



# A PSYCHIATRIST'S TOOLKIT: Supervising NPs and PAs<sup>©</sup>

This toolkit serves as a resource for NCPA members to help them in their roles as supervising physicians and to develop supervision plans that support quality, evidence-based care.

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## Introduction

Nurse Practitioners and Physician Assistants (NP/PA) have long played an important role in the provision of healthcare in North Carolina. NP/PAs have worked with psychiatrists in every practice setting—private practice, institutions, and particularly community mental health agencies. The traditional multi-disciplinary team approach of psychiatric care has instilled an appreciation for and reliance upon all clinicians in the care of this complex patient population, making the field uniquely situated to embrace the evolving health care delivery system of team-based care, collaborative care, accountable care, and shared savings. To that end, psychiatry's ability to work with other professionals, to assess skills, and to assist in their development will be even more crucial.

*"The relationship between a psychiatrist and a physician extender has been described as a captain, a co-pilot, and a first officer of an airplane. Everyone has a different job, but all are responsible. In case of an accident, everybody—including the captain—will be scrutinized."*

In many practice settings, the amount of care that the psychiatrist is able to provide is not sufficient to meet the service demands and can be greatly enhanced by well-qualified, well-supervised professionals. This toolkit is designed to educate psychiatrists about NP/PAs and to encourage them to provide appropriate and helpful supervision and to develop meaningful quality monitoring systems. Through these efforts psychiatrists can improve patients' access to quality care.

This document collects and puts into one place the tools necessary to provide a strong supervision program—licensing board requirements, suggestions for structured clinical supervision meetings, templates, and resources to make the supervisory experience a rich one that is mutually beneficial to the physician, the NP/PA, and the patients they care for together.

## Acknowledgements

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## How to Use This Toolkit

Section One of the toolkit includes descriptions of the different types of NP/PAs and their respective training, illustrating the significant variance in both medical and psychiatric training and highlighting the importance of continuous close supervision by and collaboration with the supervising psychiatrist.

Section Two summarizes the medical board and nursing board requirements for the NP/PA and psychiatrist, both for initial approval and ongoing supervision. It includes the NC Medical Board position statement on physician supervision of other health care professionals.

Section Three contains suggestions for hiring, training, and supervising NP/PAs and includes examples of how several NCPA psychiatrists are approaching these colleagues to ensure the provision of quality, evidence-based care.

Section Four describes the specifics of supervisory practice agreements that define what duties the NP/PA is allowed to perform.

Section Five concludes with liability implications of supervisory collaboration.

Addendum provides a number of templates that physicians can customize for their own practice and use. (Customization is critical to assure licensing boards that appropriate tailoring for the practice setting has taken place.)

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## 1. Requirements for Professional Licensure

**First things first, let's define who these medical professionals are.**

Psychiatrist: A psychiatrist is a medical doctor (M.D., D.O.) who specializes in mental health, including substance use disorders. Psychiatrists are qualified to assess both the mental and physical aspects of psychological problems. They are licensed by the Medical Boards of the states in which they practice. In North Carolina, that is the North Carolina Medical Board (NCMB). (Source: APA)

Nurse Practitioner: A Nurse Practitioner (NP) is one of four recognized Advanced Practice Registered Nurse (APRN) roles. An APRN is an umbrella title for RNs who have completed an accredited graduate-level education program. The four APRN roles are Nurse Practitioner, Nurse Anesthetist, Nurse-Midwife or Clinical Nurse Specialist. In North Carolina, NPs are licensed by the North Carolina Board of Nursing (NCBON), are approved to do medical acts by the NCBON and NCMB, and are regulated by both boards. (Source: NCBON, NCMB)

In North Carolina, Nurse Practitioners and Physician Assistants are currently allowed to bill Medicaid for psychiatric services. The NC Division of Medical Assistance (DMA), the state Medicaid agency, has been considering the requirement for NPs to have psychiatric certification in order to bill Medicaid for psychiatric services.

Physician Assistant: A Physician Assistant (PA) is a nationally certified and state-licensed medical professional. PAs practice medicine on healthcare teams with physicians and other providers. They practice and prescribe medication in all 50 states, the District of Columbia, the majority of the U.S. territories and the uniformed services. In our state, they are licensed by the North Carolina Medical Board. (Source: AAPA)

Psychiatry CAQ: Certificate of Added Qualifications is a certification available to PAs that requires 150 hours of psychiatry CME, 2000 hours of practice experience in psychiatry, and patient care requirements in the form of an attestation from the supervising physician describing psychiatrist-observed patient case management across a broad range of psychopathology and appropriate treatments. Once the requirements are completed, the Psychiatry Specialty Exam can be taken and, if passed, the Psychiatry CAQ is awarded. This certification is not defined in NC statute, and PAs without certification are allowed by the Medical Practice Act (MPA) to practice psychiatry without such certification.

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An important consideration in supervising other professionals is a clear understanding of their background, their training, and their experience. Since some standards vary from state to state and since there is some variation in the training, the graph below tries to illustrate the graduate education, period of time training under supervision, total patient care hours for all types of patients, and actual clinical experience in treating psychiatric patient required for licensure.

	<b>Length of Graduate Level Education</b>	<b>Years of Supervised Residency Training</b>	<b>Total Patient Care Hours Required through Training</b>	<b>Clinical Rotations in Psychiatry</b>
<b>Psychiatrist</b> (Medical Doctor/Doctor of Osteopathic Medicine)	4 years (90 credit hours)	3-7 years (Residency/Fellowship)	12,000-16,000 hours	140-180 weeks
<b>Primary Care / Internist</b>	4 years (90 credit hours)	3-7 years (Residency/Fellowship)	12,000-16,000 hours	4-12 weeks
<b>Nurse Practitioner</b>	400 contact hours of didactic education	Not Required	400 hours of supervised clinical experience	0-6 weeks
<b>Psychiatric Nurse Practitioner (PNP)</b>	400 contact hours of didactic education	Not Required	400 hours of supervised clinical experience	13-16 weeks
<b>Physician Assistant</b>	2.5 years	Not Required	2,000 hours	4-8 weeks
<b>Physician Assistant, Psychiatry Certificate</b>	2.5 years	Not Required	2,000 hours	50 weeks

As shown above, there is significant disparity in training and supervised experience among those who treat patients with psychiatric illnesses—from psychiatric physicians and NP/PAs to non-psychiatric physicians and NP/PAs. Psychiatrists are required to have years of training and supervised practice in order to receive a medical license. In addition, psychiatrists are trained in general medicine prior to their specialty training. Traditionally, the training for NPs and PAs has been primarily medical in nature, although there are programs that provide additional training and certification in psychiatry.

