



LEGAL ISSUES

By Dawn Phleger, JD

Collaborating With NPs and PAs: Best Practices for Comanagement of Patient Care

The increasing shortage of physicians combined with an increasing aging population requiring care has led to comanagement as a viable patient care model. *Comanagement* is defined as a physician and either a physician's assistant (PA) or a nurse practitioner (NP) working together as a team to manage a patient's care. In the post-acute and long-term care setting, comanagement can lead to increased quality of care and increased positive patient outcomes.

Comanagement can also be an effective form of risk management when properly implemented. NPs and PAs assess, diagnose, and manage acute and chronic health conditions independently and in collaboration with physicians and other health care providers. I will highlight the benefits of an NP or PA comanaging a patient's care in collaboration with an attending physician to achieve optimum patient outcomes.

Modeling Comanagement

Based on the literature, Allison A. Norful, RN, PhD, ANP-BC, and her colleagues at the Columbia University School of Nursing in New York City have proposed a model for NP-physician comanagement (*Ann Fam Med* 2018;16:250–256). **In their model, effective NP-physician comanagement has three vital attributes: (1) effective communication, (2) mutual respect and trust, and (3) clinical alignment, also known as a shared philosophy of care. This arrangement reinforces the concept that team-based care management in the skilled nursing setting leads to a higher likelihood of positive outcomes.**

First, effective communication is key to developing and implementing a patient care plan. The need to provide care to numerous patients across multiple settings means the physician and NP/PA may have limited direct contact with each other during their daily activities. One strategy to improve communication among a busy provider group is to use secure messaging via electronic health records (EHRs), telephone calls, or messaging services that are compliant with the Health Insurance Portability and Accountability Act of 1996.

Each state has different legal requirements for how such communications should be managed, depending on the collaboration or the nature of the comanagement team. Integrated documentation — the physician and NP/PA team documenting in the same section of the EHR — improves communication because the notes and treatment plans are readily accessible. (When documentation from the physician and

NP/PA isn't found in the same location in a patient's chart, the EHR can actually inhibit communication: half the comanagement team may miss the other's notes.)

Second, mutual respect and trust are essential to an effective comanagement team. Respect and trust develop over time. By gaining trust, physicians are less likely to feel that they need to monitor the work of the NP/PA, and the result is a more streamlined, less redundant practice.

Third, a shared philosophy of care is vital to comanagement. In the event care management strategies differ between the physician and NP/PA, a mutually agreed upon protocol for conflict resolution should be in place ahead of time to determine the final care management decision.

Effective Practice

Effective practitioner comanagement can alleviate an individual clinician's workload, which can prevent clinician strain, burnout, and fatigue. Effective comanagement can also lead to better patient outcomes, which has the added benefit of being a good risk management tool. From the patient's perspective, a good comanagement team promotes continuity of care and increases the patient's access to care because the patient has a clinician team familiar with his or her history and needs.

David B. Reuben, MD, of the David Geffen School of Medicine at the University of California–Los Angeles, and his colleagues studied the Assessing Care of Vulnerable Elders 2 (ACOVE-2) model augmented with an NP to manage chronic conditions (*J Am Geriatr Soc* 2013;61:857–867). The ACOVE-2 model consists of case finding, delegation of data collection, structured visit notes, physician and patient education, and linkage to community resources. With a collaborating NP, the adjusted model dovetails nicely with the interdisciplinary care provided in the SNF setting, and it can help inform quality measures to improve overall care in SNFs.

Dr. Reuben and coworkers found an increase in the quality of care for falls, urinary infections, and dementia in community-based primary care. They also found that the overall quality scores for the patients seen by an NP were higher for all conditions except depression. For example, for patients with a history of falls, with comanagement the quality indicators (such as falls history, orthostatic blood pressure, vision testing, and gait, balance, and strength assessment) were documented twice as often

— sometimes up to 10 times as often — when the patients were seen by an NP in a comanagement setting as compared with a classic physician-only practice.

Similarly, comanagement resulted in significant differences in documentation for the quality indicators in patients prone to urinary infections. Although the differences with dementia care were less dramatic, they still yielded higher rates of annual cognitive evaluations and monitoring for behavioral and psychological symptoms.

In multivariable analyses, adjusted for gender, age, comorbidities, and medical management style, NP comanagement remained positively and significantly correlated with patients receiving the recommended care.

Regulatory Requirements

The American Medical Association's Advocacy Resource Center provides a summary of the PA scope of practice by state (<https://www.ama-assn.org/media/21466/download>). In 47 states, PAs are supervised by physicians to varying degrees. Some states such as California require a supervisory relationship between a physician and a PA. Other states such as Maryland require a supervisory relationship between the physician and the PA for 18 months before the PA can practice independently. Other states such as Arizona allow PAs to practice independently so long as they are fully licensed by their appropriate agencies.

To provide a specific example, in California, where the relationship between the physician and the PA is supervisory rather than collaborative, the nature of the relationship requires the following:

- A supervising physician shall be available in person or by electronic communication at all times when the PA is caring for patients.
- A supervising physician shall delegate to a PA only those tasks and procedures consistent with the supervising physician's specialty or usual and customary practice.
- A supervising physician shall observe or review evidence of the PA's performance until assured of competency.

California Business and Professions Code section 3502 sets out the requirements for the Delegation of Services Agreement and the protocols that must be implemented in a comanagement relationship. For example, the protocols must cover diagnosis, management, and communication procedures with patients. These documents should be created and kept in the physician's and

PA's file and provided to the SNF (with the financial information redacted).

In the states where the NP/PA work independently and do not require a collaborative or delegation of services agreement, the comanagement team should still consider how they will work together to best manage their patients' care.

Best Practices

The studies have shown that the comanagement care model is a great symbiotic relationship that provides continuity of care, increases positive outcomes, and increases communication with the patient and/or patient's family. These benefits also make the comanagement model a significant risk management tool. Anecdotally, we have seen that increasing the presence of registered nurses and NPs in SNFs increases the quality of care provided and the timeliness of identifying and addressing changes in a patient's condition.

To ensure best practices for comanagement care provided by an NP or PA and a physician:

- Have a written Delegation of Services Agreement with the physician if the collaboration is located in a "supervisory" state.
- Have written protocols for diagnosis, management, and patient communication developed by the NP/PA and the physician as a team and signed by all parties or developed by the supervising physician (in states where the relationship between physician and NP is supervisory).
- Read and be familiar with your state's requirements.
- Ensure each team member operates within the scope of his or her regulatory and licensing restrictions. For instance,
 - The initial history and physical must be performed by the physician.
 - The PA/NP can perform alternate regulatory visits with the physician; they cannot do consecutive regulatory visits.

In any event, the "secret to success" of a comanagement relationship is clear communication, both with each other and with the residents/families who are receiving their care. 

Ms. Phleger is an associate of Wilson Getty LLP. She has experience in complex civil litigation involving claims for professional malpractice, including medical malpractice. She is a member of the American Bar Association.