Supporter

• Cosponsored by the American Society for Pharmacy Law.

Disclosures

Mark Buczko, Stacie Maass and Jeff Rochon declare no conflicts of interest, real or apparent, and no financial interests in any company, product, or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.

Learning Objectives

At the completion of this knowledge-based activity, participants will be able to:

• Explain the federal legislation and regulation impacting the role of the pharmacist/pharmacy technician in providing patient care and discuss their status.
• Describe state-level changes impacting the role of the pharmacist/pharmacy technician in providing patient care.
• Identify new legal and compliance requirements that apply to or are impacting pharmacists’ participation in patient care services and new care delivery.
• Discuss future legal issues and compliance requirements for pharmacists as their role further expands in the evolving health care system, including topics such as malpractice, false claims actions, and anti-kickback allegations.
Self-Assessment Question #1
Provider status success at the federal, state and/or private sector levels will:
  a. Better integrate the pharmacist into the patient’s health care team and help improve patient outcomes
  b. Increase opportunities for pharmacists to contribute to more efficient and coordinated delivery of care
  c. Increase patient access to health care and pharmacists’ opportunities to provide more patient care services
  d. All of the above

Self Test Assessment Question #2
Washington State ESSB 5557:
  a. Changes pharmacists’ scope of practice
  b. Requires health carriers to cover all services provided by pharmacists in their participating provider networks
  c. Requires pharmacists to be treated similar to other providers
  d. All of the above

Self Test Assessment Question #3
The claims study identified two allegations that were both the most frequent and the most severe. These are:
  a. Failure to identify drug allergy and Wrong drug
  b. Wrong dose and Failure to counsel patient
  c. Wrong dose and Wrong Drug
  d. Compounding calculation and Wrong Strength

Pathways to Provider Status
  • Federal Sector
    – Social Security, Medicare Part B & D, CMMI, ACO
    – Federal Regulations (CMS, AHRQ, HRSA)
  • State
    – Medicaid
    – Health Insurance Exchanges, state health plans
    – Existing provider status and collaborative practice
  • Private Payer
    – ACOs
    – Private or Employer-based Insurers
    – Medical Homes

Ways to Optimize Pharmacists’ Value in States
*Information provided by National Alliance of State Pharmacy Associations
Provider Designation

State Level Provider Designation

 Provider designation
 State statute
 Medicaid

*Information provided by National Alliance of State Pharmacy Associations

State Level Changes

Insurance Code
- There is sometimes a list of professionals who are defined as health care providers for the purposes of the provisions in the insurance code
- Challenge: A limited number of patients are covered by insurers who are held to these provisions (non-ERISA exempt plans)

Other Areas of State Laws
- Pharmacy Practice Act
- Business/Professional Code
- Being "on the list" as a provider here may not have much of an impact on payment for services unless areas of the insurance code, Medicaid provisions, or state employee benefit provisions refer back to this language
- Pharmacists can also be separately recognized as providers within Medicaid laws

2015 Activity

North Dakota
- SB 2104
- Included in language related to naloxone access
- Re-assertion of pharmacists as providers

West Virginia
- SB 6; HB 2006
- Adds pharmacists to the medical liabilities law
- Re-assertion of pharmacists as providers

Nebraska
- L B 37
- Includes statutory definition of pharmacists as "practitioners"
- Definition would be in the Prescription Drug Safety Act

Recent Wins

*Information provided by National Alliance of State Pharmacy Associations

Scope / Collaborative Practice Agreements/ Statewide Protocols

Scope Components/ Opportunities
- Practice of Pharmacy
- Collaborative Practice Provisions
- Immunization Authority
- Order/ interpret labs, CLIA waived tests
- Statewide protocols to enhance public health

*Information provided by National Alliance of State Pharmacy Associations

Collaborative Practice Agreements (CPAs)
- Creates formal relationship between pharmacists and physicians or other providers
- Defines certain patient care functions that a pharmacist can autonomously provide under specified situations and conditions
- Many are used to expand the depth and breadth of services the pharmacist can provide to patients and the healthcare team
State Collaborative Practice Authority Map

Collaborative agreements allowed
CPA allowed – very restrictive
Pending legislation would make vast improvements

48 States + DC = some kind of CPA

*Information provided by National Alliance of State Pharmacy Associations

CPA Applications
• Chronic Disease Management
  – Anticoagulation
  – Cardiovascular disease/hypertension
  – Diabetes
  – Others
• Acute Treatment – e.g., point of care testing, such as rapid strep test
• Public Health – e.g., Naloxone

State Protocols
• Used to address public health concerns
• Standardized protocol for any willing and qualified pharmacist in the state
• Does not require the pharmacist(s) to identify a collaborating prescriber
• Protocol defines the patient population, the minimum qualifications for participating pharmacists, the focused prescriptive authority allowed
• Protocol usually developed by a state agency (Pharmacy, Medicine, Public Health, or a combination)

