

THE Physicians Report

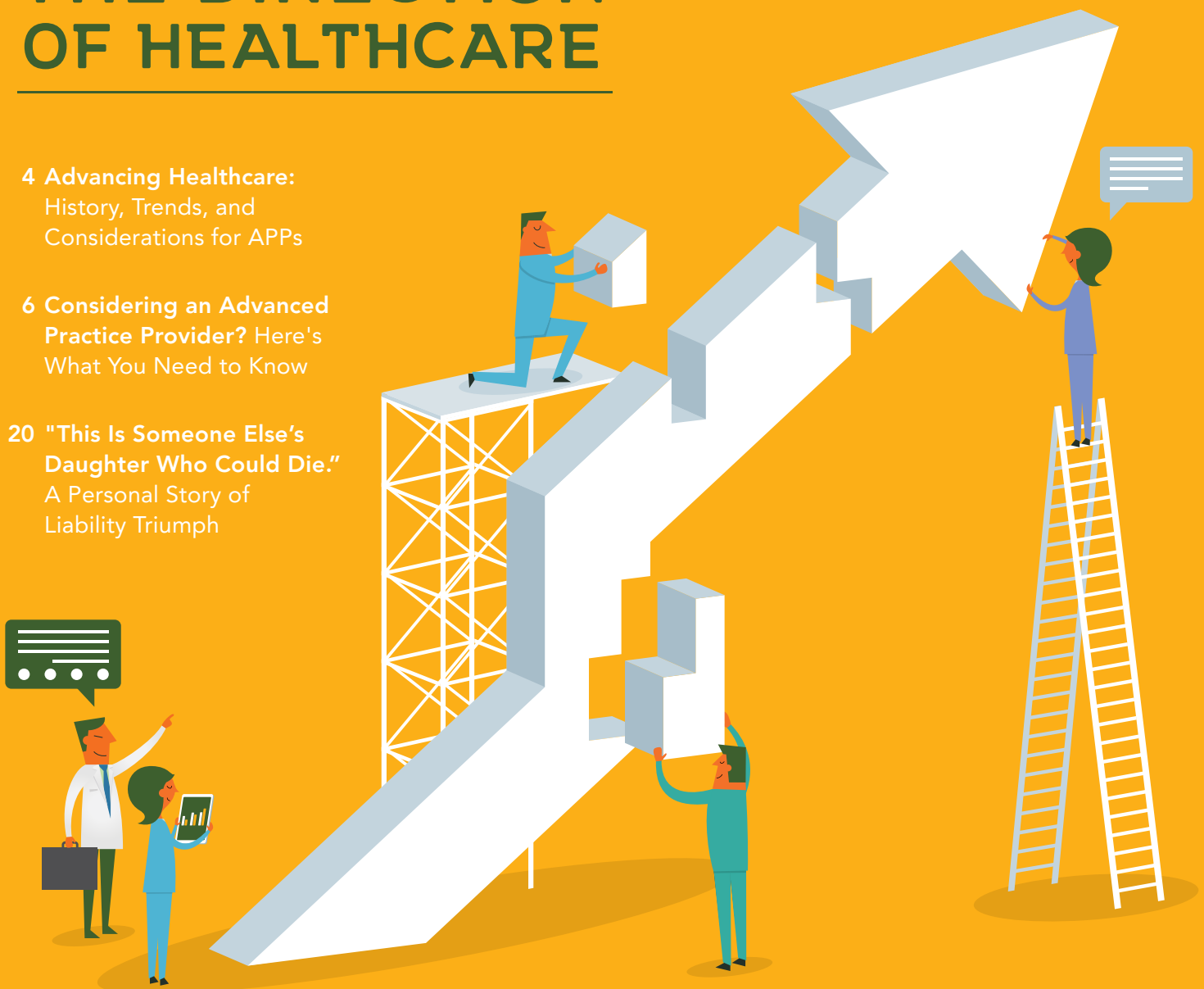
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Deepening the Bench of the Care Team

When I think back on my medical-school education from over 30 years ago, I am struck by how much the training process was focused on developing my autonomy as a solitary physician. Able to work within a team, I was also expected to function independently and be ready for any clinical setting. Three decades and several generations of residents later, the emphasis on teamwork has increased our options for colleagues who can help us survive the long days together.

At Allegro Pediatrics, a physician-owned private pediatric practice of 52 years, we have expanded our provider staff over the past several years to include a number of nurse practitioners (NPs) and physician assistants (PAs). We believe that by including provider-level support for out-of-office tasks and cross-coverage patient appointments, we are able to enhance the continuity of care when a patient's primary provider is out of office. The teamwork provided by these clinicians, with complementary emphasis on clinical training, offers our patients a range of experiences that can meet their needs more specifically.

As our local community has grown to demand services outside of typical office hours, our NPs and PAs have risen to the occasion to staff our evening urgent-care clinics. While some patient families unfamiliar with NP and PA staff are sometimes initially hesitant to see these clinicians, they readily seek their care at subsequent appointments.

The initial transition in incorporating NP and PA staff into an existing physician-only practice can be challenging if there is insufficient understanding of the academic rigor involved in each type of training program. Trust across multiple disciplines can only be developed through open-minded curiosity, exercised with respect and humility. As Patrick Lencioni has said, "Remember, teamwork begins by building trust. And the only way to do that is to overcome our need for invulnerability."



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ADVANCING HEALTHCARE

HISTORY, TRENDS, AND
CONSIDERATIONS FOR APPs

Since the country's first nurse anesthetists aided patients during the Civil War, advanced practice providers have shaped American medicine.

In the 1950s, when the Baby Boom and wartime healthcare needs expanded patient panels and strained hospitals' resources, medical training programs began looking for solutions to meet the growing need for primary- and critical-care providers.

As the Vietnam War reached its midpoint, military personnel providing overseas medical care offered a potential solution to

the provider shortage, says Paul Fry, PA-C, director of ambulatory services at California's Lompoc Health. "During the Vietnam War, there often weren't physicians available to treat overseas personnel, so Navy Corpsmen and Army Medics were doing a lot of the thought work, diagnostics, and treatment," Fry says. "These individuals gained valuable skills and knowledge that, at the time, they couldn't use as civilians."



“During the Vietnam War Navy Corpsmen and Army Medics were doing a lot of the thought work. These individuals gained valuable skills and knowledge that, at the time, they couldn’t use as civilians.”

PAUL FRY, PA-C
DIRECTOR OF AMBULATORY SERVICES
LOMPOC HEALTH

In response, Duke University launched its Physician Assistant (PA) training curriculum in 1965, enrolling four Navy Corpsmen in its inaugural class. The same year, the University of Colorado enrolled the first prospective Nurse Practitioners (NPs) in its new training program.

Similar programs quickly followed suit, springing up at the University of Washington and Baylor University. In the 1990s, Frontier Nursing University, the first U.S. school to provide graduate nursing education, enrolled its first Community-based Family Nurse Practitioner (CFNP) program to train nurses to provide primary care. Soon after, the school offered a graduate degree in nurse-midwifery.

The decades that followed saw APPs expand into various specialties as independent providers and indispensable members of healthcare teams. According to the *New England Journal of Medicine*, there were more than 157,000 NPs and 102,000 PAs nationwide in 2016, with estimated growth rates of 6.8 percent and 4.3 percent, respectively. As of 2017, CNMs number 11,826, while around 40,000 CNAs are in practice.

Collectively, APPs number in the hundreds of thousands and serve diverse patient populations in every realm of healthcare. In keeping with the drive behind the first training programs, APPs strive to expand access to healthcare for urban, rural, and underserved populations. But as Fry notes, new and shifting dynamics in the healthcare market mean today’s APPs face challenges the early program’s pioneers may not have considered.

CURRENT CONSIDERATIONS: COMMUNICATION, EDUCATION, AND INDEPENDENCE

Healthcare’s push to prioritize quality and safety without increasing costs means APPs will continue to serve as vital, increasingly integrated members of healthcare teams. A trend toward eliminating silos and encouraging interdisciplinary communication and collaboration is beneficial for both new and seasoned APPs, who may otherwise become isolated, says Fry.



“APPs tend to be hard-working, thorough, and hesitant to complain,” he notes. But this comes with its downside. “By virtue of being non-physician practitioners, they can also be insecure and become isolated if they’re not given the opportunity to build confidence.”

Another trend may be negative: that of increasingly rigorous entry-level degree requirements for APPs. While some APP licenses used to require a bachelor’s degree, graduate-level education is now standard, with doctoral programs becoming

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Considering an Advanced Practice Provider?

HERE'S WHAT YOU NEED TO KNOW

By Lori Foley, Valerie Rock, and Allison Wilson | PYA Consulting

With the compounding effect of increasing physician shortages and decreasing physician-practice profits, advanced practice providers (APPs), such as nurse practitioners (NPs) and physician assistants (PAs), are highly sought-after in most regions of the country, primarily because they are often easier to source and allow for a lower overhead cost compared to a physician.

GROWTH BY THE NUMBERS

A STATISTICAL LOOK AT THE RISING USE OF NPs AND PAs



Nurse Practitioners

PROJECTED: In 2013, Health and Human Services (HHS) projected that the current 57,000 licensed NPs in the U.S. would trend to 110,500 by 2025.

REALITY:

240,000

Licensed NPs in 2018

31%

Rate of cumulative growth to 2026, as predicted by Bureau of Labor Statistics (BLS)

1.9%

Percentage of APPs that have been named as primary defendant in an MPL case (rates remain low)



Physician Assistants

PROJECTED: In 2013, HHS projected that the then-current 33,000 licensed PAs in the U.S. would trend to 59,000 by 2025.