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## 2. Medical and Nursing Board Requirements

Many factors play into determining the necessary level of supervision between a psychiatrist and a NP/PA including proximity, practice setting, skill and experience level, etc. The chart below depicts the minimum requirements of supervision in North Carolina. Section three of this toolkit will elaborate on how to determine the appropriate level of supervision, training, and oversight beyond the minimum requirements.

### 2A. MINIMUM SUPERVISION REQUIREMENTS IN NORTH CAROLINA

	<b>PHYSICIAN ASSISTANT</b>	<b>NURSE PRACTITIONER</b>
<b>Must practice under supervision of physician licensed to practice in NC</b>	Yes	Yes
<b>Requires physical presence of physician at time and place services are rendered</b>	No	No
<b>Frequency of Meetings – must include relevant clinical issues and quality Improvement</b>	Monthly for first six months then once every six months	Monthly for first six months then once every six months
<b>Must co-sign chart entries</b>	No	No
<b>Must have a written document describing supervisory agreement, scope of practice and prescribing authority</b>	Yes	Yes
<b>Notification to practice</b>	“Intent to practice” with NCMB	“Approval to practice” with NCMB and NCBON
<b>Written prescribing instructions</b>	Yes	No (but medications must be within education & training and must be listed on CPA)
<b>CME</b>	100 hours every 2 years (at least 50 hours of Category 1 from AAPA)	50 hours every year (at least 20 hours approved by ANCC or ACCME)
<b>Supervising physicians – Primary and Back-Up documented</b>	Yes	Yes
<b>Document describing practice arrangement</b>	“Supervisory Arrangement” Must be reviewed yearly	“Collaborative Practice Agreement” Must be reviewed yearly

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## 2B. NC MEDICAL BOARD POSITION STATEMENT ON SUPERVISION

### **Physician Supervision of Other Licensed Health Care Practitioners**

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The physician who provides medical supervision of other licensed healthcare practitioners is expected to provide adequate oversight. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise the appropriate amount of supervision over a licensed healthcare practitioner which will ensure the maintenance of quality medical care and patient safety in accord with existing state and federal law and the rules and regulations of the North Carolina Medical Board. What constitutes an “appropriate amount of supervision” will depend on a variety of factors. Those factors include, but are not limited to:

- The number of supervisees under a physician’s supervision
- The geographical distance between the supervising physician and the supervisee
- The supervisee’s practice setting
- The medical specialty of the supervising physician and the supervisee
- The level of training of the supervisee
- The experience of the supervisee
- The frequency, quality, and type of ongoing education of the supervisee
- The amount of time the supervising physician and the supervisee have worked together
- The quality of the written collaborative practice agreement, supervisory arrangement, protocol or other written guidelines intended for the guidance of the supervisee
- The supervisee’s scope of practice consistent with the supervisee’s education, national certification and/or collaborative practice agreement

Physicians should also be cognizant of maintaining appropriate boundaries with their supervisees, including refraining from requesting medical treatment by the physician’s supervisee. Physician assistants and nurse practitioners are specifically prohibited from prescribing controlled substances for the use of their supervising physicians.

Practices owned solely by physician assistants or nurse practitioners may not hire or contract with physicians to practice medicine on behalf of the physician assistant or nurse practitioner owned practice. The physician assistant or nurse practitioner may contract with a physician to provide the legally required supervision of the physician assistant or nurse practitioner.

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## 3. Hiring, Training, and Supervising

**These are only examples of how some psychiatrists approach the essential elements of working in collaboration and are not meant to serve as official recommendations of NCPA.**

One of the most important and confusing things for physicians related to supervision is how much is enough? As outlined in Section Two, North Carolina has mandatory minimum guidelines for supervision. But remember, these are the minimal standards. In some cases, the minimum may be adequate; in others, more direct supervision, co-signing, and frequent meetings are required. Please read carefully the NCMB Forum Article found in Addendum A.

The most important thing for a psychiatrist or any physician who works closely with NP/PAs is the physician's comfort level with the competence of the colleague. There will be times when you need to insist on a higher level of supervision. Or, the NP/PA will ask for more support and supervision.

As the supervising physician, you should feel empowered to set the standard for the training, oversight, and supervision experience in your practice. This may depend on the practice setting (inpatient or outpatient), patient population (child, adult, geriatric), geographic area of the state (an urban area may have a larger, more experienced workforce), and certainly the experience and clinical training of the practitioner! You should not feel obligated to accept the minimum standards for any professional you are asked to supervise, even if you are employed in an agency or hospital and feel pressure to spend as little time as possible. Ultimately, your medical license is on the line with the NP/PAs who work under your supervision.

***Here are some real-life examples from practicing psychiatrists in various settings:***

### **Staff Psychiatrist at Major Urban Health System**

In hiring a new NP or PA, it is important to recognize that there is a significant difference in the amount of psychiatric training that each of these providers has experienced. Psychiatric NPs receive more psychiatric training than a PA, who may have as little as a single rotation in a psychiatric setting and a few weeks of lectures. Of course, this difference in training may matter less if one is hiring an NP or PA with several years of psychiatric experience.

In hiring an NP or PA who is straight out of training, one must realize that there is a significant investment of time to mentor the new hire. Before hiring a recently graduated NP/PA, our system recommends speaking to the supervisor and staff of the section/department in which the NP/PA will be working and informing them that a recent NP/PA graduate is being considered for their department. The expectation is that the new NP/PA will require both teaching in the form of didactics, but also in everyday supervision and mentorship during the clinical day. Make sure that the staff is willing and capable of providing an education to the new NP/PA before hiring.

