

Allied Healthcare Professionals: What's the Risk?

Presenter

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Disclaimer

Information in this presentation is neither an official statement of position nor should it be considered professional legal advice to individuals or organizations.

Learning Objectives

Participation in this seminar will better enable participants to:

- Identify trends in malpractice claims related to physicians & allied healthcare professionals; and
- Revise practice patterns to mitigate professional liability risks created by allied healthcare professionals.

Allied Healthcare Professionals

Allied Healthcare Professionals

- Advanced practice nurses
 - Nurse practitioners
 - Nurse anesthetists
 - Nurse midwives
- Physician assistants

Allied Healthcare Professionals

- Growing numbers in healthcare
 - Both NPs & PAs nearly doubled in 10 years
 - American Association of Nurse Practitioners 2014 data = 205,000 NPs
 - National Commission on Certification of Physician Assistants 2013 data = 95,583 PAs

NP Fact Sheet. American Association of Nurse Practitioners Web site. <http://www.aanp.org/all-about-nps/np-fact-sheet>. Updated March, 2015. Accessed March 26, 2015.

2013 Statistical profile of certified physician assistants: An annual report of the National Commission on Certification of Physician Assistants. July, 2014. Available at <http://www.nccpa.net/Upload/PDFs/2013StatisticalProfileofCertifiedPhysicianAssistants-AnAnnualReportoftheNCCPA.pdf>.

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- Why AHPs growing in numbers?
 - Aging patient population
 - Larger patient population through legislation (Affordable Care Act)
 - Number of new physicians not meeting demand

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- Friction between physicians & nurses?
 - IOM suggests NPs & nurses can fill missing physician gap
 - AMA immediate response - physicians have more education & training
 - Physician-led healthcare teams best

The future of nursing: Leading change, advancing health. "Key Messages of the Report." Pg. 21-30. Washington, DC: The National Academies Press, 2011.

Patchin R. AMA Responds to IOM report on future of Nursing. American Medical Association Web site. <http://www.ama-assn.org/ama/pub/news/news/nursing-future-workforce.page>. October 5, 2010. Accessed March 26, 2015.

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- Patient viewpoint?
 - Small majority of patients prefer seeing a physician (if given a choice)
 - Numbers change depending on immediate availability of physician, type of complaints, race, sex, & patient's socioeconomic status

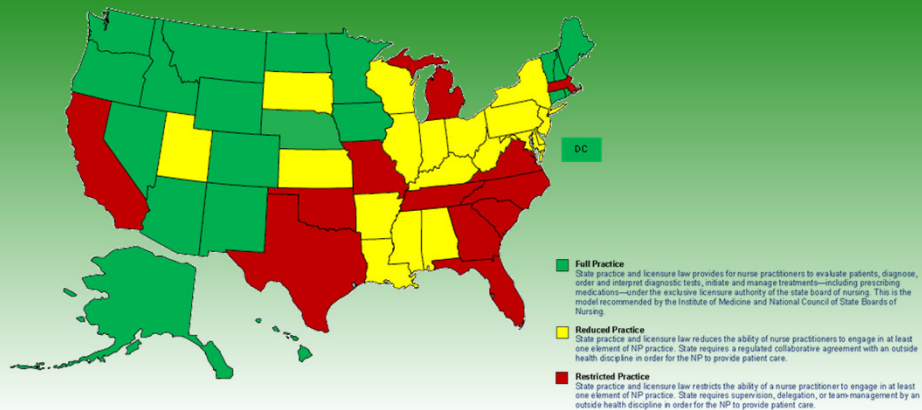
Dill M, Pankow S, Erikson C, Shipman S. Survey shows consumers open to a greater role for physician assistants and nurse practitioners. *Health Affairs*. 2013;32(6):1135-1142.

