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2-HOUR CME: SUPERVISING ADVANCED PRACTICE PROVIDERS: DEFINITIONS, AGREEMENTS, AND DELEGATION

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Q3
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CME - SUPERVISING ADVANCED PRACTICE PROVIDERS: DEFINITIONS, AGREEMENTS, AND DELEGATION

by Wayne Wenske, Senior Marketing Strategist,
with material from Tanya Babitch and Robin Desrocher

OBJECTIVES

Upon conclusion of this course, the physician will be able to:

1. identify the types of advanced practice providers, including education and licensure;
2. summarize the physician's responsibilities when supervising an advanced practice provider;
3. discuss the difference between delegation protocols and a Prescriptive Authority Agreement; and
4. define the requirements of delegating prescriptive authority to an advanced practice provider.

COURSE AUTHOR AND CONTRIBUTORS

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DISCLOSURE

Wayne Wenske, Tanya Babitch, and Robin Desrocher have no commercial affiliations/interests to disclose related to this activity. TMLT staff, planners, and reviewers have no commercial affiliations/interests to disclose related to this activity.

TARGET AUDIENCE

This 2-hour activity is intended for physicians of all specialties who are interested in practical ways to reduce the potential for medical liability.

CME CREDIT STATEMENT

The Texas Medical Liability Trust is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The Texas Medical Liability Trust designates this enduring material for a maximum of 2 *AMA PRA Category 1 Credit(s)™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

PRICING

A fee of $100 will be charged when accessing this CME course online at http://lonestara.inreachce.com.

ETHICS CREDIT STATEMENT

This course has been designated by TMLT for 1 credit in medical ethics and/or professional responsibility.

TEST

To receive CME credit, physicians should complete the test questions that follow the activity. A passing score of 70% or better earns the physician 2 CME credits.

INSTRUCTIONS

the Reporter CME test and evaluation forms must be completed online. After reading the article, go to http://lonestara.inreachce.com. Follow the online instructions to complete the forms and download your certificate.

Questions about the CME course? Please call TMLT Risk Management at 800-580-8658.

ESTIMATED TIME TO COMPLETE ACTIVITY

It should take approximately 2 hours to read this article and complete the questions and evaluation form.

RELEASE/REVIEW DATE

This activity is released on August 10, 2021 and will expire on August 10, 2024.

CME DISCOUNT

Lone Star Alliance policyholders who complete this program may earn a 2.5 percent discount that will be applied to their next eligible policy period.

DISCLAIMER

The closed claim study included in this article is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physicians' defensibility. This study has been modified to protect the privacy of the physicians and the patient.

INTRODUCTION

As we are more than 18 months into the COVID-19 pandemic, both the short- and long-term effects of the pandemic are still unknown. It may take several years to know how the pandemic will affect our day-to-day routines, businesses, or long-term health care. However, the pandemic has revealed some systemic issues in our health care system that must be addressed, including shortages of medical personnel.

According to a new study by the Association of American Medical Colleges (AAMC), even before the COVID-19 pandemic, the United States was facing an impending physician shortage. By 2034, the AAMC projects a shortage of primary care physicians of between 17,800 and 48,000 physicians, and a shortage across the non-primary care specialties of between 21,000 and 77,100 physicians. The specific drivers of this shortage are population growth and an aging population that will require more care.[1,2]

However, physicians are also a part of that aging population. More than two of five current physicians will be 65 years of age or older within the coming 10 years. The COVID-19 pandemic has also exacerbated physician trauma, stress, and burnout and may lead some physicians to accelerate their retirement plans. At the same time,

the pandemic has also caused many physicians in private practice to delay their retirement plans due to the negative economic toll of reduced hours or temporarily closing their practice.[1,2]

In the coming years, the health care system may see itself relying more and more on advanced practice providers (APPs) to help with the increasing demands of a growing and aging population, particularly in providing routine care such as checkups, follow-up appointments, and physical examinations. More APPs in the health care system will also help provide increased access to care for patients in underserved or rural areas.

An APP is a clinical medical professional who provides patient care under the direct supervision of a physician, in collaboration with a physician, or, depending on the type of APP and state-specific regulations, more autonomously.[3] These professionals are often described as "mid-level practitioners," "physician extenders," and "allied health providers."

However, as the use of APPs increases, so does the opportunity for medical liability issues. This article provides physicians with information and context for supervising APPs. Topics include legal responsibilities, scope of practice, delegation protocols, prescriptive authority, and areas of medical liability risk when managing these health care professionals.

This article focuses on APPs and physician delegation in Texas. If you practice outside of Texas, please refer to your state medical board and APP licensing boards for corresponding definitions, rules, and regulations. However, this article includes information and risk management guidance that applies to all physicians who manage APPs.

TYPES OF ADVANCED PRACTICE PROVIDERS, QUALIFICATIONS, AND LICENSURE

APPs refer to many types of health care providers, including midwives and nurse anesthetists. But the term most commonly refers to physician assistants (PAs) and advanced practice registered nurses (APRNs). PAs and APRNs each have their own definition, qualifications, and licensure.

Physician assistant

A physician assistant (PA) is a health care professional licensed to practice medicine under physician supervision. Among their duties, PAs diagnose illness, develop and manage treatment plans, order tests, prescribe medications, counsel on preventative health care, assist in surgery, and may serve as a patient's principal health care provider.

PAs receive broad medical training from intensive programs accredited by the Accreditation Review Commission on Physician Assistants (ARC-PA). They work closely with physicians in all medical and surgical specialties and provide a broad range of clinical, diagnostic, and therapeutic services. They practice in every state and are recognized by Medicare and Medicaid payors.[4]

Because of the degree of responsibility given to them and their role in extending patient care provided by physicians, the PA curriculum includes both classroom and clinical

education training, and students must complete more than 2,000 hours of clinical rotations in internal medicine, family medicine, pediatrics, obstetrics and gynecology, emergency medicine, and geriatric medicine. Rotations occur in a variety of health care settings, including hospitals, clinics, and long-term care facilities.[5]

Most applicants to a PA program have a bachelor's degree and approximately four years of health care experience before entering the program. (Programs are competitive, and many applicants enroll before they have even earned their bachelor's degree.) Most PA programs last approximately 24 to 27 months and award master's degrees.

