THE PHYSICIAN SHORTAGE CRISIS & THE USE OF ALLIED HEALTHCARE PROVIDERS

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Ms. Shoter often speaks on a national level about healthcare related litigation and has addressed such topics as risk management tips for nurses and other health care providers; identifying hospital corporate liability and institutional negligence; assessing and evaluating medical malpractice cases; tips and techniques for trying the medical malpractice case; evaluating medical records; preparing medical information for use at trial; using expert testimony to rebut emotional damages; negotiation tips for mediation and settlement; and professional civility for trial lawyers.

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A. Introduction: The Medical and Legal Challenges of the Physician Shortage Crisis

It is undisputed within the healthcare industry that due to the combination of many retiring physicians,1 an insufficient number of medical school graduates choosing primary care over subspecialties, the rapidly aging Baby Boomer generation,2 projected population growth3 including new immigrant populations,4 and the increasing number of insured patients through the implementation of the Patient Protection and Affordable Care Act (PPACA or just ACA),5 the United States is currently facing a physician shortage crisis that is expected to significantly worsen in the years to come6 if viable solutions are not identified and utilized. Though all medical specialties are impacted by the shortage, industry experts agree that primary care will be the most significantly affected.

There is no question that the health needs of aging patients will be increasing due to more comorbidities and more complex care situations that will need heightened medical attention. Aging patients will also require more medication prescriptions with greater oversight of contraindications, and there will be greater need for follow-up care including monitoring of labs and diagnostic studies as well as referral consultations with specialists. It is both foreseeable and anticipated that patient care will suffer due to a decrease in the number of available primary care

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1 According to the Deloitte 2013 Survey of U.S. Physicians, one out of three practicing physicians in the United States is over age 50, one out of four is over age 60, and six in 10 physicians say that it is likely than many will retire earlier than planned in the next 1-3 years. Some are retiring due to age and others by choice, due to the perceived (and real) future of medicine.

2 The Baby Boomer generation is defined as including those persons born between the years of 1946 and 1964. During those years, 75.8 million Americans were born. See “Facts and Statistics About the Baby Boomer Generation,” Baby Boomer Magazine.com, February 25, 2014. The first of the Baby Boomers reached senior status in 2011, with many more millions to follow in the upcoming years. The U.S. Census Bureau estimates that the nation’s population over the age of 62 will increase from about 46 million now to about 83 million by 2030. Of that population, 14 million will have diabetes and 21 million will be obese. By 2020, the American Hospital Association estimates that Baby Boomers will account for four in 10 office visits to physicians. A number of studies estimated that by 2020 the United States will be short anywhere from 24,000 to 200,000 physicians. See “Will There Be Enough Doctors?” by John Commins, published online in Media HealthLeaders. However, more recent studies, including the March 2015 Final Report by HIS Inc., prepared for the Association of American Medical Colleges (AAMC), titled “The Complexities of Physician Supply and Demand: Projections from 2013 to 2025,” states that the nation will likely face a shortage of between 46,000-90,000 physicians by 2025.

3 According to the U.S. Census Bureau’s 2014 National Population Projections, between 2013 and 2025, the nation’s population is projected to grow 10%, from 316.5 million to 347.3 million. http://www.census.gov/population/projections/data/national/2014.html


5 PPACA, commonly called “ObamaCare,” constitutes a major regulatory overhaul of the nation’s health care system and is intended to greatly expand health insurance coverage. It was signed into law on March 23, 2010 although is impact is just now starting to take effect due to health insurance reforms implemented in 2014. See Congressional Research Services’ (CRS) “Physician Supply and the Affordable Care Act,” by Elayne J. Heisler, January 15, 2013, 7-5700, www.crs.gov, R42029, for additional information.

6 A number of studies estimated that by 2020 the U.S. would be short anywhere from 24,000 to 200,000 physicians. See “Will There Be Enough Doctors?” by John Commins, published online in Media HealthLeaders. However, more recent studies, including the March 2015 Final Report by HIS Inc., prepared for the Association of American Medical Colleges (AAMC), titled “The Complexities of Physician Supply and Demand: Projections from 2013 to 2025,” states that the nation will likely face a shortage of between 46,000-90,000 physicians by 2025.
physicians to handle increased patient needs and an increased number of patients. Patients’ acute health care needs will not be able to be timely addressed if no physician is available for an office visit or consultation. Wait times will increase and patients’ medical situations will worsen. The physician shortage will also lead to a decreased ability for physicians to address patients’ preventative wellness needs so patients will develop new conditions that could potentially have been avoided and this will lead to greater acuity care levels nationwide and particularly with respect to patients who are obese, have diabetes, have an unstable gait, or who fall into other high risk categories for future medical problems.

In addition to these patient care based problems, the physician shortage will also inevitably lead to increased risk of patient harm and liability for physicians and the healthcare entities that employ physicians. When physicians are rushed and have inadequate time to spend with their patients, they are significantly more likely to fail to take a comprehensive medical history; they are more likely to miss differential diagnoses and make other medical errors/mistakes because they are inattentive; they are more likely to prescribe improper medications (due to overlooking allergies or prescribing contraindicated medications) or prescribe wrong doses of medications; and they are much more likely to be less detailed and make more errors in their medical charting due to lack of time to dictate and/or proofread their transcribed documentation. They are also more likely to fail to sufficiently perform follow-up activities with respect to reviewing and/or discussing with their patients the results of labs or diagnostic tests and consulting with referral specialists to arrive at an appropriate plan of care for the patient. These types of failures generally stem more from physician inattention and time-related neglect than from lack of competency. In addition to the potential medical harm to the patient caused by these problems, physicians and their employer healthcare entities also face potentially huge legal and financial consequences should a patient be harmed by the negligence. Both the physician and the physician’s practice or healthcare employer can be sued under direct negligence claims or vicarious liability (respondeat superior) claims.

B. Utilizing Nurse Practitioners, Physician Assistants, and Allied Healthcare Providers

1. Background and History

The term “Allied Healthcare Provider” is broadly used in the healthcare industry to identify hundreds of different types of health care providers. Allied healthcare providers work collaboratively with physicians, physician assistants and nurse practitioners to provide direct patient care. Allied health professionals represent more than 60% of all health care providers. Advanced Practice Registered Nurses (Nurse Practitioners are the most common type) and Physician Assistants do not consider themselves “allied healthcare providers” but many in the healthcare industry still use the phrase loosely in describing them. Nurse practitioners and physician assistants work independently and/or collaboratively with physicians, and/or a combination of the two, depending on their state of licensure and scope of practice, which varies considerably across the nation. The large number of states now allowing fully autonomous

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Some examples of the many types of allied healthcare providers include the certified medical assistant, certified surgical assistant, home health aide, nutritionist, occupational therapist, paramedic, perfusionist, phlebotomist, physical therapist, registered dietician, respiratory therapist, and speech language pathologist.
independent practice of nurse practitioners, and the resulting increase in the numbers of independent nurse practitioners, is transforming the way patient care is and can be delivered.

