I can't get sued for this, can I?

Doctors, PAs and APNs working together

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Objectives

1. Regulations
2. Differences PA vs APN
3. Cases with liability
4. Toolkit for safety

What's the difference?

- PA
  - Colorado Board of Medical Examiners
  - "Dependent" Practitioners
  - Supervision always in some form

- APNs -NP, CNM,CRNA
  - Colorado Board of Nursing
  - Sometimes "Independent" Practitioners
  - Articulated plan
  - May or may not be employed by Docs

Regulation PA

- CBME Rule 400 AND 410
  - See Handouts for exact text
- License

- Registration Form
  - Active until rescinded, so keep a registry of such forms, and inform CBME and COPIC when it changes
- Nameplate– “Physician’s Assistant” spelled out
- 2 PA’s per physician maximum
- Notify CBME when relationship changes

Who is likely to be the 2nd physician supervisor?

1. The named backup physician when the primary is out of town
2. The primary doc's partner
3. The physician who is on site when the primary supervisor is off
4. The next physician in alphabetical order

Primary supervisor PA - signs the paperwork

- Primary Physician Supervisor
  - "The physician who signed the form". A PA has one primary physician supervisor per employer, but if he/she has more than one employer, that PA needs a primary physician supervisor registered for each employer.
  - When in doubt liability falls to the primary supervisor

Secondary supervisor PA – on site

- Secondary Physician Supervisor
  - No form is registered with the CBME
  - PA consults Doc on a given patient encounter
  - PA must document that physician's name in that dated record
- Secondary Supervisor MIGHT assume the liability for that encounter
  - "The surrounding facts and circumstances may result in the secondary physician supervisor temporarily relieving the primary supervising physician of supervisory responsibility for the individual patient."

Rookie PA Supervision

- New PA graduates
  - First 6 months and 500 minimum encounters
  - Physician supervisor must review and co-sign all notes, within 7 days
  - On-site supervision for first 1000 PA working hours
- Mandatory “performance assessment” by end of first 6 months, then quarterly until 2 years, then twice a year thereafter

New to practice PA Supervision

- Experienced PA new to a practice setting
  - First 3 months and 500 minimum encounters
  - Physician supervisor must review and co-sign all notes, within 14 days
  - No “on-site” mandate
- Mandatory “performance assessment” by end of first 6 months, then twice a year thereafter

Veteran PA Supervision

- Experienced PA in existing setting
  - Mandatory "performance assessment" twice a year
  - No "on-site" mandate
  - No "co-signing" mandate

The Performance Assessment

- An assessment of the medical competency of the PA
- A review and initialing of selected charts
- An assessment of a sample of referrals
- An assessment of the H&P skills and documentation
- If you're in a lawsuit lawyers will review these
- CBME may audit

Who is liable?

- 18 month old presents to the ED with diarrhea and fever. Seen by the PA and treated with IV fluids. D/Ced with BRAT diet and F/U instructions. At DC pulse is still 144
- On dictation PA states that she had discussed the case with the ED doc. The ED doc does not recall the discussion
- The next AM the child is found expired. On autopsy salmonella sepsis is found
- The ED doc (who is not the primary supervisor) calls RM and asks "I'm not liable for this , am I?"

Primary vs. secondary liability

Advanced practice nurses (APN)

- Include NP, CRNA, CNS and CNM
- Accepted Course of Study
- CO Board of Nursing CBON

Difference between PA and APN

Note the absence of:

- Co-signing
- Primary vs. secondary supervision
- Physical presence of supervision
- Any specific restrictions to scope of practice
  - Simply stated as APN's education and experience

Advanced Practice Nurses (APNs)

- Role/specialty
  - Nurse Practitioner
  - Certified Nurse Midwife
  - Certified Registered Nurse Anesthetist
  - Clinical Nurse Specialist
- Population focus
  - Examples: Family practice across lifespan, gerontology, neonatology, women's health, psychological/mental health, etc.
  - Not defined as a specific disease, health problem or intervention

APNs with Prescriptive Authority (RXNs)

- New requirements
- No more Collaborative Agreements
- Different pathways for new, existing, or transferring from other state RXNs
- All share common end of "Articulated Plan"

Articulated Plan

- Written document, signed by RXN-P and mentor(s) at time of development
- Documented mechanism for consultation or collaboration
  - Includes written plan of resources or contacts
  - Includes written plan for collaboration with other providers regarding safe prescribing
- QA program for safe prescribing
  - Individually driven, does not require other's signature

Articulated Plan

- Identifies decision support tools for prescribing
  - Examples: e-databases, evidence-based guidelines, antimicrobial reference guides, etc.
- Documentation of ongoing continuing education in pharmacology and safe prescribing
  - Does not require set number of CE hours
- Annual review
  - Responsibility for review resides with RXN, not physician

Three Paths to Full RXN

Path 1: New Applicants

Requirements for Provisional RXN (RXN-P) as of July 1, 2010 or later

1. A graduate degree in a nursing specialty
2. Education in use of drugs as established by Board of Nursing (BON)
3. National certification (grandfathers APNs already on registry prior to July 1, 2010)
4. Professional liability insurance per BON Rule XXI
5. 1800-hour preceptorship with physician, or physician and RXN, who have corresponding education, training, and experience