Our system has embarked on a unique method of training psychiatry NPs and PAs with the establishment of a Psychiatry Advanced Clinical Practitioner (ACP) Fellowship. This is a year-long period of supplemental training

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for psychiatric NPs and for PAs who want additional intensive specialization training in psychiatry. Our ACP fellows have 16-week rotations on inpatient psychiatry, outpatient psychiatry, ED psychiatry, and consult liaison psychiatry. Additionally, they receive weekly didactics/presentations on major psychiatric topics. Case presentations and journal club are also a part of their regular didactics.

Supervision goes beyond the requirements for formal supervision. In our view at our system, supervision is a daily activity. The NP/PA must be able to access his/her supervising psychiatrist in order to staff cases or ask questions. This means that the supervising psychiatrist must be readily available, either in person or via telephone/teleconference.

## **Child and Adolescent Psychiatrist in a Rural Community**

As a child and adolescent psychiatrist working as a medical director for a rural community agency that serves children and adolescents, I was asked to serve as a preceptor for a student NP. During the 6 month preceptorship, the student NP shadowed me observing all clinical activities. After a period of approximately one month, I observed the NP student performing different aspects of clinical work. Patients were discussed in detail with regular feedback on NP student's performance. Once I felt the student was ready, the NP began seeing patients individually, with an oral presentation, and then patients were seen jointly by myself and the student.

After the completion of the preceptorship and subsequent graduation, the NP was hired to help develop outpatient psychiatric services for the agency. The Psychiatric Nurse Practitioner (PNP) and I met weekly on a formal basis and I continued to be available for informal consultation in person and by phone. I also assisted the PNP in developing relationships with other community providers (pediatricians, therapists, etc.). In addition, the PNP participated in weekly clinical staff meetings that included formal lectures, clinical reviews, and oral/video case presentations.

Four years later, the PNP is the primary clinician for the outpatient psychiatric services serving many children and adolescents in this rural area. I continue to have monthly formal meetings with the PNP and continue to be available by phone for consultation. The formal meetings between us include discussions of specific topics identified by either party as areas of improvement along with presentations of complex cases. In our rural setting and with an NP who is a recent graduate, providing this level of supervision gives both of us peace of mind as she practices in such a remote location.

## **Psychiatrist in a Community Hospital**

In general, introduction of a NP/PA to any psychiatric practice depends on several variable factors such as whether he/she is freshly graduated from school, he/she has had other medical experience and is transferring to the psychiatric field, he/she has graduated from an accredited psychiatric training program, or he/she is an experienced and accredited psychiatric PA or NP who is moving to the practice.

For example, I supervise three NPs and two PAs who have varying degrees of on-the-job training in our setting. The integration, training, and supervision are significantly different between outpatient,

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consult/liaison (C/L), and inpatient settings. All training should be specifically individualized between the supervisor and supervisee.

In an Inpatient setting, it is our practice for the NP/PA to shadow the psychiatrist for the first month, observing the interview, eliciting information, developing a differential diagnosis and initiating a specific treatment plan including appropriate polypharmacy. The NP/PA will perform ancillary services and begin to write follow-up notes. Gradually, depending on the level of achievement, the NP/PA will conduct the intake interview in the presence of the attending and discuss his/her thoughts on the initial diagnosis and treatment. At the end of the six months, the NP/PA should be competent to conduct a psychiatric interview and implement the recommendation of the attending. All dictated notes and charting should be co-signed for the first six months. After six months, co-signing the charting is optional, depending on the bylaws of the hospital.

In C/L services, the NP/PA should follow the psychiatrist for at least one month to observe the variety of consults. During this time, the psychiatrist will interview, formulate a diagnosis and initiate a treatment plan. The NP/PA should be given ample opportunities to observe the documentation process and charting by the psychiatrist. The NP/PA may see the patient for the follow up, discuss the adjustment of medications and write a note. Between 3 to 6 months, the NP/PA may start seeing uncomplicated consults, report the findings, formulate a diagnosis and suggest a treatment plan with the psychiatrists either in person, via telepsychiatry, or by telephone. The NP/PA can document the consult findings in the chart on behalf of the attending. After six months, he/she may perform uncomplicated consults independently and if needed, discuss the case with the attending. In my experience, for the first six months, every consult should be co-signed by the attending. After six months depending on the bylaws of the hospital, co-signing can be optional.

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## 3A. CHECKLIST FOR SUPERVISION

Regardless of the frequency of supervision as described in the prior examples, the *quality* of the supervision time is important. Many psychiatrists find it easier to structure this time. **Addendum B (Suggested Checklist for Supervision of NP/PSs)** and **Addendum C (Quality Improvement Meeting Form)** are documents a psychiatrist could use to organize the supervision meeting and document it for the file.

Addendum B is a template checklist that identifies which documents must be on site and in the file according to NCMB and NCBON standards, should you be audited. It also serves as a concrete vehicle for following up from previous sessions and noting improvements from a Quality Improvement perspective. This not only helps document supervision, but it is a useful tool for discussion that should serve to improve care that is delivered by both of the professionals. Topics or concerns that should be addressed include ethical issues, administration concerns or future topics for Quality Improvement.

## 3B. PSYCHIATRIC CONTINUING EDUCATION

Part of supervision is also being able to make recommendations for additional education when the need or opportunity arises. You might attend a local or national meeting together. Other suggestions include:

1. AudioDigest Psychiatry
2. NCPA Annual Meeting
3. Lifelong Learning Modules thru AACAP
4. Focus: The Journal of Lifelong Learning in Psychiatry (APA)
5. Journal reviews
6. Risk management courses
7. Ethics courses
8. Psychiatric Drug Alert; Child & Adolescent Psychiatric Alert and Psychiatric Alert NOS monthly publications

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## 3C. MONITORING QUALITY OF CARE

Below are examples of different elements of practice that can be included in a quality monitoring program. These elements can be reviewed by the psychiatrist through a record review or other means and serve as a measure of the quality of care that the NP/PA is providing. Through this, opportunities for training and education can be identified. This list is not meant to be exhaustive.

