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Careful Collaboration:

Mitigating Risks in the Physician-APP Relationship

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TABLE OF CONTENTS

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RETURN TO TABLE OF CONTENTS

Careful Collaboration:
Mitigating Risks in the Physician-APP Relationship

INTRODUCTION

The Bureau of Labor Statistics projects that between 2023 and 2033, advanced practice nurse practitioner ("APRN" or "NP") jobs will grow by 46%,[1] and physician assistant (PA) jobs will increase by 28% in the same time period.[2] Almost all states require some form of healthcare team collaboration for PAs to practice to their full extent.[3] Twenty-three states have some form of reduced or restricted practice necessitating collaborative agreements between NPs and physicians.[4] Over the next ten years, the demand for supervising physicians will correspondingly increase for care provided by PAs and in states where APRNs do not have autonomy to practice independently.

Focused and purposeful collaboration between APPs and their supervising physicians should prioritize maximizing patient safety and mitigating risk in the clinical environment.

The role of NPs and PAs (collectively also referred to as "advanced practice providers" or "APPs") is a vital one. These positions provide increased access to healthcare for patients and relieve physician overload, which carries benefits across routine and specialty care settings and during national physician shortages. Focused and purposeful collaboration between APPs and their supervising physicians should prioritize maximizing patient safety and mitigating risk in the clinical environment.

The cases in this publication primarily focus on APRNs and PAs, but the principles of liability and the risk management recommendations apply to all types of APPs. Prior to exploring these principles, it is important to understand PA and NP training, education, and regulations that govern their practice as outlined in the table below.[5,6,7,8,9] This understanding can better equip those serving in a collaborative or supervisory role to utilize these clinicians to their maximum potential without exceeding the scope of practice or breaching the standard of care.

RETURN TO TABLE OF CONTENTS

	PAs	NPs
Education	• Individuals earn a master's degree at minimum and may complete a postgraduate residency or fellowship program. • Education is modeled on the medical school curriculum that involves both didactic and clinical education training. • Students complete 2,000 hours of clinical rotations in medical and surgical disciplines, including family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, and psychiatry. • Students are trained as medical generalists for all patients regardless of age or gender.	• Individuals must be registered nurses (RNs), hold a bachelor of science in nursing (BSN), and complete an NP-focused graduate master's or doctoral nursing program. • Students are trained in the advanced practice of nursing where they gain the advanced clinical knowledge and skills to diagnose, manage, and prescribe medications and other treatments for patients. • Students complete 1,000 hours of supervised clinical practice. • Students are trained in a chosen health population focus area: family, adult/gerontology, neonatal, pediatrics, women's health, or psychiatric/mental health.
Laws & Regulations	• Regulated by state medical boards in most states	• Regulated by state nursing boards in most states
Practice	• Generally work under a physician's supervision or with some level of collaboration	• May practice independently in some states

LIABILITY CONSIDERATIONS FOR SUPERVISING PHYSICIANS: OMISSIONS ARE RISKY

While liability for negligence on behalf of the APP is not automatically attributed to a supervising physician, the relationship does not exist without some risk. If, through proper and expected communications and oversight, a physician should have realized an existing gap in the APP's skills or judgment that factored into alleged injuries, contributory fault could be alleged. These are care areas that should prompt additional or specified oversight.

The potential for liability exposure for physicians exists, even if they are not directly involved in the patient's care when an APP's action or inaction causes harm. This can be in the form of direct or vicarious liability. Physicians can be directly liable when they hire incompetent APPs or when they fail to properly train or supervise APPs.[10] Physicians can also be vicariously liable for the acts or omissions of an APP based upon their relationship (for example, when the physician is the APP's employer).[10] In a single case there may be allegations of both direct and vicarious liability.

RETURN TO TABLE OF CONTENTS

CASE ONE:

Failure by PA to Consult with Supervising Physician and Alleged Missed Diagnosis of Appendicitis in the Emergency Room Setting

Emergency care by APPs has increased dramatically in recent years. The emergency medicine workforce is comprised of 60% to 70% emergency physicians, 25% APPs, and a small fraction of nonemergency physicians.[11]

In the following case, the APP covering the emergency room (ER) did not consult with the on-site supervising physician and was alleged to have missed the presentation of acute appendicitis. Normalization of communication and consultation within the supervising physician-APP relationship may lead to a more comprehensive exam and proper diagnosis.