Graduates of an ARC-PA-accredited program may be certified by the National Commission on Certification of Physician Assistants (NCCPA). This grants them the use of a PA-C designation to indicate current certification. To maintain the PA-C designation, 100 hours of CME must be completed every two years and a recertification exam taken every six years.

In Texas, Chapter 204, Section 153 of the Texas Occupations Code describes the eligibility requirements for PA licensure as follows:

"To be eligible for a license under this chapter, an applicant must:

(1) successfully complete an educational program for physician assistants or surgeon assistants accredited by the Committee on Allied Health Education and Accreditation or by that committee's predecessor or successor entities;
(2) pass the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants;
(3) hold a certificate issued by the National Commission on Certification of Physician Assistants;
(4) meet any other requirement established by physician assistant board rule; and
(5) pass a jurisprudence examination approved by the physician assistant board as provided by Subsection (a-1).

(a-1) The jurisprudence examination shall be conducted on the licensing requirements and other laws, rules, or regulations applicable to the physician assistant profession in this state. The physician assistant board shall establish rules for the jurisprudence examination under Subsection (a)(6) regarding:

(1) the development of the examination;
(2) applicable fees;
(3) administration of the examination;
(4) reexamination procedures;
(5) grading procedures; and
(6) notice of results.

(b) In addition to the requirements of Subsection (a), an applicant is not eligible for a license, unless the physician assistant board takes the fact into consideration in determining whether to issue the license, if the applicant:

(1) has been issued a license, certificate, or registration as a physician assistant in this state or from a licensing authority in another state that is revoked or suspended; or
(2) is subject to probation or other disciplinary action for cause resulting from the applicant's acts as a physician assistant." [6]

Changing titles?

In June 2021, the American Academy of Physician Assistants (AAPA) House of Delegates voted to change the professional title of "physician assistant" to "physician associate" by a majority vote of 198 to 68.[7] The reason behind this title change was to "position PAs to successfully compete in the ever-changing healthcare marketplace by boosting the profession's relevance and impact among stakeholder groups, especially patients." [8]

However, this change is not without controversy. During the same month, the American Medical Association's (AMA) House of Delegates held a special meeting to assert their opposition to this title change as being potentially confusing to patients. "About one-quarter of patients wrongly believe that physician assistants are physicians or are unsure" of who these professionals are. [9]

The Texas Medical Association (TMA) and several physician specialty societies also oppose the title change. The AAPA has acknowledged that implementing this change would require changes to current federal and state laws and regulations. [10]

Orthopedic Physician Assistant

An Orthopedic Physician Assistant (OPA or OPA-C) has substantial differences from a PA. They are trained differently, have different education standards, and take a separate certification examination. OPAs have a more limited scope of practice, working directly with a physician in a supportive role. They are not allowed to prescribe medication, establish a diagnosis, or order or interpret diagnostic tests. They are not recognized as providers under Medicare.

Most OPAs are trained on the job, and work as orthopedic technologists or surgical assistants, with duties that emphasize orthopedic disease and injury, management of equipment and supplies, operating room techniques, cast application and removal, office procedures, and an orientation to prosthetics and orthotics.

Prerequisites for most OPA programs include a bachelor's degree with at least two years of coursework in basic and behavioral sciences. Educational requirements for an

OPA designation may be obtained in an OPA, PA, or APRN program.

An OPA may become certified (OPA-C) through examination by the National Board for Certification of Orthopaedic Physician's Assistants (NBCOPA). However, it is not required, and most states do not regulate OPA practice or OPA-C certification.[11]

Advanced practice registered nurse

An advanced practice registered nurse (APRN) is a registered nurse (RN) who has completed advanced nursing education and certification to practice in one of several, expanded health care roles. According to the Texas Administrative Code, an APRN "acts independently and/or in collaboration with other health care professionals" to provide health care services in a variety of settings, including homes, hospitals, offices, schools, ambulatory clinics, private practices, or long-term care facilities. APRN licensure may or may not include prescriptive authority.[12]

An APRN must be licensed in one or more of the following roles and population focus areas.

- Certified Nurse Practitioner (CNP): A CNP is an RN who has completed either a master's or a doctoral degree program and a national certification from the American Academy of Nurse Practitioners Certification Board (AANPCB). A CNP must practice under the rules and regulations of the state in which they are licensed. In Texas, a CNP is licensed by the Texas Board of Nursing. CNPs are recognized by all U.S. state nursing boards, Medicare, and Medicaid.

- Certified Nurse-Midwife (CNM): A CNM is is an RN who has completed a graduate-level program in nurse-midwifery that is certified by the American Midwifery Certification Board. "CNM educational programs are accredited by the American College of Nurse-Midwives (ACNM) and recognized by the U.S Department of Education. These programs must also meet the standards of the Texas Board of Nursing, which regulates CNMs in Texas. A CNM can practice in all 50 states and the District of Columbia. CNMs are recognized by Medicaid.[13]

  In Texas, there are two types of midwives who may legally practice: Licensed Midwives (LMs) and CNMs. LMs are non-nurses licensed by the Texas Department of Licensing and Regulation. The Texas Midwifery Act, included in the Texas Occupations Code, applies to LMs and includes rules on education, licensing, and practice. Unlicensed midwifery is illegal in Texas.[13, 14]

- Certified Registered Nurse Anesthetist (CRNA): A CNRA is is an RN with a Master of Science or doctoral degree from an accredited nurse anesthesia program. The CRNA must hold certification from the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA), the Continued Professional Certification (CPC) Program, and nursing license from the state of practice. Beginning in 2025, CRNAs will be required to have a PhD-level doctorate.[15]

  CRNAs can be responsible for administering anesthesia services to patients, and for monitoring the patient's vital signs throughout a procedure. They also monitor the patient after a procedure until he or she has fully recovered from the effects of anesthesia. CRNAs typically work in hospitals, pain clinics, trauma or surgical centers, plastic surgery clinics, podiatry clinics, or dental clinics.[15]

  In Texas, physician supervision of a CRNA's *performance* is not required; however, the administration of anesthesia **must be ordered or authorized** by a physician, such as an anesthesiologist or a surgeon or physician performing a procedure.[16]

- Clinical Nurse Specialist (CNS). A CNS is is an RN with a Master of Science in Nursing or a higher degree. The CNS also holds a certification from the American Nurses Credentialing Center or the American Association of Critical-Care Nurses.