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AHP Regulations

- State specific
- Laws differ for NP's & PA's
- NP's typically require collaboration
- PA's require supervision
 - Usually requires immediate availability of physician (in-person, phone, or other telecommunications method)

2015 NP State Practice Environment



2015 Nurse practitioner state practice environment. American Association of Nurse Practitioners Web site.
<http://www.aanp.org/images/documents/state-leg-reg/stateregulatorymap.pdf>. Updated March 5, 2015. Accessed April 13, 2015.

AHP Regulations (cont'd)

- Trend for NPs & PAs - more stringent on entry into practice & less stringent on scope of practice
- Compliance with state regulations does not insulate AHP or physician working with AHP from professional liability claims or allegations

Gadbois E, Miller E, Tyler D, Intrator O. Trends in state regulation of nurse practitioners and physician assistants, 2001 to 2010. *Med. Care Res. Rev.* April, 2015;72:200-219.

National Practitioner Data Bank (NPDB)

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
MD or DO	13,613	11,737	11,256	10,862	10,783	9,885	9,780	9,518	9,447	8,875
APN	247	242	242	263	294	242	272	319	298	264
PA	104	103	107	120	132	150	179	164	172	168

- Paid claims against physicians have declined, but reported paid claims against AHPs have steadily risen
- AHPs involved in 3.9% of claims listed

National Practitioner Data Bank. Generated using the Data Analysis Tool at <http://www.npdb.hrsa.gov/analysisistool>. March 25, 2015.

National Practitioner Data Bank (NPDB) South Dakota

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
MD or DO	32	26	20	37	20	11	16	14	11	26
APN	0	0	1	1	1	0	1	1	1	0
PA	0	1	1	3	2	0	0	2	0	1

- SD - paid claims against physicians have declined
- Not enough data to trend AHPs
- AHPs involved in 7.5% of claims listed

National Practitioner Data Bank. Generated using the Data Analysis Tool at <http://www.npdb.hrsa.gov/analysisistool>. March 25, 2015.

Medical Professional Liability

- AHP rarely sole defendant
- Risks for physicians
 - Vicarious liability
 - Negligent training/supervision
 - Bad outcome for common patient

Central Anesthesia Associates v. Worthy

Court Decision: Anesthesiologist could not delegate supervision of a student-CRNA to a physician assistant (Central Anesthesia Associates P.C. v. Worthy, 254 Ga. 728 (1985)).

Quirk v. Zuckerman

Court Decision: Physician-patient relationship existed when care is communicated through MLP (Quirk v. Zuckerman, 765 N.Y.S.2d 440 (2003)).

Marchisotto v. Williams

Court Decision: Supervising physician is both medically and legally responsible for PA's actions when under the direction of the physician (Marchisotto v. Williams, 2006 WL 1152576 (N.Y.Sup. 2006)).

Common Allegations - AHPs

Failure to:

- Timely diagnose
- Timely refer to supervising/collaborating physician or specialist
- Improper performance

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Case Study 1

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AHP Case Study 1

- 61 YOM (5'10", 163 lbs.) c/o abd pressure; mild mid-sternal pain
 - HTN, hypercholesterolemia, family hx MI
 - Zestril, ASA, Viagra & Vitamin E
- Examined by PA
 - BP 140/78, P 99, & R 16
 - Normal physical exam
 - Bowel sounds slightly ↑ & tender to palp in epigastric areas

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Case Study 1 (cont'd)

- EKG: non-specific ST-T waves changes
 - Compared to prior EKG - no acute changes
- Prevacid & return for lab work
- Supervising physician did not evaluate pt
 - Concurred with PA's EKG interpretation

Case Study 1 (cont'd)

- Wife awakened by agonal respirations
 - Called 911 & began CPR
- Paramedics arrived
 - Pulseless, apneic, no BP, pupils fixed & dilated
 - Resuscitation unsuccessful
- Death certificate: COD - MI

Autopsy Report

- Multifocal CAD
 - 80-90% stenosis of LCX
 - 80% multifocal stenosis of LAD
 - 40-50% stenosis of RCA
 - Slight LVH; no evidence of aneurysm
- Bilateral pulm congestion, negative for PE
- Acute gastritis, normal esophagus, small bowel & pancreas
- Diverticulosis of sigmoid & rectal colon