Could a conversation between the PA and supervising physician have altered the patient's course of treatment and outcome?

RETURN TO TABLE OF CONTENTS

A 23-year-old female patient presented to the ER with complaints of burning with urination, abdominal pain, fever, decreased appetite, nausea, vomiting, and a cough. Her temperature was 102 degrees with other vitals noted as normal. On exam the abdomen was soft, nontender to palpation, and nondistended. Mild wheezing was noted on the pulmonary exam. A urinalysis was unremarkable, and tests for strep, influenza A, and influenza B were negative. An abdominal x-ray report indicated a mildly prominent but nonspecific bowel gas pattern that possibly represented ileus or gastroenteritis, with no evidence of obstruction or perforation. A chest x-ray was normal.

The PA diagnosed the patient with abdominal pain, possible gastroenteritis, and bronchitis. The patient was given a dose of ceftriaxone, prescribed azithromycin, and advised to use over-the-counter cetirizine and simethicone for symptom relief upon discharge. She returned three days later with worsening abdominal pain. A CT scan of the abdomen and pelvis revealed a perforated appendix with abscess formation and peritoneal thickening. The patient underwent an open laparotomy, required intubation, and had an extended recovery in the ICU.

The supervising physician, also the on-site ER physician, cosigned the PA's notes a few days later, confirming her role as a supervising physician and available for consultation.

DISCUSSION

The PA documented a normal abdominal exam and an unremarkable x-ray, concluding there was no clinical indication for a CT. However, experts felt there should have been a higher suspicion of acute appendicitis along with corresponding imaging and lab orders. They also noted the PA should have consulted the on-site supervising physician. Experts also felt that the PA's abdominal exam documentation lacked detail, omitting key signs like guarding McBurney's point tenderness or rebound tenderness. Experts believed a physician consult would have resulted in a more thorough abdominal exam and an earlier diagnosis and treatment of appendicitis. Experts felt that fever of unknown origin in the emergency department setting, especially with abdominal pain, should have prompted the PA to confer with the on-site supervising physician. A lawsuit alleging failure to timely diagnose and treat appendicitis was filed and, ultimately, this case was settled.

Supervising physicians help guide APPs to reach clinically appropriate and high quality medical decisions. Chart reviews and frequent check-in meetings play a factor in this relationship. However, there is often no substitute for a real-time consultation, where the physician may play a more active role in a patient's treatment and in determining an accurate differential diagnosis.

RETURN TO TABLE OF CONTENTS

RISK REDUCTION STRATEGIES

Not all APPs will be subject to a supervision requirement within their specific state, as APRNs can practice independently and with full practice authority in 27 states and Washington, DC.[4] However, for PAs and those APRNs not practicing independently, it is important to keep in mind these general guidelines at the outset and throughout the supervising physician-APP relationship:

- APPs must be comfortable with and willing to reach out to their supervising physician to convene on complicated cases, or when multiple diagnoses are involved in the acute care setting. Raising clinical concerns and questions should be encouraged when coordination of care is warranted or beneficial.
- Using an evidence-based framework such as TeamSTEPPS® can improve communication and teamwork in healthcare settings.
- When consulted, supervising physicians must be prepared to provide real-time guidance and support in the medical decision-making process and seek to understand the full clinical picture.
- Supportive documentation should be detailed and include all aspects of the physician's involvement and discussions with the APP.
- It is important for the supervising physician and APP to have clear and consistent expectations for when consultation should occur, in accordance with best practices and any facility or hospital requirements.
- When reviewing and signing off on patient care documented in the medical record, it is crucial to identify incomplete documentation that does not allow for meaningful supervision and request more thorough documentation.

