Advanced Practice Providers: Risk Strategies for Supervision

EXPLORE 2023

Speaker bio

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Dr. Billingham has 35 years of experience as an emergency medicine physician. He speaks nationally on emergency medicine and has lectured in more than 300 CME courses on risk management, operations, patient safety, documentation, information technology, coding and billing, and malpractice prevention.

As MedPro's Chief Medical Officer, he is responsible for leading the company's Patient Safety & Risk Solutions team and working with other leaders to support clinical risk, claims, underwriting, and sales efforts.

Prior to joining MedPro, Dr. Billingham served as President and CEO for EPIC RRG. He also served on the physician advisory boards of several technology companies and the American College of Emergency Physicians' Medical Legal Committee and Coding and Nomenclature Committee. He is Emeritus Chairman of the Emergency Medicine Patient Safety Foundation and has served on the Emergency Department Practice Management Association's Board of Directors.

Dr. Billingham also founded and served as Medical Director for the Center for Emergency Medical Education and was a co-founder of the National Emergency Medicine Board Review Course.

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Today's faculty, as well as CE planners, content developers, reviewers, editors, and Patient Safety & Risk Solutions staff at MedPro Group have reported that they have no relevant financial relationships with any commercial interests.

Objectives

At the conclusion of this program, participants should be able to:

- Differentiate the scope of practice for Nurse Practitioners and Physician Assistants
- Interpret claims data for Advanced Practice Providers
- Evaluate the common allegations asserted in medical malpractice cases that include Advanced Practice Providers
- Apply risk management principles and best practices to mitigate the risks of supervising these professionals.

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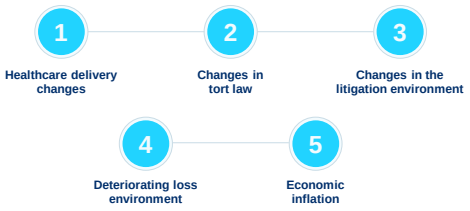
Healthcare Liability Market Update

5 macro factors impacting the US HCL industry



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1. Healthcare delivery changes

Corporatization of medicine
Including private equity investments

CV19 impact on population health
Deferred care, missed care, etc.

Healthcare consolidation
Larger, more complex healthcare systems

Healthcare staffing
Contract staffing, provider burnout, turnover, violence

Physician employment
Less private practice, more corporate/hospital

Scope of practice
Expanding for PAs, NPs, CRNAs, etc.

Shifting environment of care
More outpatient, home health, telehealth, etc.

Technology innovations
AI, genetics, etc.

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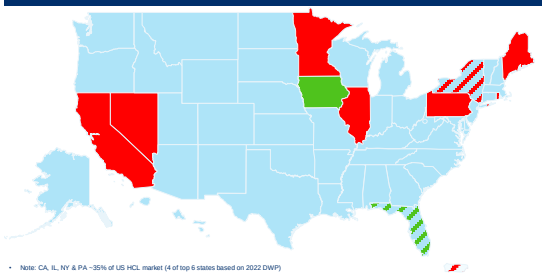
2. Changes in tort law



- Note: CA, IL, NY & PA ~35% of US HCL market (4 of top 6 states based on 2022 DWP)

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3. Changes in the litigation environment

- **COVID-19 impact**
  - Judges are pressuring parties to settle by setting unreasonable deadlines and stacking trial dates.
  - Directives from high courts are affecting scheduling.
  - Pressure creates difficulties for attorneys, experts, and insureds.
  - COVID-19 "healthcare halo" not a significant factor in influencing juries.
- **Compromise Verdicts/Splitting the Baby**: Jurors are awarding $$ even when liability not clear.
- **Aging trial bar**: we are focused on identifying and helping to train next-gen "First Chairs."
- **Changing jury pool**: what can we expect from millennial jurors?

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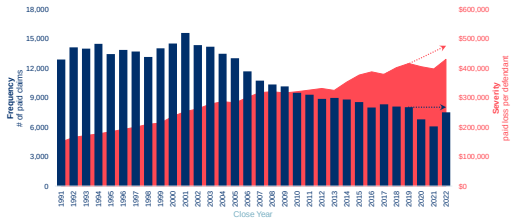
4. Deteriorating loss environment ...

- Industry trends: frequency flat & severity up



- Source: National Practitioner Data Bank Public Use Data File, December 2022, Physicians & Surgeons Countrywide

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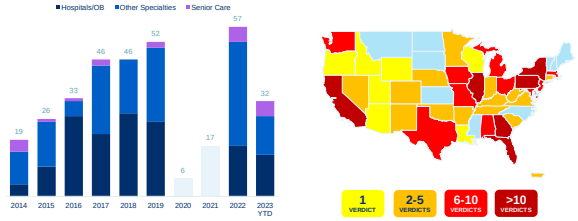
... severity & social inflation increasing: $10+ shock verdicts

- As courts reopen, US HCL verdicts $10+ resume … expanding beyond "Judicial Hellholes"



- Source: TransRe and various internet articles with publication dates between 01/01/2014 and 07/19/2023.