Most members of the healthcare industry are convinced that the physician shortage crisis necessitates an increased reliance on nurse practitioners, physician assistants, and allied healthcare providers. According to the Deloitte 2013 Survey of U.S. Physicians, “eight in ten physicians agree that the wave of the future in medicine over the next decade involves interdisciplinary teams and care coordinators” and that “mid-level professionals will play a bigger role in direct primary care delivery.”8 Despite ongoing industry controversy on the issue of independent practice versus collaborative/supervised practice, the scope of practice level of nurse practitioners and physician assistants has been steadily expanding to help solve the physician shortage problem. The handwriting on the wall – including regulatory licensure changes, changes to professional degree programs, and mandates under ACA – reflects that it no longer remains an issue of “should” but rather, an issue of “how” these professionals will be more involved in providing direct primary care to patients. Moreover, as the nurse practitioner and physician assistant roles continue to expand with the shortage of available physicians to meet patient demand, more creative patient care delivery system models are being created and implemented – some voluntarily and some mandated as per ACA – to replace and, as some would argue, completely transform the traditional physician-patient model of delivery of care.

Neither the current physician shortage situation nor the current “hot topic” issue of expanding the use and authority levels of other healthcare professionals is new. In fact, the nurse practitioner concept first took flight in 1965 as a direct result of the physician shortage situation caused by the creation of Medicare and Medicaid, which was about to add many millions of additional insured patients to the healthcare system.9 Wanting to expand the nurse’s role in health care and seizing the opportunity of the physician shortage crisis, Loretta Ford, a nurse, joined forces with Henry K. Silver, M.D., a pediatrician, and together they started the first clinical training program for nurse practitioners at the University of Colorado’s Schools of Medicine and Nursing. The demonstrated success of that program led Dr. Eugene A. Stead, Jr. to initiate, also in 1965, the first formal educational program for physician assistants at Duke University. Dr. Stead believed that mid-level practitioners could increase patients’ access to health services by extending the time and skills of the physician and for his efforts and success, he is credited with being the founder of the physician assistant profession. A few years later, in 1968, Dr. Silver started a Pediatric Physicians Assistant program at the University of Colorado Medical Center, and the concept spread across the nation.

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9 In 1965, Medicare and Medicaid, enacted as Title XVIII and Title XIX of the Social Security Act, were created; Medicare was designed as a national social insurance program that granted coverage to patients aged 65 and older and to younger patients with qualifying disabilities and Medicaid was designed as an insurance coverage program for low-income populations.
Though Ms. Ford (who is still alive today at age 94) always believed that nurse practitioners should be allowed to work independently, because she was working with Dr. Silver and the Colorado medical school to give birth to the nurse practitioner profession, her colleagues even back in 1965 were concerned that the model would focus on nurses being supervised by physicians rather than serving as colleagues and partners in health care delivery. In fact, by the 1980s, when nurse practitioner educational degree programs began appearing all over the United States, nurse practitioners were indeed all working in a collaborative supervised relationship with physicians. However, since that time, the situation has changed a great deal and the allowable scope of independent practice (non physician-supervised) has significantly expanded to become almost a new national norm.

2. The Nomenclature Debate and Its Significance

Even the language used to describe these professionals is not without controversy. The healthcare industry routinely refers to these professionals as “Advanced Practice Registered Nurses” (APRNs) and/or “Nurse Practitioners” (NPs) and as Physician Assistants (PAs) but they are also regularly referenced as “Non-Physician Providers,” “Allied Health Providers,” “Physician Extenders,” “Mid-Level Providers,” and even “Limited License Providers.” The American Association of Nurse Practitioners (AANP), who describes itself on its website as “the largest and only full-service national professional membership organization for nurse practitioners (NPs) of all specialties,”11 feels very strongly about the verbiage that should and should not be used and has issued a position paper specifically addressing “Use of Terms Such as Mid-Level Provider and Physician Extender.” According to its paper, the AANP opposes use of all these other terms. AANP believes that nurse practitioners “are licensed, independent practitioners” and it therefore “encourages employers, policy-makers, health care professionals and other parties to refer to NPs by their title” or, collectively, as “independently licensed providers, primary care providers, health care professionals and clinicians.” AANP takes the position that these other terms originated in medical organizations, are not interchangeable, confuse the patients and public, and “call into question the legitimacy of NPs to function as independently licensed practitioners.” The American Academy of Physician Assistants (AAPA), the national professional society for physician assistants, does not seem to take a formal position on the other frequently used nomenclature but it does consistently refer to its professionals simply as “Physician Assistants.”12

Despite the AANP’s articulated position, physicians and many others in the healthcare industry continue to use all of the aforementioned terms interchangeably – presumably just out of habit or lack of knowledge but, perhaps, sometimes by choice. The debate over the language to be used in describing these professionals underscores the larger controversy about the autonomy of practice. The “war of words” is, of course, one of the battlegrounds in the realm of public perception.

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11 See http://www.aanp.org/
12 The AANP is opposed to the use of the term “Assistant Physician” but that issue arises in the context of a separate debate about a different type of licensure issue. See AAPA Position Paper, “Support of Standardized Licensure Requirements for Health Professionals to Assure Public Protection and Transparency,” December 2014.
3. An Overview of the Differences in Education, Training, Licensure, Certification and Scope of Practice

a. The Physician

There is no debate that physicians invest significant effort into medical education and must undergo rigorous, time-intensive, and costly educational and clinical training. Education consists of four years of undergraduate studies that includes pre-med courses in the sciences and four years at an accredited medical or osteopathic medical school which includes preclinical and clinical education. Physicians may obtain M.D. or D.O. degrees; M.D.s practice allopathic medicine, the classical form of medicine, which is focused on the diagnosis and treatment of human diseases whereas D.O.s practice osteopathic medicine, which is centered around a more holistic view of medicine in which the focus is on seeing the patient as a “whole person” to reach a diagnosis, rather than treating the symptoms alone. Osteopathic medical schools are considered to be less competitive than allopathic medical schools but professionals with either degree are considered physicians.