  These qualifications are for a specialized area of nursing that can involve care for specific patient populations (e.g. geriatrics or pediatrics); settings (e.g. critical care or hospice); diseases (e.g. heart disease or cancer); clinical specialties (e.g. infectious disease or pulmonary disease); care types (e.g. rehabilitation); or types of problems (e.g. pain or addiction).

  "They use their expertise to assess, diagnose, and treat patients. But their role often extends into other areas, like health care management and research." [17]

In Texas, licensure for a CNP or a CNS must also include one of the following population-focus areas.

- Certified Nurse Practitioner:
  - acute care adult
  - acute care adult/gerontology
  - acute care pediatric
  - adult
  - adult/gerontology
  - family
  - gerontological
  - neonatal
  - pediatric

  - psychiatric/mental health
  - women's health
- Certified Nurse Specialist:
  - adult health/medical surgical nursing
  - adult/gerontology nursing
  - critical care nursing
  - gerontological nursing
  - pediatric nursing
  - psychiatric/mental health nursing [18]

REPRESENTATION AND IDENTIFICATION

According to Texas law, a registered nurse who holds current licensure by the Texas Board of Nursing as an APRN shall, at a minimum, use the designation "APRN" and the APRN licensure title, which consists of the current role and population focus area, granted by the Board.[19]

When seeing or treating patients, the APRN must wear and provide clear identification. The identification must include the APRN's current designation and licensure title, which consists of the current role and population focus area, as granted by the Texas Board of Nursing. "An APRN may also include additional certifications or educational credentials in his/her identification, so long as the certifications and/or credentials are current, accurate, and not misleading as to their meaning." [19]

A physician assistant licensed by the Texas Medical Board (TMB) shall keep his or her Texas PA license available for inspection at the PA's primary place of business and shall, when engaged in professional activities, wear a name tag identifying the PA as a "physician assistant." [20]

SCOPE OF PRACTICE

The scope of practice, or the legal parameters a health care provider must adhere to when providing care to a patient, is based on the education, qualifications, experience, and competence of the individual health care provider. The designated scope of practice can vary by state, by specialty, and from individual to individual.

In Texas, the scope of practice for APPs **does not** include independent medical decision-making, diagnosis, or prescribing. However, an APP may perform these acts ***if*** delegated by a physician. If you are practicing outside of Texas, please consult your state medical board when working with an APP.

Scope of practice: Advanced practice registered nurses

For APRNs, both professional and individual scopes of practice exist. Each APRN must establish his or her own scope of practice by balancing the roles, functions, patient populations, and practice settings of their area of practice (professional scope of practice) with their own experience, skill, knowledge, and understanding (personal scope of practice). A professional scope of practice is usually defined by national professional specialty and APRN organizations, and typically offer broad parameters for the scope of practice. It's up to the individual APRN to then apply their own individual scope to the professional scope to settle on the right scope of practice for them.

"The Texas Board of Nursing recognizes that individual scopes of practice will vary and that what is within the individual scope of practice for one advanced practice registered nurse may not be within the individual scope of practice for another advanced practice registered nurse authorized to practice in the same role and specialty. However, it is important to keep in mind that the Board holds each advanced practice registered nurse accountable for knowing and practicing within his/her professional and individual scope of practice." Therefore, an APRN must exercise sound professional judgment in accepting any given assignment and/or performing a given procedure.[21]

Over time, an individual APRN's education will evolve – and scope of practice may expand – as the APRN gains clinical experience in a variety of settings; training through continuing education and formal course work; and advancements in health care.

"However, there are finite limits to expansion of scope of practice without completing additional formal education. Advanced practice registered nurses cannot change their legally recognized titles or designations through experience or continuing nursing education; these changes may only be achieved through additional formal educational preparation and meeting all legal requirements to use that title and practice in that specialty set forth by the BON [Texas Board of Nursing]." [21]

According to the TMB, an APRN's scope of practice "shall be in addition to the scope of practice permitted a registered nurse and does not prohibit the advanced practice nurse from practicing in those areas deemed to be within the scope of practice of a registered nurse." [22] These nursing duties, consistent with the Texas Board of Nursing's Nursing Practice Act, TMB rules, and other state laws and regulations, include:

- "the observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a person who is ill, injured, infirm, or experiencing a change in normal health processes;
- the maintenance of health or prevention of illness;
- the administration of a medication or treatment as ordered by a physician, podiatrist, or dentist;
- the supervision or teaching of nursing;
- the administration, supervision, and evaluation of nursing practices, policies, and procedures;
- the requesting, receiving, signing for, and distribution of prescription drug samples to patients

at practices at which an advanced practice registered nurse is authorized to sign prescription drug orders as provided by Subchapter B, Chapter 157;
- the performance of an act delegated by a physician under Section 157.0512, 157.054, 157.058, or 157.059; and
- the development of the nursing care plan." [22, 23]

The APRN can perform nursing acts without physician supervision **but must be supervised by a physician when performing delegated medical acts or exercising delegated prescriptive authority**.[22]

Scope of practice: Physician Assistants
According to the Texas Occupations Code, the scope of practice of a PA "includes providing medical services delegated by a supervising physician that are within the education, training, and experience of the physician assistant." These services, which may be conducted in a clinic, hospital, ambulatory surgical center, patient home, nursing home, or other institutional setting, may include:

- obtaining patient histories and performing physical exams;
- ordering or performing diagnostic and therapeutic procedures;
- formulating a working diagnosis;
- developing and implementing a treatment plan;
- monitoring the effectiveness of therapeutic interventions;
- assisting at surgery;
- offering counseling and education to meet patient needs;
- requesting, receiving, and signing for the receipt of pharmaceutical sample prescription medications and distributing the samples to patients in a specific practice setting in which the PA is authorized to prescribe pharmaceutical medications and sign prescription drug orders; and
- making appropriate referrals.