Case Study 1 (cont'd)

- Lawsuit filed against practice & physician
- Allegation:
 - Failure to evaluate, dx, & treat heart disease resulting in MI & death
- Discussion
- Outcome: _____

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Case Study 2

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AHP Case Study 2

- 50 YOF (5'7", 220 lbs.) GYN exam by NP
 - Smoking 30 yrs - 1 ppd, seizures, GERD, anxiety, gall bladder surgery, hysterectomy & HTN
 - Tegretol, Premarin, Ativan, Maxzide, Pravachol, Adalat, & ketoprofen
- Normal BP & GYN exam
 - Hemorrhoids
 - R knee pain & swelling
 - Reminder for annual GYN exam

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AHP Case Study 2 (cont'd)

- Complaints of rectal bleeding
 - “On & off” blood on paper & in toilet
 - Constipation, alternating with normal BMs, abd pain, gas, bloating, & post-BM sensation
 - BP 152/86, wt 234 lbs
- External & internal hemorrhoids
 - Negative FOBT
- Assessment: hemorrhoids & IBS

AHP Case Study 2 (cont'd)

3 Months later

- Treated by GI for acid reflux
 - Denied hematemesis, hematochezia, & melena
 - Prilosec & follow-up in 6 months or earlier

AHP Case Study 2 (cont'd)

- Returned to NP c/o cysts on R wrist
 - Dx - benign ganglion cyst: referred to surgeon
 - Did not ask about hemorrhoids/rectal bleeding
- Presented to new physician for physical
 - No complaints
 - Colonoscopy & mammogram

AHP Case Study 2 (cont'd)

- Colonoscopy
 - Sigmoid mass consistent with Ca, multiple colon polyps, diverticulosis, & suboptimal prep
- Biopsy
 - Moderately differentiated adenocarcinoma with desmoplasia
 - Adenomatous polyp with severe atypism
- CT
 - Low density nodule in L lower liver
 - Consistent with cavernous hemangioma
 - No definite tumor identified

AHP Case Study 2 (cont'd)

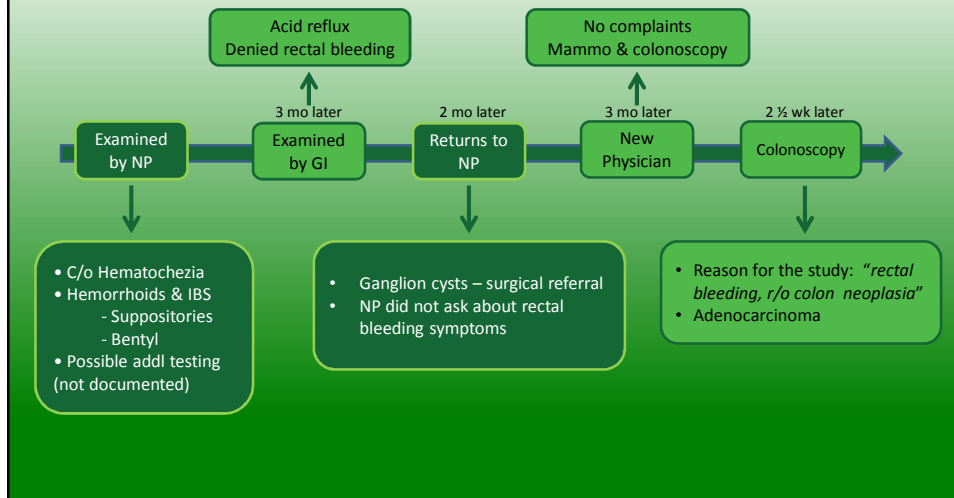
- Repeat colonoscopy
 - Multiple polyps
 - Rare diverticulosis
 - Sigmoid colon mass at 15 cm
- Referred to general surgeon
 - Resection of sigmoid colon & rectum
 - Partial omentectomy
 - Diverting transverse loop colostomy

