Data Insight:
Cases Involving Physician Assistants and Nurse Practitioners
This publication contains an analysis of the aggregated data from MedPro Group’s cases closing between 2009-2018 with an indicator of a Physician Assistant (PA) or Nurse Practitioner (NP) involvement in the case.

Our data system, and analysis, rolls all claims/suits related to an individual patient event into one case for coding purposes. Therefore, a case may be made up of one or more individual claims/suits and multiple defendant types such as hospital, physician, or ancillary providers.

Cases that involve attorney representations at depositions, State Board actions, and general liability cases are not included.

This analysis is designed to provide insured doctors, healthcare professionals, hospitals, health systems, and associated risk management staff with detailed case data to assist them in purposefully focusing their risk management and patient safety efforts.

A comparison to other physician cases is provided for perspective.
...involve PAs or NPs who played a contributing role in the patient’s outcome.
- These cases are representative of approximately 10% of all physician and hospital cases.
- Two-thirds involve outpatients (includes all outpatient settings and the emergency department).
- Of the total, 56% involve PAs and 44% involve NPs.

...when compared to physician/hospital cases they:
- Result in slightly higher frequency of clinically severe patient outcomes.
- Result in similar frequency, and payment size, of indemnity payments.

...are more likely to involve:
- Diagnostic related, office-based claims;
- General medicine, Orthopedic, and Emergency specialties; and,
- Communication, credentialing, training and supervision contributing risk factors.

Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome
Primary responsible services

A malpractice claim can have more than one responsible service, but the “primary responsible service” is the specialty that is deemed to be most responsible for the resulting patient outcome.

Within the coding taxonomy, PAs and NPs are not identified as the primary responsible service; instead, the specialty under which they practice is identified, giving insight into the wide scope of specialties who utilize the services of these advanced practice providers.
Most frequent responsible service types

Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome
Claimant type – a comparison

PA & NP cases are noted less often in the inpatient setting.

PA/NP

- Outpatient: 55%
- Inpatient: 29%
- Emergency department: 13%

All physician

- Outpatient: 40%
- Inpatient: 9%
- Emergency department: 52%

Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome; any totals not = to 100% are a result of rounding
Specific location of the event

The majority of cases arise in the office setting. Of note, there has been a slight upwards trend in the number of cases arising in an inpatient setting across the most recent 5 years (2014-2018) of this analysis.

Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome
More than two-thirds of total dollars paid* are attributed to a combination of outpatient & emergency department cases. On average, the total dollars paid on PA & NP cases are not significantly different from those spent to defend/resolve all physician cases.

Claimant type

- Outpatient: 55%
- Inpatient: 29%
- Emergency department: 13%

Total dollars paid

- Outpatient: 52%
- Inpatient: 34%
- Emergency department: 14%

Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome; *expense + indemnity; any totals not = to 100% are a result of rounding
PA & NP cases involve a high clinical severity patient injury slightly more often than do all physician cases (53%). Like the PA & NP cases, a larger percentage of all high severity physician cases arise in the ED & inpatient settings.

Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome; *NAIC rating scale; any totals not = to 100% are a result of rounding
Multiple allegation types can be assigned to each case; however, only one “major” allegation is assigned that best characterizes the essence of the case. Within the coding taxonomy, each allegation category is comprised of several sub-categories.

Cases involving PAs and NPs are primarily diagnosis-related; these and medication-related cases seen more frequently when compared to all physician cases.

Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome
Notable differences between PA & NP cases:
PAs are more often involved in surgical allegations than NPs (23%, 12%, respectively).
NPs are more often involved in medication-related allegations than PAs (16%, 11%, respectively).

Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome
## Most frequent allegations* – by claimant type

<table>
<thead>
<tr>
<th>Allegation category</th>
<th>Outpatient % of case volume</th>
<th>Emergency department % of case volume</th>
<th>Inpatient % of case volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis-related</td>
<td>40%</td>
<td>75%</td>
<td>22%</td>
</tr>
<tr>
<td>Medical treatment</td>
<td>23%</td>
<td>16%</td>
<td>17%</td>
</tr>
<tr>
<td>Medication-related</td>
<td>18%</td>
<td>5%</td>
<td>10%</td>
</tr>
<tr>
<td>Surgical treatment</td>
<td>13%</td>
<td>2%</td>
<td>36%</td>
</tr>
<tr>
<td>OB-related</td>
<td>1%</td>
<td>1%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome; *accounting for >90% of all allegations by each claimant type
Focus on diagnosis-related allegations – the diagnoses

As with physician cases, missed/delayed/wrong diagnoses of cancer and cardiac conditions are the most frequent. Inadequate patient assessments and diagnostic decision-making are frequently noted risk issues.*

Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome; * to be addressed more fully on subsequent pages.
Focus on surgical treatment allegations

PA/NP post-operative management of the patient is more often the issue, rather than circumstances involving the actual procedure. Inadequate provider to provider communication, failure to appreciate and recognize clinical signs and symptoms of complications, and improper education/training are recurring risk issues.*

* Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome; * to be addressed more fully on subsequent pages
Contributing factors are multi-layered issues or failures in the process of care that appear to have contributed to the patient outcome and/or to the initiation of the case. Generally there is not just one error that leads to these cases, but rather a combination of issues.