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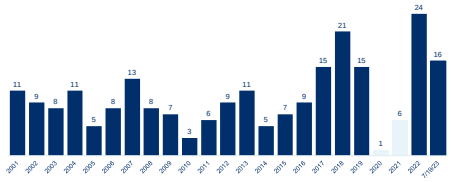
… including $25M+ aberration verdicts



- Source: Trans Re and various internet articles with publication dates between 1/1/2016 and 7/19/2023

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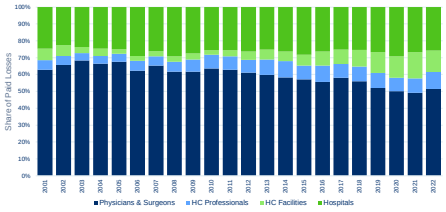
… and losses shifting from HC Providers to HC Entities



- Source: S&P Global Market Intelligence

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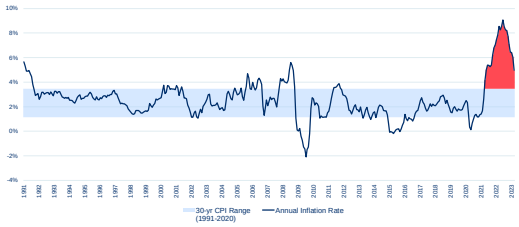
5. Economic inflation above historical norms



- Source: US Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers (CPI-U) https://data.bls.gov/timeseries/CUUR0000SA0

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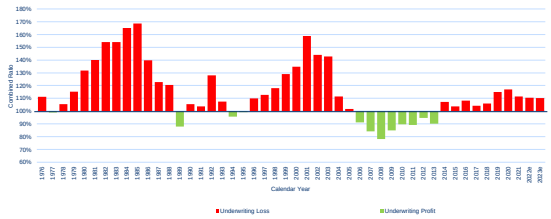
US HCL industry has poorly responded to recent challenges

- The industry continues to face profitability challenges …



- Sources: AM Best Aggregate & Averages, S&P Global Market Intelligence. Competitor dividends included. Excludes MedPro Group.

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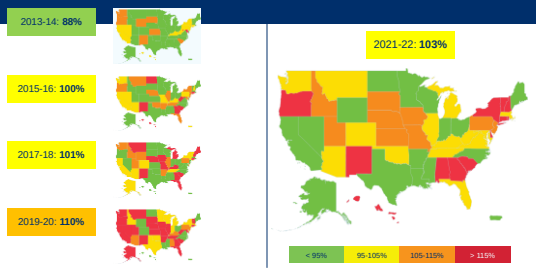
Another way to view US HCL industry



- Sources: S&P Global Market Intelligence. State Page Data and Ins. Exp. Exhibit – Allocation to Lines of Direct Business Written Data. HCL Combined Ratio before reinsurance. Competitor dividends included.

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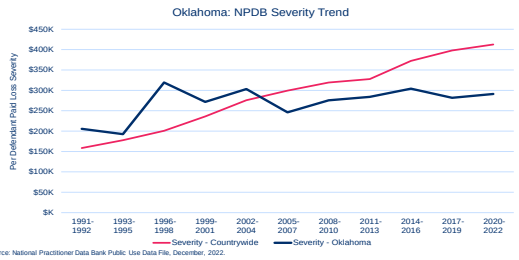
Oklahoma Market Update

All data YE 2022 and in $M unless noted

Oklahoma loss trends



- Source: National Practitioner Data Bank Public Use Data File, December, 2022.

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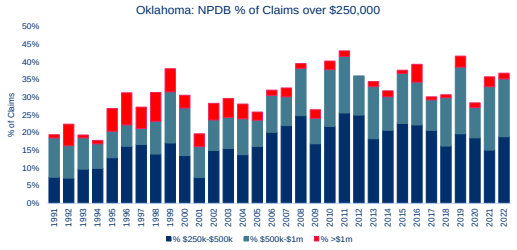
Oklahoma loss trends



- Source: National Practitioner Data Bank Public Use Data File, December, 2022.

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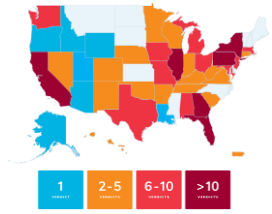
Increasing HCL shock verdicts / social inflation nationwide



Oklahoma > $10M

Nurse, Correctional Health	82
General Surgeon	17.5
Obstetrics, Hospital	15
Correctional Medicine	12.3

- Sources: Chart: Trans Re and various internet articles with publication dates between 01/01/2016 and 05/19/2023.

Hyperlinks to verdicts are clickable in slideshow mode

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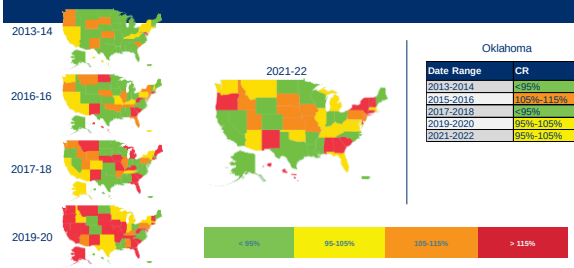
Increasing HCL industry underwriting losses



Oklahoma

Date Range	CR
2013-2014	<95%
2015-2016	105%-115%
2017-2018	<95%
2019-2020	95%-105%
2021-2022	95%-105%

- Source: S&P Global Market Intelligence. State Industry HCL combined ratio based on state incurred losses and defense costs, expenses, and policyholder dividends.