REALITY:

166,000

Licensed PAs in 2017

37%

Rate of cumulative growth to 2026, as predicted by Bureau of Labor Statistics (BLS)

Source: American Association of Nurse Practitioners, Department of Health and Human Services, Bureau of Labor Statistics

While the case for utilizing APPs is fairly clear, this decision can be complicated for many practices. Some groups have historically only employed physicians, and are not sure how an APP will fit into their practice profile. Common considerations include: *What will they do? Will patients want to see them?* and *Will I feel comfortable allowing them to care for my patients?* These are all valid questions that require thought, education, and due diligence.

While reasons for the addition of an APP vary by practice, in most cases consideration is based on physician shortages and patient-access concerns. According to a 2018 study by IHS Inc., there will be a physician shortage of 42,600 to 121,300 by 2030.¹ Conversely, the United States Bureau of Labor Statistics predicts an NP overage of approximately 68,040 full-time equivalents (FTEs) by 2025. Similarly, there will be a predicted PA overage of approximately 19,000 FTEs by 2025.^{2,3} In cases where the first available appointment is several weeks or months out, and there is difficulty finding physicians due to shortage, geographic location,

or both, APPs can serve as a solution. Although the licensure scope varies by state, an APP can usually perform many of the ambulatory-care service that patients require.

ROLES

There are also cases in which physicians stretch their capabilities to fill patient-access gaps in areas of limited physician resources. This is often managed by extending office hours and scheduling shorter appointments to allow for more visits. While this may suffice as a temporary solution, it can be an exhausting pace to sustain over an extended period of time, potentially driving existing physicians to leave for a more suitable schedule. It can also impact patient-experience and group-quality scores, if patients feel they've received inadequate time and attention. The fatigue of working at this pace may also contribute to clinical oversight or error. Adding APPs in this scenario affords more time for patient visits and follow-up, and allows physicians to complete tasks in a more efficient manner so they can enjoy a better work-life balance.

(Continued on page 8)



Setting Up Your Success

Guidance for the Use of APPs

When considering the addition of an advanced practice provider (APP), provider organizations should take time to educate themselves on the nuances of these provider types as a part of their due diligence. Education is critical, as some organizations inadvertently create compliance risk due to lack of either knowledge or adherence to APP requirements.

See a detailed outline of these considerations and learn more about setting your clinic up for success: Page 10



(Considering an APP, continued from page 7)

APPs can also be an asset as practices expand locations or manage hospital-rounding responsibilities. In some cases, APPs manage their own panel of patients, similar to a physician's. In other cases, APPs are used to assist with hospital rounding and follow-up visit management for patients under a physician's care plan. Utilization of APPs in these areas can free physicians to see more complex patients or reduce their overall workload.

Additionally, when considering office expansion, practices utilizing APPs may allow for a more effective transition of physician time. In some cases, the physician and APP may rotate through each location, providing continuous patient coverage. In other cases, APPs may be hired as full-time staff for a satellite office (allowance for which varies by state and scope of license). These options not only stabilize physician workload during the establishment of an additional location, but also afford increased patient access in outlying communities at a lower cost than hiring a physician, and expand the practice's potential profit.

COMPLIANCE

There are numerous compliance considerations that accompany APP

employment, such as payer credentialing, billing, and physician supervision. If groups have never operated under this model, these requirements may be foreign. However, education in these areas is critical to avoid creating compliance risk due to lack of either knowledge or adherence to these requirements.

Groups will also need to research their states' scope of license for PAs and NPs, respectively, to determine the most appropriate provider for their needs. Depending on that practice scope, a PA may be sufficient if the practice wants an APP to work in collaboration with the physician in managing patient care. However, if the practice requires a provider with capabilities for more autonomy to reduce routine physician involvement, an NP may be a better option. Also, clinical training requirements are different for PAs and NPs, and may impact the practice's determination based on patient clinical needs.

EXPERIENCE LEVELS


Additionally, the level of experience required of APPs will vary from practice to practice, and sometimes between physicians within the same practice. As with other clinical support roles, some physicians prefer an experienced employee



What's in a name?

The term “advanced practice provider” is the generally accepted term for advanced clinicians in all fields of medicine. But other less-preferred terms, from “mid-level provider” to “associate provider” and “physician extender,” are still being used by some—and clinicians are respectfully calling for change.

In an article entitled “Advanced Practitioners Are Not Mid-Level Providers,” published in the *Journal of the Advanced Practitioner in Oncology*, Catherine S. Bishop, DNP, reports that the term “mid-level practitioner” was defined by the U.S. Department of Justice’s Drug Enforcement Administration specifically in reference to healthcare providers allowed to administer controlled substances under U.S. law, and is an outdated and misapplied term.

“There is nothing ‘mid’ about either an APN or a PA,” Bishop notes. “I think all would agree that we provide a high level of care. Our skill set, education, training, and knowledge go above and beyond what would be considered mid-level. I propose that we be in charge of what we are called, not the government or other entities. Respectfully educating our institutions, human resource departments, recruiters, medical colleagues, and patients is a first step in changing the terminology.” 

who can onboard efficiently and work autonomously. However, in some cases experienced APPs have developed their own clinical workflow habits, and may be harder to retrain. Therefore, some physicians prefer newly trained providers and will recruit from local educational institutes in order to train APPs in the manner in which they prefer to practice. Both require a time investment from the physician and administration to ensure that the APP is operating according to expected practice guidelines.

OPERATIONAL CONSIDERATIONS

Another consideration is potential impact on practice operations. In some cases, more space may be required to accommodate an additional provider, necessitating a potential expansion of the current office or the addition of new space. Either way, this determination should be made in advance of hiring an APP, so that existing physician workflow is not adversely impacted by decreased available exam rooms or workspaces.

Also, physician-scheduling templates may need to be reviewed, and possibly revised, based on the proposed role of the incoming provider. For example, if physicians typically have morning schedule blocks for hospital rounding,

and the plan is for the incoming provider to assist with patient rounding, a determination should be made for the best use of those available physician time slots to accommodate patient access. Perhaps the outpatient clinic could open earlier, the physician could allocate a portion of that time to administrative tasks, or both.

Consideration should also be given to staff roles and any necessary revisions thereof. If the APP will support a panel of patients or operate similarly to a clinic’s physician, additional staff may be needed in the front office and clinical and billing areas to properly support an increased patient volume. Additionally, if the practice has never employed an APP, staff will need training on proper procedures. These may include notifying patients whether they will be seen by an APP or a physician, routing clinical messages or prescriptions requiring physician input or signatures, and adhering to payer guidelines for billing services provided by an APP. This is critical for the practice in preserving an effective workflow, maintaining or improving patient satisfaction, and avoiding potential liability.

FINANCIAL CONSIDERATIONS

Financial due diligence is another critical step when evaluating the addition of an APP. Consistent with the addition of any

(Continued on page 31)

Adding an Advanced Practice Provider to Your Practice

Guidance for the Use of APPs

Are you considering adding an advanced practice provider (APP) to your practice?

There are numerous compliance considerations that accompany APP employment, such as payer credentialing, billing, scope of practice, and physician supervision. Start off on the right course by establishing a compliant structure within which to onboard these important professionals.

BEST PRACTICES FOR APP UTILIZATION

When feasible and practical, create and maintain policies and procedures for APP utilization according to the most stringent payer policy governing the use of APPs. Consider the following best practices for structuring APP services and billing:

1. To increase efficiency, utilize APPs in the most independent fashion payers allow. Carefully determine when and how physicians will render face-to-face care to the same patient on the same day. Shared visits—Medicare beneficiaries see both an APP and a physician in the office setting—must meet “incident to” guidelines to bill under the physician. In other words, the APP must be credentialed and bill Medicare when services he or she provides are not following a plan of care established by a physician.
2. APPs may provide services within their scope of practice per a written protocol and under the supervision required by state law without regard to “incident to” service rules. Medicare services can be billed under the APP, and such independent services may include evaluation for new conditions and new patients. Those services should be billed under the APP’s Medicare billing number, and Medicare will pay 85 percent of the physician’s fee schedule. Other payers’ APP reimbursement varies.
3. APPs may provide “incident to” services to established Medicare patients in the office (POS 11) and bill under the physician’s Medicare billing number if both of the following criteria are met:
 - The APP is following a physician’s documented course of treatment, including management of commonly anticipated symptoms of the underlying established or chronic condition.
4. The APP and physician may provide a split/shared service for an established patient’s established problems. Each provider should document his or her services separately; as a best practice, both providers should sign their entries, but at least ensure the billing provider signs. If a new problem is evaluated in the shared service, the visit should be billed under the APP. However, some Medicare Administrative Contractors (MACs) allow for the physician to document a plan of care for a new problem presented during an established patient shared visit, and bill under the physician.
 - The patient presents with no new conditions or symptoms of an unrelated undiagnosed condition at the encounter.
 - Shared/split visits may be billed under the physician’s billing number in the inpatient/outpatient or emergency-room setting.



APP CONTRACTING AND CREDENTIALING

Some, but not all, payers have specific requirements for enrolling and contracting with APPs. As part of your initial considerations, it is important to know what to review in order to understand any requirements to which you may be bound.

1. Review current payer contracts, provider manuals, and bulletins for APP provisions.

Contact your payers to inquire about their credentialing and contracting of APPs. Document the name of the person you spoke with, the date, and what was conveyed.

Review hospital policies on utilization and credentialing limitations.