After medical school, physicians receive three to seven years of graduate medical education (GME) via a residency program with training in a particular specialty (as an example, the internal medicine residency requires three years whereas general surgery residency requires five years). One to three years of further sub-specialty training through a fellowship is needed for a subspecialty. Physicians have the option of undergoing additional education and training to become Board Certified in a particular field of specialty and there are a very large number of options. To become Board Certified, most specialties require an application, an examination, Continuing Medical Education (CME), and, oftentimes, later recertification with a recertification application and examination and additional CME. Physicians are licensed through their state Medical Board and must adhere to state practice standards, including completion of CME, to remain in good standing with their licensure.

There is little dispute that when rendering patient care, and particularly internal or family medicine primary care, due to their extensive education and training, physicians are able to provide their patients with the benefit of a full understanding of both the body’s separate parts and its collective inter-reactions so that differential diagnoses can be considered and the whole-body can be treated.

b. The Physician Assistant

Typically, students who aspire to become a physician assistant obtain a regular undergraduate Bachelor’s degree or complete a post high school accelerated physician assistant program that usually takes five years and awards a Bachelor’s degree and a Master’s degree. To be admitted to most physician assistant educational programs, students must complete many of the same science-related pre-med prerequisite courses that medical schools require. Additionally, many programs require a significant number of hands-on direct patient contact hours before applying, so many candidates have already worked in the health care industry for a few years in some other capacity – as a nurse, nurse’s aide, paramedic, emergency medical technician, surgical assistant, phlebotomist, pharmacy technologist, radiology technologist, or mental health worker.
The Physician Assistant Master’s educational program generally lasts a little over two years and includes courses in basic sciences, behavioral sciences and clinical medicine. The last year involves typically 2,000 hours of clinical rotations. After passing the Physician Assistant National Certifying Exam (PANCE), administered by the National Commission on Certification of Physician Assistants (NCCPA), the title earned is Physician Assistant-Certified (PA-C). Additional education is required for specialty certifications and re-certifications. There are over 65 specialties and sub-specialties for physician assistants. Physician assistants have continuing education requirements.

Physician assistants are supervised by a physician but they do not practice under the physician’s license; rather, they are licensed in their own state in their own name through a state licensing medical board or a state regulatory agency. Licensed physician assistants are permitted to perform a wide range of diagnostic and therapeutic procedures and can deliver many types of patient services on their own. They routinely take patient histories, perform examinations, order labs and diagnostic tests, and develop patient treatment plans. Because they have a generalist type of medical education, they bring many skills to the table and are able to practice in a variety of practice settings.

The use of physician assistants can make physicians more efficient and free up physician time to manage more complicated patient cases. According to the AAPA’s 2013 Annual Survey, there were more than 100,000 physician assistants in the United States. The AAPA’s website contains breakdowns of each state, but looking at Illinois, as an example, 31.3% of physician assistants specialize in primary care (which includes family medicine) and another 8.8% specialize in internal medicine subspecialties. Surgical subspecialties constitute 35.5% in Illinois and are likewise very popular around the nation. Illinois, 45.7% of physician assistants work in a physician group or solo physician practice and 34.9% work in the hospital setting. In Illinois, the typical physician assistant sees 61-70 patients per week. States with the largest number of clinically practicing physician assistants include California, Florida, New York, North Carolina, Pennsylvania and Texas.

State laws vary considerably with respect to the physician assistant’s allowable scope of practice. In most states, the supervising physician and the physician assistant jointly establish and enter into a written agreement outlining the scope of practice; but in many states like Wisconsin and Ohio, state law lists the specific services that a physician assistant can provide; in other states like South Carolina and West Virginia, the allowable scope of practice services must be approved by the state medical board. In most states, physician assistants’ prescriptive authority is determined at the practice level by the supervising physician but in some states, like Arkansas, physician assistants are not authorized to prescribe Schedule II medications. With respect to supervision, there is a very wide divergence between states as to the number of physician assistants that one physician is allowed to supervise – for instance, Vermont has no limit; in Texas, no more than seven may be supervised; in Connecticut, no more than six may be supervised; in Washington, no more than five may be supervised; in New Jersey, no more than four may be supervised; in Nevada, no more than three may be supervised; and in Pennsylvania,

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13 A list of state licensing boards is on AAPA’s website, at https://www.aapa.org/threecolumnlanding.aspx?id=347
14 See 2013 AAPA Annual Survey
15 Id.
no more than two may be supervised. There are also numerous differences between states as to how co-signatures are to be handled – in many states like South Dakota, co-signature requirements are determined at the practice level by the supervising physician; but in Kansas, the number of charts that must be reviewed by the physician depends on the length of the supervisory relationship; in Oregon, the supervising physician must review a percentage of patient charts that the physician assistant has seen on a monthly basis; in Nebraska, the physician must review 100% of patient charts for physician assistants who practice at a secondary site; and in Washington, the supervising physician must review and countersign medical orders within two working days. These differences between states significantly impact the way patient care is overseen and they provide challenges to providers who seek to relocate to new states or work in multiple states simultaneously.

Physician assistants can be employed in a wide variety of clinical settings, both urban and rural. Statistically, most physician assistants are typically employed in either the physician group private practice or hospital setting though the hospital setting includes inpatient, outpatient, emergency department, operating room, or intensive care unit. The physician assistant workforce is much younger than the physician workforce, with 77% under age 50. Approximately 36% of physician assistants work in combined primary care and internal medicine subspecialties. A projection in 2013 was that supply of primary care physicians would grow about 58%, from 27,700 to 43,900 between 2010 and 2020. The Bureau of Labor Statistics predicts a 38.4% employment growth in the physician assistant profession between 2012 and 2022.

c. The Nurse Practitioner

Historically, there have been many degree pathways to becoming a nurse, including eventually becoming a Nurse Practitioner. Ultimately, all nurse practitioners must complete a Master’s or Doctoral degree program and obtain advanced training. Some candidates get to that point by initially completing a Diploma program, which usually takes three years to complete; an Associate’s Degree in Nursing Program (ADN), which requires at least two years of college including some science courses; or a Bachelor’s of Science in Nursing Program (BSN), which requires four years including science and research courses. An Accelerated Master’s degree in Nursing (MSN) program is available by combining one year of a BSN program with two years of graduate study. The Diploma and ADN programs have a more “hands-on” approach to education whereas the BSN and MSN programs emphasize research and nursing theory. A BSN is typically necessary for administrative positions and is a prerequisite for admission to an MSN program. The first level of nurse is the Licensed Practical Nurse (LPN). More education and testing is required to become a Registered Nurse (RN), which carries with it the ability to perform additional advanced duties and receive higher earnings.