Most risk issues are found across all settings, although some are more prevalent in specific locations.
Contributing factors – a comparison

The prevalence of diagnosis-related allegations increases the volume of clinical judgment factors. Supervision (especially in outpatient settings) is noted in more than one-third of the PA/NP cases.

Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome; more than one issue is coded per case, therefore totals do not = 100%
Insufficient communication with other providers, nurses, and supervising physicians regarding relevant facts about the patient’s care is a concern noted across all locations.

However, these issues are more prevalent in locations where multiple providers are more likely to be involved with a patient’s care (inpatient and the emergency department).

Cases involving insufficient provider to provider communication tend to be more expensive to defend than cases without such issues.

Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome
Contributing factors – important distinctions by claimant type

Outpatient

Breaks in clinical systems designed to ensure that diagnostic findings are followed-up in a timely manner and reported to the patient; and, Patient behavioral issues, specifically those involving non-adherence to recommended treatment; these can have a detrimental impact on outcomes.

Emergency department

Breaks in clinical systems designed to ensure that diagnostic findings are reported to the provider and to the patient; this process is often complicated by diagnostic test results which are not returned until after the patient has been discharged.

Inpatient

Inconsistent coordination of care amongst providers; and, Inadequate patient monitoring for evolving signs and symptoms.

Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome
Contributing factors – important distinctions by claimant type

Communication

- % of cases with communication factors
  - Among providers
  - With patient/family

Clinical systems

- % of case volume with clinical systems factors
  - Patient followup
  - Reporting findings
  - Identifying provider coordinating care

Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome
Contributing factors – additional distinctions by claimant type

**Outpatient**

Inadequate staff training/education and credentialing factors are significantly more frequent in the office setting.

**Emergency department**

Premature discharge from care due to poor patient assessment is predominately an emergency issue.

**Inpatient**

Failure to appreciate (and reconcile) the significance of evolving patient signs, symptoms and test results is noted more frequently in the inpatient setting.

Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome
Contributing factors – additional distinctions by claimant type

Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome
Patient 65 year old male presented to office with onset of shortness of breath & lightheadedness, & a history of diabetes, hypertension & smoking

Summary Physician assistant (PA) ordered a stat chest x-ray, read by the radiologist as indicative of pneumonia and a widening of the mediastinum. Upon receipt of the results, the PA ordered cough medicine and an antibiotic to treat the pneumonia.

PA recommended that the patient follow up with a chest CT due to the vascular abnormality seen on the x-ray, but the patient delayed due to not feeling well.

One week later, the patient called to report persistent shortness of breath; the PA ordered a dose of tapering steroids but did not ask the patient to come in to the office for evaluation and did not remind the patient that the CT had not yet been completed.

Several days later, the patient obtained the chest CT. Results revealed bilateral pleural effusions, but the report was not called to the PA by the radiologist. The PA did not read the report until the next day when the patient’s wife called to report more symptoms.

Outcome The patient was sent to the ED where it was determined he had suffered a myocardial infarction and stroke.
# Case example: Failure to establish differential diagnosis leads to premature discharge from the ED

<table>
<thead>
<tr>
<th>Patient</th>
<th>Female in her mid-forties presented to ED with sudden onset of neck and upper back pain during exercise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary</td>
<td>Patient was triaged to the “quick care room” for evaluation by nurse practitioner (NP).</td>
</tr>
<tr>
<td></td>
<td>Patient reported prior history of TMJ and symptoms were noted to be consistent with past flares.</td>
</tr>
<tr>
<td></td>
<td>NP did not order any cardiac diagnostic testing, but did prescribe pain medications and muscle relaxants, with instructions for the patient to follow up with an oral surgeon and neurologist in two days if no improvement.</td>
</tr>
<tr>
<td></td>
<td>Patient was discharged with diagnoses of cervical strain with spasm and TMJ exacerbation.</td>
</tr>
<tr>
<td>Outcome</td>
<td>One hour later, the patient was returned to the ED via ambulance but succumbed to what an autopsy revealed as coronary artery disease with significant blockage.</td>
</tr>
</tbody>
</table>
Summary

Physician assistants and/or nurse practitioners are noted as contributorily responsible providers in approximately 10% of physician and hospital cases over this time period.