AHP Case Study 2 (cont'd)

- Chemotherapy
- Lawsuit filed against NP & physician
 - Delayed Dx of colon Ca resulting in additional surgery, tx & recurrence

Case Study 2 Timeline

50YOF (5'7", 220 lbs.) Smoker, seizures, GERD, anxiety, hysterectomy & HTN



AHP Case Study 2 (cont'd)

- Outcome: _____

Suggestions for Physician Consultation

- Patient fails to respond to treatment
- Unexplained physical findings
- Computer EKG interpretation differs from AHP's interpretation
- EKGs performed due to symptoms
- Potentially serious or life-threatening conditions
- Emergencies after initial care
- Patient requests to see physician

Risk Mitigation Strategies

- Familiarity with applicable state laws
- Verify AHP's credentials upon hiring or supervising/collaborating
 - Recheck periodically
 - Some states require annual review of collaboration agreement
- Develop written collaborative care guidelines

Risk Mitigation Strategies

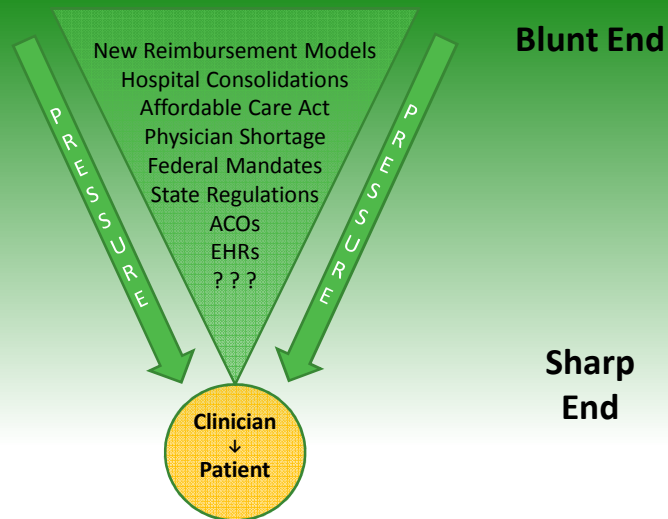
- Delegate functions/responsibilities consistent with both physician's & AHP's competence & expertise
- Periodically discuss AHP care with pts
 - Ask for honest, constructive feedback

Suggestions When New AHPs Join Your Practice

- Survey private payers for their AHP reimbursement guidelines
- Schedule one-on-one time for AHP with physician
- Develop & document scheduling protocols for staff
- Load appointment parameters into schedule
- Instruct billing office to train AHP
- Marketing & communication plan to introduce AHP
- Include professional development into compensation

Toth C. Seven surefire ways to start a nonphysician practitioner off right. *J Med Pract Manage.* 2014;29(4):214-215.

Two Ends of Health Care Systems



Liability Concerns

- Assuming too much responsibility
- Inadequate supervision
- Absence of/deviation from written protocols
- Exceeding scope of authorized practice or prescriptive authority
- Failure/delay in seeking collaboration or referral

Murphy's Law is Wrong!

What can go wrong usually goes
_____, and over time we come
to think a safety threat does
_____ or is not as bad.

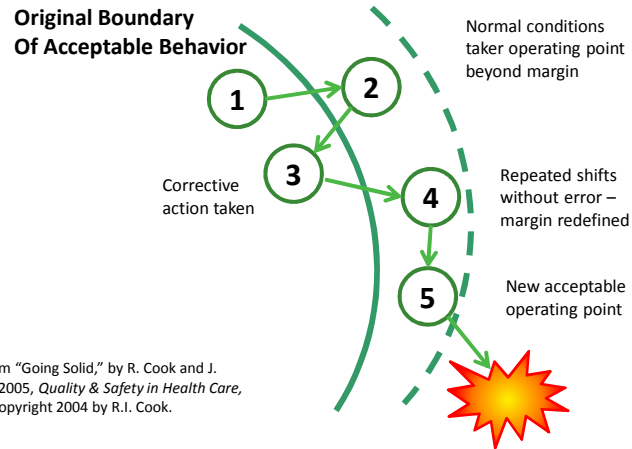
- Sydney Decker

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Normalization of Deviance

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Flirting With The Margin



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Risk Mitigation Strategies

- True collaboration = more than having or following agreement or protocol
- Review of care = more than signing-off on documentation
- Encourage communication, collaboration & questions