Before delegating any of these duties to a PA, ensure that the duties are consistent with the PA's training, education, and experience, and have been outlined by established practice guidelines or protocols.[24]

PHYSICIAN DELEGATION OF MEDICAL ACTS

The Texas Medical Practice Act (MPA) is the section of the Texas Occupations Code that provides all the definitions, provisions, and rules that physicians must follow in the state of Texas to practice medicine safely and legally. Within this act, rules for supervising APPs are provided along with "general authority" to delegate certain medical acts.

Rules pertaining to the supervision of APPs are mainly found in Chapter 157 of the MPA, which comprises Chapters 151 through 168 of the Texas Occupations Code, and TMB Rules 185 and 193.6. The TMB Rules are codified in the Texas Administrative Code, Title 22 and can be accessed on the TMB website at https://texreg.sos.state.tx.us/public/readtac$ext.viewtac.

According to the MPA, a "physician may delegate to a qualified and properly trained person acting under the physician's supervision any medical act that a reasonable and prudent physician would find within the scope of sound medical judgment to delegate." The physician must judge if the person performing the delegated task can "properly and safely" perform the task; can perform it in its "customary manner;" and that the performance of the task "is not in violation of any other statute." In addition, the physician must ensure the person performing the task "does not represent to the public that the person is authorized to practice medicine." [25]

The MPA also states that the "delegating physician remains responsible for the medical acts of the person performing the delegated medical acts." In the event of a claim or review, the TMB may determine whether (1) the act constitutes the practice of medicine, and (2) if the act may be properly or safely delegated by physicians to others.[25]

Failure to adequately supervise an APP can expose a physician to liability for "unprofessional or dishonorable conduct" under Texas law. A physician risks having his or her license revoked or suspended if authorizing a nonphysician to carry out standing delegation orders or medical orders that "authorize the exercise of independent medical judgment or treatment." [26]

A physician's decision to delegate must depend on the qualifications of the employee and the acts to be delegated. For example, one medical act that may be reasonably assigned to an RN may be inappropriate to assign to a medical assistant. Similarly, responsibility for a panel of patients would not be appropriate for an RN, but may be in keeping with the education, licensure, and scope of practice for assignment to an APP.

Because physicians who delegate duties within their practices are vicariously liable for the activities performed by staff members, physicians should maintain employee records for each staff member. These records may include a written job description, signed confidentiality agreements, verification of current licensure, signed acknowledgment of policies and procedures, and transcripts for all training obtained.

A physician expected to supervise APPs may or may not be directly involved in the hiring decisions. Therefore, it is important to be aware of new staff members and to promptly raise any concerns about the conduct of and/or quality of care being provided by an APP.

While the APP will ideally be of high caliber in care and reliability, consider regularly checking the APP's work habits. This may include occasionally asking patients who have had visits with the APP for feedback. Such checks can reassure the physician of the APP's performance; ensure that the physician is aware of issues regarding the APP's work; and help alert the physician to problems or issues that may lower patient satisfaction.[27]

DELEGATION PROTOCOLS – PAs AND APRNs

In Texas, PAs and APRNs must adhere to "mechanisms" that provide them with the necessary authority to perform the medical acts delegated to them. These mechanisms may include a protocol, a written agreement, or a written authorization that details the working arrangements between the PA and/or the APRN and the practice where they work.

TMB rules define a protocol as a "written authorization delegating authority to initiate medical aspects of patient care, including delegation of the act of prescribing or ordering a drug or device at a facility-based practice." The TMB also states that a protocol is "separate and distinct" from a Prescriptive Authority Agreement as defined by the MPA and related rules. However, a Prescriptive Authority Agreement may "reference or include the terms of a protocol(s)." [28]

Guidelines for written delegation protocols are provided within the TMB rules and state the protocols must be developed, agreed upon, and signed by the physician and the PA or APRN; reviewed and re-signed at least annually; and maintained on site. The protocol must contain a list of the types or categories of dangerous drugs and controlled substances that may or may not be prescribed by the APP; limitations on the number of dosage units and refills permitted; and instructions given to patients for follow-up monitoring.[28]

The protocols do not need to describe the exact steps a PA or APRN must take when treating each specific disease, condition, or symptom. However, the protocols should be customized to the specific APP based on his or her specialty area, education level, and experience.[28]

The TMB also states that delegation protocols and the Prescriptive Authority Agreement may be combined into one document. (The Prescriptive Authority Agreement is described later in this article.) [29]

PHYSICIAN SUPERVISION

Before a physician may supervise an APP in Texas, he or she must notify the appropriate board of their intent to do so and be approved to supervise.

If you supervise a PA, you must notify the TMB at https://www.tmb.state.tx.us/page/renewal-supervisor-online-registration. If you supervise an APRN, you must notify the Texas Board of Nursing at https://www.bon.texas.gov/index.asp. Again, if you practice outside of Texas, please

consult with your state medical board about any required notifications.

Because the working relationship between a physician and an APP is collaborative, it is important to also have a supervisory agreement or collaborative care plan in place before you start working with an APP. Use this agreement or plan, in addition to TMB guidelines, to fully describe the working arrangements between the physician, the APP, and the practice. The agreement should be executed, signed, and dated by the primary supervising physician and the APP.

The issues to be covered in the agreement should include, but are not limited to:

- lines of acceptable communication, such as cell phones, email, EHR, etc.;
- methods of communicating so that the physician can always be reached by the APP;
- scope of practice for the APP, which may be different for each APP based on the individual's education and experience;
- limitations of practice, including specialty and services provided or performed;
- locations of the practice where the physician and the APP will work together; and
- working environment, such as expectations for hours worked, pay, and benefits.

These protocols should define the role of the APP in detail and cover the main types of cases that the APP will see (for example, "always document neurovascular status on a pediatric supracondylar fracture before and after casting"). These protocols can further provide general clinical practices, such as limiting the number of times a patient can see the APP without seeing the physician or specifying the types of injuries or symptoms that must be examined by a physician within 24 hours. A physician must document any delegation of such authority to the APP through a protocol and must maintain permanent record of all protocols the physician has signed.