2. Research relevant state scope-of-practice and licensure requirements; similarly to physician state licensure, payers expect you to follow state requirements.
3. Note that some payers, such as many Medicaid payers, do not allow APPs to bill under a physician's provider number when performing independent services—the payer expects the practice to bill services under the APP.
4. Credential APPs with payers that require credentialing; evaluate whether you should credential with payers where credentialing is optional, based on your ability to meet supervision, coverage, and clinical-practice requirements combined with financial considerations. The best practice is to credential APPs with all payers allowing credentialing.

- Signed documentation by both the APP and the physician may be used to support the reported code.
 - At minimum, the physician must document a portion of the evaluation and management (E/M) encounter, preferably one of the key elements (history, exam, or medical decision-making), and sign the note to support his or her face-to-face service with the patient.
5. An APP may serve as a scribe if services he or she performs are documented distinctly and separately from those services he or she is scribing for the physician.
- When the APP is utilized as a scribe, he or she is not acting independently in E/M service, surgical, or other billable encounters; his or her function is to document the words and actions of the physician with no clinical judgment.
 - Some hospitals, per the Joint Commission's prior policies, prohibit the use of an individual as both a scribe and a provider in the same encounter. To that end, some electronic medical records (EMRs) have limitations for scribes and practitioner licenses. However, the Joint Commission has now updated its policy (as of August 2018) to allow for the dual roles of scribing and performing clinical responsibilities.¹
 - Documentation of scribed services must include the following:
 - Who performed the service.
 - Who recorded the service, with the record entry noting the name of the person "acting as a scribe for Dr. X." (For example: "I, David Jones, PA, am scribing for, and in the presence of, Jane Davis, MD.")
 - The physician's signature and date, acknowledging that the physician reviewed and signed the entry. (Per Medicare's update in Transmittal 713, the physician's signature meets minimum standards.)² The physician is attesting that the note is an accurate record of both his or her words and actions during that visit. (For example: "I, Jane Davis, MD, personally performed the services described in this documentation, as scribed by David Jones, PA, in my presence, and it is both accurate and complete.")
 - The qualifications of each person.
6. Critical-care services may not be billed as shared visits. These services should be rendered, documented, and billed by one provider based on the documentation of the billing provider. When multiple physicians and APPs provide critical-care services on the same date of service and are part of the same group practice, the physicians' service time should be aggregated, and the service billed under one physician's national provider identifier (NPI). The APPs' service time should be aggregated, and service billed, under one APP's NPI. (Note that at least one provider—the billing provider as designated on the claim—must independently meet at least 30 minutes of critical-care service in order to bill the service with critical-care service codes.)

Sources

¹ Documentation Assistance Provided by Scribes, https://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFAQId=1809.

² <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R713PI.pdf>.



APP SCOPE OF PRACTICE AND LICENSURE

States frequently oversee specific licensure and scope-of-practice requirements for nurse practitioners (NPs) and physician assistants (PAs), and often they differ.

1. Review the didactic and clinical training of both NPs and PAs to determine which is more in line with your needs and clinical philosophy. Different types of APPs have varying supervisory requirements, prescriptive authority, and rules for written protocols.
2. Contact your state's licensing board to understand the differing levels of autonomy and scope of practice for your state, including physician-supervision requirements (e.g., physical proximity and documentation-review requirements), as well as any limitations on medication-prescribing abilities.
 - Some states clearly specify which services can be delegated to an APP, and some permit the supervising physician to determine the services he or she believes the APP is qualified to perform.
 - Some states require state-authorized written protocols; others require the protocol to be on file at the practice site and available if requested.
3. Understand and operationalize any documentation requirements necessary to meet scope-of-practice and licensure regulations.



PHYSICIAN OVERSIGHT

Physicians utilize APPs in different ways, in light of various goals and perspectives. Differing state rules for PAs and NPs may influence a physician's or group's decision for the type of APP to select.

1. Understand physician-supervision requirements, and evaluate how they will be met from an operational perspective.
2. Draft and execute required collaborative agreements that govern the supervisory relationship.
3. Provide documentation and coding training to new providers (new to medicine, and new to the practice/specialty). Oversight intensity may lessen as the clinical relationship matures and the physician grows comfortable with the APP's clinical approach, bedside manner, documentation adherence, etc.
4. Communicate and provide clinical mentorship to develop the APP to become a strong provider.



PAYER BILLING GUIDELINES

As an extension to payer enrollment and contracting, it is critical to understand each payer's billing guidelines with regard to APPs and to evaluate your internal processes to ensure they are met.

1. Develop clear tools to assist with patient scheduling and billing. If the practice decides to follow Medicare "incident to" guidelines, it should funnel new Medicare patients or Medicare patients with new problems to physicians. If a practice chooses to allow an APP to see all types of patients that fit the APP's scope of practice, the billing system will need to be set up to bill:
 - Using the APP's billing number for payers that credential him or her.
 - Using the supervising physician's billing number when the payer allows the APP to bill under the physician's NPI.
2. Medicare Administrative Contractors (MACs) have varying policies regarding "incident to" and shared visits. Ensure an in-depth knowledge of your MAC's requirements. For instance, one MAC states clearly that no office-based new-patient shared visits can be billed by a physician; rather, the service should be billed under the APP. Another MAC states that office-based shared visits in which the physician documents his or her service and plan of care for any new problem—and the APP follows that plan of care—can be billed under the physician.

3. Not all MACs provide clarifications, so use more conservative interpretations of “incident to” when your MAC is silent. The most conservative interpretation for Medicare “incident to” services is as follows:
 - The APP is an expense to the practice (e.g., not provided at the expense of another entity).
 - The APP provides the service face-to-face to the patient with appropriate collaboration and physician supervision.
 - The patient’s presenting conditions are established.
 - The physician creates a plan of care during a face-to-face encounter prior to the APP’s encounter with the patient.
 - A supervising physician is in the office suite during the visit (direct supervision).
 - The service is billed under the supervising physician.
 - Further, shared visits in the office are billed under the APP when the service includes a new patient or new problem, and thus does not meet “incident to” requirements.
4. Once the structure, policies, and procedures for the APP utilization design are established, develop appropriate controls and monitors, and educate the team to minimize issues.
5. Conduct periodic (at least annual) documentation and claim audits to ensure APP services are documented and billed according to the appropriate guidelines.

(Advancing Healthcare, continued from page 5)

more common. This may discourage otherwise qualified people with relevant experience from pursuing APP certification.

“We want to guard against academic inflation for entry requirements, so we don’t price ourselves out of the market and become unavailable to the rural communities we serve,” says Fry. “It’s important to maintain our focus on underserved communities.”

a physician is involved in care helps drive the idea that we need to remain interdependent,” he says.

This collaboration helps address another prominent consideration for APPs and their colleagues: concerns about medical liability. In some cases, these concerns might impact hiring decisions or discourage close collaboration between APPs and physicians. But strong working




“Interdependence between physicians and APPs creates the collaboration that reduces risk. If organizations want to decrease risk, they need physicians willing to take on the supervisory role”

PAUL FRY, PA-C
DIRECTOR OF AMBULATORY SERVICES, LOMPOC HEALTH

As APPs grow their ranks and reputation, he notes, there’s also a push for greater independence for some, while others wish to retain their interdependence on supervising physicians. This tension is shown by disparities in Medicare reimbursement rates for different APPs: some are reimbursed at 100 percent, while PAs are reimbursed at 85 percent unless a physician is involved in the care.

A multi-level reimbursement plan that encourages physician-APP collaboration is actually something that should be protected, says Fry, because it supports important communication between members of healthcare teams. “Reimbursing PAs at 100 percent when


relationships between members of healthcare teams creates the best outcomes for providers and patients.

“Personally, I want to protect interdependence with the supervising physician,” Fry says. “Interdependence between physicians and APPs creates the collaboration that reduces risk. If organizations want to decrease risk, they need physicians willing to take on the supervisory role. That means not just signing charts, but developing a relationship over the years and helping an APP grow their skills, experience, and judgment.” 

Sources
American Academy of PAs, Duke University, *New England Journal of Medicine*, Frontier Nursing University, American College of Nurse-Midwives



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ADVANCED PRACTICE PROVIDERS AND MEDICAL LIABILITY

Many advanced practice providers (APPs) don't expect to be involved in medical-liability litigation. There's good reason for this—relatively few medical-liability cases involve advanced practice providers.

In a recent article for Medscape, healthcare attorney Carolyn Buppert, MSN, JD, notes that fewer than one percent of closed malpractice claims involve nurse practitioners.

That may explain why getting sued can be surprising for APPs, says Andrea Hunter, PhD, a trial consultant specializing in medical defense with Seattle-based Mind Matters Jury Consulting. "They don't encounter the reality of getting sued very often," she says. "The world of medical litigation is often very foreign to them."

Because most guidance and information for providers involved in a lawsuit is aimed at physicians, APPs can benefit from resources that are specific to their experiences in trial. "APPs tend to take patient care very seriously and personally, and that can have personal ramifications when they're involved in a lawsuit," notes Hunter. "All providers experience this, but with APPs it seems to be heightened."

With more APPs caring for patients each year, the number of malpractice cases involving these clinicians will likely grow, says Bob Sestero, JD, a medical-malpractice attorney with Evans, Craven & Lackie, P.S., in Spokane. "APPs are in a tough position," he says. "They can be asked to have the autonomy and responsibility of a licensed physician, which may leave them vulnerable when the inevitable bad outcome occurs."

Hunter is quick to point out that there's good news for APPs, however: juries tend to respect their professional expertise, and public perception is of their role in healthcare is positive. With the right preparation and support, these providers can fare well before, during, and after a trial.

JURIES RESPECT ADVANCE PRACTICE PROVIDERS EVEN WHEN THEY DON'T UNDERSTAND THEIR ROLES

As more patients entrust their healthcare to APPs, the public tends to view these practitioners in a positive light, which carries over into the jury box. “In general, APPs are well respected, and juries hold these providers and their recommendations in high esteem,” Hunter says. “But jury members typically do not know or understand the difference between different APP credentials, or the different levels of supervision required for different types of APPs.”