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Advanced Practice Providers

Key Points - Clinically Coded Data

- **Throughout this analysis, nationwide data reflecting nurse practitioners (NP) and physician assistants (PA) in a "primary role" is reflected, with targeted focus on several Oklahoma-specific data points.** Overall, Oklahoma case volume reflecting NP and PA involvement is low (N=57). In general, Oklahoma data compares similarly to the nationwide data.
- **NPs and PAs are noted in 18% of clinically coded cases opened between 2012-2021.** An increasing number of cases involving NPs and/or PAs are noted, and **most significantly, clinical and financial severity trends are climbing.**
- **Ambulatory settings** account for almost **two-thirds of the case volume**.
- **Diagnostic, medical, surgical and medication-related allegations** account for the majority of case volume. With the exception of surgical allegations, the distribution of allegations is similar among NPs and PAs.
  - Diagnostic allegations primarily reflect cancers, cardiac conditions and treatment of injuries (fractures, wounds). 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, and failures during the patient follow-up process.
- **Medical treatment allegations** reflect a higher volume of **medical management cases** as opposed to procedural issues. Procedural performance cases, which most commonly involve skin lesion excisions, can be impacted by delayed recognition of complications, while **management cases most often reflect issues with selection of the most appropriate procedure for the patient, and appreciating and reconciling symptoms and test results**.
- **Problems with selection of the most appropriate medication regimen,** monitoring/assessing the patient while on that regimen, insufficient education of patients/families about the risks of medications, and sub-optimal communication among providers about medication regimens and evolving signs/symptoms are the **most common contributing factors in medication cases**. Failure to identify which provider is coordinating care is noted as a specific risk issue in anticoagulant cases.

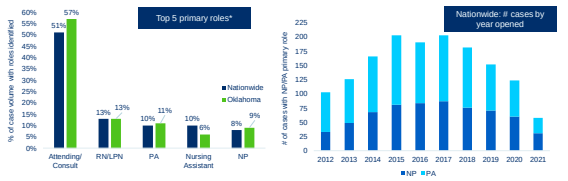
MedPro Group + MLMIC cases opened 2012-2021, NP or PA as primary responsible service rate (Nationwide N=1486, NP=640, PA=886; Oklahoma N=57, NP=27, PA=33); more than one rate possible per case)

Key Points - Clinically Coded Data

- **Cases involving the management of surgical patients,** including pre-, intra-, and post-operatively, are often related to NP or PA response to developing complications. While complications of procedures may have been the result of procedural error, the **failure to timely recognize and/or monitor/manage the issue prevents the opportunity for early mitigation of the risk of serious adverse outcome**.
- **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.
  - The three most common contributing factors linked directly to an NP or a PA are clinical judgment, communication and supervision. However, **administrative, documentation, clinical environment and clinical systems factors emerge as the evident drivers of closed case financial severity.**

MedPro Group + MLMIC cases opened 2012-2021, NP or PA as primary responsible service rate (Nationwide N=1486, NP=640, PA=886; Oklahoma N=57, NP=27, PA=33); more than one rate possible per case)

Overall Case Volume



While the attending/consult physician role is most prevalent, in the nationwide data, **NPs and PAs combined are noted in 18% of all cases***. As the involvement of NPs and PAs in healthcare has continued to climb, **it is not surprising to see cases noting NPs and PAs in the primary role steadily increasing over many of the past 10 years**. The unexpected more recent decline in this data set is likely related to the fact that not all cases opened in 2020 and 2021 have yet matured for coding.

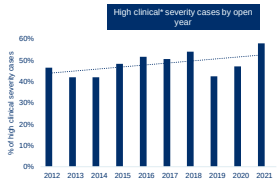
Clinical Severity*

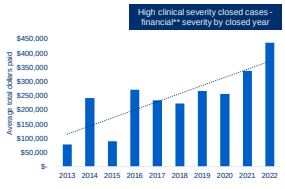
Clinical Severity Categories	Sub-categories	Nationwide % of case volume	OK % of case volume	Nationwide NP % of case volume	OK NP % of case volume	Nationwide PA % of case volume	OK PA % of case volume
LOW	Emotional Injury Only	8%	4%	8%	4%	7%	3%
	Temporary Insignificant Injury						
MEDIUM	Temporary Minor Injury	44%	40%	37%	37%	50%	45%
	Temporary Major Injury						
	Permanent Minor Injury						
HIGH	Significant Permanent Injury	48%	56%	55%	59%	43%	52%
	Major Permanent Injury						
	Grave Injury						
	Death						

Typically,

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

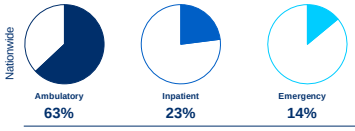
Nationwide: Clinical* & Financial Severity



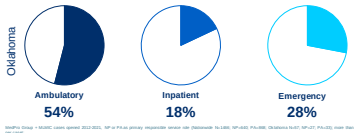


Across the years, the **percentage of cases opened each year noting a high clinical severity outcome is steadily rising**. Likewise, the **average cost to resolve** high clinical severity cases is **rapidly increasing**.

Claimant Type



Nationwide	NP	PA
Ambulatory	65%	62%
Inpatient	25%	21%
Emergency	10%	17%



Oklahoma	NP	PA
Ambulatory	70%	45%
Inpatient	8%	25%
Emergency	22%	30%

MedPro Group • MUSIC cases opened 2012-2021, NP or PA as primary responsible service rate (Nationwide N=1486, NP=642; PA=888; Oklahoma N=97, NP=27, PA=33); more than one rate possible per case).