An Advanced Practice Registered Nurse (APRN) is a Registered Nurse who has obtained either a Master’s degree in Nursing or a doctorate degree (discussed below) in one of four

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17 “Projecting the Supply and Demand for Primary Care Practitioners Through 2020,” Health Resources and Services Administration (HRSA). November 2013.
specialty roles: (1) Nurse Practitioner (NP); Certified Nurse Midwife (CNM), Certified Registered Nurse Anesthetist (CRNA), and Clinical Nurse Specialist (CNS). Master’s programs typically include classroom education (with courses such as anatomy, physiology and pharmacology) and clinical experience.

In 2004, the American Association of Colleges of Nursing (AACN), a national organization that speaks for nursing education and represents more than 750 member schools of nursing, published a position paper that addressed the idea of converting the APRN degree from a Master’s degree to a Doctor of Nursing Practice (DNP) degree by the year 2015. The concept stemmed from the idea that advanced practice nursing is one of only a few remaining health care disciplines that does not offer a doctorate degree for licensed independent practitioners – unlike for medical doctors (MD), osteopaths (DO), dentists (DMD/DDS), podiatrists (DPM), optometrists (OD), pharmacists (PharmD), psychologists (PsyD), physical therapists (DPT), and occupational therapists (DOT). In 2008, a Nurse Practitioner Roundtable was gathered to formally address the issue. In July 2008, the APRN Consensus Work Group and the National Council of State Boards of Nursing APRN Advisory Committee published the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education, which established the desired framework for the uniform future education and accreditation of nurse practitioners. To date, the project has been endorsed by over 40 nursing organizations across the country. All APRN training programs are currently recommended – but are not yet required – to convert their Master’s degree to a Doctor of Nursing Practice degree by the year 2015. As per AACN’s “DNP Fact Sheet” published August 2014, DNP programs are now available in over 48 states and by 2013 the number of enrolled students was over 14,600. A per an AACN Press Release issued in October 2014, many schools will be maintaining both the Master’s and DNP degree options until they are able to fully transition over into full adoption of the DNP which is the goal.

The push for and the prevalence of DNP degree programs across the country and the creation of a national Doctors of Nursing Practice Conference, sponsored annually since 2008, by a group now called Doctors of Nursing Practice, Inc., indicates that the nurse practitioner community is actively seeking to transform not only the way business is done but also the public perception of the profession, i.e. in considering these professionals as “doctors” in their specialty as opposed to “nurses.” As will be discussed it a bit, their efforts to assume more independence and expanded scope of practice are supported by ACA’s mandates to increase the primary care workforce in the coming years.

Most nurse practitioners are nationally certified through the American Nurses Credentialing Center (AANC) or the American College of Nurse Practitioner (ACNP). These, and other, national professional organizations offer a very extensive list of subspecialty certifications.

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18 See website of American Association of Colleges of Nursing, [http://www.aacn.nche.edu](http://www.aacn.nche.edu)
19 See American Association of Nurse Practitioners’ (AANP) “Discussion Paper: Doctor of Nursing Practice”
20 Id.
21 The American Association of Nurse Anesthetists approved this recommendation but is not requiring program compliance until 2025.
22 See AACN’s website, [http://www.aacn.nche.edu/media-relations/fact-sheets/dnp](http://www.aacn.nche.edu/media-relations/fact-sheets/dnp)
23 The group was started in 2006 as “Doctors of Nursing Practice, LLC” which became “Doctors of Nursing Enterprises, LLC” in 2012; also in 2012, “Doctors of Nursing Practice Professional Development, Inc.” changed its name to “Doctors of Nursing Practice, Inc.” See [http://www.doctorsofnursingpractice.org/about-us/history](http://www.doctorsofnursingpractice.org/about-us/history)
Just by way of example, a nurse practitioner can be certified as a Family Nurse Practitioner, Acute Care Nurse Practitioner, Adult Nurse Practitioner, Gerontological Nurse Practitioner, Adult-Gerontology Acute Care Nurse Practitioner, Adult-Gerontology Primary Care Nurse Practitioner, Psychiatric-Mental Health Nurse Practitioner, Adult Psychiatric-Mental Health Nurse Practitioner, Pediatric Primary Care Nurse Practitioner or Emergency Nurse Practitioner.

Nurse practitioners are regulated by state nursing board licensure laws and state nursing practice policy with respect to scope of practice and prescriptive authority. The phrase “scope of practice” refers to the types of services and the terms under which the practitioner is legally allowed to provide under state law. Scope of practice laws vary considerably by state. In many states, such as Kentucky, nurse practitioners can independently diagnose and treat patients without physician involvement. However, in other states, such as Illinois, nurse practitioners are required to establish a collaborative agreement with a physician in order to practice. In some states, such as Arizona, nurse practitioners have authority to prescribe without physician involvement; in other states, such as Kentucky and New York, nurse practitioners must have a collaborative agreement with a physician in order to prescribe drugs. In most states, nurse practitioners have authority to refer patients for physical therapy but in other states, such as Michigan, physician referral is required for physical therapy.

These differences in scope of practice laws make it not only confusing but also challenging for nurse practitioners to comfortably move between states, particularly when an employer entity is located in two adjacent states and the nurse practitioner wants to work in more than one state. The nursing industry has been working for several years now, through advocacy of the Consensus Model for APR Regulation, to try to create more uniformity in state requirements regarding licensure, accreditation, certification and education (collectively referred to as LACE).

In its 2010 report titled The Future of Nursing, The Institute of Medicine (IOM) recommended that states increase their scope of practice for nurse practitioners so that they could provide more direct primary care and “practice to the full extent of their education and training.” In the last five years, that is exactly what has been happening on a national level. As a result of state law changes, more nurse practitioners are now allowed to work independently and they can and do work in virtually any healthcare setting. In the coming years, ACA will be moving more patients out of hospitals and into the local communities and nurse practitioners will be needed to help treat those patients in those outpatient settings. Nurse practitioners are particularly well-suited for primary care work because, according to the AANP, 86% of nurse practitioners are prepared with a primary care focus. Additionally, 18% of nurse practitioners practice in rural communities with fewer than 25,000 residents where there are already naturally occurring physician shortages. However, it should be noted that states that require nurse practitioners to enter into a collaboration agreement and be more closely supervised by physicians will be unable to benefit from nurse practitioners who are interested in practicing in rural communities and/or medically underserved areas/populations (MUA/P) because the supervision requirements will make it difficult for them to work in those remote, rural areas.