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SOUTH DAKOTA PHYSICIAN ASSISTANTS

Disclaimer: This information is provided for general guidance and should not be considered legal advice. Laws in this area are evolving and may have changed since this information was compiled. Please contact your local legal counsel for the most up-to-date information regarding the practice of Physicians Assistants in South Dakota.

Scope of Practice:

A PA may provide medical services that are delegated by the physician if the service is within the PA's skills, forms a component of the physician's scope of practice, and is provided with supervision, including:

- Initial medical diagnosis and institution of a plan of therapy or referral;
- Prescribing and provision of drug samples or a limited supply of labeled medications, including controlled substances listed on Schedule II in chapter 34-20B for one period of not more than thirty days, for treatment of causative factors and symptoms. Medications or sample drugs provided to patients shall be accompanied with written administration instructions and appropriate documentation shall be entered in the patient's record. PA's may request, receive, and sign for professional samples of drugs provided by the manufacturer;
- Responding to emergencies and initiating emergency treatments, including chemical or physical restraint orders when the patient may do personal harm or harm others;
- Completing and signing of official documents such as birth or death certificates;
- Taking X-rays and performing radiologic procedures; and
- Performing physical exams for participation in athletics. [[SDCL § 36-4A-26.1\(1-6\)](#)]

Supervision:

Defined as: "the act of overseeing the activities of, and **accepting responsibility for**, the medical services rendered by a PA." [[SDCL § 36-4A-1\(4\)](#)]

Practice Agreement:

- Authored and signed by the PA and the supervising physician.
- Prescribes the delegated activities which the PA may perform.
- Describes the PA's level of competence and supervision provided by the physician.
- A signed copy must be kept at the PA's primary practice site.
- A signed copy must be filed with and approved by the board prior to the PA beginning practice.
- No PA may practice without an approved practice agreement. [[SDCL § 36-4A-1.1](#)]

The practice agreement must also contain the practice location(s) of the PA, and the supervision plan. [[SDAR 20:52:01:03](#)]

A PA is considered an agent of the supervising physician in the performance of all practice-related activities. [[SDCL § 36-4A-26.1](#)]

The supervising physician must be continuously available for consultation. At least twice per month, the physician and the PA must meet face-to-face to discuss patient care and review the PA's practice. One of the two meetings may be held via telecommunications; however, this must be outlined in the supervision agreement and approved by the board. [[SDAR 20:52:01:03.01](#)]

If the PA is practicing at a location other than where the supervising physician practices, the supervising physician must be physically present in each practice location of the PA at least once every 90 days. [[SDAR 20:52:01:03.02](#)]

Prescribing:

Prescribing drugs is not directly addressed by the statutes other than as outlined above under "Scope of Practice."

SOUTH DAKOTA ADVANCED PRACTICE NURSES

Disclaimer: This information is provided for general guidance and should not be considered legal advice. Laws in this area are evolving and may have changed since this information was compiled. Please contact your local legal counsel for the most up-to-date information regarding the practice of Advanced Practice Nursing in South Dakota.