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Location

Most common locations	Nationwide % of case volume	OK % of case volume	Nationwide NP % of case volume	OK NP % of case volume	Nationwide PA % of case volume	OK PA % of case volume
Office/clinic	47%	42%	51%	52%	45%	39%
Emergency department/ urgent care	20%	33%	15%	30%	23%	33%
Patient room/ICU	11%	11%	14%	7%	9%	12%
Inpatient surgery	9%	7%	4%	0%	12%	12%
Ambulatory surgery	5%	7%	4%	11%	5%	3%

MedPro Group • MUSIC cases opened 2012-2021, NP or PA as primary responsible service rate (Nationwide N=1486, NP=642; PA=888; Oklahoma N=97, NP=27, PA=33); more than one rate possible per case)

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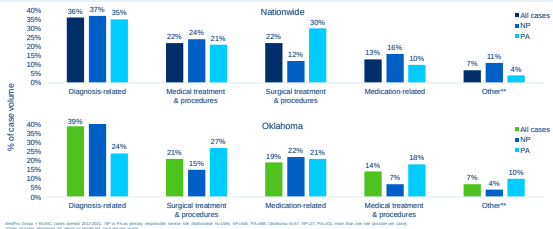
Major Allegations

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.**



MedPro Group • MUSIC cases opened 2012-2021, NP or PA as primary responsible service rate (Nationwide N=1486, NP=642; PA=888; Oklahoma N=97, NP=27, PA=33); more than one rate possible per case). *Other includes allegations for which no significant case volume exists.

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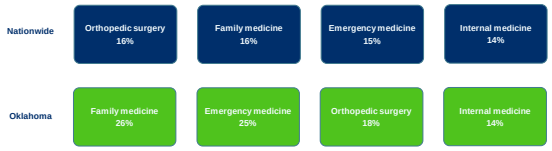
Primary Responsible Services

The **primary responsible service** in each case is the **specialty that is deemed to be most responsible** for the resulting patient outcome. The **four most common responsible services in cases with a NP or PA identified as the primary role are noted here** *(meaning, for example, in the nationwide data, an NP or PA is functioning under the orthopedic surgery specialty in 16% of the cases).*



MedPro Group + MLMIC cases opened 2013-2021, NP or PA as primary responsible service role (Nationwide N=1689, NP=842, PA=886; Oklahoma N=97, NP=27, PA=23); more than one role possible per case)

OKLAHOMA LAW Supervision of APPs

- Physician may supervise a total of six (6) PAs and/or APRNs. This does not apply to a medical director or supervising physician of a state institution, correctional facility or hospital. Upon request, the Board may waive this requirement.(1)
- The supervising physician is accepting responsibility for the care provided by the APP. (2,5,7)
- Supervising Physician does not have to be in the same location, but they must be available through direct contact, telecommunications or other appropriate electronic means for consultation, assistance with medical emergencies, or patient referral. (4,7,9)
- The APP and the Supervising Physician must have a supervision agreement in place in order for the APP to practice.(5,8)
- The statutes for supervision include references to protocols and guidelines to be followed by the APPs. (4,10,11)
- It is important to be review your licensure to ensure accuracy of the listed APPs you are supervising (or not supervising)

1OAC §435.15-3-13.(c)
All references to APRNs and Supervising Physicians assume that APRN has prescriptive authority

Supervision of APRN*

- A Supervising Physician who executes an agreement to supervise an APRN* includes agreement/attestation to:
  - I agree to be available for consultation, collaboration, medical emergencies, and patient referral through direct contact, telecommunications or other appropriate means.
  - Supervision of Advanced Practice Registered Nurses with prescriptive authority means overseeing and accepting responsibility for the ordering and transmission of written, telephonic, electronic or oral prescriptions for drugs and other medical supplies, subject to a defined formulary
- APRN*s may not prescribe Schedule II drugs. The defined schedule of drugs to be prescribed by APRN*s consistently states III, IV and V.
- No specific parameters for review of charts.
- It is important to note that APRNs are governed by the Oklahoma Nursing Board, and any disciplinary action would be initiated by them.

*prescriptive authority

Supervision of PA

- PAs are not permitted to provide health care services independent of physician supervision.
- No specific parameters for review of charts.
- Complex illness provision included in statutes:
  - In patients with newly diagnosed complex illnesses, the physician assistant shall contact the supervising physician within forty-eight (48) hours of the physician assistant's initial examination or treatment and schedule the patient for appropriate evaluation by the supervising physician as directed by the physician.
  - The Supervising Physician shall determine which conditions qualify as complex illnesses based on the clinical setting and the skill and experience of the physician assistant.
- PAs can prescribe Schedule II-V drugs under the direction of a Supervising Physician.
- PAs are governed by the Oklahoma Medical Board.

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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."