That speaks to a need for more public education around the roles and responsibilities carried out by different APPs like nurse practitioners and physician assistants, Hunter notes. “Even with so many APPs caring for patients today, there’s still confusion in the public about their roles and responsibilities,” she says. “In a jury trial, we engage in deliberate education with juries, because we can’t assume that all members will understand the differences.”

Sources: Andrea Hunter, PhD, senior consultant and partner, Mind Matters Jury Consulting (based in Seattle, Washington)

“APPs are in a tough position. They can be asked to have the autonomy and responsibility of a licensed physician, which may leave them vulnerable when the inevitable bad outcome occurs.”

BOB SESTERO, JD
MEDICAL-MALPRACTICE ATTORNEY, EVANS, CRAVEN & LACKIE, P.S.

KEY LIABILITY CONSIDERATIONS FOR ADVANCED PRACTICE PROVIDERS INCLUDE:

Knowing when to seek input

In many medical lawsuits, a central question becomes, “When does the APP need to recognize the need for more input?” “Usually there are no policies or lists telling the APP when physician involvement is indicated,” Sestero notes, “so the decision then involves the ‘exercise of judgement,’ which tells a jury that a provider may not be negligent if he or she makes the wrong therapeutic or diagnostic choice as long as he or she followed the standard of care in getting to the pivotal choice. In one of our medical cases, the physician assistant acknowledged that his supervisor was in clinic, not more

than 50 feet away, on the day of the patient’s presentation. The plaintiffs’ counsel very effectively pointed out the supervising physician could have looked at the patient in just a few minutes.”

In cases like this one, Sestero says, there is no downside to an APP asking for assistance from a supervising physician. “If there are questions on the differential diagnosis list, or if the treatment or intervention is a tough call, a decision to ask for review will provide an additional layer to their defense through the ‘exercise of judgment,’” he says.

Seeking support, education, and coaching prior to deposition

Many APPs are passionately focused on patient care, a quality that serves them

well in their careers. But the qualities that make APPs compassionate, capable providers may not serve them as well in the courtroom, Hunter points out. “While APPs have significant clinical expertise, they can often benefit from learning how to effectively answer questions in a deposition,” she says. “APPs are often excellent communicators and want to explain themselves in a conflict, but their natural tendencies toward educating and explaining can work against them in litigation. In a deposition, APPs are not there to educate or explain. We work with providers, physicians and APPs alike, to help them better tell their truth in an adverse and anxiety-ridden setting.”

(Continued on page 17)



Scope-of-practice Laws by State

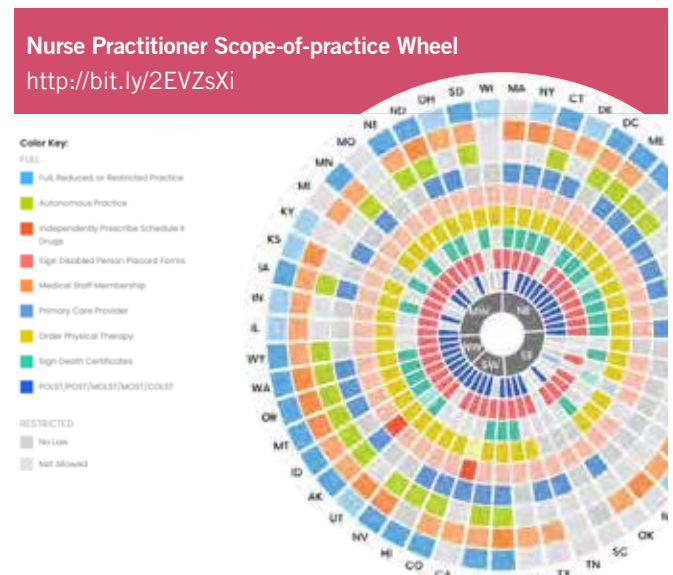
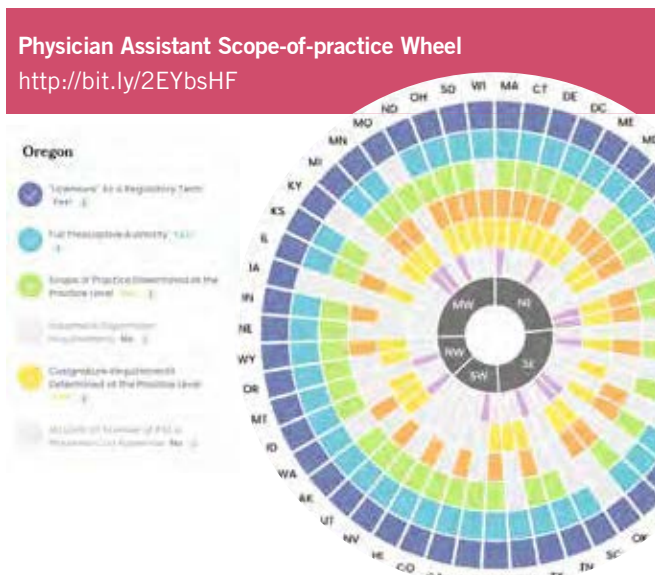
Scope-of-practice laws vary from state to state. The following depicts laws for the use of physician assistants in the states where our members practice.

| PHYSICIAN ASSISTANTS | Alaska | Idaho | Oregon | Washington | Wyoming |
|---|--------|-------|--------|------------|---------|
| "Licensure" As a Regulatory Term: Does the state refer to the PA as "licensed" rather than "certified" or "registered"? Using the term "licensure" makes it the state's responsibility to authorize PA practice. | Yes | Yes | Yes | Yes | Yes |
| Full Prescriptive Authority: Does the PA have full prescriptive authority without state-level restrictions? | Yes | Yes | Yes | Yes | Yes |
| Scope of Practice Determined at the Practice Level: Do the PA, collaborating physician, and healthcare team determine a PA's scope of practice based on the individual needs of the practice? | Yes | Yes | Yes | No | Yes |
| Adaptable Supervision Requirements: Does the state define the collaborative relationship between PAs and physicians with all practice settings in mind? | No | No | No | Yes | Yes |
| Cosignature Requirements Determined at the Practice Level: Are cosignature requirements determined based on the practice's individual needs? | Yes | Yes | Yes | Yes | Yes |
| Number of PAs a Physician May Collaborate With at the Practice Level: Is the number of PAs a physician may collaborate with determined based on the practice's individual needs? | Yes | No | No | No | No |

Source: Barton Associates

Online Tools for More Information

The following interactive wheels are available online from Barton Associates and may serve as a helpful overview of specific state requirements for both PAs and NPs. For more detailed information, please also review each state's practice acts.





“It’s about practicing with the appropriate level of autonomy, and knowing when to seek assistance so you aren’t asked to do more than you should.”

BOB SESTERO, JD
MEDICAL-MALPRACTICE ATTORNEY
EVANS, CRAVEN & LACKIE, P.S.

(Advanced Practice Providers and Medical Liability, continued from page 15)

Balancing autonomy and growth in career planning

Early in a professional partnership, a supervising physician and an APP may check in frequently, giving the APP ample time to ask questions. Over time, this important two-way communication may become less frequent for several reasons.

In busy clinical settings where providers care for large patient panels under immense time pressure, supervising a highly capable APP may seem like a low priority. In these environments, APPs may be discouraged from seeking input from physicians, or fear that doing so will label them as less-competent providers. As caring, empathetic people, APPs may also opt to spend more time on patient care and end up deprioritizing their own need for mentorship and supervision. But inadequate communication increases the risk for the supervising physician and the APP, says Sestero. “It’s about practicing with the appropriate level of autonomy, and knowing when to seek assistance so you aren’t asked to do more than you should,” he says.

To create environments where APPs can thrive, Sestero emphasizes, organizations must work to build a culture where both new and seasoned APPs feel safe asking for input, supervision, and support. And APPs must set their own personal boundaries to ensure that they are not asked to exceed their own comfort level by caring for too many patients with

inadequate supervision, particularly early in their careers. Instead, long-term career goals should be considered, incorporating a plan to gradually increase independence and autonomy as needed.

Looking for employers who offer training and support for APPs


Healthcare’s growing demand for APPs means that many of them will have plenty of employment opportunities. When evaluating potential employers, APPs should consider each organization’s formal process for training and supervising APPs, as these can become critical factors if and when a medical-liability lawsuit arises.

When plaintiffs can point out shortcomings in APP mentoring, training, and monitoring, a medical defense is weakened, Sestero notes—and this is true even when physician supervision is deemed adequate. “In one of my cases, a patient seen by a physician assistant rapidly deteriorated after the clinic visit, and there was no merit to the claim that the supervising physician failed to properly oversee and monitor the PA relative to the plaintiff/patient,” he recalls. “But the plaintiffs’ counsel effectively attacked the medical group’s failure to maintain a ‘process for monitoring.’”

Requesting consistent oversight protocols over time

In busy clinical settings, APPs may be required to care for growing

patient panels with varying degrees of supervision. Indeed, supervisory requirements for different APPs vary by license and by state, creating more confusion around the requirements for physician supervision for each advanced practitioner. As a physician gains confidence and trust in an advanced practice provider, regular check-ins might happen with less frequency and urgency.

When APPs find themselves with less contact and access to their supervising physician over time, clarification about protocol is in order, says Sestero. “While no physician wants to be contacted by an APP with every medical question that arises, it benefits the APP to recognize when there is a need for additional input. A medical-liability case involving an APP will nearly always contemplate a supervising physician’s responsibilities relative to the APP, though the APP’s responsibilities involve following the standard of care in their respective area of practice. It’s a tenuous balance between an APP’s confidence in their own diagnostic and treatment abilities and their obligation to seek timely input. When in doubt, ask.” 