This is especially important for PAs, because TMB rules require PAs to employ mechanisms that provide medical authority when such mechanisms are indicated, including but not limited to, Prescriptive Authority Agreements, standing delegation orders, standing medical orders, protocols, or practice guidelines.[30]

Physician Supervision – Physician Assistants

Texas law includes rules that apply specifically to physicians who supervise PAs. These rules state that a PA may only be supervised by physicians who hold a current physician's license in Texas that is "unrestricted and active." As previously noted, the physician must notify the TMB of his or her intent to supervise a PA. The notification must state that the supervision will be according to TMB rules and that the physician will be professionally and legally responsible for the care provided to patients by the PA.[31]

Before entering a working relationship, the physician and the PA must **both** ensure that:

- the PA's scope of practice is clearly defined;
- the medical tasks delegated to the PA are appropriate to the PA's level of skill or competence;
- the methods of access to and communicating with the supervising physician are defined;
- the process for evaluating the PA's performance is established; and
- the PA is licensed to practice and has a current registration permit. If any change in the PA's licensure status occurs, including but not limited to a permit expiration, license cancellation, or entry of a disciplinary order, the PA must immediately notify his or her supervising physician(s).[30]

The TMB puts no limits on the number of supervising physicians a single PA may have. In addition, there are no limits on how many APPs (PAs or APRNs) a single physician may supervise. The rules encourage the use of "prescriptive authority agreements, standing delegation orders, standing medical orders, protocols, or practice guidelines" by requiring PAs to follow such mechanisms when indicated.[30]

Texas law also states that while supervision of a PA shall be "continuous," it does not necessarily require the physician to be in the constant physical presence of the PA while they perform delegated acts and services. However, if the physician is not present, the PA must be able to easily contact his or her supervising physician. Means of communication (cell phone, regular phone, text messaging) must always be available whether the supervising physician is on site or not.[30]

If a supervising physician is unavailable to supervise the PA, arrangements must be made for an alternate physician to provide that supervision. Alternate supervision must be outlined in writing; this is required in Prescriptive Authority Agreements.[32]

The alternate supervising physician shall "affirm in writing and document through a log where the physician assistant is located, that he or she is familiar with the prescriptive authority agreements, protocols, or standing delegation orders in use, as applicable, and is accountable for adequately supervising care provided pursuant to those prescriptive authority agreements, protocols, or standing delegation orders. The log shall be kept with the prescriptive authority agreements, protocols, or standing orders. The log shall contain dates of the alternate physician supervision and be signed by the alternate physician acknowledging this responsibility.

The physician assistant is responsible for verifying that the alternate physician is a licensed Texas physician holding an unrestricted and active license. Alternate physicians may not collectively provide supervision for more than a 30-day period. If the primary supervising physician cannot return to supervising the physician assistant after 30 days, a new primary supervising physician must provide supervision." [32]

PRESCRIPTIVE AUTHORITY AGREEMENTS

According to Texas law, a physician may only delegate prescriptive authority to a maximum of seven PAs or APRNs (or the full-time equivalent to seven full-time equivalent PAs for a maximum of 350 clinic hours per week). "The only exception relates to supervision and prescriptive delegation to medically underserved population or in a facility-based practice." [33]

When delegating the act of prescribing or administering drugs or devices to a PA or APRN, the supervising physician must do so through a Prescriptive Authority Agreement (PAA). A PAA has many requirements as described by the TMB.

These requirements include that a PAA must be in writing and signed and dated by the physician and the APPs he or she supervises. The PAA and any amendments to it must be reviewed by the physician and the APPs annually, and re-signed and re-dated.[34]

Other minimum requirements for a PAA include:

- must state the names, addresses, and all professional license numbers of the participants in the agreement;
- must state the nature of the practice, practice locations, or practice settings where the PAA is active;
- identify the types or categories of drugs or devices that may or may not be prescribed;
- provide a general plan for addressing consultation and referral;
- provide a plan for addressing patient emergencies;
- state the general process for communicating and sharing information between the physician and the APRN or PA related to the care and treatment of patients;
- describe and carry out a *prescriptive authority quality assurance and improvement plan* that includes:
  - chart review, with the number of charts to be reviewed agreed upon by the physician and APP; and
  - documented meetings between the APP and the physician to share information and discuss patient care improvement, patient treatment and care, needed changes in patient care plans, and issues relating to referrals; and
- if alternate physician supervision is needed or to be used, designate one or more alternate physicians who may:
  - provide appropriate supervision on a temporary basis; and
  - participate in *prescriptive authority quality assurance and improvement plan* meetings.[34]

As stated, when creating a *prescriptive authority quality assurance and improvement plan*, the physician and APP must determine the number of charts to include in a chart review. The number of charts reviewed may vary from one practice setting to another. When making this determination, consider the length of time the APRN or PA has been in practice; how long you and the APRN or PA have worked together; whether you and the APRN or PA work in the same location; and the complexity of your patient care needs. According to the TMB, "the number or percentage of charts reviewed may be an important factor in determining the quality of the physician's supervision." [35, 36]

For PAAs entered on or after September 1, 2019, Texas law requires that meetings should be scheduled on a monthly basis "at least." This frequency is required no matter the length of time the physician has been practicing with the APPs in the agreement. However, face-to-face meetings are no longer strictly required for PAAs established on or after September 1, 2019. The format for these meetings can be decided upon by the physician and APPs, such as being physically together in the same room or conducted remotely, such as by telephone or videoconferencing.[29, 34]

DRUGS AN APP CANNOT PRESCRIBE

According to Texas law, physicians **may not** delegate an APP to prescribe or order controlled substances in Schedules I or II. The only exception is for Schedule II drugs in an inpatient facility or for hospice care.