IN SUPERVISING PHYSICIAN-APP RELATIONSHIPS, AWARENESS MATTERS

Each state dictates the rules, confines, and expectations of the supervising physician-APP relationships serving the patients in that state. Licensing boards often require notification of all supervisory relationships. It is the responsibility of healthcare professionals to provide care within these regulations, where applicable. To ensure supervision and practice align with current rules, consider the following strategies:

- Stay current on rules and regulations that lay out the necessary elements for any required supervision and delegation or collaborative agreement, and ensure compliance with ongoing quality improvement obligations.
- For states requiring such notification, update your medical board to reflect the status of any supervised APPs. Also, notify when a relationship ends, so as not to invite plaintiffs to name you in a claim related to care by an APP after your supervision ceased.
- Maintain ongoing competency evaluation and clear role delineation. Actively educate and train APPs, regularly assessing their skills and knowledge, and have a firm understanding of the APP's current level of training, education, expertise, and scope of practice. Per the AMA Code of Medical Ethics, to achieve the necessary level of trust, "all members of the team should be candid about their professional credentials, their experience, and the role they will play in the patient's care."[12]

RETURN TO TABLE OF CONTENTS

CASE TWO:

How an Integrated Team Approach Can Reduce Clinical Risk Liability

Up to 85% of urgent care patients are seen only by an APP rather than a physician.[13] State law will define the relationship structure and requirements between supervising physicians and APPs. However, in urgent care settings it is prudent for facility owners, supervising physicians, and APPs to clearly understand the setting-specific roles and workflow responsibilities between physicians and the APPs they supervise. All job descriptions, practice protocols, and supervision agreements should be written to accurately describe the type of patients to be seen and the level of treatment to be provided.[13] In addition, supervising physicians should explain to the APP how they envision their roles, separately and collaboratively. This includes defining which patient presentations and complaints are appropriate for care by an APP, and when they must consult with or refer the patient to the supervising physician or a specialist.[13] Supervising physician involvement in the clinical care provided by their supervised APP adds an additional, expert perspective, thereby increasing quality of care.

Consider how thorough documentation of the care provided and clear discharge instructions helped achieve a defense verdict in this case.

RETURN TO TABLE OF CONTENTS

After a dumbbell was dropped on his right ring finger, a 17-year-old patient was taken to an urgent care center (UCC) and treated for a deep 1-cm laceration with an avulsion at the base of the nail bed. The patient was examined and treated by the APRN on duty, who also asked the supervising physician to look at the wound. X-rays indicated no fracture. The APRN cleaned and sutured the wound and applied a sterile tube dressing on the finger. The APRN discharged the patient with instructions to return in two days for a wound check and dressing change by the same supervising physician. The patient was prescribed acetaminophen with codeine and cephalexin. He was advised verbally and in writing to watch for redness, swelling, tenderness, and drainage, as these symptoms may warrant earlier follow-up. The patient did not return as instructed.

Four days later the patient saw blood on the finger dressing and removed it, feeling what he described as excruciating pain. He returned to the UCC without the dressing. There was no bruising, crepitus, or joint instability. The patient was seen at the UCC by a new physician whose exam revealed a circumferential indentation around the injured finger with significant edema and mild maceration of the finger pad. The new physician could not assess capillary refill due to the wound. The patient was advised to go to the ER where a consult with a hand surgeon was ordered. The hand surgeon examined the patient in the ER and noted the area of constriction around the proximal phalanx to be minimal without purulent drainage from the nail bed. The patient was told that this could be managed as an outpatient but would require close and continued monitoring with the hand surgeon to ensure continued improvement.

The patient was compliant with the first few follow-up appointments with the hand surgeon but failed to return as instructed. The patient eventually returned after the tip of his finger had been progressively darkening for two weeks. The hand surgeon explained amputation would be the best treatment and the patient proceeded. After the patient missed several postoperative appointments, the operative site appeared infected, and cultures were obtained. Positive cultures for multiple organisms prompted a referral to infectious disease. The patient was treated with oral and intravenous antibiotics but required further surgery, including wound debridement.

After an extended and costly recovery, a lawsuit was brought on behalf of the patient. The lawsuit alleged that at his initial urgent care visit, the APRN applied the original bandage too tightly, causing the eventual amputation and subsequent complications. The lawsuit also alleged negligent supervision by the APRN's supervising physician. The litigation resulted in a defense verdict at trial.