Sources

Bob Sestero, medical-malpractice attorney, Evans, Craven & Lackie, P.S. (Spokane, Washington)



Andrea Hunter, PhD, senior consultant and partner, Mind Matters Jury Consulting (based in Seattle, Washington)

Growing TEAM MEDICINE

A Program
for Nurturing
Advanced Practice
Providers at
Vancouver Clinic

Known for compassionate, skilled care with a strong focus on patient-provider communication, Advanced Practice Providers (APPs) are vital members of many modern healthcare organizations.



As the need for patient-centered healthcare continues to grow, smart healthcare organizations are snapping up newly minted APPs to meet growing demand.

Healthcare organizations that understand how to attract and support APPs will be poised to better serve their communities, says Mark Mantei, CEO of Vancouver Clinic, where around a third of the staff (currently numbering around 350) are APPs. “In the last five years, the number of APPs we employ has grown by around 30 percent,” Mantei says. “We now have about 120—around a third of our providers. This includes audiologists, physical therapists, nurse practitioners, physician assistants, and midwives.”



Mantei stresses that building a robust roster of APPs didn't happen by accident. "We've been very deliberate about attracting more APPs," he says. A vital component of this effort was the launch of Team Medicine, Vancouver Clinic's two-year development program that provides supervision and professional-development opportunities for APPs while gradually increasing autonomy. The program's goal is to help APPs grow in a supported clinical environment as they build their own practices and panels of patients.

In this interview, Mantei describes the program's background, design, and results in greater depth.

How does Vancouver Clinic support strong engagement between APPs, administrators, and board members?

As the clinic hired more APPs, we recognized that they wanted a stronger voice in our group. Together with our chief medical officer, I met with as many APPs as I could. We encouraged them to form a council to give them formal input to our board and medical director. Our APPs play a critical role here, and they have a lot of input on how we run the clinic. Our goal is to train practitioners to work at the level of their training and work collaboratively with other providers to deliver the best care, and we know that APPs have a significant role to play there.

When did you recognize the need for a program like Team Medicine?

With the shortage of physicians both locally and nationally, we knew this would be a critical need for us. So a few years ago, we became more focused about attracting and supporting APPs in order to continue to meet primary-care needs in our community. Two and a half years ago we launched Team Medicine, a development program for newly graduated physician assistants and nurse practitioners built on a "residency program" model. Team Medicine allows providers to work directly with a supervising physician.

How does Team Medicine provide APPs with both mentorship and autonomy?


When new nurse practitioners and physician assistants join the program, they'll join a small group in either internal medicine or family medicine, with a ratio of around four or five APPs to one physician. In addition to taking part in patient care, they meet regularly for

"Our main goal is to remain a strong, independent presence in the Pacific Northwest, providing lower-cost, higher-quality care and continuing to expand our geographic reach and availability to patients."

MARK MANTEI, CEO
VANCOUVER CLINIC
VANCOUVER, WASHINGTON



(Continued on page 32)

A close-up photograph of a young girl's face, showing her eyes wide open in a surprised or shocked expression. Her mouth is slightly open, and her skin is fair. The background is a soft, out-of-focus teal color. The text is overlaid on the left side of the image.

“This is
someone
else’s
daughter who
could die.”

Those were the first thoughts
that went through Elizabeth
Strubel’s mind when she learned
of the unexpected outcome.

The worst part? The way she found out.

“I suddenly had long-time high-school friends calling to see if I was OK,” she recalls. “They had read it on the front page of our hometown newspaper before I even knew about it myself.” The local paper hadn’t attempted any contact for comment, or even to verify the story’s facts. They’d just run with the story, on the heels of a more devastating missed meningitis case, thinking they had an ongoing public-health issue to cover—which amounted to a dramatic upheaval for Elizabeth Strubel, PA-C, and her family.

In addition, the news broke one week before Elizabeth’s delivery of a closely-monitored, high-risk pregnancy. Her road to motherhood had already been stressful, as she had previously endured miscarriages, plus the devastating stillborn delivery of her first child. The stress of the widely publicized claim made this next high-risk pregnancy even riskier.

The personal doubt

“At first, I went over it in my mind so many times and thought, ‘I don’t see any obvious mistakes. What did I miss, what’s wrong with me?’” Elizabeth says.

“At first, I went over it in my mind so many times and thought, ‘I don’t see any obvious mistakes. What did I miss, what’s wrong with me?’”

ELIZABETH STRUBEL, PA-C

The family impact

“Because it was so public, it involved my entire family—everyone was impacted by the press,” Elizabeth remembers. “We had a family meeting with my parents, siblings, aunts, and uncles to discuss how we could proceed. I wanted their input, since the public nature of the story had an impact upon them too. My husband’s clients were even remarking to him about what they had read. My mother’s colleagues commented. Everyone in the family had to answer to it at some point.”

Elizabeth, a physician assistant since 2008, notes that in a situation like the one she was in, it’s easy to start doubting everything you do. You question whether you’re in the right profession. You wonder if every sore throat you see is really something more serious, something deadly. Are you missing something important or dangerous? “You will just want to quit, give it all up, and become a coffee barista,” she says, “until you realize how much you really are helping most patients.”

“Now I just make sure every chart I close can stand up in court,” she says. “I make sure I’ve included the details of my thinking. At first, I might have been a bit less efficient, but now I’ve found the right balance. And I sleep well at night, knowing I’ve done the best job I can with each patient—and it’s reflected in the chart.”

Doubt from colleagues— real or imagined

Perhaps working as an advanced practice provider (APP) puts one under even more pressure. As if her own self-doubt wasn’t powerful enough, Elizabeth felt the doubt of some physicians too, who were already skeptical of APPs at the clinic. “There are physicians among us who don’t think we should be seeing patients,” she says. “My case probably didn’t help that opinion.”

However, the doctors who reached out to her with support during this time made all the difference. While you can’t discuss the details of a case, it makes a difference to have people in your corner when you doubt yourself and feel that others are doubting you—whether their doubt is real or imagined.

As for those you think will question your performance? She says that you just have to know there will be some people who don’t have all the facts—and they might not be in your corner even if they did, so don’t focus on them. Focus on those who show you support.

The surprising part

“It was surprising to me how personal it was,” Elizabeth recalls. “I’m such a perfectionist—we all are, or we wouldn’t be doing this work. But even if you do everything right, a claim can surface.”

Also surprising to her was the fact that no one could talk about it with her, and

(Continued on page 22)



Elizabeth Strubel surrounded by colleagues. Back row, L to R: Clyde Byfield, MD, Janet Dear, MD, Naiman Khan, MD, Stephan Schepergerdes, MD. Front row, L to R: Joe Russell, PA-C, Elizabeth Strubel, PA-C, Elisabeth Lawler, DO

(This Is Someone Else's Daughter, continued from page 21)

how alone it made her feel. “At every turn, I heard, ‘I can’t discuss the details with you,’” she recalls. “Most work phone lines are recorded, and people can’t tell you ‘Oh, it’ll all blow over,’ because no one knows for sure how things will play out.”

Elizabeth’s advice for others:

Be as honest as possible with your defense team. “Your attorney can’t help you if he or she is blindsided by something,” Elizabeth says. “I told my attorney everything—absolutely everything I was thinking, remembering, and feeling. I was terrified, and all this was happening at such a vulnerable time for me anyway. I think most people try to act strong and tough, but I think knowing how scared I was helped my attorney realize what was needed to prepare me.” Her attorney drove hours to meet with her personally, always picked up her calls, and, if she had questions he didn’t yet have answers to, always got back to her.

By the time she testified at her deposition, Elizabeth had gained the confidence to present her story without doubt and fear. “My attorney told me he didn’t think he’d ever seen anyone depose as well,” she says. “I credit all he did to prepare me for that pivotal day.”

Find the people and sources who support you. While some providers experience a claim and try to keep their families out of it, Elizabeth didn’t have that option. But the silver lining behind all the press coverage of her case was that she

was able—she might say forced—to tap into the tremendous unconditional support that family and close friends will offer.

“My husband was hugely reassuring,” she recalls. “He told me, ‘We’ve been through worse together; we’ll get through this.’” In addition, her extended family shared the attitude that, “Whatever it takes, we’re behind you.”

She also recommends relying on whatever spiritual foundations are grounding and provide solace. Taking the news so personally, she also describes feeling a deep ache inside her for the patient and the patient’s family. “We did a lot of praying—for the patient, and for all of us who were affected,” she recalls.

Talk to those who have been through it before. Fortunately, during her case Elizabeth was able to access the PI Peer Support Program. “It was critical to have someone who had been through the process to bounce things off of,” she says. “I had a couple of Peer Support phone calls with someone who was assigned to me by Physicians Insurance; this gave me a sounding board and guided me to talk to my attorney about certain things.”

Elizabeth also had a more senior physician pull her aside and talk to her about his own experience. “He gave me great advice about how to handle the case with my kids,” she recalls. “His own kids were around the same age as mine



when he went through a claim. He told me that after it was over, he was surprised to find out how relieved they were that he wasn't going to jail! Kids have no grasp of the situation." Knowing that, she and her husband were careful to filter their discussions around the kids and reduce how much of the stress came into their home.

Trust the process. At times it might seem like it takes an extremely long time to resolve things or move them along. Says Elizabeth, "There is a process that takes place, and it is for your benefit. It doesn't happen like on *Law & Order*." In fact, even for a pretty straightforward case like hers—which was dismissed during the deposition stage—the whole process still took 18 months.