Physicians may delegate prescribing or ordering controlled substances in Schedule III, IV, or V to an APP under these requirements:

- "the prescription, including a refill of the prescription, is for a period not to exceed 90 days;
- with regard to the refill of a prescription, the refill is authorized after consultation with the delegating physician and the consultation is noted in the patient's chart; and
- with regard to a prescription for a child less than two years of age, the prescription is made after consultation with the delegating physician and the consultation is noted in the patient's chart." [37]

CASE STUDY: ORDERING IMPROPER MEDICATION

Presentation

A 40-year-old man with a history of a Grade 4 gliosarcoma underwent a left parietal craniotomy at Hospital A. After the craniotomy, the patient received two five-day courses of 400 mg of the chemotherapy drug temozolamide ordered by his oncologist. Temozolamide is typically given in 150 mg doses for five-day cycles every 28 days for up to six cycles, with a complete blood count taken between cycles.

The patient came to the emergency department (ED) at Hospital A after experiencing intractable seizures. The patient was admitted, and imaging studies identified a recurrent brain tumor in the left parietal lobe. The history and physical for the admission listed the patient's medications and stated the patient had also taken temozolamide "400 mg daily x 5." The patient's family was upset about the tumor's reoccurrence and requested a transfer to Hospital B for a second opinion and treatment.

Physician action

At Hospital B, the patient's admission was handled by the neurosurgeon's APRN. Hospital B was in the process of converting to a new electronic health record (EHR). Upon the patient's transfer to Hospital B, a floor nurse entered the patient's medications into the EHR as interpreted from Hospital A's record, including 400 mg of temozolamide daily. The APRN who admitted the patient dictated a history and physical that did not mention temozolamide, but he did complete a medication reconciliation form wherein he checked off to continue all medications, including temozolamide and signed the form. This order was not co-signed by the neurosurgeon.

The neurosurgeon saw the patient the next day. In the consultation note regarding medications, the neurosurgeon noted "see prior history." The neurosurgeon had not adapted to the new EHR system, and he did not review the list of medications. The neurosurgeon took the patient to surgery for a repeat left craniotomy and tumor resection three days after admission. An Order Reconciliation Form that ordered the continuation of all medications was signed by the neurosurgeon's nurse practitioner postoperatively.

Six days following surgery, the patient was discharged from the hospital and transferred to an inpatient rehabilitation facility with orders to continue all medications. The admitting physician at the rehabilitation facility signed the medication order as is and continued the temozolamide.

After ten days in the rehabilitation facility, the patient was readmitted back to Hospital A under the care of his oncologist due to his declining condition. After completing diagnostic studies and reviewing the medical records from Hospital B and the rehabilitation facility, the oncologist discovered that the patient had received a massive overdose of temozolamide.

The patient remained hospitalized at Hospital A for more than four months with liver toxicity, pulmonary toxicity, bone marrow insufficiency, skin rash with scaling and sloughing, wound dehiscence leading to removal of cranial hardware, and a need for total parenteral nutrition.

Following discharge from Hospital A, the patient remained in rehabilitation and skilled nursing facilities until being transferred to hospice. The patient died eleven months after the initial admission to Hospital B.

Allegations

A lawsuit was filed against Hospital B, the APRN, the neurosurgeon, and the admitting physician for the rehabilitation facility. The allegations included:

- ordering or authorizing an improper medication;
- failure of the APRN to consult with a physician;
- failure of the neurosurgeon to properly supervise an APRN; and
- failure to be sufficiently knowledgeable about temozolamide before ordering it.

Legal implications

Although the patient had a fatal illness and did not have long to live, the purpose of undergoing the craniotomies was to improve his quality of life. The plaintiff's expert stated that the craniotomies would have given the patient two more years to live. Instead, the patient lived eleven months with a poor quality of life.

The defense was unable to find an expert who could support the care of any of the providers. The physician reviewers stated that it is within the standard of care for physicians to check the list of medications, regardless of involvement of an APRN. The neurosurgeon's failure to do so made him vicariously liable for the APRN's actions. The plaintiff's expert indicated that the neurosurgeon's exposure was limited but existed nonetheless.

The reviewers were also critical of the APRN for not consulting with the neurosurgeon, and felt he had an obligation to understand what medications he was ordering. If he was unaware of the medication temozolamide, further education was warranted.

The neurosurgeon remained adamant that he was not responsible for this error. He felt that the hospital was responsible for adopting an EHR that was too difficult to use, the pharmacy was responsible for not catching the error when dispensing the drugs, and the nurses who gave the medication were responsible because they did not question what they were giving the patient.

Disposition
At mediation, Hospital B settled on behalf of its nursing and pharmacy staff. Settlements were also made on behalf of the APRN and the neurosurgeon. The APRN was eventually disciplined by the Texas Board of Nursing.

Risk management considerations
An employer may be vicariously liable for the negligence of its employee, if the employee was acting within the scope of employment. While it is common for a surgeon to rely on hospitalists and APRNs for medication management, the attending physician is ultimately responsible for being aware of the medications prescribed.

It is imperative for physicians who employ APPs to have a written scope of practice in each APP's personnel file. In this case, prescribing temozolamide was out of this APRN's scope of practice as the drug is typically used in oncology. Physicians should make sure that their APPs understand their duties and monitor to ensure guidelines are being followed.

It is recommended that medications are reviewed with the patient and documented at each encounter. Simply noting "see prior history" is inadequate documentation.

When inaccurate information is entered into an EHR system, it is often copied from one encounter to the next without being updated or corrected. Physicians must remain vigilant in reviewing information that is entered into an EHR to make sure that it is accurate and applies to the current encounter.

AREAS OF RISK

As seen in the case study, physicians who supervise APPs and delegate medical acts for treating patients are exposed to specific types of liability risk. These areas of risk described below are often at the root of many medical liability claims involving the delegation and supervision of APPs.

- **Vicarious liability**. As described in this article, physicians who delegate duties within their practices can be held vicariously liable for the activities performed by staff members.

- **Failure to adequately supervise**. This often includes not being aware of the APP's actions, not meeting regularly with an APP, allowing unsupervised care of a patient with the APP exercising his or her own medical judgment, and not maintaining appropriate or detailed delegation protocols or a PAA.