CRICO Strategies. (2020). The Power to Predict: Leveraging Medical Malpractice Data to Reduce Patient Harm and Financial Loss. Retrieved from https://www.rmf.harvard.edu/Insights/Case-Info Reports/Power-to-Predict

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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

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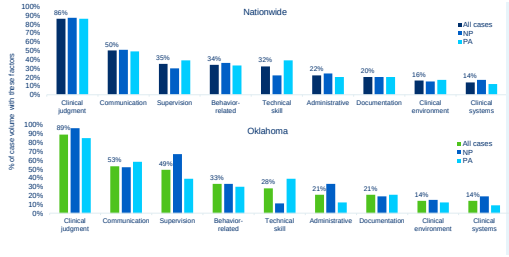
Contributing Factor Category Definitions

Administrative	Factors related to medical records (other than documentation), reporting, staff training/education, ethics, policy/protocols, regulatory
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, 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 Role



With the exception of supervision and technical skill, **overall there are relatively few differences between NP and PA case volume distribution of contributing factors.** The comparative prevalence of PA-involved cases with technical skill and supervision issues noted is reflective of the high percentage of PA-involved orthopedic surgery cases.

MedPro Group + MUSIC cases opened 2012-2021, NP or PA as primary responsible service rate (Nationwide N=1680, NP=640, PA=888; Oklahoma N=97, NP=27, PA=33); more than one rate possible per case). More than one factor per case; therefore totals >100%.

Nationwide: Contributing Factor Focus by Claimant Type: Clinical Judgment

The same contributing factors can be seen across settings (claimant types), although there are some visible differences. All factors are also linked to roles within the case*. This visual reflects **those cases in which a CLINICAL JUDGMENT factor is specifically linked to either an NP or PA.**

Most common clinical judgment details	All claimant types	Ambulatory	Inpatient	Emergency
Failure to appreciate/reconcile relevant sign/symptom/test result	47%	48%	52%	34%
Failure/delay in ordering diagnostic test	28%	32%	20%	32%
Failure to establish differential diagnosis	20%	21%	15%	23%
Failure/delay in obtaining consult/referral	20%	27%	12%	11%
Lack of/inadequate history/physical	18%	17%	16%	23%

The prevalence of diagnosis-related allegations in this data set (36% of all cases) increases the volume of clinical judgment factors.

One additional factor stands out. **Inadequate assessment resulting in premature discharge from care is present in 32% of the Emergency claimant type cases.**

MedPro Group + MUSIC cases opened 2012-2021, NP or PA as primary responsible service rate (Nationwide N=1680, NP=640, PA=888; Oklahoma N=97, NP=27, PA=33); more than one rate possible per case). More than one factor per case; therefore totals >100%. *Linking available for all cases ended after July 2015.

Nationwide: Contributing Factor Focus by Claimant Type: Communication

The same contributing factors can be seen across settings (claimant types), although there are some visible differences. All factors are also linked to roles within the case*. This visual reflects **those cases in which a COMMUNICATION factor is specifically linked to either an NP or PA.**

Most common communication details	All claimant types	Ambulatory	Inpatient	Emergency
Suboptimal communication among providers	57%	49%	75%	57%
Suboptimal communication between providers and patients/families	48%	58%	25%	43%

Communication failures with other providers, including nursing staff and supervising physicians, regarding relevant facts about the patient's care is **a concern noted across all locations**, especially in the inpatient setting. Of note, **a failure to escalate concerns is specifically noted in the inpatient cases**.

Inadequate patient education about medication risks and the management of patient expectations are the most often noted provider to patient communication concerns.

MedPro Group + MLMIC cases opened 2012-2021, NP or PA as primary responsible service rate (Nationwide N=1680, NP=840, PA=888; Oklahoma N=97, NP=27, PA=23); more than one rate possible per case). More than one factor per case, therefore totals >100%. *Linking available for all cases coded after July 2021

Nationwide: Contributing Factor Focus by Claimant Type: Supervision

The same contributing factors can be seen across settings (claimant types), although there are some visible differences. All factors are also linked to roles within the case*. This visual reflects **those cases in which a SUPERVISION factor is specifically linked to either an NP or PA.**

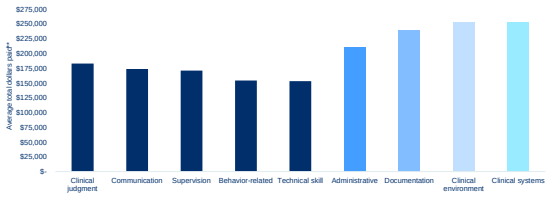
Most common supervision details	All claimant types	Ambulatory	Inpatient	Emergency
Supervision of PAs	63%	64%	56%	82%
Supervision of NPs	34%	33%	44%	9%

Insufficient supervision and oversight is present in 35% of all NP/PA case volume. As might be expected given the increasing autonomy of NPs, **more of the supervision issues are attributed to PAs**. **Physician sign-off on charts without review of/participation in care is a specifically noted concern** in cases arising in the emergency department.

MedPro Group + MLMIC cases opened 2012-2021, NP or PA as primary responsible service rate (Nationwide N=1680, NP=840, PA=888; Oklahoma N=97, NP=27, PA=23); more than one rate possible per case). More than one factor per case, therefore totals >100%. *Linking available for all cases coded after July 2021

Nationwide: Contributing Factor Focus by Financial Severity

The focus has been on the three most common contributing factors linked directly to an NP or a PA – clinical judgment, communication and supervision. When refocusing on ALL factors noted in NP and PA cases, **administrative, documentation, clinical environment and clinical systems factors emerge as the evident drivers of closed case financial severity.**



MedPro Group + MLMIC cases opened 2012-2021, NP or PA as primary responsible service rate (Nationwide N=1680, NP=840, PA=888; Oklahoma N=97, NP=27, PA=23); more than one rate possible per case). More than one factor per case, therefore totals >100%. *Linking available for all cases coded after July 2021. **Total dollars paid = expense + indemnity (closed cases N=1680).