1. In General

Advanced Practice Registered Nurse includes both Certified Nurse Practitioners (CNP) and Certified Nurse Midwives (CNM). [[SDCL § 36-9A-1\(8\)](#)]

A CNP or CNM must:

- be licensed by the Board of Nursing as an RN;
- complete an approved program for the preparation of nurse practitioners, AND
- pass any examination which the board requires. [[SDCL § 36-9A-4](#)]

A. Scope of practice

1. Advanced practice nurses may: [[SDCL § 36-9A-13.1](#)]
 - i. Provide advanced nursing assessment, nursing intervention, and nursing case management;
 - ii. Provide advanced health promotion and maintenance education and counseling;
 - iii. Utilize research findings to evaluate and implement changes in nursing practice, programs, and policies; and
 - iv. Recognizing the limits of knowledge and experience, plan for situations beyond expertise and consult with or refer clients to other healthcare providers as appropriate.
2. In addition to the practices listed above for advanced practice nurses, Nurse practitioners also may: [[SDCL § 36-9A-12](#)]
 - i. Make initial medical diagnoses and institute plan of therapy or referral.
 - ii. Prescribe medications and provide drug samples or a limited supply of labeled medications, including controlled substances listed in Schedule II, for one period of not more than 30 days, for treatment of causative factors and symptoms. Medications must be accompanied with written instructions and appropriate documentation shall be entered in the patient's medical record.
 - iii. Write a chemical or physical restraint order when the patient may do personal harm or harm others.
 - iv. Complete and sign official documents such as death or birth certificates, or similar documents required by law.

- v. Perform physical examinations for participation in athletics and the certification that the patient is healthy and able to participate in athletics.

B. CRNA's

1. In addition to all the functions allowed to be performed by a registered nurse, a CRNA may also do the following:
 - i. Develop an anesthesia care plan;
 - ii. Induce anesthesia;
 - iii. Maintain anesthesia at the required levels;
 - iv. Support life functions during perioperative period;
 - v. Recognize and take appropriate action for untoward patient responses during anesthesia;
 - vi. Provide professional observation and management of the patient's emergence from anesthesia during the immediate postoperative period;
 - vii. Conduct post-anesthesia visit and assessment when appropriate; and
 - viii. Participate in the life support of the patient for whatever cause. [\[SDCL § 36-9-3.1\]](#)
2. These functions must be performed in collaboration with a licensed physician, as a member of a physician-directed health care team.
 - i. Collaboration is defined in this section as “the act of communicating pertinent information or consulting with a physician member of the healthcare team, with each provider contributing their respective expertise to optimize the overall care delivered to the patient.” [\[SDCL § 36-9-3.1\]](#)
3. A CRNA may perform these functions in either:
 - i. A licensed healthcare agency either as an employee or as granted privileges by the agency, its medical staff and its governing body; or
 - ii. The office of a licensed physician. [\[SDCL § 36-9-3.2\]](#)

2. Prescribing

Certified Nurse Practitioners and Certified Nurse Midwives may prescribe controlled substances under the following requirements:

- The CNP or CNM must have a collaborative agreement authorizing prescriptive authority, including controlled substances;
- The CNP or CNM must obtain South Dakota controlled substances registration through the Department of Health; and
- Must register with the DEA at an address in South Dakota.

3. Supervision

- A CNP or CNM “may perform the overlapping scope of advanced practice nursing and medical functions only under the terms of a collaborative agreement with a licensed physician.” [\[SDCL § 36-9A-17\]](#)

- A CNP or CNM must collaborate with a licensed physician. Collaboration by direct personal contact with each collaborating physician must occur at least twice per month, unless the Agreement states otherwise, then it can be once per month in person and once via telecommunication. [[SD Admin. Code § 20:62:03:03](#)]
- A Collaborative agreement is required. The Collaborative agreement must be reviewed and approved by the boards. [[SD Admin. Code § 20:602:03:08](#)]
- A Collaborative agreement is defined as: “a written agreement authored and signed by the nurse practitioner or nurse midwife and the physician with whom the nurse practitioner or nurse midwife is collaborating. A collaborative agreement defines or describes the agreed upon overlapping scope of advanced practice nursing and medical functions that may be performed, consistent with § 36-9A-12 or 36-9A-13, and contains such other information as required by the boards. A copy of each collaborative agreement shall be maintained on file with and be approved by the boards prior to performing any of the acts contained in the agreement.” [[SDCL § 36-9A-15](#)]