Three Paths to Full RXN

Path 1: New Applicants

- 1800-hour “mentorship”
- Articulated Plan

Three Paths to Full RXN

Path 2: Transfer from Another State

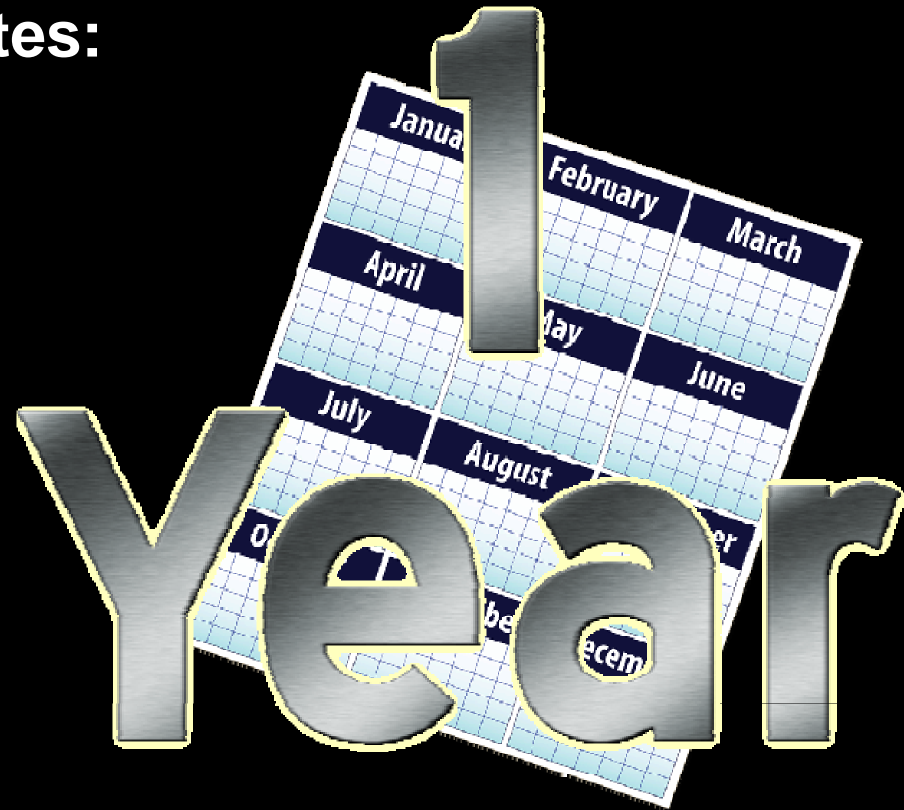
RXN coming to Co from another state as of July 2010

1. A graduate degree in a nursing specialty
2. Education in use of drugs as established by BON
3. National certification (grandfathers APNs already on registry prior to July 1, 2010)
4. Professional liability insurance per BON Rule XXI
5. 3600 hours of documented prescribing experience to become a Provisional RXN

Three Paths to Full RXN

Path 2: Transfer from Another State

- Within one year completes:
  - Articulated Plan



Three Paths to Full RXN

Path 3: Current APN with Prescriptive Authority

- **Current APN with Prescriptive Authority in Colorado as of July 1, 2010**
  - **Articulated Plan by July 1, 2011**
  - **Professional Liability Insurance**

Must Renew RXN Every Two Years

- Continued national certification - unless grandfathered before July 1, 2010
- Continuous professional liability insurance per BON Rule XXI
- Current Articulated Plan (RXN must review annually)

Physician Potential Involvement in training RXN

- Preceptorship of new applicants moving to RXN-P
  - All prescriptions must be signed by person with full prescriptive authority
  - Preceptor shall not require payment or employment as condition of entry
  - Reasonable expenses may be paid for preceptor's time and expertise but should be agreed upon during structuring of preceptorship

Physician Potential Involvement with RXNs

- Articulated Plan
  - "One-time" signature
  - "Physician is not responsible for conducting the annual review of the Articulated Plan" (Rule 950)
- Employment
- Curbside consultation
- Active consultation

What creates vicarious liability in a physician/RXN relationship?

1. Physician employs the RXN
2. Language in the plan about oversight
3. Hospital requires physician oversight
4. Documentation of a curbside consult makes it look like a formal consultation
5. All of the above

Treadmill

- 66 yo male with OA of R Knee and severe COPD is scheduled for adenosine treadmill
- The NP administering the test is employed by the cardiology group and is new to the practice. There is no physician on site
- The patient complains of dyspnea during the procedure but it is continued for 8 minutes till the patient suffers a respiratory arrest. Resuscitation is unsuccessful
- She is a new to cardiology NP and did not know of the adenosine contraindication in COPD

Who is liable?

- The APN
- The ordering cardiologist
- The practice
- All the above

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- Primary care/ED
  - Heads
  - Hearts
  - Guts
  - Bugs
  - Failure to DX CA
- Specialist
  - Technical misadventure
  - Postop complications
  - Documentation of complicated conditions

Same thing your specialty gets sued for!!

A clear understanding of what can be seen alone

- What one group does is to define
  - Simple problems that can be seen alone
  - Medium issues discussed with Doc
  - Riskier patients seen with supervisor

The physician can determine

- Scope of practice
- PA's "dependent practitioner"
- RXN's via collaborative agreement, employment and/or consultation role
- Not specifically determined by regulations of CBME or CBON

Handoff

- A handoff is defined as a transfer of information and responsibility from one provider to another

Defensibility

- The plaintiffs' bar and patient's perspective
- "Never even saw a doctor"

High risk scenario

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High risk Diagnoses should be reviewed

Thank you

Now – What one thing will you do differently in your practice?

What are the lessons learned?

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