Statewide Protocols vs CPAs

CPAs
• Negotiated between prescribers and pharmacists
• Requires pharmacist to identify a collaborating prescriber
• Could be patient-, disease state-, or patient population-specific
• Services may be broad and address a variety of conditions
• Care may or may not be protocol-driven
• Parameters are modifiable and negotiable between the participating providers

Statewide Protocols
• Standardized for any willing and qualified pharmacist in the state
• Pharmacist/pharmacy doesn’t need to find someone to sign off
• Not patient-, pharmacist-, or provider-specific
• Very focused service
• Protocol-driven authority
• Parameters are not modifiable by individual pharmacists

Recent Legislative Changes - CPAs

Indiana – SB 368 (2015)
  – Allows pharmacists to collaborate with NPs and PAs
  – Defines MTM

  – Allows multiple pharmacists, practitioners and patients to be included on one agreement

Maryland – HB 716 (2015)
  – Allows CPAs with NPs; added to dentists, physicians, podiatrists, midwives
  – Allows pharmacists to initiate therapy

  – Allows pharmacists to collaborate with nurse practitioners in addition to physicians and expands to pharmacists beyond institutional settings

*Information provided by National Alliance of State Pharmacy Associations
Payment for Pharmacists Services

Payment for Services

2015 Activity

Recent Wins

Washington: SB 5557
- Required the pharmacist to be included in Washington State insurance networks and be eligible to bill for services within the scope of practice already covered for other providers
- Signed into law

North Dakota: SB 2320
- Adds MTM as a covered benefit in Medicaid
- Signed into law

Other Issues Related to Pharmacists Expanding Services

Board of Pharmacy – e.g., Some states Boards are questioning ability of pharmacist-related authorities to extend beyond regulated pharmacies (e.g., physician offices)

Attorney General – e.g., Some state AGs have recently weighed in on profession’s authorities, such as whether “initiate therapy” is same as “prescribe”

Insurance Commissioner - Interpret insurance laws and regulations covering state-governed plans; e.g., definition of “administer” or “provide”

Potential Requirements for Coverage

Credentialing: The process by which an organization or institution obtains, verifies, and assesses an individual’s qualifications to provide patient care services

Privileging: Permission or authorization granted by a hospital or other health care institution or facility to a health professional (e.g., physician, pharmacist, nurse practitioner) to render specific diagnostic, procedural, or therapeutic services

Additional Training/Certifications – e.g., for immunization administration, states require completion of a qualified training program

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Pharmacy’s Federal Provider Status Efforts

H.R.592 / S.314
Pharmacy and Medically Underserved Areas Enhancement Act
- Representatives Brett Guthrie (R-KY), G.K. Butterfield (D-NC), Todd Young (R-IN), and Ron Kind (D-WI) introduced on January 28, 2015
- Senators Chuck Grassley (R-IA), Sherrod Brown (D-OH), Robert Casey (D-PA), and Mark Kirk (R-IL) introduced on January 29, 2015
- Amends section 1861 of the Social Security Act to recognize pharmacists’ services within Medicare Part B

Patient Access to Pharmacists’ Care Coalition
H.R.592 / S.314 – Scope of Proposal
- Pharmacists – State-licensed pharmacists with a B.S. Pharm. or Pharm. D. degree who may have additional training and certificates depending on state laws
- Services – Services authorized under state pharmacy scope of practice laws
- Patients – Services provided in/for Medically Underserved Areas (MUA), Medically Underserved Populations (MUP), or Health Professional Shortage Areas (HPSA)

No impact on state scope of practice

Provider Status’ Effect on Pharmacy Practice and Health Care

Potential Operational Changes
- Changes in workflow
  - Increase in pharmacist’s face-to-face time with patients
  - Shift to appointment-based care
- Changes in facilities
  - Need for more private consultative areas
  - Need for access to electronic health records
  - Increase central-fill
  - Provision of care off site

Potential Operational Changes
- Changes in billing mechanisms
  - Medical insurance
  - Partnerships for bundle payments
  - Outcomes based vs fee for service
- Changes in role of the pharmacist
  - Building patient relationships/engage patient in their care
  - Increased collaborations/team-based care
  - Effective documentation for care delivered
  - Additional training or verification of performance ability
  - Performance appraisal system - meeting outcomes vs # of Rxs
- Liability
Problems and Opportunities

- Total health care spending in the United States is expected to reach $4.8 trillion in 2021, up from $2.6 trillion in 2010 and $75 billion in 1970.\(^1\)
  - Health care spending will account for nearly 20 percent of GDP, by 2021.\(^1\)
- The US spends almost $300 billion annually on medication problems including medication non-adherence.\(^2\)
- Chronic diseases cost the US health care system $1.7 trillion annually (more than 75% of health care spending).\(^3\)

\(^3\) Partnership to Fight Chronic Disease. 2009 Almanac of Chronic Disease. Available at: http://www.fightchronicdisease.org/resources/almanac-chronic-disease-0.