1. Monitoring of metabolic syndrome with antipsychotics
2. Management of depression, psychotic disorders, anxiety, and bipolar disorders
3. Documentation of substance use history and referral to substance abuse treatment
4. Documentation on nutrition education
5. Screening for substance use disorders
6. Documentation of trauma history
7. Justification for the use of two or more antipsychotics.
8. Suicide/homicide risk assessment
9. Clozapine CBC monitoring
10. Appointment No Shows

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## 4. Requirements of Supervisory Practice Agreements

Regardless of the professional (NP or PA), a written supervisory agreement is required. This document describing the practice arrangement is called “Collaborative Practice Agreement” (CPA) for NPs and “Supervisory Arrangement” for PAs. It is a written document developed and agreed upon by the supervising physician and NP/PA that includes the drugs, devices, medical treatment, tests and procedures that may be prescribed, ordered and performed by the NP/PA, along with a pre-determined plan for emergency services. A copy of the CPA or Supervisory Arrangement must be maintained at each practice site and reviewed annually. Neither the NC Medical Board nor the Joint Subcommittee of the Medical Board and Board of Nursing require one specific format that the PA or NP must use. However, each agreement must address how the NP/PA and supervising physician will operationalize NP/PA rules in that practice to comply with the administrative code/rules.

All Practice Agreements (CPA or Supervisory Arrangement) must include these common elements:

- 1) General statements regarding what both parties (MD and NP/PA) are agreeing to do
- 2) Availability of physician and arrangements for backup physician
- 3) Population to be treated
- 4) List of medications that can be prescribed including controlled substances
- 5) Specific duties
- 6) Emergency plans
- 7) Quality improvement
- 8) Mode of supervision

**Two Examples of Supervisory Practice Agreements can be found in Addendum D (for PAs) and E (for NPs).**

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## 5. Liability Implications of Supervision

### Liability Implications When Supervising and Collaborating With Other Licensed Health Care Practitioners

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Collaboration and supervision between medical disciplines are becoming increasingly common as there are more patients and fewer psychiatrists to provide direct care. Nurse practitioners (NPs) and physician assistants (PA) are becoming more widely used in psychiatry. When supervising or collaborating with other licensed healthcare practitioners such as NPs and PAs, there are a number of factors to consider.

First, it is crucial to know what your relationship is and define your role whether you are the other provider's supervising physician or if another physician is in that role. There are state guidelines which you must adhere to if in a supervisory role working with NPs and PAs. As such, be aware of the requirements set forth by the North Carolina Medical Board (NCMB) and the regulations set forth under North Carolina law. It is also important to be aware of your role within the agency/clinic. There may be differing liability risks if in the role as a partner/shareholder versus an independent contractor.

Second, if you are not in a supervisory role, is it a collaborative relationship where there is shared responsibility of the patient? Whether in a supervisory or collaborative relationship, this should be identified at the outset of your relationship. It is important that you have an agreement in place with your agency/hospital/other licensed healthcare provider prior to beginning. Again, it is important that you are aware of your responsibilities with respect to Collaborative Practice Agreements (CPAs) and Supervisory Arrangements (SA) as set forth under the NCMB and North Carolina law.

If either in the role as a supervisor or in a collaborative role, it is important to know if you will be requested to "sign off" on another provider's treatment notes/plan. Even if you are not in the role as the "supervising physician" and the other provider had a bad outcome and a lawsuit is brought, you may be included in the case as a defendant by nature of your role in signing off on the note/plan. If being requested to "sign off," this may have liability implications even if you did not have any involvement with the patient. In other words, know what you are signing off on.

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## Liability Implications, continued

### Conclusion

In order to minimize liability exposure, it is important that all parties involved in the collaborative/supervisory relationship understand and abide by all aspects of North Carolina and federal law. Prior to entering such an arrangement, it is prudent for the psychiatrist to consult with a local attorney and/or risk management professional.

### Risk Management Tips

- Understand your state and federal laws and regulations.
- Adhere to ethical guidelines (APA's [The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry](#)).
- Be aware of your employment contractual obligations and the policies and procedures of your agency/clinic.
- Define your role and have a clear delineation of responsibility. Know what your responsibilities are for patient care.
- Whether in the role of supervisor or collaborator, it is important to maintain effective communication, including documentation.
- Keep in mind you may be held liable for the acts of those you supervise. Be aware of the education, training, and experience of the other provider and ensure that sufficient supervision is provided.
- If in a supervisory or collaborative arrangement, ensure that you adhere to state regulations and have a collaboration agreement in place. It is important to have an attorney review the agreement on your behalf prior to signing to ensure you are aware of your responsibilities. Should you deviate from the agreement, ensure you are following the regulatory guidelines set forth in North Carolina.
- If you have questions, it is important to discuss them with a local attorney or your risk management professional.

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## 7. In Conclusion

There are a number of reasons why psychiatrists should be encouraged to provide supervision to NP/PAs in their regions. When an NP/PA is appropriately supervised and engaged in a collaborative effort, access to good psychiatric care is improved and the mental health workforce grows and strengthens. Through extension, a psychiatrist is able to oversee the health care treatment of more patients, particularly relevant in areas with limited resources. NP/PAs play an important role in the health care delivery system, and when they are unable to procure quality supervisors, the system fails.

There are even more reasons why psychiatrists should assess the quality of the supervision they are providing. Providing strong, effective supervision protects your medical license, earns you respect in your community as a quality provider, strengthens the safety net for the patients in your region, and offers mutually beneficially opportunities to improve. In addition, as the healthcare delivery system evolves into one patterned on team-based care, a psychiatrist's ability and proficiency in providing supervision, overseeing quality, and understanding quality improvement processes, will be in high demand.