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According to an “NP Fact Sheet” on AANP’s website, the AANP reports that there are currently over 205,000 nurse practitioners who are licensed in the country. The average age of nurse practitioners is 49 years. 86.5% are prepared in primary care. 44.8% hold hospital privileges and 15.2% have long term care privileges. 84% see patients who are covered by Medicare and Medicaid. 97.2% prescribe medications, which average 19 prescriptions per day. 69.5% of nurse practitioners see three or more patients per hour. The Bureau of Labor Statistics predicts that by 2022, the field of nurse practitioners will grow by 33.7%, resulting in 37,100 new positions.

4. Common Objections to Independent Practice

In its 2010 The Future of Nursing Report, the OIM recommended that “[n]urses should be full partners with physicians and other health care professionals in redesigning health care in the United States.” Since that time, the consensus in the healthcare industry is that increased reliance on the use of nurse practitioners, physician assistants and allied health professionals is necessary. Most physicians and physician organizations seem to be fully supportive of the collaborative interdisciplinary approach. However, and foreseeably, many of those groups have demonstrated reluctance to fully embrace the expanding autonomous/independent practice model of care for nurse practitioners.

Objections often raised include the argument that nurse practitioners are less educated and have less training and whole-body medical knowledge than physicians and thus, quality of patient care will suffer if nurse practitioners are used on a more regular basis without physician supervision or collaboration. Physician groups flatly reject the nursing industry’s advocacy arguments that the nurse practitioner provides care that is “equivalent” to that rendered by the physician. For example, the American College of Physicians (ACP), a large medical specialty society comprised of internists, released a position paper in 2009 that directly addressed the expanding roles of nurse practitioners and physician assistants. In its conclusion, ACP stated:

“The future of health care delivery will require multidisciplinary teams of health care professionals that collaborate to provide patient-centered care. The key to high performance in multidisciplinary teams is an understanding of the distinctive roles, skills, and values of all team members. Just as the ACP celebrates the special attributes and capabilities of advanced practice nurses, it recognizes the unique role that a personal physician plays in patient care. Advanced practice nursing

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25 See [http://www.aanp.org/all-about-nps/np-fact-sheet](http://www.aanp.org/all-about-nps/np-fact-sheet); See, also, the following cited sources for these statistics: AANP National NP Database, 2014; 2012 AANP Sample Survey; and 2013-2014 AANP National Nurse Practitioner Practice Site Census
26 The OIM describes itself as follows: “Established in 1970 as the health arm of the National Academy of Sciences, the Institute of Medicine is a nonprofit organization that works outside of government to provide unbiased and authoritative advice to decision makers and the public.” See last page of OIM’s The Future of Nursing Report, 2010.
27 By way of example, the AANP has formally stated that “In fact, the standard of care for patients treated by an NP is the same as that provided by a physician or other health care provider in the same type of setting” and that “NPs are independently licensed practitioners who provide high-quality and cost-effective care equivalent to that of physicians.” See AANP’s position paper titled “Use of Terms Such as Mid-Level Provider and Physician Extender.”
should not substitute for nor replace primary care medical practice as provided by
general internists, family physicians, and other physicians.”

More recently, on its webpage, the American Academy of Family Physicians (AAFP),
who has almost 116,000 members, acknowledges that the United States “will need nearly 52,000
more primary care physicians by 2025” and advocates for the Patient Centered Medical Home
(PCMH) model, which is “an emerging care delivery model” in which “information technologies
provide essential connectivity that allows family physicians to play a central role in coordinating
and monitoring all aspects of the patient’s care.” The AAFP points out that “Despite the family
physician’s singular qualifications for guiding patients in the Patient Centered Medical Home,
many primary care doctors could face encroachment on their scope of practice by clinicians
seeking to gain exclusive domain over certain services.” The AAFP and further states that:

“The AAFP continues to believe that the scope of allied health professionals’
respective practices should not undermine or impede the ability of family
physicians to lead the PCMH or provide a traditional array of comprehensive
services. Given family physicians’ extensive education and training, we believe
patient safety and care quality are best served by ensuring that many of the
services provided by allied health professionals are done so only under supervision
of a physician.”

The nurse practitioner industry counters these arguments with studies and research that
support the conclusion that the care rendered by nurse practitioners is of quality and results in
favorable patient outcomes.

Another commonly cited objection to the expansion of the scope of practice of other
professionals to fill the physician shortage gap is the argument that using nurse practitioners,
physician assistants, and allied health professionals leads to lower reimbursement and less income
to the employing physician practice and/or the healthcare entity. While this is true, as physicians
do generally charge more and do typically get reimbursed at higher rates for insured patients, the
other side of the argument is that the lower amounts earned/reimbursed are compensated for by
the increased volume of being able to see more patients and provide more services in the same
time period. According to the Medical Group Management Association (MGMA), physician
assistants typically generate revenue greater than what their compensation costs their employers.
According to one report, for every dollar of charges that a physician assistant generates for the
medical practice, the employer pays on average 30 cents to employ the physician assistant. With
respect to nurse practitioners, in 1997, Medicare expanded reimbursement for nurse practitioners
to all geographical and clinical settings allowing direct Medicare reimbursement, but at 85% of
the physician rate. The exception is if the nurse practitioner is billing “incident to,” which means

28 American College of Physicians. Nurse Practitioners in Primary Care. Philadelphia: American College of
Physicians; 2009: Policy Monograph. (Available from American College of Physicians, 190 N. Independence Mall
West, Philadelphia, PA 19106.)
29 See, for example, numerous studies cited by the AANP in its “Quality of Nurse Practitioner Practice” paper,
http://www.aanp.org/publications/position-statements-papers
that the physician is present in an office setting. Medicare holds each practitioner responsible for his/her own billing, coding and documentation.