Clinical and financial severity, allegations, and associated responsible services track similarly to that of all physician cases with a few noted exceptions:

- More outpatient cases with PAs/NPs:
  - Emergency department and office settings account for over two-thirds of all cases and are more frequently diagnostic in nature.
  - Within the diagnostic allegations, the diagnoses involved are nearly identical to physician cases.

- Within the inpatient cases:
  - Surgery-related allegations, specifically those involving post-operative patient management are the most frequent, followed by diagnosis-related allegations.

- PAs are noted in more surgery allegations, but more medication-related allegations are attributed to NPs.

- Supervision, coordination of care, provider communication, credentialing and training are common contributing risk factors, with differences noted between practice settings.

Data source: MedPro Group closed cases, 2009-2018; PA/NP noted in a contributory role to the patient outcome
Recommendations

- Insufficient communication with other providers, nurses and supervising physicians regarding relevant facts about the patient’s care is a concern.
  - Ensure that PAs/NPs are comfortable communicating their concerns without fear of appearing non-confident.
  - Ensure that PAs/NPs understand that they are an essential part of a care team and that they must share pertinent patient information, which, when combined with other provider observations, could indicate a much more severe issue.
  - Ensure hand-off communication is effective and unrushed.
  - Authorize and invoke the “stop the line” concept by anyone who identifies a risk to a patient.
  - Encourage escalation of concerns up the chain of command.
  - Make sure that in all locations, nursing understands the role of the PA/NP to ensure appropriate care coordination.

- Documentation styles can be widely varied when multiple providers (supervising physician and PA/NP) are involved in a single patient’s care.
  - Inconsistent documentation of patient symptoms and a provider’s clinical rationale for treatment can result in patient care errors and create malpractice case defensibility issues.
    - Ensure consistent documentation among providers, with explanations where there is any inconsistency.
    - Do not sign off on charted information without thoroughly reading it.
Insufficient supervision/oversight/training is a frequently noted risk issue in PA/NP cases.

- Supervision involves more than just signing charts.
- Ensure that required supervision is a regular, on-going activity.
- Establish that all staff who will be working on your behalf fully understand each the norms/policies/procedures of each facility or office location.
- Be able to effectively communicate how you are able to determine and/or assess the competency of PAs/NPs to perform their assigned tasks.
- Use supervisory time to ensure that the PA/NP is comfortable relating doubts or questions.

Scope of practice is something that should be defined for each PA/NP and can be enhanced and/or expanded upon demonstration of requisite skills and knowledge.

- Not all PAs/NPs are the same; different experiences should result in more or less supervision.
- PAs/NPs are not typically assigned a specialty designation. Therefore their interchangeability into other “specialty” jobs (say, surgery to primary care) should be treated with caution. Regardless of length of experience as a PA or NP, they may need to be viewed as a novice in a new setting.
Resources to support the recommendations: MedPro Group

- Clinical Judgment in Diagnostic Errors: Let’s Think About Thinking
- Communication in the Diagnostic Process
- Supervision of Advanced Practice Providers
- Strategies to Support Patient Comprehension
- Test Result Communication Failures
  https://www.medpro.com/documents/10502/5086245/Communication+of+Test+Results.pdf
- Documentation Essentials

More resources are available at www.medpro.com/dynamic-risk-tools
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### Categories
- **Tools & resources**
- **Educational opportunities**
- **Consulting information**
- **Videos**
- **eRisk Hub**
  - Cybersecurity Resource

### Categories Descriptions
- **Education**: Materials and resources to educate followers about prevalent and emerging healthcare risks
- **Awareness**: Information about current trends related to patient safety and risk management
- **Promotion**: Promotion of new resources and educational opportunities

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MedPro Group has entered into a partnership with CRICO Strategies, a division of the Risk Management Foundation of the Harvard Medical Institutions. Using CRICO’s sophisticated coding taxonomy to code claims data, MedPro Group is better able to identify clinical areas of risk vulnerability. All data in this report represent a snapshot of MedPro Group’s experience with specialty-specific claims, including an analysis of risk factors that drive these claims.

Disclaimer

This document should not be construed as medical or legal advice. Because the facts applicable to your situation may vary, or the laws applicable in your jurisdiction may differ, please contact your attorney or other professional advisors if you have any questions related to your legal or medical obligations or rights, state or federal laws, contract interpretation, or other legal questions.

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