And the final reason why psychiatrists can and should provide meaningful supervision to other professionals: physician satisfaction. All of the physicians involved in developing this toolkit described the professional relationship as meaningful and valuable in their own practice of medicine.

This toolkit has tried to put important information, intriguing ideas, and helpful checklists and templates in your hands. There are probably many questions that have not been answered in the attempt to be succinct. Please call the NCPA office to ask or to offer your own suggestions.

There are different ways to provide supervision and review care, and it is very important that psychiatrists develop a plan to ensure that the care provided meets all requirements, is evidence based, and is of high quality. By doing this, psychiatrists can help ensure that all patients have access to good psychiatric care and better meet the needs of underserved areas in North Carolina.

## Resources

NC Board of Nursing FAQs for Nurse Practitioners:

<http://www.ncbon.com/dcp/i/nursing-practice-nurse-practitioner-faq--nurse-practitioner-np>

NC Medical Board FAQs for Physician Assistants:

[http://www.ncmedboard.org/resources-information/faqs/physician\\_assistant](http://www.ncmedboard.org/resources-information/faqs/physician_assistant)

# Addendum A.

## "Supervision of Midlevel Practitioners: How much is enough?"

Janelle Rhyne, MD; Forum #3, 2008 (newsletter of the NC Board of Medical Examiners)

On a basic level, we all know what it means to supervise someone. But how much supervision is appropriate when it comes to the physician's duty to oversee physician assistants or nurse practitioners?

There is no one right answer. The level of supervision expected by the North Carolina Medical Board depends on a range of factors, such as the number of practitioners under a physician's supervision and whether supervisor and supervisee practice at the same physical location. Each professional relationship will look different, based on the unique circumstances of each case. The bottom line—which all physicians who supervise midlevel practitioners would do well to keep in mind—is that the physician is ultimately responsible for ensuring that high quality medical care is provided to each patient. Physicians also should understand that they may be held accountable if they fail to provide adequate oversight or if PAs or NPs under their supervision make errors or exhibit poor clinical judgment.

This article will review the NC Medical Board's position on supervision of midlevel practitioners and provide an overview of the corresponding rules and regulations. It also will cover some of the common problems that arise.

### **First, a little context**

It's never been more critical for supervising physicians to understand their obligation to provide adequate oversight. Midlevel practitioners are an increasingly important part of how we deliver primary care in North Carolina. Between 1996 and 2005, the number of PAs practicing in North Carolina increased by 100 percent, according to an analysis published in 2007 by researchers at the Cecil G. Sheps Center for Health Services Research. The number of NPs in the state increased 220 percent over the same period, according to the same research. As of October, nearly 10 percent of all physicians licensed by the NC Medical Board supervised one or more PAs. Nearly 8 percent supervised one or more NPs.

Some of these midlevel practitioners see patients at locations where there is no physician on-site and little face-to-face interaction with the supervising physician. In recent years, North Carolina and other states have seen rapid growth of "retail" health clinics in drug and discount stores. These clinics, which handle a set menu of common ailments, are typically staffed exclusively by nurse practitioners whose clinical practice is overseen by offsite physicians. The Board has observed that the level of supervision at such clinics varies widely. Even when midlevel practitioners work at the same practice location as their supervisors, it is no guarantee that adequate oversight is in place.

The Board frequently reviews and takes regulatory action in cases in which the level of supervision of PAs and NPs is an issue. Sometimes the cases involve administrative or procedural issues. This category might include such conduct as a PA seeing patients before receiving a confirmation of intent to practice

## **"Supervision of Midlevel Practitioners," continued**

from the NCMB or failure on the physician's part to meet a midlevel practitioner in person and observe that person's clinical practice before agreeing to supervise. It's not uncommon for supervising physicians to be disciplined for keeping insufficient documentation of quality improvement meetings or having no, or inadequate, scope of practice and prescriptive authority documents.

The Board also reviews many cases that involve quality of care provided by midlevel practitioners. In one recent case, a PA failed to properly diagnose abdominal aortic aneurysm in a patient who later died. The case led to a malpractice payment on the behalf of the PA. After reviewing the facts of the case (the Medical Board reviews every new malpractice payment made on behalf of each NC licensee) the NCMB issued Public Letters of Concern to both the PA and the supervising physician, who had signed off on the midlevel practitioner's diagnosis. Prescribing problems also generate a fair number of cases. For example, a PA or NP might prescribe controlled substances without adequately documenting the need or prescribe to family members. It is fairly typical for the Board to discipline both the midlevel practitioner and the physician in these types of cases, resulting in public records for each practitioner.

### **So what is appropriate supervision?**

The NCMB recognizes that determining the right level of supervision is no easy matter. There are numerous possible practice settings and supervisory situations, as well as a spectrum of skill and experience levels among supervised practitioners. Appropriate supervision will be different for each and every situation. However, North Carolina statute and administrative rules set out basic criteria. Following these requirements conscientiously when you establish supervisory relationships is the best defense against future problems.

The rules that pertain to supervision of PAs and NPs are too lengthy and complex to fully cover in this article. Briefly, rules for establishing the supervisory relationships among PAs, NPs and supervising physicians require:

- That the PA or NP file, respectively, an 'intent to practice' or 'approval to practice' form with the appropriate regulatory board(s) and obtain confirmation of its receipt and/or approval before performing medical acts, tasks or functions under the supervising physician. PAs must file this form with the NCMB. NPs, who are dually approved by the NC Board of Nursing and the NCMB, must submit the 'approval to practice' form to both the NCMB and NCBON.
- That the PA or NP work with the primary supervising physician to create a written document that outlines in detail the practice arrangement, including scope of practice, duties, responsibilities and terms for prescribing and dispensing of drugs and medical devices. The delegation of medical tasks must be appropriate to the skill level and competence of the PA or NP. This document must be signed by both the supervisee and the supervising physician(s).
- That a process for evaluation of the supervisee's performance be established.
- That the PA or NP receive from the supervising physician written instructions for prescribing, ordering and administering medical devices and a written policy for periodic review by the physician. In order to prescribe controlled substances, the midlevel practitioner must have a valid DEA registration and prescribe in accordance with all applicable policies and guidelines.