DISCUSSION

In this case, the APRN examined the patient, ordered appropriate imaging, and cleaned and sutured the finger wound. Despite having treated crush injuries previously, the APRN called and asked the supervising physician to see the patient. The supervising physician participated in the case, looked at the finger wound, approved the treatment plan, and reiterated the APRN's discharge instructions including follow-up. The supervising physician's interaction with the patient allowed for supportive continuity of care and increased emphasis on expectations for follow-up. In addition to their collaborative approach to care, the supervising physician and APRN's comprehensive documentation complemented each other's diagnosis, treatments, and patient instructions. In a setting such as a UCC, where certain patient injuries are commonplace, it is oftentimes difficult to have a clear, personal recollection of the clinical treatment course for a specific patient visit. This coordinated approach and thorough documentation helped to prevent a "he-said-she-said" cycle during litigation.

RETURN TO TABLE OF CONTENTS

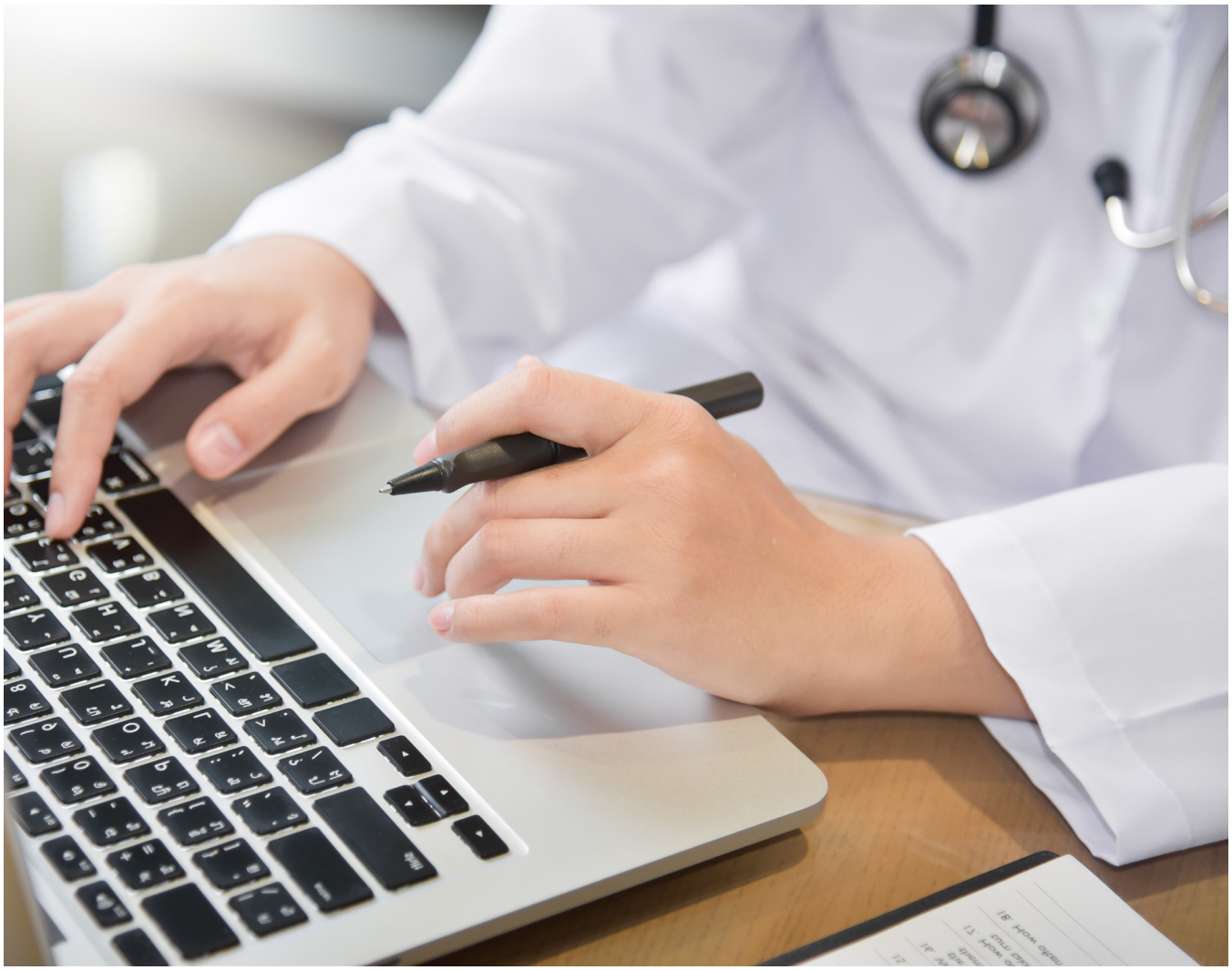
RISK REDUCTION STRATEGIES

The integrated healthcare team approach of supervising physician-APP will not be going away any time soon, and this approach should be embraced from the perspective of patient safety and organizational strategy. A *Journal of Interprofessional Education & Practice* article discusses the integration of APPs into value-based care. The journal noted, "The literature … supports that a strong collaboration with APPs can increase physician's productivity, improve patient outcomes and satisfaction, and fills an important gap in the care delivery system through interprofessional collaboration."[14]

A thorough and consistent methodology by and between a supervising physician and APP can lead to more clinically appropriate, comprehensive, and efficient care when the clinical situation calls for it. Effective collaboration between an APP and their supervising physician can enhance the quality of care and ensure patient-centered care.[12] In the foregoing case study, the team approach to care utilized by the UCC team, appropriate documentation, and timely referral contributed to the defense team's ability to successfully resolve the liability claim. Consider the following strategies:

- Ensure documentation by both supervising physician and APP provides evidence of a comprehensive examination and complete treatment course. Regularly reviewing medical records together can prompt necessary changes to documentation practices to ensure the documentation is supportive and detailed.
- Actively engage patients to help ensure an understanding of diagnosis and treatment plans by asking open-ended questions. Consider using the teach-back method[15] to identify issues that require more patient education.
- Adequately document patient education and follow-up instructions, as well as a patient's verbalized understanding of such.