Some in the industry also argue that patients will be confused or unhappy if they are asked to receive treatment from a professional who is not a licensed physician. While many patients may indeed prefer to be treated by a licensed physician, there are studies that reflect that the public is becoming receptive to increased use of nurse practitioners. For instance, a national telephone survey of 1000 adults conducted in September 2013 by The Mellman Group, Inc. for the AANP reflects that 62% of those polled supported allowing nurse practitioners to provide healthcare services, such as prescribing medications and ordering diagnostic tests, without the oversight of a physician. Moreover, according to that survey, of those who had been treated by a nurse practitioner, 72% favored legislation to allow patients to choose nurse practitioners as their primary care provider.31 Another survey, this one conducted by Health Research Institute, likewise reflects that 75% of consumers say that they “would be comfortable seeing a nurse practitioner or physician assistant for physicals, prescriptions, the treatment of minor injuries, and ordering lab tests.”32 Additionally, in Gallup’s December 2014 Honesty and Ethics annual survey, 80% of Americans polled thought that nurses have “very high” or “high” honesty and ethical standards as compared to 65% who felt that way about medical doctors.33 According to a study performed by the Kaiser Foundation Research Institute, patient satisfaction levels regarding services provided by physician assistants ranged from 86-96% and patient wait times were less.34

5. Advantages to Use of Other Providers

There are many advantages to utilizing these other professions in the face of physician shortage. Giving patients greater access to a larger number of treating providers allows for more availability of care with a shorter wait time for patients. Access to additional providers also allows for more time for a longer consultation period with the patient, during which time a more comprehensive medical history can be elicited and a more in-depth conversation can be held to address symptoms, treatments, and questions. There is also more time for detailed documentation in the medical record, which allows for better future recall of what transpired during that visit. Having additional providers involved also allows more time for detailed referral consults to specialists, as well as needed follow-up for monitoring. Moreover, using nurse practitioners, physician assistants and allied health providers also allows a different scope of practice perspective to enter into the equation, which provides additional opportunities for more emphasis on preventative wellness care.

The idea of collaboration between physicians and these other professional providers is not very controversial and almost everyone agrees that it is not only a good idea, but is absolutely necessary given the physician shortage crisis. The U.S. Bureau of Labor Statistics projects that employees in health care will account for 5 million new hires by 2022. Most physician practices are

33 See http://www.gallup.com/poll/1654/honesty-ethics-professions.aspx
in fact eager to hire nurse practitioners and/or physician assistants to help reduce their workload and they agree that it also results in increased patient accessibility to care. The issue only becomes controversial when the other provider is seeing patients in a less physician-supervised and collaborative manner and in a more independent practice function, with a significantly increased scope of autonomous practice.

6. The Changing Model of Patient Care Delivery and What Can Be Learned from the Long Term Care Interdisciplinary Model

The long term care skilled nursing facility is a long standing model of primary care delivery for the elder population. Long term care is a heavily regulated industry. Numerous state and federal statutes and regulations dictate precisely how operations are to be handled, how care is to be delivered, and what professional specialties are to provide the care. Regulations specify that nursing homes must have an Administrator who oversees all operations. A Medical Director is required; he/she is often a contract employee who comes in and makes rounds to the residents. The Medical Director is often the residents’ primary care treating provider and generates physician’s orders that are followed by a multi-disciplinary staff of professionals. If the resident suffers a physical or mental change in condition, the physician is immediately notified and assesses the situation and generates new orders as needed. Additional services are often contracted out to consultants such as psychiatrists, neuropsychologists, advanced wound care specialists, podiatrists, dentists, etc. Nurse practitioners and physician assistants often work for the Medical Director’s medical office and often come to the nursing facility to check the progress of residents and render care.

Nursing is by far the largest department in nursing homes and typically accounts for the majority of the budget. The Director of Nursing, usually a Registered Nurse, oversees the nursing staff, which is comprised of a few Registered Nurses, many Licensed Practical Nurses, a few Medication Technicians, and many Certified Nursing Assistants, who assist the residents with the activities of daily living. While nurse practitioners are sometimes hired by nursing homes, they are more often hired as contract consultants, either on their own or through the nursing facility’s contract with the treating physician’s office. A Therapy department provides physical therapy, occupational therapy, speech therapy and restorative therapy as ordered by the physician; therapists are all members of their own profession and the therapy department often separately bills. A Dietary department, staffed with Registered Dieticians, oversees the residents’ nutrition and hydration needs, though they too take orders from the treating physician. There is a Social Services department, staffed by licensed social workers, as well as an Activities department. There is also a Pharmacy department (usually a contract vendor) that oversees distribution of ordered medications and audits the medication orders. Hospice/palliative care enters the picture when needed.

All of the care rendered in the nursing facility is orchestrated as a collective symphony using physicians, nurses, and a large number of allied healthcare providers. Nurse practitioners and physician assistants are being used more in recent years but were not part of the original model. The resident has an interdisciplinary Care Plan that takes into account care needs from all of the various departments/discipline. The departments work together to provide the care needed. There are team care planning meetings where members of the interdisciplinary care team
communicate and brainstorm for joint strategy about the care needed. There are also patient/family care conferences with members of the interdisciplinary staff; these meetings provide an opportunity for the staff to educate the family on the resident’s condition or medical issues, to hear new information from the family, and to address any concerns. The staff also has shared access to the resident’s medical chart (some portions are electronic and some still on paper) so information can be researched and verified as needed.

There are many moving parts in the nursing home setting but it is a unique model in that so many interdisciplinary professionals are all working collaboratively, most under one roof, each working at the top of his/her own licensure or certification, to do his/her part to provide care from his/her area of specialty perspective. In this model, nursing is primary but nursing still follows care orders from the treating physician/Medical Director. There has been an increase in recent years of more nurse practitioners entering into the nursing home setting, both to provide more oversight as a nursing facility employee (with respect to wound care and other specialty areas, for example) or as part of the physician’s office.

Very significant changes in the healthcare industry – all of which directly impact the physician-patient delivery of care relationship – have already been underway for some time now with respect to providers’ scope of practice, physician shortage, electronic records, telemedicine, and insurance coverage, just to name a few areas. New mandates under ACA that are just starting to take effect and which may be implemented in the coming years make it clear that patient care delivery will look very different in the future. The physician shortage crisis has been an anticipated problem for at least the last 15 years and thus, much thought and many advocacy efforts have helped mold our current situation which involves increased independent scope of practice of nurse practitioners and physician assistants and greater involvement of allied health providers. The traditional model of the patient receiving care from his lifelong family doctor and then paying him directly for services rendered is long gone and is being replaced with far more complicated systems that involve much more documentation and many more people, some of whom have helpful specialty health-related credentials and others who have no medical training but bring other skills to the table, such as technology, quality improvement initiatives and/or other business systems.