## "Supervision of Midlevel Practitioners," continued

- For PAs in a new practice arrangement, meetings with the primary supervising physician must occur monthly for the first six months to discuss clinical matters and quality improvement (QI). After the first six months, such meetings must take place at least every six months. All meetings must be documented.
- Generally, the rules for established NPs entering a new practice arrangement mirror those for PAs. New NPs entering their first collaborative practice arrangement must meet more frequently with the supervising physician and meet additional requirements.
- That midlevel practitioners identify themselves clearly and appropriately. PAs should wear name tags identifying themselves as physician assistants; NPs should wear tags identifying themselves as nurse practitioners.

This is just a summary of the rules. The full texts include important requirements about the level of detail expected in collaborative practice agreements and supervisory arrangements, how often these documents must be reviewed and updated, how meetings should be documented and how long those records must be kept, among other subjects. Supervising physicians, NPs and PAs will want to become intimately acquainted with these requirements. The applicable rules and statutes can be found on the NCMB Web site, [www.ncmedboard.org](http://www.ncmedboard.org). Click on the tab marked 'For Physician Extenders/ Perfusionists' and select Rules and Regulations from the menu at the left of the page.

To further guide its licensees on the subject of physician supervision of midlevel practitioners, the NCMB in 2007 adopted a position statement titled, "Physician Supervision of Other Licensed Health Care Practitioners". The position emphasizes the Board's expectation that physicians provide adequate oversight and ensure that quality medical care is provided to patients seen by midlevel practitioners. It also lists several of the factors that help determine the appropriate level of supervision. The full text of the position statement is published below. It also can be found on the Board's Web site.

Finally, this year the Board established a random audit program to ensure compliance with rules and laws that govern PA supervision. A similar program for NPs has been established in conjunction with the NC Board of Nursing. Half of these audits are conducted by mail, with randomly selected practices completing forms to indicate compliance, and the other half are conducted by field investigators who visit practices in person. The purpose of the audits is to document compliance, which is consistent with excellence in clinical care. Practices are typically given the opportunity to correct any deficiencies in their supervisory arrangements with PAs and NPs. However, some audits may turn up problems that may lead the NCMB to take disciplinary action.

I encourage any physicians who supervise midlevel practitioners—or are contemplating such relationships—to become thoroughly familiar with what is required before Board investigators knock on their doors.

## "Supervision of Midlevel Practitioners," continued

### **PA documents you must have on site**

- Proof of licensure and registration
- Statement of supervisory arrangement with primary supervising physician (Scope of Practice)
- Signed and dated record of meetings between primary supervising MD and PA relevant to clinical problems and QI measures
- List of all back-up supervising physicians, signed and dated by MDs (primary and backups) and PA
- Written prescribing instructions to include written policy for periodic review of these instructions by primary supervising MD
- DEA registration and pharmacy permit, if applicable

### **NP documents you must have on site**

- Proof of RN licensure, registration and approval to practice
- Proof of registration and national certification if applicable
- List of all back-up supervising MDs, signed and dated by primary and back-up MDs and NP
- Collaborative Practice Agreement with documentation and annual protocol review
- CE documentation
- QI process documents to include documentation of NP-MD consultation meeting
- DEA Registration and Pharmacy Permit, if applicable

# Addendum B.

## CHECKLIST FOR SUPERVISION

Date: \_\_\_\_\_

Name of NP/PA: \_\_\_\_\_

Name of Supervising Physician: \_\_\_\_\_

### Check When Complete

\_\_\_\_ 1. Documents in Order and On Site

\_\_\_\_ a. licensure and registration

\_\_\_\_ b. Supervisory Arrangement or Collaborative Practice Agreement

\_\_\_\_ c. Primary and Back-up Supervising Physicians (Signed and Dated)

\_\_\_\_ d. DEA registration and pharmacy permit (if applicable)

\_\_\_\_ e. Written Prescribing Instructions (PA's only)

\_\_\_\_ f. CE documentation

\_\_\_\_ 2. QI Topic for this meeting: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_ 3. Areas for Improvement: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_ 4. Chart review (related to QI topic covered)

\_\_\_\_ Adequate documentation of symptoms

\_\_\_\_ Medications prescribed and documented

\_\_\_\_ Side effects

\_\_\_\_ 5. Case Presentation: \_\_\_\_ Oral \_\_\_\_ Written \_\_\_\_ Video

\_\_\_\_ 6. Follow up of last QI areas for improvement

\_\_\_\_ 7. Other concerns addressed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Addendum C.

## Quality Improvement Meeting Form (SAMPLE)

QUALITY IMPROVEMENT PROCESS – DOCUMENTATION FOR MEETINGS SHALL INCLUDE:

1. CLINICAL ISSUES DISCUSSED (practice relevant clinical issues):

2. PROGRESS TOWARD IMPROVING OUTCOMES:

3. RECOMMENDATIONS (IF ANY) FOR CHANGES IN TREATMENT PLAN:

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NP/PA Signature

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Date

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MD signature

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Date

# Addendum D.

## (Sample) Supervisory Agreement for Physician Assistant

Mental health services may be provided by a physician assistant to children, adolescents, adults, and geriatric patients. Services provided may include: psychiatric evaluation, diagnosis, and treatment. This may include management of both acute and chronic mental illness.

As primary supervising physician, (ENTER PHYSICIAN NAME), I agree to:

- A. Be available for face to face or telephone consultation, collaboration and necessary referrals during office hours
- B. Meet periodically to discuss clinical issues
- C. Be available for supervision as defined in the protocol for management of clinical problems, evaluation of care and improvement of patient outcomes.

As physician assistant, (ENTER PA NAME), I agree to:

- A. Utilize mutually developed practice protocols, and consult and collaborate on clinical problems and refer as needed
- B. Prescribe medications from the formulary and consult when needed for those medications not approved in the formulary
- C. Maintain a record of consultations
- D. Document and maintain a record of supervision

Dr. (ENTER NAME) and (ENTER PA NAME) agree to the ongoing development of this relationship and evaluation formally and informally. The objective, practice goals, protocols, and details of the supervisory arrangement will be reviewed on a yearly bases.