Nationwide: Contributing Factor Focus by Financial Severity: Details

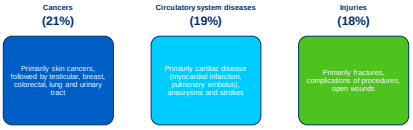
Administrative, documentation, clinical environment and clinical systems factors are drivers of closed case financial severity. The most commonly noted details are listed below.

Factor (in order of increasing financial severity)	Most common details
Administrative	Policy/protocol not followed, and/or lack of policy/protocol
	Insufficient staff training
	Credentialing issues
Documentation	Insufficient/lack of documentation of clinical findings
	Insufficient/lack of documentation related to physician review of/participation in care
Clinical environment	Events occurring during night/weekend/holiday shifts
Clinical systems	Failure/delay in performing recommended diagnostic test
	Patient did not receive test results; lack of provider follow-up with patients after test results received

MedPro Group + MLMIC cases opened 2012-2021, NP or PA as primary responsible service rate (Nationwide N=1000, NP=640, PA=888; Oklahoma N=97, NP=27, PA=35); more than one rate possible per case); More than one factor per case; therefore totals >100%

Nationwide: Focus on Diagnosis-Related Allegations

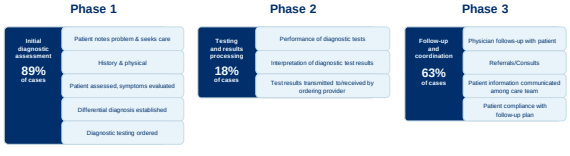
Diagnosis-related allegations encompass wrong diagnoses, failures/delays, and misdiagnoses. See below for the top diagnoses* noted in these cases.



MedPro Group + MLMIC cases opened 2012-2021, NP or PA as primary responsible service rate (Nationwide N=1000, NP=640, PA=888; Oklahoma N=97, NP=27, PA=35); more than one rate possible per case); *as a percentage of all diagnosis-related allegations

Nationwide: Focus on Diagnosis-Related Allegations

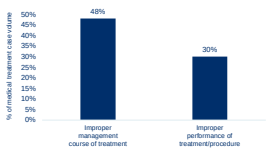
Diagnosis-related allegations encompass wrong diagnoses, failures/delays, and misdiagnoses. Note the key opportunities to reduce diagnostic errors along the diagnostic process of care* below.



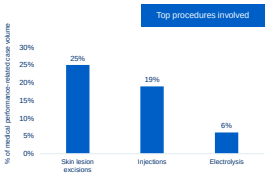
MedPro Group + MLMIC cases opened 2012-2021, NP or PA as primary responsible service rate (Nationwide N=1000, NP=640, PA=888; Oklahoma N=97, NP=27, PA=35); more than one rate possible per case); *each step reflects a combination of contributing factors; diagnostic process of care algorithm courtesy of CandeRx, a division of CRICO Strategies

Nationwide: Focus on Medical Treatment Allegations

Top allegation details



Top procedures involved

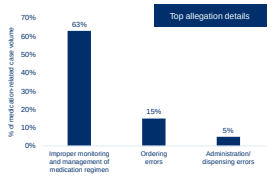


Procedural performance cases can be impacted by delayed recognition of complications, while management cases most often reflect issues with selection of the most appropriate course of treatment for the patient, and appreciating and reconciling symptoms and test results.

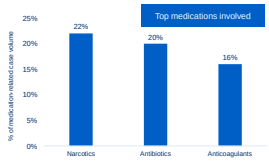
MedPro Group + MLMIC cases opened 2012-2021, NP or PA as primary responsible service role (Nationwide N=1486; NP=840; PA=888; Oklahoma N=97; NP=27; PA=35); more than one role possible per case)

Nationwide: Focus on Medication-Related Allegations

Top allegation details



Top medications involved

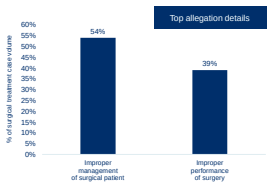


Problems with selection of the most appropriate medication regimen, monitoring/assessing the patient while on that regimen, insufficient education of patients/families about the risks of medications, and sub-optimal communication among providers about medication regimens and evolving signs/symptoms are the most common contributing factors. Failure to identify which provider is coordinating care is noted as a specific risk issue in anticoagulant cases.

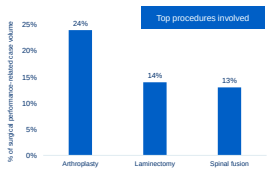
MedPro Group + MLMIC cases opened 2012-2021, NP or PA as primary responsible service role (Nationwide N=1486; NP=840; PA=888; Oklahoma N=97; NP=27; PA=35); more than one role possible per case)

Nationwide: Focus on Surgical Treatment Allegations

Top allegation details



Top procedures involved



Cases involving the management of surgical patients, including pre-, intra-, and post-operatively, are often related to the NP or PA response to developing complications. While complications of procedures may have been the result of procedural error, the failure to timely recognize and/or monitor/manage the issue prevents the opportunity for early mitigation of the risk of serious adverse outcome.