- Recognize when a clinical presentation indicates treatment beyond the scope of either the supervising physician or APP, and necessitates timely referral to a higher level of care.

RETURN TO TABLE OF CONTENTS



CASE THREE:

Failed Accountability for Proper Documentation Complicated the Defense of a Missed Diagnosis Claim

Clear and thorough documentation is a paramount step to providing detailed, supportive evidence of any medical decision-making rationale, which tests and diagnostics were performed, and what treatment a patient was provided. Concurrent, complete, and complementary chart notes by a supervising physician and APP can mean the difference between a dismissal or settlement of a claim.

In which ways could the supervising physician and PA have ensured the patient's care was adequately documented?

RETURN TO TABLE OF CONTENTS

Following a kitchen knife injury, a 53-year-old male patient suffered a left middle finger laceration and was treated at the ER by a PA and the PA's supervising physician. The physician saw the patient, who was bandaged and still bleeding, and noted avulsion over the volar aspect of the finger's proximal Interphalangeal (PIP) joint, vascular involvement, and slightly decreased sensation of the distal fingertip. At the supervising physician's request, the PA then saw the patient and noted that he anesthetized, irrigated, and inspected the laceration for vessels, bony abnormalities, and foreign bodies. The PA charted that he did not appreciate any tendon injury before placing simple sutures. The physician returned to see the patient after the laceration had been sutured. As instructed, the patient was timely seen for suture removal by his PCP, who referred him to an orthopedic hand surgeon a month later for continued diminished function, stiffness, and pain.

The hand surgeon's exam revealed a well-healed laceration but no evidence of flexor tendon function of the left middle finger, with stiffness in the PIP and distal Interphalangeal joints and with pain to passive motion. The patient was diagnosed with a chronic flexor tendon laceration. Although he was compliant with occupational therapy, stretching, and wearing a splint, his issues persisted. He was scheduled for tendon reconstruction surgery. During surgery the surgeon found a complete transection of the flexor tendon with the ends retracted significantly, just proximal to the PIP joint.

The patient sued alleging that, in the least, a partial tear to the flexor tendon went undiagnosed at the initial ER visit, allowing the injury to remain hidden or worsen to a complete rupture or tear of the tendon. This alleged miss by the supervising physician and PA was purported to have delayed care and treatment by the orthopedic hand specialist and to cause permanent impairment to the patient's hand and finger. While the damages in this case were minimal, lack of comprehensive documentation led to a settlement.