  Again, under Texas law, failing to adequately supervise can result in a liability claim for "unprofessional or dishonorable conduct." This kind of claim may result in a physician having his or her license revoked or suspended.

- **Failure to monitor prescribing of inappropriate drugs**. This could also lead to accusations of failing to adequately supervise.

- **Documentation**. A fundamental risk management technique is to maintain clear, complete, and contemporaneous documentation. Doing so increases the quality and continuity of your patient care. Errors in patient records have led to misdiagnosis, slow responses, medication errors, and failures to obtain informed consent.

  When delegating to others, it is important to clearly document all orders given, including prescriptions; shared responsibilities; all protocols, guidelines, and plans, including the PAA and any amendments to it; and annual reviews, meetings, discussions, and patient feedback.

- **Communication**. Effective communication between a physician and the providers he or she supervises is critical in establishing and confirming that proper care is given to a patient. When employing an APP, it is important to ensure understanding of written protocols regarding PAAs, responsibilities, scope of practice, and standing delegation orders. The protocols should address conditions and/or circumstances that warrant a consultation between the APP and supervising physician.

- **Written policies and procedures**. These are helpful to ensure a standardized process is followed by both the supervising physician and staff members, and that each care team member understands their responsibilities. Whenever policies and procedures are updated or changed, communicate these changes within your organization or practice. Instruct all employees to sign and date the policies and procedures to acknowledge they have read and understand the changes.

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MEDICATION ERROR: INCORRECT DOSE OF WARFARIN

by Laura Hale Brockway, ELS, Vice President, Marketing

PRESENTATION

An 87-year-old woman called Cardiologist A's office to request a refill of her warfarin. She had been prescribed the medication for her Factor V Leiden condition.

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. This study has been modified to protect the privacy of the physicians and the patient.

PHYSICIAN ACTION

The patient was visiting her daughter in Town B and asked for the prescription to be called in to a local pharmacy. The cardiology practice — which was located in Town A, where the patient's prescriptions were usually filled — agreed to call it in to a pharmacy in Town B.

The cardiology practice recorded all patient phone calls. During the call, the patient mistakenly asked for a refill of 10 mg tablets of warfarin. The correct dosage was 2 mg. A medical assistant called in the prescription for 10 mg to a pharmacy in Town B.

The prescription was picked up that day and there was no verbal counseling given to the patient.

From October 25 to November 5, the patient took 11 tablets. The patient saw Cardiologist A in his office on October 29 for a scheduled appointment. She reported shortness of breath with exertion and bruising on her arms. She did not discuss her refill in Town B.

On November 4, the patient went to a local emergency department (ED) reporting abdominal pain. She was diagnosed with a hiatal hernia and told to follow up with her physician. The patient did not tell ED staff about her warfarin prescription and her International Normalized Ratio (INR) was not tested during this visit.

The patient called Cardiologist A's practice on November 5 to report bruising on her arms, hands, and fingers. She called two more times that day to report an elevated INR and a stomachache. These messages were passed on to Cardiologist A, who told her to go to the ED.

At the ED, she reported her abdominal symptoms. Lab work revealed that her hemoglobin was low from the previous day, from 10.4 down to 7. She was transferred by ambulance to a regional hospital and was initially diagnosed with hemorrhagic shock. An EGD showed gastrointestinal hemorrhage and acute post-hemorrhagic anemia.

The patient was taken to surgery on November 6 where 1500 ml of blood and hematoma was found in her stomach, small bowel, colon, mesentery, mesocolon, retroperitoneum, and the distal part of her esophagus. She was diagnosed with abdominal compartment syndrome due to a hematoma in the wall of the viscera.

On November 7, a hematologist assessed coagulopathy with prolonged Prothrombin Time/International Normalized Ratio and Partial Thromboplastin Time (PT/INR, PTT) tests, likely due to warfarin toxicity. Two more surgeries were performed on November 8 and 11. The patient was discharged to a skilled nursing facility on November 25, but was admitted back to the hospital on November 28 for additional gastrointestinal hemorrhage. She returned to the skilled nursing facility on December 12 and went home on March 7.

The patient has recovered, and she no longer takes warfarin.

ALLEGATIONS

A lawsuit was filed against Cardiologist A and the cardiology practice. The allegations were negligence and vicarious liability for the incorrect refill dosage of 10 mg of warfarin.

LEGAL IMPLICATIONS

The physicians who reviewed this case were critical of Cardiologist A for signing off on a prescription for 10 mg of warfarin when the patient's dose was 2 mg. It was this increased dosage that led to the complications the patient experienced.

There was no indication that the patient's medical record was checked — by anyone in the cardiology practice — to verify the correct dose of warfarin before the prescription was called in. Cardiologist A was also criticized for not asking the patient about her warfarin during the October 29 appointment.

The medical assistant admitted that she made a mistake by not verifying the warfarin dosage for the patient.

DISPOSITION

This case was settled on behalf of Cardiologist A and the cardiology practice.

RISK MANAGEMENT CONSIDERATIONS

Medication errors are a significant cause of preventable adverse events. A study conducted by the Centers for Disease Control and Prevention reported that adverse drug events account for nearly 100,000 hospital admissions each year for adults 65 or older. Approximately two-thirds of these admissions are related to unintentional overdoses involving commonly used medications. Almost one-third involved warfarin-related hemorrhages.[1]

This case is a good example of why having and following written medication refill protocols is important. Such protocols specify who can approve refills, what types of medications can be refilled over the phone or patient portal, how to confirm refills, and when to schedule follow-up appointments based on refill requests. Had the medical assistant followed these protocols, the dosing error may have been prevented.

An employer can be found vicariously liable for the negligence of an employee, as long as the employee was acting within the scope of employment. While it is common for a physician to rely on medical assistants for

refill management, the treating physician is ultimately responsible for being aware of the medications prescribed.

Cardiologist A was also criticized for not discussing the patient's warfarin during her office visit on October 29. It is good risk management practice to review a patient's medications at each visit to monitor compliance and help prevent adverse interactions. This reconciliation should be documented in the patient's medical record.

