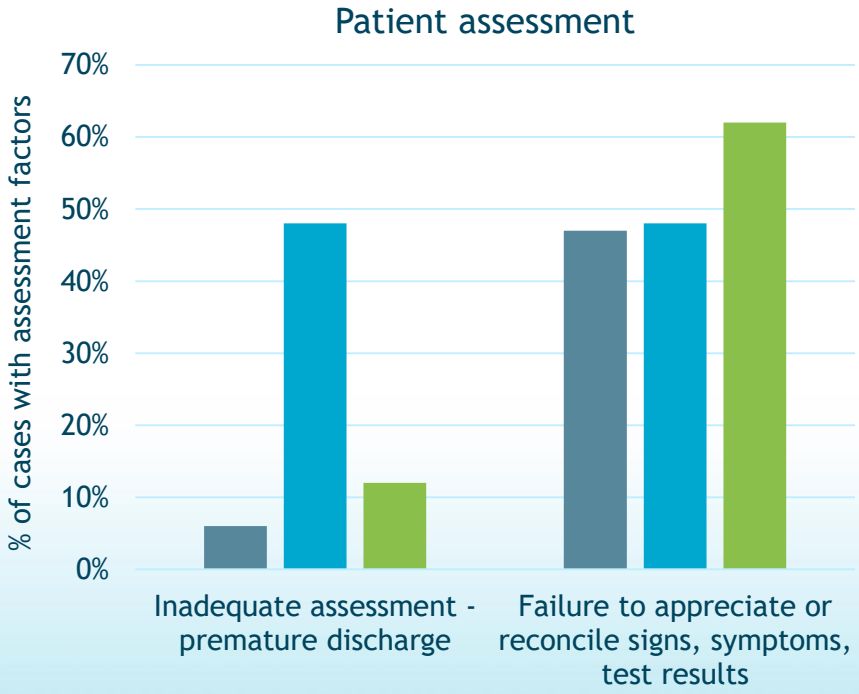
Outpatient	**Inadequate staff training/education and credentialing** factors are significantly more frequent in the office setting.
Emergency department	Premature discharge from care due to **poor patient assessment** is predominately an emergency issue.
Inpatient	Failure to appreciate (and reconcile) the significance of evolving **patient signs, symptoms** and test results is noted more frequently in the inpatient setting.

Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome

Contributing factors – additional distinctions by claimant type

Outpatient | Emergency department | Inpatient





Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome

Case example: Failure to establish differential diagnosis leads to premature discharge from the ED

Patient	Female in her mid-forties presented to ED with sudden onset of neck and upper back pain during exercise
Summary	Patient was triaged to the “quick care room” for evaluation by nurse practitioner (NP).
	Patient reported prior history of TMJ and symptoms were noted to be consistent with past flares.
	NP did not order any cardiac diagnostic testing, but did prescribe pain medications and muscle relaxants, with instructions for the patient to follow up with an oral surgeon and neurologist in two days if no improvement.
	Patient was discharged with diagnoses of cervical strain with spasm and TMJ exacerbation.
Outcome	One hour later, the patient was returned to the ED via ambulance but succumbed to what an autopsy revealed as coronary artery disease with significant blockage.

Summary

- Physician assistants and/or nurse practitioners are noted as contributorily responsible providers in 10% of physician/hospital cases over this time period.
- Clinical and financial severity, allegations, and associated responsible services track similarly to that of all physician cases with a few noted exceptions:
  - More outpatient cases with PAs/NPs:
    - Emergency department and office settings account for over two-thirds of all cases and are more frequently diagnostic in nature.
  - Within the inpatient cases:
    - Surgery-related allegations, specifically those involving post-operative patient management are the most frequent, followed by diagnosis-related allegations.
- PAs are noted in more surgery allegations, but more medication-related allegations are attributed to NPs.
- **Supervision, coordination of care, provider communication, credentialing and training** are common contributing risk factors, with differences noted between practice settings.

Recommendations

- Insufficient communication with other providers, nurses and supervising physicians regarding relevant facts about the patient's care is a concern.
  - Ensure PAs/NPs are comfortable communicating their concerns
  - Ensure hand-off communication is effective and unrushed
  - Invoke the "stop the line" concept for high risk patients
  - Encourage escalation of concerns up the chain of command
- Documentation styles can be widely varied when multiple providers (supervising physician and PA/NP) are involved in a single patient's care.
  - Inconsistent documentation of patient symptoms and a provider's clinical rationale for treatment can result in patient care errors and create malpractice case defensibility issues

Recommendations, continued…

- Insufficient supervision/oversight/training is a frequently noted risk issue in cases.
  - Supervision involves more than just signing agreement
  - Ensure that required supervision is a regular, on-going activity
  - Establish that all staff working on your behalf fully understand policies & procedures
  - Communicate how you will assess competency of PAs/NPs in performing role
  - Use time to ensure that the PA/NP is comfortable relating doubts or questions
- Scope of practice is something that should be defined for each PA/NP and can be enhanced and/or expanded upon demonstration of requisite skills and knowledge
  - Not all PAs/NPs are the same; different experiences should result in more or less supervision
  - PAs/NPs are not typically assigned a specialty designation. Therefore their interchangeability into other “specialty” jobs (say, surgery to primary care) should be treated with caution. Regardless of length of experience as a PA or NP, they may need to be viewed as a novice in a new setting.