Furthermore, while Elizabeth remembers just wanting it all to be over as quickly as possible, the time elapsed during her case allowed for the plaintiff's side to reveal and document—via the press and social media—critical inconsistencies in their story. And though allowing the plaintiff depositions to happen first took longer, it gave Elizabeth valuable time to learn about the process and become more comfortable with the proceedings.

Trust your team. Elizabeth didn't always know why her legal counsel wanted her to do things, but she saw in the end that they knew what they were doing and asking of her. "I was just a small square of the quilt, so I didn't immediately see

(Continued on page 24)



“Elizabeth put herself entirely in our hands, allowing herself to benefit from all the expertise our defense team provided—from taking guidance from attorneys, claims representatives, and our trial consultants, down to accepting the offer of peer support. Her openness and willingness to do what was asked of her paid off beautifully.”

VERELETA STEWARD
SENIOR CLAIMS REPRESENTATIVE



“Personally, I will be forever grateful for the physicians and colleagues who stood by me from start to finish during my claim; they really made a difference in my life.”

ELIZABETH STRUBEL, PA-C



(This Is Someone Else's Daughter, continued from page 23)

the overall design that was coming together,” she remembers. She says she eventually came to think of her attorney as the coach, and herself as the quarterback: “He told me what I needed to do in the game and, even if I wasn’t sure at times, I had to do what the coach was telling me.”

Her legal counsel had her attend every deposition. While it was time-consuming and stressful, it also allowed her to learn more about the process, gain comfort with the proceedings, and take notes. When she was deposed, she was prepared and confident.

“My team had me prepped right down to the blue suit I bought for the deposition,” she recalls proudly. “When we walked into the conference room for the deposition, we all looked sharp, we sounded sharp—we were there to prove the appropriateness of my patient care, and it showed. It all paid off.”

Elizabeth’s claim representative, Vereleta Steward, says, “I have never seen such a dramatic transformation in someone we have represented. During the 18 months leading up to the deposition, she went from being utterly broken and emotional over the claim, to being a confident and professional witness in her own defense.”

As for when one of your colleagues is going through it? Keep checking in. Elizabeth says that some of her colleagues or friends checked in on her in the beginning, but eventually, their check-ins became infrequent.

“You have to get up, go to work, and do a good job—all with this going on in the background, for months and months,” she says. “It’s just this huge battle in your mind.” She says she could have used far more day-to-day support from people around her—including just having the situation

acknowledged. “While someone being sued can’t discuss the details of their case, they will certainly appreciate knowing that you’re thinking of them and what they might be going through,” she emphasizes. “Personally, I will be forever grateful for the physicians and colleagues who stood by me from start to finish during my claim; they really made a difference in my life.”

For Elizabeth, as for others before her, the experience of a claim is certainly one she would have preferred to do without. But as her husband predicted, there are worse things one might have to go through, and in the end, she got through it just fine—with great success, in fact. Immediately after Elizabeth’s confident deposition, the plaintiff attorney approached the defense team, sharing that his recommendation to his client would be to dismiss the claim. [PR](#)

Centering Patient Care

How APPs Offer Easy Access, Better Health, and Lower Costs

Improving patient care and health outcomes while lowering costs is healthcare's "Triple Aim," a popular business strategy championed by Donald M. Berwick, MD, MPP, president emeritus and senior fellow of the Institute for Health Improvement (IHI). While the Triple Aim approach of "Better Care, Better Health, Lower Costs" is widely embraced, implementation often proves elusive. But organizations targeting the Triple Aim can hit their marks—and for over 25 years, the Centering model of care has led the way.

THE CENTERING MODEL

Centering started in the 1990s, when Sharon Schindler Rising, MSN, CNM, FACNM, realized that traditional prenatal care wasn't meeting the needs of all patients. To facilitate rich, meaningful engagement between expectant parents, their providers, and their communities, Rising developed CenteringPregnancy, a group-care model that increased patients' access to quality care without increasing costs.

The Centering model's three components are healthcare, interactive learning, and community building. Women opt into Centering groups based on their anticipated delivery date and remain

in the same groups through the post-partum period.

At regular group appointments lasting 90 minutes each (ten times longer than a traditional prenatal visit), providers—often certified nurse midwives—provide one-on-one healthcare for each group member, along with group education. Group members engage in community building and celebrate shared milestones to promote individual health empowerment and activate personal agency.

As neighboring healthcare groups learned of the model, demand for CenteringPregnancy groups grew. By 2016, the model had expanded to serve an estimated 50,000 women per year at 400 sites. Over two decades, the program has served over 70,000 families nationwide.

IMPROVING OUTCOMES, CHANGING HEALTHCARE

The Centering model has been widely adopted and well-studied. Over 200 published articles, including three randomized trials, have reported improved health outcomes for new mothers, including a 47 percent reduction in preterm birth, better attendance

at prenatal visits, higher levels of satisfaction, increased breastfeeding rates, longer pregnancy spacing, and improved immunization rates.

Yale University reported a 33 percent reduction in preterm birth for women in Centering groups, along with higher satisfaction and improved readiness for birth. Thanks in large part to lower rates of preterm birth, the University of Kentucky estimates that CenteringPregnancy saved their health system approximately \$2.1 million over two years.

In 2001, Rising established the non-profit Centering Healthcare Institute (CHI) to expand the model to other sectors of healthcare. Today, more than a dozen CHI consultants conduct training groups and site visits to help organizations successfully implement group-care models for prenatal care, parenting, and chronic conditions. Its enduring success proves that when patient care remains centered, healthcare organizations can achieve their Triple Aim. [PR](#)

Sources

Centering Healthcare Institute; American Academy of Nursing



Tips from the Trenches

Practical Advice on How to Reduce Your Risk of Being Sued

by Elizabeth A. Leedom, JD

Every provider practices in the knowledge that someday he or she may be named as a defendant in a malpractice suit.

The fear of being sued is not unfounded, as more than 75% of physicians in specialties that are considered “low risk” for malpractice claims will be sued before reaching 65 years of age. So how does one mitigate the risk of being sued? The following discussion looks at some common causes of malpractice claims, and how to lower your risk of being sued in each of these areas.

1. Failure to Follow Up on Abnormal Test Results

Given the sheer number of test results the average healthcare practitioner handles, it’s easy to see how something could slip through the cracks. If an abnormal test isn’t acted upon, and later turns out to be significant, the volume of test results alone isn’t an excuse that a jury is likely to accept. You need a reliable system with more than one check to be sure that potentially significant results

are read, acknowledged, and conveyed to the patient—and that proper follow-up occurs. Many electronic medical record (EMR) systems have procedures in place to help facilitate this. But as we have seen in several recent cases, sending an electronic request to medical assistants to contact the patient may not be enough. Is there evidence in the chart, for instance, that the patient was actually called? It is critical that these efforts to reach patients are timely and thoroughly documented. The amount of effort that’s reasonable to expend in trying to reach a patient depends on the seriousness of the test result, within the context of the patient’s clinical picture; more concerning results obviously require additional effort.

It’s also important, when seeing the patient again, that you take the opportunity to look back through the patient’s



progress notes and lab tests to see if there are any abnormalities that have not already been addressed. In most EMR systems, the Results tab can conveniently show you any recent abnormal results.

2. Failure to Diagnose a More Serious Condition

Failures to diagnose and delays in diagnosis are probably the most common reasons patients sue their physicians. Such claims are often based on hindsight, but can be tricky to defend, because the undiagnosed condition was likely present when the care and treatment at issue was given.

In defending failure-to-diagnose claims, I frequently find that the defendant physician actually did

consider what later turned out to be the correct diagnosis, but the clinical picture did not support that diagnosis at the time. Unfortunately, the physician's clinical judgment in the moment, as to why the diagnosis did not fit, was often not contemporaneously documented. I therefore encourage you to always document your medical reasoning—write down the specific reasons why you place the more serious diagnosis lower on your differential. If your judgment later turns out to have been in error, the jury will at least know that at the time, you thought about the possible diagnosis but determined that it didn't fit the facts of the case. A jury that understands that will be more willing to give the physician the benefit of the doubt. If there is no documentation of your medical decision-making, on the other hand, the patient's attorney can easily argue that you didn't even think of the diagnosis at all.

3. Dealing with a Bad Outcome

No one wants his or her patients to experience a bad outcome from medical care. Accordingly, there's a natural instinct among doctors to distance themselves from their patients who have experienced such an outcome, so as not to be reminded of it. That is the opposite of what the patient needs, and the opposite of what will reduce your risk of being sued in that unfortunate event. Instead, make it a point to meet with the patient and their family members, often and without time pressures, to acknowledge that the outcome was not as everyone had hoped. It's okay to express sadness or regret that this outcome occurred—even legally. Under Washington law (RCW 5.64.010), expressions of apology are not admissible as evidence if they're made within 30 days of the patient's injury. (Similarly,

and under the same statute, offers of payment of medical expenses are not admissible in a later malpractice action.) Be prepared to explain what happened and how. Be sure to ask the patient and their family if they have any other questions—and enlist referrals to other specialists or social workers to try to lessen the impact of the bad outcome. Your insurance company and/or your hospital should have risk-management specialists who can help; do not be reluctant to reach out to them.