Dr. (ENTER NAME) and (ENTER PA NAME), as parties to the supervisory arrangement, are responsible and accountable for performing in accord with the supervisory arrangement and within their separate and distinct scopes of practice.

Agreed to by: \_\_\_\_\_  
ENTER DOCTOR NAME

\_\_\_\_\_  
ENTER PA NAME

APPROVAL DATE: \_\_\_\_\_

REVIEW DATE: \_\_\_\_\_

## Annual Reviews of Supervisory Arrangement

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Physician Assistant Date

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Primary Supervising Physician Date

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Physician Assistant Date

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Primary Supervising Physician Date

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Physician Assistant Date

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Primary Supervising Physician Date

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Physician Assistant Date

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Primary Supervising Physician Date

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Physician Assistant Date

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Primary Supervising Physician Date

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Physician Assistant Date

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Primary Supervising Physician Date

## PROTOCOLS FOR SUPERVISORY ARRANGEMENT

### A. Availability of supervising physician

The primary supervising physician is available on a continuous basis during Physician Assistant working hours. This can be done by direct communication or telecommunication. In the absence of the primary supervising physician, a backup supervising physician will be available.

### B. Populations treated

Children 5 and up, adolescents, adults, and geriatric patients; clinical problems treated will include but not be limited to schizophrenia, depressive disorders, mood disorders, anxiety, adjustment disorder, Developmental Disabilities, ADHD, and other disruptive behavioral disorders

### C. Specific duties include but are not limited to:

- Regularly scheduled hours of work
- Initial psychiatric assessments
- Documentation of assessment/evaluation findings
- Medication evaluation for returning patients
- Interpretation of assessment and diagnostic findings
- Establish diagnoses and formulation of treatment plan and recommendations
- Prescribe medications and prescribing treatments and any other therapeutic measures
- Dispense samples for all formulary categories
- Order laboratory, EKG, and other diagnostic tests
- Counsel education and guide patients and families on various aspects of illness, their treatment and other resources available to them
- Brief therapy with patient and or family
- Refer to other health care providers for medical consultation as appropriate
- Plan for situations beyond the control and expertise of the NP/PA
- Consult with and refer to other mental health care providers
- Evaluation the success and appropriateness of services provided and health outcomes
- Other duties as may, from time to time, be assigned by the primary supervising physician

## PRESCRIBING MEDICATIONS

\*Controlled substances may be prescribed and ordered as allowed by the NC Medical Board. The PA will be responsible for maintaining an assigned DEA license.

Approved Formulary:

Any form or combination of the following generic classes of medications may be prescribed, ordered, or dispensed unless the medication is listed as excluded by the formulary:

- |   |   |
|---|---|
| <input type="checkbox"/> All antipsychotic medications  | <input type="checkbox"/> All mood stabilizers     |
| <input type="checkbox"/> All antidepressant medications | <input type="checkbox"/> All antiparkinson agents |
| <input type="checkbox"/> All benzodiazepines            | <input type="checkbox"/> All hypnotics            |
| <input type="checkbox"/> All stimulants                 | <input type="checkbox"/> All thyroid supplements  |
| <input type="checkbox"/> All alpha adrenergic agonists  | <input type="checkbox"/> All antihistamines       |

- All medications available for treatment of tremors
- All medications available for treatment of dementia
- All medications available for ADHD treatment
- All trimonoamine modulators
- All nutritional Supplements

Other medications as appropriate for the treatment of medical conditions as indicated with the collaboration of the supervising physician.

**PREDETERMINED PLAN FOR EMERGENCY SERVICES**

1. Immediate consultation with primary supervising physician or backup physician if necessary
2. If the situation is life-threatening, law enforcement or emergency medical services will be called
3. Family members or another contact person may be contacted to arrange for transportation for treatment or evaluation when needed
4. Arrange for petition by family, the nurse practitioner/physician assistant or other mental health employees if necessary and appropriate
5. Referral to 24 mental health emergency services as appropriate

**QUALITY IMPROVEMENT**

1. Meetings for supervision will be scheduled monthly for the first six months (ENTER DATES). Then supervision meetings will be held every six months and more frequently as needed.
2. Clinical problems will be discussed. This will include a review of 1-3 cases representative of the clinical problems treated. Discussion will consist of interventions used, response and progress toward goals and or a plan to improve outcomes
3. Documentation of the meetings including the discussion and ways to improve practice and outcomes will be maintained. This will be signed by both the physician and the PA
4. The supervisory arrangement will be reviewed yearly during supervision
5. The physician assistant and the supervising MD will meet at other times as needed to review clinical problems, interventions and treatment issues of patients.

**PHYSICIAN ASSISTANT-PHYSICIAN SUPERVISION**

Occurs by various modes:

1. Direct consultation with PA and patient
2. Verbal reporting with presentation, consultation, and review of individual patient treatment and outcomes
3. Review of clinical records, plans of treatment and face to face conferences as needed regarding assessment, treatment, and outcomes of patients.