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Risk Management Strategies

Common Risks Associated with NPs and PAs

1. Inadequate supervision
2. Exceeding scope of practice
3. Poor communication with supervising physician
4. Failures and delays in diagnosis, treatment, medication
5. Failure to obtain tests

Common Claims Findings

1. Absence or inadequate practice guidelines
2. Failure to consult with a physician
3. Inadequate supervision
4. Assumption of too much responsibility
5. Indemnity payment often made by supervising physician's policy
6. Most prevalent misadventure for PAs and NPs: error in diagnosis

43

Theories of Liability

1. Physician's breach of duty of care for a patient
2. Vicarious liability for acts of the agent
3. Unprofessional conduct
   - Ignorance of a provider's licensure status is not a defense that a physician employed, aided or abetted an unlicensed person to engage in the practice of medicine (*Kahn v. Division of Medical* Quality (1993) 12 Cal.App.4th 1834, 16 Cal.Rptr.2d 385)

Theories of Liability

1. Negligent supervision
   - Failure to follow PAC and BRN regulations
   - Respondeat superior
   - Controls action of AHP (vicarious liability)

2. Negligent credentialing
   - Failure to verify education and licensure status

3. Disciplinary action
   - Unprofessional conduct
   - Exceeding scope of practice
   - Hiring unlicensed persons

45

Top 10 Risk Mitigation Strategies

1. Credentials and background check
2. Training, periodic review and evaluation for clinical competence and documentation
3. Ensure skill competency
4. Review and update agreement and SP to ensure it complies with the law
   - Written protocols
   - Avoid protocols that may create unrealistic standards

46

Risk Mitigation Strategies (continued)

5. Appropriate supervision
   - Continually monitor; ensure skill level not beyond legal allowances for the state
   - Understand the difference in scope of practice for both
6. Culture of safety
7. Chart audits
   - MD signature implies understanding and agreement with diagnosis and treatment plan
8. QI activity and risk management programs

47

Risk Mitigation Strategies (continued)

9. Collaborate with the NP and PA
10. Patient satisfaction surveys
11. Clarify situations requiring immediate communication with a physician
    - Symptoms and conditions that can be evaluated by NPs or PAs
    - Medical procedures that can be performed

48

Thank you

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Questions

Resources: MedPro Group

- Clinical Judgment in Diagnostic Errors: Let's Think About Thinking
  https://www.medpro.com/documents/10502/2820774/Article_Clinical+Judgment.pdf
- Communication in the Diagnostic Process
  https://www.medpro.com/documents/10502/2820774/Communication+in+the+Diagnostic+Process.pdf
- Supervision of Advanced Practice Providers
  https://www.medpro.com/documents/10502/2899801/Checklist_Supervision+of+Advanced+Practice+Providers.pdf
- Strategies to Support Patient Comprehension
  https://www.medpro.com/documents/10502/2899801/Checklist_Patient+Comprehension.pdf
- Test Result Communication Failures
  https://www.medpro.com/documents/10502/5086245/Communication+of+Test+Results.pdf
- Documentation Essentials
  https://www.medpro.com/documents/10502/2899801/Checklist_Documentation+Essentials.pdf

More resources are available at www.medpro.com/dynamic-risk-tools

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Follow us on Twitter @MedProProtector
twitter.com/MedProProtector

- Tools & resources
- Educational opportunities
- Consulting information
- Videos
- eRisk Hub Cybersecurity Resource

Education	Materials and resources to educate followers about prevalent and emerging healthcare risks
Awareness	Information about current trends related to patient safety and risk management
Promotion	Promotion of new resources and educational opportunities

A note about MedPro Group data

MedPro Group has entered into a partnership with CRICO Strategies, a division of the Risk Management Foundation of the Harvard Medical Institutions. Using CRICO's sophisticated coding taxonomy to code claims data, MedPro Group is better able to identify clinical areas of risk vulnerability. All data in this report represent a snapshot of MedPro Group's experience with specialty-specific claims, including an analysis of risk factors that drive these claims.

Disclaimer

This document should not be construed as medical or legal advice. Because the facts applicable to your situation may vary, or the laws applicable in your jurisdiction may differ, please contact your attorney or other professional advisors if you have any questions related to your legal or medical obligations or rights, state or federal laws, contract interpretation, or other legal questions.

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