DISCUSSION

The type of finger injury at issue involved potential extensor and flexor tendon involvement, and experts felt that visualization of the laceration alone was insufficient. With this clinical presentation, experts opined that extensive evaluation and assessment of the flexor and extensor tendons for range of motion, integrity, sensation, function, and strength were required. While the supervising physician later stated that all of the appropriate tests were completed, the medical record was silent as to any thorough inspection or visualization of the tendons, which could be ruptured or partially ruptured proximal or distal to the open laceration on the skin.

In this case, both the PA and the supervising physician believed that the other had ensured documentation of a complete, detailed exam of the wound and internal structures, including the extensor and flexor tendons. However, the medical record stated only that the PA did not appreciate any tendon injury, and the supervising physician did not identify any nerve or tendon damage while the wound was actively bleeding. Additionally, the supervising physician later confirmed that he expected the PA would also conduct a thoroughly documented exam that specifically checked for tendon injury. There was a question remaining as to why, if the complete examination for this injury was conducted, it was not noted in detail within the medical record.

RETURN TO TABLE OF CONTENTS

RISK REDUCTION STRATEGIES

Implementation of written expectations for the supervising physician-APP relationship at the outset of the relationship sets up the healthcare team for success.[16] Effective collaboration for complex patient populations is necessary to achieve high quality care. The goal of setting clear expectations for the physician and APP team early on is to promote consistent and safe communication, understand the APP's scope of practice, and establish more effective team-based treatment.[16] Standardization of the relationship expectations has been met with positive feedback by clinicians, and includes provision of a working framework for the physician-APP team, with a more strategic understanding of roles and responsibilities.[16]

As always, ensuring thorough documentation of all care provided avoids the appearance of missed opportunities for appropriate care. Subsequent recitation of custom, habit, and routine practice should not be relied upon in lieu of contemporaneous documentation. The defense of a medical malpractice claim will be more difficult when the medical chart does not support that an appropriate evaluation was completed by either the supervising physician or APP. Consider the following strategies:

- Supervising physicians working alongside their APPs should strive for a culture of safety, fostering open lines of communication to ensure collaboration. This cultivates a relationship where roles and duties are well-defined, rather than assuming the other will handle a specific aspect of care or documentation.
- It is important for the supervising physician and APP to understand the division of treatment expectations and develop a routine for the particular care setting. For example, for a finger or hand laceration in the ER setting, does the APP personally assist in evaluation, assessment, exam, and diagnosis? Or will the supervising physician complete the examination, diagnose the patient, and then hand off to the APP for suture and review of written instructions, with a final reevaluation by the physician?
- In situations where there is overlapping care or specific documentation sections or requirements, it is prudent to confirm that duties and explicitly assigned tasks are done appropriately both during and following the patient's healthcare experience.

ADDITIONAL RESOURCES

ProAssurance seminar: *Identifying Emerging Risks for Advanced Practice Registered Nurses*[17]

Offered for continuing medical education, this ProAssurance seminar reviews areas of professional liability risk for physicians and APRNs.

Risk & Insurance®: *APRN Professional Liability Risk: What Health Care Risk Managers Must Understand*[18]

ProAssurance Senior Risk Management Consultant Wendy Alderman is interviewed in this article that focuses on the liability risks specific to APRNs.

RETURN TO TABLE OF CONTENTS

Careful Collaboration:
Mitigating Risks in the Physician-APP Relationship

CONCLUSION

APPs provide high quality services across all healthcare settings, in both preventive and specialty care offices and facilities. A focused, deliberate, and thoughtful collaboration, which includes specific accountability and documentation responsibilities between supervising physicians and APPs, must begin at the outset of the relationship. Continued and open dialogue between a supervising physician and APP will build the foundation for an efficient, high quality approach to patient care. This alliance will set the stage for patient safety and satisfaction, increase access to healthcare, and lower the risk of liability.

RETURN TO TABLE OF CONTENTS

ENDNOTES

The documents referenced in this article, along with many other risk management resource documents and past editions of *Claims Rx*, are available on the ProAssurance website, by calling Risk Management at 844-223-9648, or by email at RiskAdvisor@ProAssurance.com.

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RETURN TO TABLE OF CONTENTS