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NAME OF MD

DATE

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NAME OF PA

DATE

# Addendum E.

## Collaborative Practice Agreement for Nurse Practitioner (SAMPLE)

### A. Purpose

The purpose of this document is to describe the scope of practice for the nurse practitioner (NP) who signs this agreement, as well as, provide written authorization by the supervising physician for the NP to initiate and provide psychiatric and medical care for the consumers of \_\_\_\_\_(agency)

### B. Scope of Practice and Medical Functions Authorized

1. The NP is authorized to provide psychiatric and medical care under this collaborative practice agreement (CPA) in all outpatient office locations of above agency, and to any contracting agencies.
2. An NP, who is board certified as a family psychiatric/mental health nurse practitioner, is licensed to provide psychiatric and limited medical care, as defined by the ANA scope of practice to adult, geriatric and pediatric populations.
3. The NP is authorized to provide the following medical functions. *(NOTE: This is sample language only to assist the practitioners in discussing and writing the medical functions authorized. Practicing outside the scope of a CPA is a basis for discipline. The CPA should provide authorization for the specific medical acts the NP will be performing.)*
  - a. Provides psychiatric diagnostic evaluations to assess for and determine psychiatric illness. Diagnoses that can be made include but are not limited to mood and anxiety disorders, psychotic disorders, disruptive behavior, developmental disorders, eating disorders, delirium and dementia, substance use disorders and personality disorders.
  - b. Request and interpret lab and other diagnostic procedures, such as EKGs, to rule out medical etiology for psychiatric illness or other medical conditions; and to assist in diagnosis, and monitoring for adverse effects from medications.
  - c. Request assessments/evaluations, as needed, to confirm or support diagnoses, or guide treatment, including but not limited to psychological and educational testing; speech/language, vision, and hearing assessment; neurological evaluation; or referral to their primary care physician.
  - d. Prescriptive Authority.
    - i. Drug categories that may and may not be prescribed by the NP (including controlled (II-V), legend, and over the counter drugs) are listed in Attachment A.
    - ii. May prescribe drugs commonly used in psychiatry following accepted standards of practice as recommended by either the American Psychiatric Association or the American Association of Child and Adolescent Psychiatry. These drugs may be prescribed "off label" (without FDA approval) if it is an accepted standard of practice.
    - iii. May only prescribe drugs for consumers being served above agency or any contracting agencies
    - iv. May provide pharmaceutical samples to consumers.
  - e. Provide on call coverage when scheduled.
  - f. Provide education to the consumer as indicated about psychiatric illness and, medication (including adverse effects).
  - g. Obtain consultation from the collaborating psychiatrist for complicated illnesses perceived by the NP to be beyond one's knowledge and skills.
  - h. Provide follow up services to consumers after surgical implantation of a vagal nerve stimulator, including computerized adjustment of device, to provide optimal response.
  - i. The NP may refer a consumer's care to the psychiatrist if the NP feels the case exceeds the NP's scope of practice which was part of their graduate curriculum.

4. The NP does not have the legal authority to involuntarily commit a person to inpatient psychiatric treatment.

#### C. Plan for Emergency Services

In the event of a life-threatening medical or psychiatric emergency, the consumer is informed to call 911 or to present to the local hospital emergency room. For an urgent need, a provider is available on call 24 hours, seven days per week through the agency emergency phone line.

#### D. Quality Assurance

1. A collaborating physician, either primary, back-up or on-call, is continuously available to the NP, either in person or by telephone, for consultation.
2. Upon employment or at the beginning of the collaborative relationship, the supervising physician and NP will meet initially every week for the first 4 weeks of employment to provide education, evaluate skills, or specific case consultation. These meetings may include discussion of clinical problems, progress toward improving outcomes, and recommendations, if any, for changes in treatment. After the first month, these meetings will occur at least monthly for the next five months of the collaboration and then at least once every six months. A short summary of these interactions will be documented and signed by both the physician and NP. Documentation of the collaborative practice agreement will be retained for five calendar years.
3. The NP will document any consultation with a supervising physician for a specific case in the consumer's medical record.

#### E. Education and Certification Requirements for Registration as a Nurse Practitioner

The following items will be maintained and available on site for the Nurse Practitioner:

1. Proof of RN licensure (current RN licensure status may be verified at [www.ncbon.com](http://www.ncbon.com)).
2. Proof of current registration.
3. Proof of current approval to practice.
4. Proof of current national certification.
5. Proof of a current DEA number.
6. A copy of the collaborative practice agreement.
7. The nurse practitioner will maintain documentation of completing 50 contact hours each year of AMA or ANCC approved continuing education courses.

F. Review and Revision of collaborative practice agreement. This collaborative practice agreement will be reviewed, revised (if indicated), and signed by the nurse practitioner and supervising physician on an annual basis.

G. The collaborative practice agreement is not intended to be, nor should it be, a substitute for the exercise of professional judgment by the nurse practitioner.

H. Texts and References for the NP, including but not limited to:

1. American Psychiatric Association (2013). **Diagnostic and Statistical Manual of Mental Disorder (Fifth Edition)**. Washington D.C.: American Psychiatric Association.
2. American Academy of Child and Adolescent Psychiatry. <http://www.aacap.org>. **Practice parameters for child and adolescent psychiatry.**

3. American Psychiatric Association. <http://www.psych.org>. **Practice parameters for the treatment of psychiatric disorders.**
4. **Epocrates**, [www.epocrates.com](http://www.epocrates.com), updated daily.

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Nurse Practitioner

Date

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Primary Supervising Physician

Date

# Annual Reviews of Collaborative Practice Agreement

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Nurse Practitioner Date

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Primary Supervising Physician Date

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Nurse Practitioner Date

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Primary Supervising Physician Date

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Nurse Practitioner Date

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Primary Supervising Physician Date

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Nurse Practitioner Date

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Primary Supervising Physician Date

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Nurse Practitioner Date

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Primary Supervising Physician Date

## Attachment A:

### Standard Formulary of Drug Classifications for use by the NP

#### Approved Drug Categories:

- Analgesics and Antipyretics
- Anti-Infective Agents
- Anti-Inflammatory Drugs
- Antihistamines and Decongestants
- Autonomic Drugs
- Cardiovascular Drugs
- Central Nervous System Agents
- Expectorants and Cough Preparation
- Gastrointestinal Drugs
- Hormone and Synthetic Drugs
- Pulmonary Drugs
- Spasmolytics
- Vitamins/Minerals

#### Restricted Drug Categories:

(May not be prescribed)

- Agents of Electrolytic, Caloric & Water Balance
- Antineoplastic Agents
- Birth Control Drugs and Devices
- Blood Derivatives
- Blood Formation
- Coagulation Agents
- Diagnostic Agents
- Heavy Metals
- Local Anesthetics
- Ophthalmic Drugs
- Oxytoxics
- Prosthetics/Orthotics
- Radioactive Agents
- Other