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FAILURE TO DIAGNOSE AND TREAT AN EPIDURAL ABSCESS

by Gracie Awalt, Marketing Associate

PRESENTATION

A 60-year-old man came to a chiropractor on February 14 with back pain after falling two weeks earlier. The chiropractor performed soft tissue manipulation of the patient's back.

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. This study has been modified to protect the privacy of the physicians and the patient.

PHYSICIAN ACTION

On February 26, the patient came to the emergency department (ED) of a hospital reporting back pain that had lasted three weeks. He explained that he had seen a chiropractor. After an examination by Emergency Medicine Physician A, the patient was given pain medication and muscle relaxers and discharged.

On March 3, the patient could not stand without help and was transported by ambulance to the ED. In the ED, the patient had full range of motion and denied experiencing numbness or tingling in his extremities. The results of CT imaging were unremarkable. Emergency Medicine Physician B believed the patient had a prostate infection and gave him pain medication and antibiotics before discharging him.

On March 10, the patient returned to the ED reporting severe bilateral mid-back pain for five weeks. In the treatment notes, Emergency Medicine Physician C wrote that an MRI of the lumbar spine showed "relatively mild multilevel disc disease with mild neural foraminal narrowing scattered in the lumbar spine but no central stenosis or definite evidence of neural impingement. Questionable small posterior annular fissure at L4-5." The patient was given oral steroids and discharged.

The patient returned to the ED on March 13. An examination by Emergency Medicine Physician D found the patient had no weakness or numbness, and reflexes and motor strength were normal. After reviewing the patient's previous records, the physician noted the following: "Low back pain. Recent MRI essentially negative. Neuro intact. Needs pain control. Low suspicion for infection. Follow up with primary care."

On March 15, the patient returned to the ED by ambulance and was seen by Emergency Medicine Physician E at 5 p.m. The patient reported the onset of paralysis earlier that day. Emergency Medicine Physician E documented normal reflexes in the patient's legs, and "some movement with pain… but no movement otherwise." An additional lumbar MRI was obtained with no significant findings. The patient was admitted to the care of Hospitalist A.

Emergency Medicine Physician E documented that he spoke with Neurosurgeon A and asked him to follow up with the patient. However, Neurosurgeon A did not see the patient on March 15. That evening, the patient was experiencing atrial fibrillation and transferred to the ICU for cardiac management.

At 6 p.m. on March 16, Neurosurgeon A sent an email to the on-call Neurosurgeon B informing him that he had not seen the patient. After reviewing the patient's chart, Neurosurgeon B ordered a stat MRI that revealed severe spinal canal edema and stenosis at T8 due to compression fracture. The next day, Neurosurgeon B took the patient to surgery to drain and irrigate an epidural abscess.

After surgery, the patient did not recover motor function. He developed pulmonary emboli, osteomyelitis, and a large sacral decubitus ulcer. The patient was discharged to a rehab facility; afterwards, he was in and out of nursing facilities. A note from the patient's primary care physician described bilateral leg paraplegia and incontinence of bowel and bladder without sensory awareness.

ALLEGATIONS

The patient filed a lawsuit against Emergency Medicine Physicians B, C, and D, Hospitalist A, Neurosurgeon A, the hospital, and the chiropractor. It was alleged that all of the defendant providers failed to diagnose and treat an epidural abscess in a timely manner, causing damage to the patient's spinal cord resulting in paraplegia.

LEGAL IMPLICATIONS

TMLT consultants for this case were critical of the care provided. A neurology consultant believed that Emergency Medicine Physician E did not get neurosurgery involved in the patient's care in a timely manner after the patient described onset of paralysis on March 15. This consultant believed it was important to know exactly what was said to Neurosurgeon A when a neurosurgical consultation was requested on March 15. They believed by the time Neurosurgeon B ordered an MRI on March 16, it was too late to change the patient's outcome.

An emergency medicine consultant thought Emergency Medicine Physician A performed an inadequate exam of the patient on February 26. This consultant believed that on the patient's third ED visit on March 10, Emergency Medicine Physician C did not order an adequate neurologic exam. This consultant believed both Emergency Medicine Physician C and E should have ordered a full spine MRI. This consultant was also critical of Neurosurgeon A for failing to ensure the patient was seen in a timely manner, and believed that the patient's neurological function could have been partially saved if there was intervention on March 15.

A treating physician for this case, Neurosurgeon B, was critical of Neurosurgeon A's care. Several plaintiff's experts believed Neurosurgeon A, Hospitalist A, Hospitalist B, and the nurses involved did not meet the standard of care. One consultant believed Emergency Medicine Physicians B, C and D should have obtained imaging of the patient's thoracic spine due to complaints of mid-back pain.

DISPOSITION

This case was settled on behalf of the defendant physicians.

RISK MANAGEMENT CONSIDERATIONS

One issue in this case was that Neurosurgeon A did not

see the patient on March 15 after Emergency Medicine Physician E asked him to see the patient. It is unclear what was exactly said to Neurosurgeon A when the request was made, but the patient was not seen that day, delaying the diagnosis of severe spinal canal edema and stenosis.

Clear communication among physicians is paramount, and a sense of urgency may not have been conveyed clearly to Neurosurgeon A in this case. It can be useful to implement a structured communication strategy when conveying patient information to multiple providers.

The Institute for Healthcare Improvement has used the SBAR situational briefing guide as a standardized communication format between physicians regarding changes in patient status or needs. SBAR stands for:

- **Situation**: What is going on with the patient?
- **Background**: What is the clinical background or context?
- **Assessment**: What do I think the problem is?
- **Recommendation**: What do I think needs to be done for the patient?[1]

This method provides a predictable structure for clearly communicating the entire patient care scenario. In this case, the SBAR method may have helped Neurosurgeon A understand the urgency of the situation, possibly preventing the delay in care.

SOURCE

1. Dingley C, Daugherty K, Derieg MK, et al. Improving Patient Safety Through Provider Communication Strategy Enhancements. Advances in Patient Safety: New Directions and Alternative Approaches. Available at https://www.ncbi.nlm.nih.gov/books/NBK43663/?report=reader. Accessed June 30, 2021.

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