4. Occurrence of a Risk or Complication from a Procedure

A thorough informed-consent discussion is key to defending against a suit based upon a later risk or complication. If you've taken the time to explain the specific risks and possible complications to the patient beforehand, the fact that the complication did in fact occur will be more understandable to the patient. Be sure to take advantage of any patient-education materials on the specific procedure to be done, too. Many professional societies, insurers, and even medical-device manufacturers have excellent, patient-friendly materials describing common procedures. It's always important to document the specific risks and complications that were discussed, and you can work with your EMR specialists to create smart phrases, applicable to your practice, that can be used to simplify this documentation process. It's also important to develop a custom and practice of explaining to patients that even though a risk may be low, undesirable outcomes can and do happen, and therefore could happen to them. Statistics are fine in conveying this information—but remember, in an individual case, the chance of experiencing the complication is either 0 or 100%.

(Continued on page 35)



GOVERNMENT RELATIONS

2019 Legislative Session Update

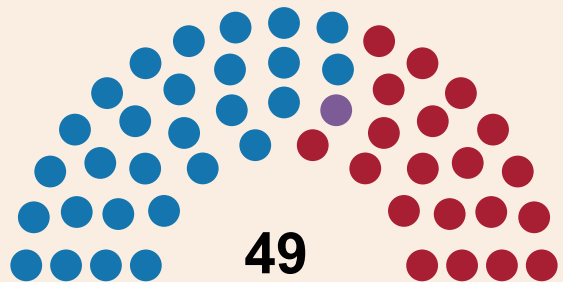
Effective advocacy is crucial for ensuring that the concerns of our members and their patients are heard by lawmakers at both the state and national level. Physicians Insurance works in close cooperation with many other organizations that pursue similar goals, establishing the company as a leading advocate on healthcare-liability policy.

We provide advocacy on challenges to the healthcare-liability system that may create new causes of action against healthcare professionals and other providers, alter the standard of care, create strict liability for providing or not providing care, and impose onerous or unnecessary duties on healthcare professionals and other providers. We support comprehensive effective legislation that will enhance the healthcare-liability system, promote meaningful patient-safety initiatives, improve healthcare quality, and support communication between healthcare professionals, providers, and patients.

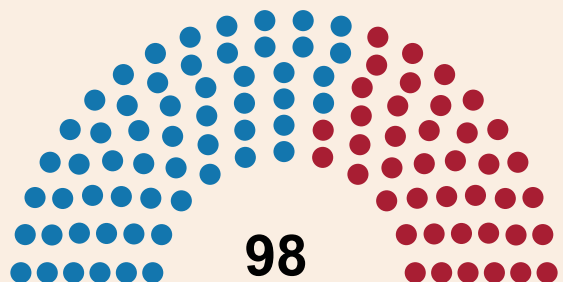
WASHINGTON

The historical legislative environment in the Washington senate continues, with one Democrat senator caucusing with the Republicans. Democrats control both chambers of the Washington state legislature by significant margins, as well as the Governor's Office: Senate 28D-21R / House of Representatives 57D-41R.

WASHINGTON STATE SENATE



WASHINGTON STATE HOUSE OF REPRESENTATIVES





Expansion of a New Class of Beneficiaries—Wrongful Death (PASSED)

SB 5163—*Changes to wrongful-death laws*: Passed the Washington State Senate with a significant-margin vote of 30–17; passed the Washington State House of Representatives with a significant-margin vote of 61–37 and was signed by Governor Inslee on April 26, 2019.

Read the bill: <https://bit.ly/2MCJk3h>

Prior to the enactment of this legislation, wrongful-death law would preclude parents and siblings residing outside the U.S. from bringing a suit for wrongful death of a child or sibling. The law also precluded a parent or sibling from bringing a wrongful-death claim involving the deceased, except where the parent or sibling was financially dependent on the deceased. The changes to the law removed the financial-dependency and residency requirements for parents and siblings. Further, to recover economic and non-economic damages, a parent or legal guardian must demonstrate “significant involvement” in the life of an adult child, such as giving or receiving emotional, psychological, or financial support, to or from the adult child. In addition, a deceased person’s estate is able to recover economic losses in a wrongful-death claim.

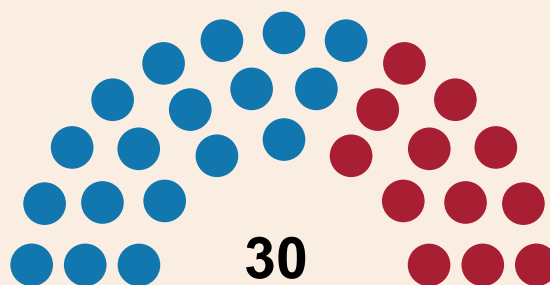
The law is retroactive and applies to all claims not time-barred or pending in court on the effective date of the bill (July 28, 2019).

We anticipated the passage of this legislation and have been working the issue for several legislative sessions. Although we did not support the bill, we supported the fact that its language was significantly reduced to include only parents and siblings as secondary beneficiaries. Please contact us if you have any questions regarding this potential increased liability exposure in Washington.

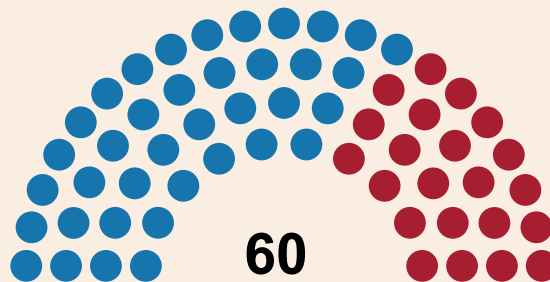
OREGON

As in Washington, the Democrats control both chambers of the Oregon state legislature by significant margins, as well as the Governor’s Office: Senate 18D-12R/House of Representatives 38D-22R.

OREGON STATE SENATE



OREGON STATE HOUSE OF REPRESENTATIVES



Noneconomic Damage Cap—Personal Injury and Wrongful Death (DEFEATED)

HB 2014—*Removes noneconomic damages for bodily injury claims*: Died in the Oregon Senate on June 4, 2019, with a very narrow-margin vote of 14–15. All senate Republicans and four senate Democrats voted to defeat the bill. The bill had passed the Oregon House of Representatives in March 2019 with a significant-margin vote of 36–22.

Read the bill: <https://bit.ly/2WxtJPL>

If HB 2014 had passed the Oregon state legislature, it would have maintained the current law that provides a \$500,000 cap on noneconomic damages in wrongful-death cases, but eliminated the cap on noneconomic damages in bodily-injury cases, which is currently set by statute at \$500,000. However, recent judicial decisions have provided ambiguity in whether the bodily-injury cap is unconstitutional. HB 2014, in part, was intended to provide clarity by eliminating the bodily-injury cap. There is no cap on economic damages in either bodily-injury or wrongful-death cases.

(Continued on page 30)



(Government Relations, continued from page 29)

The minority report that included a \$1.5 million cap on non-economic damages for both bodily injury and wrongful death also failed on the floor of the Oregon Senate, by a party-line vote of 11–17.

Read the bill: <https://bit.ly/2WqgAKN>

The debate over noneconomic damage caps is longstanding in Oregon. Most of the speeches on the floor during this session promoted the merits of finding a compromise and a bipartisan solution, which indicates that the debate over the noneconomic damage cap for bodily injury and wrongful death will continue in future legislative sessions.

In addition to legislative activity, we continue to participate in the Oregon Rural MPL premium-subsidy plan, which pays part of the premiums of participating rural physicians and other health providers.

IDAHO

Idaho continues to maintain a significant Republican majority in both chambers of the state legislature, and has a Republican governor. The 2019 legislative session produced no legislation that adversely impacts the healthcare-liability system.

NATIONALLY


We continue to support and work closely with the MPL Association, our national trade association. Anne Bryant, Senior Director of Government Relations at Physicians Insurance, is

the chair of the MPL Association's Government Relations Committee.

Current federal healthcare-liability reform efforts:

- **Accessible Care by Curbing Excessive LawSuits (ACCESS) Act:** Efforts are underway to increase bipartisan cosponsors to reintroduce the ACCESS Act, which is similar to California's Medical Injury Compensation Reform Act (MICRA). The ACCESS Act provides comprehensive effective reforms that will enhance the liability system, and promotes caps on noneconomic damages while supporting the improvement of healthcare quality.
- **Good Samaritan Health Professionals Act:** Efforts continue to promote federal Good Samaritan legislation, which provides liability protection for healthcare professionals and facilities providing uncompensated services to victims of federally declared disaster areas.
- **Telemedicine Liability:** Efforts continue to expand access to telemedicine services by establishing federal reforms specifically targeted at creating a uniform liability standard for interstate care.

We continue to serve as a trusted, reliable source for our members and key members of Congress, state legislatures, and state executive branches, with a

fair, balanced, and solution-centered approach that promotes the improvement of healthcare quality and patient safety. President Thomas Jefferson once said, "We in America do not have government by the majority. We have government by the majority who participate." Physicians Insurance participates. 



GOVERNMENT RELATIONS

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(Considering an APP, continued from page 9)

other service, the practice should ensure that the addition of the APP will not place financial burden on the organization. The financial analysis should first consider the proposed additional revenue associated with incremental patient visits. Evaluating this revenue is important to ensure that the practice is not double-counting current revenue from the existing patient volume that may be absorbed by the APP. The projected incremental revenue should then be compared to expenses such as compensation, benefits, incremental staff, and buildout costs to evaluate projected profit. As with any new provider, a ramp-up period may be needed, depending on the severity of current patient-access bottlenecks. However, in some cases the group may not be considering the addition of an APP based on increased revenue. The addition may be to provide the physician with opportunities for increased administrative time, to improve physician work-life balance, or to focus on other roles. In these scenarios, the group should compare estimated costs to existing practice revenue and ensure the additional expense is sustainable.