MedPro Group + MLMIC cases opened 2012-2021, NP or PA as primary responsible service role (Nationwide N=1486; NP=840; PA=888; Oklahoma N=97; NP=27; PA=35); more than one role possible per case)

Case Examples

The following stories are reflective of the allegations and contributing risk factors which drive cases involving nurse practitioners and physician assistants.

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.

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Case Examples

SETTLED

$750,000

CONTRIBUTING FACTORS

Clinical environment

Night/weekends

Clinical judgment

Patient assessment – narrow diagnostic focus

Failure to appreciate and reconcile relevant sign/symptom/test result

Misinterpretation of diagnostic studies

Choice of practice setting (failure to refer to the ED)

Documentation

Lack of documentation – review of participation in care

FAILURE TO DIAGNOSIS ISCHEMIC HEART DISEASE RESULTING IN PERMANENT HEART DAMAGE

A female in her early 70's with history significant for coronary artery disease, hypertension, diverticulosis, and smoking, presented to an urgent care facility on a weekend with complaints of mild (1/10) chest pain, pressure, and a burning sensation in the right anterior chest and upper back **for the past 24 hours**. She was seen by a physician's assistant (PA).The patient stated she typically consumed "a lot of tomato juice" and that eating exacerbated her pain. She stated that antacids helped to alleviate her symptoms..

The PA's physical examination of the patient noted that she was in no acute distress, with stable vital signs. **A 12-lead echocardiogram (ECG) was interpreted as sinus rhythm with a left bundle branch block.** The patient reported her last cardiology visit was over a year ago and her last stress test was over five years ago. She was advised to schedule a follow up with her cardiologist and to return to the urgent care facility the next day for a follow-up on the abnormal ECG. (Of note, the **facility's supervising family medicine physician did not see the patient nor sign-off on the PA's treatment until three days later.**)

That same evening, the patient's pain returned. She called 911 and then collapsed at home. When EMS arrived, they did CPR, revived the patient, and took her to the Emergency Department (ED). It was determined that she had **suffered an ST-elevation myocardial infarction (STEMI).** The patient underwent surgery, and had two stents and a defibrillator device placed, but suffered permanent, significant heart damage.

The patient claimed the permanent damage to the heart was from failing to properly read the ECG and diagnose ischemic heart disease. Experts who reviewed the ECG noted that the **PA failed to recognize concerning ST elevations on the ECG which were concerning for myocardial ischemia**. Experts also opined the **PA failed to refer the patient to the ED immediately for further cardiac evaluation.**

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Case Examples

SETTLED

$4.3M

RESPONSIBLE SERVICE

Internal medicine (supervising specialty)

PRIMARY ROLE

Nurse practitioner

FAILURE TO DIAGNOSE STROKE

Patient's **anticoagulation regimen** was being regularly monitored every six months by his internal medicine physician; INR levels remained stable and in the therapeutic range.

On **a Sunday, the patient presented to an urgent care clinic for a headache and neck pain** (8/10 reported pain level). The **physician assistant (PA) prescribed Vicodin** and discharged the patient to home.

Two days later, the patient **returned to the same clinic with increased head and neck pain** (now 10/10). The **nurse practitioner (NP) examined him, and prescribed a muscle relaxant**. The NP's chart documentation was very poorly written; it contained no detail regarding whether a neurological exam was completed, only that the patient had "no focal deficits." No head CT was ordered, despite readily available chart reference to the patient's chronic anticoagulant use, and repeat visits for head and neck pain.

The next day, the patient was taken to the Emergency Department with a vertebral dissection and hemorrhagic stroke.

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Case Examples

SETTLED
$600K

RESPONSIBLE SERVICE
General surgery (supervising specialty)

PRIMARY ROLE
Physician assistant

IMPROPER PERFORMANCE OF SURGERY AND IMPROPER MANAGEMENT OF A SURGICAL PATIENT

A general surgeon performed a laparoscopic reduction and repair of a complex para-esophageal hiatal hernia. On post-operative day one, the patient complained of left shoulder pain. Some lab results were concerning, but **no new differential diagnoses were considered**.

Discharge was planned, but the **patient stated he didn't feel ready**; he **told the surgical physician assistant (PA) that he was unable to eat or drink** (even clear liquids didn't go down smoothly).

Despite a low grade fever, belching, nausea, and newly elevated blood pressures, the patient was discharged to home three days post-operatively on pureed diet. **He died one day later**.

Autopsy revealed gastric necrosis and perforation. **Experts were critical, opining there was a deviation by both the general surgeon and the surgical PA** in prematurely discharging this patient; both failed to order imaging studies and timely intervene with placement of a nasogastric tube for decompression or surgery that **would have avoided his death**.

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Risk Mitigation Strategies

- **Insufficient communication with other providers, nurses and supervising physicians regarding relevant facts about the patient's care is a concern.**
  - Ensure that NPs/PAs are comfortable communicating their concerns without fear of appearing non-confident.
  - Ensure that NPs/PAs understand that they are an essential part of a care team and that they must share pertinent patient information, which, when combined with other provider observations, could indicate a much more severe issue.
  - Ensure hand-off communication is effective and unrushed.
  - Authorize and invoke the "stop the line" concept by anyone who identifies a risk to a patient.
  - Encourage escalation of concerns up the chain of command.
  - Make sure that in all locations, nursing understands the role of the NP/PA to ensure appropriate care coordination.
- **Documentation styles can be widely varied when multiple providers 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.
  - Ensure consistent documentation among providers, with explanations where there is any inconsistency.
  - Do not sign off on charted information without thoroughly reading it.