Some of the new care delivery models are already in play across the nation. Almost all of these new models focus on more collaborative and/or interdisciplinary care that will utilize nurse practitioners, physician assistants and allied healthcare providers much more than in the traditional patient-physician care delivery mode but not so unlike the nursing home long term care model. The use of their services and the ways their services will be used will continue to evolve based on emerging delivery models, changes in payment models, and new information technology.

The Affordable Care Act (ACA) specifically calls for new patient care delivery models. In Section 5501, ACA discusses “Strengthening Primary Care and Other Workforce Improvements” and “Expanding Access to Primary Care Services.” ACA defines the “primary care practitioner” as an individual who is a physician (who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine) or is a nurse practitioner, clinical nurse specialist, or physician assistant. The language contained in ACA evidences a clear intent to
expand the use of these other professionals in what used to be the domain of the primary care physician.

As an example, ACA’s Patient-Centered Medical Home (PCMH) is a new model for patient primary care delivery that moves away from the traditional physician office-based delivery of care system. Rather, here, the patient has an ongoing relationship with a primary care team of professionals, led by a physician, who coordinate the patient’s care across all systems and also provides ongoing proactive and preventative care. “The PCMH model involves transformation of the underlying processes of care, such as shifting from physician-centric care processes to those incorporating all members of the health care team practicing at the level of their licenses.” The PCMH model involves use of a Practice Facilitator, physicians, nurse practitioners, physician assistants, allied health providers, electronic records, and telemedicine.

ACA includes significant financial investments intended to expand the role of nurse practitioners with respect to providing primary care services. For example, up to $50 million dollars – plus many millions more in grants – have been specifically earmarked for the creation of nurse-managed clinics. Nurse Managed Health Centers (NMHCs) are community based primary healthcare services, operated under the leadership of an advanced practice nurse. They emphasize health education, health promotion, and disease prevention, and their target population is usually the underserved. The NMHC is not-for-profit and usually uses sliding scales for payment. A few of them are Federally Qualified Health Centers.

“Minute Clinics” or “Retail Clinics,” also sometimes called “walk-in medical clinics,” or “nurse-in-a-box,” are gaining popularity and are having much financial and reputational success around the country. Between 2007 and 2014, the number of retail clinics in operation increased from approximately 300 to 1,800. These clinics provide walk-in care to patients. They are typically led by nurse practitioners but are also staffed by physician assistants and collaborating physicians are usually involved through agreements though they are not generally present at the clinic. The retail clinic model seeks to provide accessible but lower cost care to patients who, about half of the time, lack a primary care physician provider. The health care provided is limited in scope to minor illnesses and injuries as well as preventative care. The nurse practitioner or physician assistant refers the patient to a higher level of care if deemed needed.

It should be noted that the American Academy of Family Physicians (AAFP) has issued a position paper stating that while it acknowledges that retail clinics provide “a limited scope of health care services” for patients, it believes that “this can ultimately lead to fragmentation of the patient’s health care unless it is coordinated with the patient’s primary care physician’s office.” The AAFP further states that:

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35 See Agency for Healthcare Research Quality’s (AHRQ) “Developing and Running a Primary Care Practice Facilitation Program: A How-to Guide,” p.16
37 Illnesses such as upper respiratory infection, bronchitis, ear infections, urinary tract infections, and screening blood pressure check or lab test. Immunizations are also routinely performed.
“The AAFP opposes the expansion of the scope of services of retail clinics beyond minor acute illnesses and, in particular, opposes the management of chronic medical conditions in this setting. Protocol-based decision and diagnostic models are used in most non-physician led retail clinics, resulting in a missed opportunity to address more complex patient needs. These missed opportunities range from preventive care services to critically important diagnoses which may not be specifically covered in the pre-generated protocol decision program. The AAFP is committed to the development of a health care system based on strong, team-based patient-centered primary care – defined as first contact, comprehensive, coordinated, and continuing care for all persons. Care delivered in retail clinics can be a component of patient-centered care, but must work in coordination with the patients’ primary care physician to ensure that care is not further fragmented.”38

With respect to use of other allied health care providers, Community Paramedicine (CP) is another new model of primary care patient care delivery that is merged with elements of urgent care. As described in a report titled “Community Paramedicine: A Promising Model for Integrating Emergency and Primary Care,” the authors explain:

Community paramedicine (CP) is a new and evolving model of community-based health care in which paramedics function outside their customary emergency response and transport roles in ways that facilitate more appropriate use of emergency care resources and/or enhance access to primary care for medically underserved populations. CP programs have been independently developed in a number of states and countries, and thus are varied in nature. These programs typically have been designed to address specific local problems and to take advantage of locally developed collaborations between and among emergency medical services (EMS) and other health care and social service providers.39

As per the Joint Committee on Rural Emergency Care, “community paramedics” are defined as “a state licensed EMS professional that has completed a formal internationally standardized educational program through an accredited college or university and has demonstrated competence in the provision of health education, monitoring and services beyond the roles of traditional emergency care and transport and in conjunction with medical direction. The specific roles and services are determined by community health needs and in collaboration with public health and medical direction.”40

38 See AAFP’s website for its “Retail Clinics” policy, http://www.aafp.org/about/policies/all/retail-clinics.html
39 See “Community Paramedicine: A Promising Model for Integrating Emergency and Primary Care,” by Kenneth W. Kizer, MD, MPH, Distinguished Professor, UC Davis School of Medicine (Department of Emergency Medicine) and Betty Irene Moore School of Nursing; Director, Institute for Population Health Improvement, UC Davis Health System; Karen Shore, PhD, Senior Policy Analyst, Institute for Population Health Improvement, UC Davis Health System; Aimee Moulin, MD, Assistant Professor, Department of Emergency Medicine, UC Davis School of Medicine; Report prepared for the California HealthCare Foundation and California Emergency Medical Services Authority in partial fulfillment of the Leveraging EMS Assets and Community Paramedicine Project funded by the California HealthCare Foundation (Grant Number 17119, Regents of the University of California).
In this model of care delivery, 911 calls are sent to a triage nurse call-taker who dispatches an ambulance on a low priority level to check the patient’s respiratory status or blood sugar or to look for fall risks. The concept is that the already-existing EMS system, with paramedic-staffed ambulances, is perfectly positioned to perform house calls. The community paramedic coordinates with the triage nurse, and, as needed, with the hospital or clinic and/or the patient’s primary care physician or nurse practitioner to deliver the appropriate care which could be anything from emergency transport, to arranging a wheel chair van or taxi to a clinic or physician office, getting a prescription filled, or a home visit.