HIRING AND ONBOARDING

When an organization has completed the due-diligence process and decides to move forward with the addition of an APP, the next critical step is the interview process. During the interview, the group should clearly define overall performance expectations and practice culture to provide the best opportunity for a long-term relationship. Also at this time, the group should clearly and honestly communicate the required work schedule (office hours, evenings, weekends, etc.) and desired level of patient care (outpatient, inpatient, or both). Since the position requirements may not be suitable for all candidates, it is best to identify this prior to hiring and onboarding. Additionally, narrowing the candidate pool to those for which the work environment is suitable will allow a focus on more specific areas of clinical care and


The hiring process should be approached with the same thoroughness as hiring a physician, since the incoming provider will interact with patients and impact the group's reputation.

workflow during onboarding and training. The hiring process should be approached with the same thoroughness as hiring a physician, since the incoming provider will interact with patients and impact the group's reputation.

Ideally, the group would assign the APP a physician mentor (not necessarily the same as the supervising physician that state nursing protocols require). As part of the onboarding process, the physician mentor would closely monitor the APP for at least three months in order to observe workflow and standard of care on both sides. This will also foster healthy dialogue regarding the APP's strengths and areas for improvement early in the process. Physicians or other leaders within the organization can also use this time to address any issues with the APP scheduling template, patient wait times, bedside manner, etc.

Compliance areas—timely completion of documentation, billing, and adherence to HIPAA and OSHA policies—are often overlooked until there are significant issues. The onboarding period is an ideal time to monitor these areas and help the

APP establish desired behaviors. In support of this, some groups utilize onboarding for clinical shadowing, which allows an opportunity for the incoming APP to more thoroughly understand physician patient care and workflow, in addition to what has already been directly communicated to them. When the APP begins to see patients independently, the mentor or supervising physician should continue shadowing through a documentation review to ensure that clinical decision-making is consistent with practice standards, and that documentation requirements are met. Feedback should remain consistent throughout the onboarding and oversight period, and continue intermittently thereafter.

While increasing patient demand and rising access issues, coupled with shrinking margins, makes alignment of physicians and APPs attractive, time and consideration are critical to evaluating the best solutions for the organization and for building the proper foundation for a long-term fit. With proper education and planning, the utilization of APPs in a physician practice can provide a viable solution to address increasing burdens and to fill a critical gap in population care for the foreseeable future. 

Allison Wilson and Valerie Rock are consulting senior managers at the professional-services and certified public accounting firm PYA. Lori Foley is Office Managing Principal of the firm's Atlanta office and Managing Principal of Compliance Services. PYA helps clients navigate and derive value amid the complex challenges related to regulatory compliance, mergers and acquisitions, governance, business valuations and fair market-value assessments, and more. For more information, please visit www.pyapc.com.

Sources

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- ² <https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm>
- ³ <https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/primary-care-national-projections2013-2025.pdf>

“With Team Medicine, bringing in APPs who can serve primary-care needs has allowed us to help meet the growing need for primary care more effectively.”

MARK MANTEI, CEO
VANCOUVER CLINIC
VANCOUVER,
WASHINGTON



FAST FACTS

PHYSICIANS: 337

TOTAL STAFF: 1196

SERVICE AREA: 7 locations
in the Vancouver, WA, area

MEMBER SINCE: 1987

*(Growing Team Medicine,
continued from page 19)*

additional education and training. They have consistent access to their supervising physician for questions, but they perform patient-care responsibilities in-clinic. Their employment contracts look very similar to those of our physician staff. They're building their own practice and panel with the guidance and support of a healthcare organization around them.


How has this effort paid off?

The program is still new—we just graduated our first nurse practitioner this year. Overall, the progression and growth we've seen through the program has shown that this model works. As of now, Team Medicine is fully enrolled and in high demand.

Overwhelmingly, our work to attract and support APPs has been beneficial to the clinic, our providers, and our patients. With Team Medicine, bringing in APPs who can serve primary-care needs has allowed us to help meet the growing need for primary care more effectively.

Bringing more APPs into the ranks has expanded the clinic's reach without increasing costs. We're always looking to improve value in healthcare, and if you can look at ways that APPs can contribute to value, they can actually lower costs. This is what we found in some high-demand specialties like obstetrics and gynecology, where we were experiencing high demand in our community. Bringing in midwives to provide care, in particular through our Centering Pregnancy group-prenatal-care

program, has expanded access to care, relieved the strain on our OB-GYNs, and created positive outcomes for both providers and patients.

At Vancouver Clinic, we view APPs as part of our care system. Patients are in great hands with our APPs because they're trained, supported, and encouraged to ask questions of specialty experts. We've put a lot of effort into making this a comfortable place for all types of providers to practice, and we're seeing positive results in the clinic and in the communities we serve. 

You Provide Confidential Care to Patients.

KavuMD™ does the same for you.



Confidential | Convenient | On-demand

As a physician, you have one of the most difficult jobs in the world.

You save lives and are committed to the health and fulfillment of your patients.

Now you can invest in your own fulfillment while receiving the same level of privacy and dedication you provide for others.

Your Physicians Insurance membership includes access to KavuMD, a confidential, consultative teletherapy for physicians who want to nurture their professional and personal fulfillment.

As a highly trained professional, you appreciate expertise. KavuMD psychologists specialize in working with physicians and advanced-practice providers, and they understand the unique demands of healthcare careers—because they're healthcare providers too.

KavuMD providers listen first, and consult with you using approaches proven to build fulfillment—whether that means evidence-based practices such

as MBCT and ACT, or other approaches that fit your individual needs. Spouses or partners are welcome to join in the process if they wish.

HOW IT WORKS

Physicians Insurance members can access KavuMD's network of licensed psychologists at www.kavumd.org. Select the provider you prefer and schedule an initial appointment—the first two are complimentary through your Physicians Insurance affiliation. If subsequent appointments are desired, you'll pay the provider's regular rate and a nominal fee to KavuMD.

KAVUMD IS:

- **Confidential.** KavuMD does not collect your personal information. Only your provider will know your name. Plus, because KavuMD offers teletherapy, you won't be recognized in a waiting room.

- **On-demand.** You're in control. You select your provider; you set your appointment.
- **Independent.** KavuMD is not affiliated with any healthcare employer or any health-insurance company.
- **Convenient:** You can connect to your provider with a computer or smartphone from any location, or in person if that's your preference—all on your schedule.

You chose a career in medicine to help others. Let KavuMD help you maintain your momentum and thrive long-term.

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Book a tele-appointment now at www.KavuMD.org

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and turn generational
obstacles into opportunities



Whether you're communicating with a colleague or a patient, you bring your generational values, ethics, and characteristics along—as do those around you. Each generation sees the world differently, and understanding these differences is the key to success for how your organization's culture works together—as well as for how your team serves and cares for patients.


It's possible your workplace employs people from five different generations, from Traditionalists (1925–1946), through Millennials (1982–1995), all the way to Generation Z (born after 1995). It's even more likely you're treating patients from all those generations—and no matter who they are, we know you care about connecting and communicating with them.

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(Tips from the Trenches, continued from page 27)


5. Communicating with Patients Outside the Chart via Cell Phone, Social Media, and Email

While communications outside the chart may not be the reason a patient brings a lawsuit, such communications may make your case more difficult to defend. First, communication through such non-secure routes may violate state and federal privacy provisions. Second, such communications are likely to be saved by the patient, and could later be used against the defense in a lawsuit. Third, the casual nature and tone of the communications may not give a sense of professionalism and appropriate physician-patient boundaries in the eyes of a jury. (Can you imagine how a jury might react to an emoji-laced text telling the patient that his or her post-op pain is not unexpected and doesn't require further evaluation?) Finally, communications outside the chart are not available to other members of the care team who may need the information, setting up potential communications failures.

Most EMR systems provide patients with the ability to communicate non-urgent matters via secure email. Such email communications are part of the chart and meet privacy requirements. If you do communicate with a patient after

hours on your cell phone, either log into the chart remotely to document the call, or make a note to add the communication to the chart when you have the opportunity. Texting with patients is very problematic, as you may not see the text or respond to it right away—plus, the information is difficult to put into the chart later.

6. Lawsuit Risk-reduction Strategy: Build Solid Patient Relationships

While the odds of being sued during your career are, statistically, unfortunately high, having a good professional relationship with your patient can at least make the patient more reluctant to sue, and more likely to say good things about you at a deposition, if it comes to that. Such relationships are built over time, on a foundation of good communication. Taking the time to listen to your patient, to directly answer his or her questions, and to explain your medical thinking and proposed treatments in understandable terms will help build this foundation. 

Elizabeth A. Leedom is Vice President and Corporate Secretary at Bennet Bigelow & Leedom, P.S. and is an experienced trial lawyer representing hospitals, physicians, and other providers. She is regularly selected on the "Super Lawyers" and Best Lawyers® lists, most recently in 2017 when she was also selected to the Top 50 Women Lawyers list.



ADDRESS SERVICE REQUESTED

WELCOME

NEW CHAIRMAN AND BOARD MEMBER

As a result of the April 2019 annual meeting, we're pleased to announce David Carlson, DO, as the new Chairman of the Board, and Jordana Gaumond, MD, as a new addition to the Physicians Insurance Board of Directors.



David Carlson, DO
Family Medicine
MultiCare Health System
Tacoma, WA



Jordana L. Gaumond, MD, FACS
General Surgery
The Oregon Clinic
Portland, OR

WELCOME TO OUR NEW MEMBERS!

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Rockwood Clinic/Multicare
Spokane, WA

Thrive Pediatrics
Meridian, ID

Umpqua Community Health Center
Roseburg, OR

HOSPITAL EXCESS

Overlake Medical Center
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Salem Health
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**Yakima Valley Memorial Hospital/
Virginia Mason Memorial**
Yakima, WA