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Risk Mitigation Strategies

- **Insufficient supervision/oversight/training is a frequently noted risk issue in NP/PA cases.**
  - Supervision involves more than just signing charts.
  - Ensure that required supervision is a regular, on-going activity.
  - Establish that all staff who will be working on your behalf fully understand the norms/policies/procedures of each facility or office location.
  - Be able to effectively communicate how you are able to determine and/or assess the competency of NPs/PAs to perform their assigned tasks.
  - Use supervisory time to ensure that the NP/PA is comfortable relating doubts or questions.
- **Scope of practice is something that should be defined for each NP/PA and can be enhanced and/or expanded upon demonstration of requisite skills and knowledge.**
  - Not all NPs/PAs are the same; different experiences should result in more or less supervision.
  - NPs/PAs 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 NP or PA, they may need to be viewed as a novice in a new setting.

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Addendum: Oklahoma Law Supervision of APRN

- **2 §59-567.3a.12**
- "Supervision of an Advanced Practice Registered Nurse with prescriptive authority" means overseeing and accepting responsibility for the ordering and transmission by a Certified Nurse Practitioner, a Clinical Nurse Specialist, or a Certified Nurse-Midwife of written, telephonic, electronic or oral prescriptions for drugs and other medical supplies, subject to a defined formulary.
- **3 §63-2-312.C**
- An advanced practice nurse who is recognized to prescribe by the Oklahoma Board of Nursing as an advanced registered nurse practitioner, clinical nurse specialist or certified nurse-midwife, who is subject to medical direction by a supervising physician, pursuant to Section 567.3a of Title 59 of the Oklahoma Statutes, and who has complied with the registration requirements of the Uniform Controlled Dangerous Substances Act, in good faith and in the course of professional practice only, may prescribe and administer Schedule III, IV and V* controlled dangerous substances.
- **4 §567.4a.1.**
- Define the procedure for documenting supervision by a physician licensed in Oklahoma to practice by the State Board of Medical Licensure and Supervision or the State Board of Osteopathic Examiners. Such procedure shall include a written statement that defines appropriate referral, consultation, and collaboration between the APRN and the supervising physician. The written statement shall include a method of assuring availability of the supervising physician through direct contact, telecommunications or other appropriate electronic means for consultation, assistance with medical emergencies, or patient referral.
- 5 Agreement for Physician Supervising Advanced Practice Prescriptive Authority

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Addendum: Oklahoma Law Supervision of PA

- **6§59-519.2.3.**
- Nothing in the Physician Assistant Act shall be construed to permit physician assistants to provide health care services independent of physician supervision.
- **7§59-519.2.7.**
- "Supervision" means overseeing the activities of, and accepting responsibility for, the medical services rendered by a physician assistant. The constant physical presence of the supervising physician is not required as long as the supervising physician and physician assistant are or can be easily in contact with each other by telecommunication
- **8§59-519.7.A.**
- No health care services may be performed by a physician assistant unless a current application to practice, jointly filed by the supervising physician and physician assistant, is on file with and approved by the State Board of Medical Licensure and Supervision. The application shall include a description of the physician's practice, methods of supervising and utilizing the physician assistant, and names of alternate supervising physicians who will supervise the physician assistant in the absence of the primary supervising physician
- **9§59-519.7.B.**
- The supervising physician need not be physically present nor be specifically consulted before each delegated patient care service is performed by a physician assistant, so long as the supervising physician and physician assistant are or can be easily in contact with one another by means of telecommunication.
- **10§59-519.7.C.**
- In patients with newly diagnosed complex illnesses, the physician assistant shall contact the supervising physician within forty-eight (48) hours of the physician assistant's initial examination of the patient and schedule the patient for appropriate evaluation by the supervising physician as directed by the physician. The supervising physician shall determine which conditions qualify as complex illnesses based on the clinical setting and the skill and experience of the physician assistant.
- **11§59-519.7.D.1-2.**
- A physician assistant under the direction of a supervising physician may prescribe written and oral prescriptions and orders. The physician assistant may prescribe drugs, including controlled medications in Schedules II through V pursuant to Section 2-312 of Title 63 of the Oklahoma Statutes, and medical supplies and services as delegated by the supervising physician and as approved by the State Board of Medical Licensure and Supervision after consultation with the State Board of Pharmacy on the Physician Assistant Drug Formulary. "2. A physician assistant may write an order for a Schedule II drug for immediate or ongoing administration "on site. Prescriptions and orders for Schedule II drugs written by a physician assistant must be included on a written protocol determined by the supervising physician and approved by the medical staff committee of the facility or by direct verbal order of the supervising physician. Physician assistants may not dispense drugs, but may request, receive, and sign for professional samples.
- **12§63-2-312.E**
- A physician assistant who is recognized to prescribe by the State Board of Medical Licensure and Supervision under the medical direction of a supervising physician, pursuant to subsection D of Section 519.6 of Title 59 of the Oklahoma Statutes, and who has complied with the registration requirements of the Uniform Controlled Dangerous Substances Act, in good faith and in the course of professional practice only, may prescribe and administer Schedule II through V controlled dangerous substances.

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MedPro Group & MLMIC Data

MedPro and MLMIC 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, MedPro and MLMIC 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.

Candello
Safety in Numbers

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