C. Practical Legal Risk Management Tips When Employing Nurse Practitioners, Physician Assistants, & Allied Healthcare Providers

Physicians, their medical practices, and the healthcare entities that employ nurse practitioners, physician assistants and allied health providers are still significantly more likely to be sued for medical malpractice than the individual nurse practitioner, physician assistant or allied health care provider. However, as the care delivery models start to change in a more expanded way and more patients are directly treated by and have more exclusive interactions with just a nurse practitioner or a physician assistant, particularly if the provider has an independent scope of practice, it is foreseeable that these professionals will begin to be sued more often.

A patient who has been harmed by care rendered may file a direct cause of action against the provider for medical negligence. A patient may also file a direct liability cause of action against the employer of the provider, asserting that the employer or the supervising physician negligently hired, negligently retained, and/or negligently supervised the employee. There may also be an indirect cause of action for vicarious liability, asserted under the respondeat superior doctrine, filed against the physician or the employer in which the patient seeks to hold the defendant liable for the negligent care rendered by the employee. In vicarious liability claims, the critical issue is a determination of whether the physician or the employer had control or direction over the provider’s work activities.

Some of the most common claims asserted when there is a collaborative relationship in place include arguments that there was non-existent or delayed consultation by the nurse practitioner or physician assistant with the supervising physician; that there was a failure to supervise by the physician; that there was an insufficient examination of the patient (either in taking a history or physical examination); that there was a failure to diagnose or identify a particular medical condition; that there was a failure to monitor the patient or follow up with a needed lab, diagnostic test, or testing result; and that there was a failure to refer or to timely refer the patient to a needed specialist. Poor or insufficient documentation is often a problem as well, because if the documentation is not clear or complete, the provider will find it challenging to remember all the details of the situation (including conversations with the patient about risks and consent issues) and will find it factually challenging to prove the care rendered was proper or that those conversations about the care occurred.

There are some simple risk management tips that an employer can utilize to minimize the chances of a claim for negligent hiring, retention and supervision of a nurse practitioner,
physician assistant or an allied health provider. However, the trick is to consistently follow the tips with each employee on a regular and ongoing basis as a course of doing business. What follows are some simple tips; the list is not intended to be exhaustive.

Before the provider is employed, it is wise—and often mandated under state and/or federal law—to perform a thorough background/credentialing check. This should include criminal checks, civil checks and, if dealing with an elder or vulnerable patient population, abuse registry checks. Personal references should always be checked. Retaining documentation of these checks is essential in the event you need to prove, many years later, that the checks were performed and there were no “red flag” warning signs indicating that the provider should not be hired. The employer should also ensure that there will exist proper malpractice coverage for the provider. Sometimes the provider needs to be added as an “additional insured;” in other situations, the provider may be obligated to have his or her own separate coverage and may have to add the employer entity as an “additional insured.” The coverage language should be examined to ensure that the scope of work being performed by the provider is actually covered by the liability policy.

It is essential to know—and understand—your state’s scope of practice limitations for the nurse practitioner, physician assistant, or allied health provider, as set forth in the regulations of the relevant state Board or licensing agency so that you will be able to comply with any limitations in the law when directing your provider employee. It is also critical to understand your state and the federal government’s reimbursement policies for the type of provider you are hiring. There are countless subtleties and exceptions to the reimbursement rules and if they are not strictly adhered to, there will be a violation of law and/or inability to get reimbursed for the work performed by the employee provider. With respect to the collaborative Practice Agreement to be entered into with the provider, that is too extensive a topic to address herein but suffice it to say that the agreement should be comprehensive enough to address all aspects of the relationship to avoid any ambiguities or sources of misunderstanding down the road. The clearer the language can be, the better. Make sure to retain an original signed and dated copy of the Agreement for your file.

During the course of your provider’s employment, several risk management tips can be employed to reduce the risk of being sued for negligent hiring, retention, training, and supervision. It is critical to train your non-professional support staff about the role of the nurse practitioner and physician assistant so that they will understand the delineation of duties and responsibilities. You should also find a method of formally educating your patients about the role of these providers—either by using brochures or an information sheet that is distributed (with an acknowledgment of receipt signed and retained), or by a short speech by a staff member, or in some other way that formally communicates the necessary information to the patient so that you can minimize the later chance that the patient will claim not to have known or consented to the use of that provider. It is very helpful, also, for your employed provider to wear a name badge that specifically and clearly identifies the professional’s title/credentials.

Putting aside any state requirements for the physician to formally review medical charts documented by the physician assistant, it is prudent for the physician to periodically audit patient charts and as well, to discuss the work performed by the provider so that recommendations can be made for improvement. Documentation of this supervision is important to later prove that it was done. Also with respect to supervision, the physician should be available for consult as needed by
the nurse practitioner or physician assistant and should be responsive with respect to both time and content.

It is important for the physician or employer office to maintain a credentialing and continuing education file for the provider. It is often insufficient to simply trust that the provider has met his or her licensure and/or continuing education requirements. Moreover, if you have a long-standing employee provider, it is still a good idea to periodically perform an updated licensure check, as well as a criminal check to ensure the employee is still in good standing and remains a good candidate for continued retention employment. Using patient satisfaction forms can be a helpful way to further confirm that your employee provider is performing his or her duties sufficiently and will serve to be another source for identifying problematic behaviors, attitudes, or professional failures regarding care issues.

D. Conclusion

The physician shortage crisis is a reality that carries both medical and legal consequences. Nurse practitioners, physician assistants and allied healthcare providers have been tapped by the healthcare industry and the government to step in and assist with patient care in new and more extensive ways. Providers whose licensure now allows independent practice – moving away from physician-supervised collaborative practice – has resulted in grave reservations among physicians but also provides many opportunities for better wellness prevention and faster access to care since there will be more available providers. With more independence of practice and more industry-reliance on these other healthcare providers also come new models of patient care delivery. There is a clear trend away from the physician-patient practice model and a move towards more collaborative, team-based care delivery, particularly with respect to primary care, as the nation seeks ways to care for the growing number of newly insured and aging patients who are flooding the healthcare system. With the increased use of employed nurse practitioners, physician assistants and allied healthcare providers and the experimentation with these new care delivery models comes more legal risk exposure that must be mitigated by sound employment practices.