Potential Impact on Patients and Health Care

Percentage of Medicare Fee for Service Beneficiaries by Number of Chronic Conditions

<table>
<thead>
<tr>
<th>Number of Chronic Conditions</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 1</td>
<td>32%</td>
</tr>
<tr>
<td>2 to 3</td>
<td>32%</td>
</tr>
<tr>
<td>4 to 5</td>
<td>23%</td>
</tr>
<tr>
<td>6+</td>
<td>14%</td>
</tr>
</tbody>
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Medicare enrollment is expected to grow from roughly 50 million in 2015 to over 80 million in 2030.

Washington State Experience

\(\text{SB 5557} \) Pharmacists as Patient Care Providers

Provider Status Components

- Simply achieve:
- Scope of Practice allowing to provider patient care
- Provider Designation in law
- Health Plan/Payer Recognition as Medical Providers

Pharmacist Practice Act

Scope of Practice

- In 1979, Definition of Pharmacy Practice (RCW 18.64.011) amended to include:
  - “the initiating or modifying of drug therapy in accordance with written guidelines or protocols previously established and approved for his or her practice by a practitioner authorized to prescribe drugs”
    - aka Collaborative Drug Therapy Agreements (CDTA)
  - “monitoring of drug therapy and use”
  - “administer” drugs and devices
    - “administer” is defined as: “the direct application of a drug or device, whether by injection, inhalation, ingestion, or any other means, to the body of a patient or research subject” (RCW 18.64.023).
Collaborative Drug Therapy Agreements (CDTA) WAC 246-863-100

- These agreements shall include:
  - Practitioner(s) authorized to prescribe and pharmacist(s).
  - Duration of Agreement: Valid maximum of 2 years. Renewable.
  - Type(s) of prescriptive authority decisions pharmacist(s) are authorized to make including:
    - Types of diseases, drugs, or drug categories involved.
    - Type of prescriptive authority activity authorized in each case.
    - Procedures, decision criteria, or plan when making therapeutic decisions.

CDTA Protocol Areas

- Public Health and Prevention
- Immunizations
- Emergency Contraception
- Tobacco Cessation
- Wellness Visits
- Medication Management
- Refill Authorization
- Comprehensive Medication Reviews
- Transitions of Care
- Chronic Disease Management
- Anticoagulation
- Dyslipidemia
- Diabetes
- Hypertension
- Pain
- Asthma/COPD
- Oncology/Chemotherapy

And many more

CDTA in Washington

Must be “On file” with the Board of Pharmacy

- 1993 57 agreements
- 1997 110 agreements
- 1999 358 agreements
- 2004 659 agreements
- 2005 982 agreements
- 2008 1,625 agreements
- 2012 2,550 agreements
- 2015 Over 10,000 agreements

Monitoring of Drug Therapy and Use WAC 246-863-110

- Collecting and reviewing patient drug use histories
- Measuring and reviewing routine patient vital signs
- Ordering and evaluating the results of lab tests relating to drug therapy
  - blood chemistries and cell counts
  - drug levels in blood, urine, tissue or other body fluids
  - culture and sensitivity tests
  - when performed in accordance with policies and procedures or protocols applicable to the practice setting

“Provider Designation” by State Practice Laws

- Pharmacists are healthcare providers in Washington State; i.e., “Provider Designation”
  - Incorporated in all appropriate practitioner and HC provider definitions
  - Needed inclusion in Legend Drug Act
    - 2013 Legislation HB 1182 passed and signed by Governor
Medical Provider Recognition by Payers
i.e. Payment for Services

• Prior to SB 5557, not recognized by health plans for services except:
  • Limited to:
    – Individual specifically identified pharmacist provided services such as vaccine administration, MTM etc.
    – “Incident to” or “Facility Only” billing for services in concert with a physician in certain settings.

Solution? “Every Category of Provider” Law

• In 1995, RCW 48.43.045(1) requires health plans in Washington to include access to every type or “every category” of licensed medical provider to provide health care services to care for conditions included in the basic health plan.
  • Pursuant to WAC 284-43-205, “health carriers shall not exclude any category of provider licensed by the State of Washington who provide health care services or care within the scope of their practice for conditions covered by basic health plan (BPH) services as defined by RCW 48.43.005(4)

“Every Category of Provider” Law

• RCW 48.43.045 Initially interpreted by Insurance Commissioner Kreidler’s office to NOT include pharmacist provided services therefore NOT enforced.
  • We worked with OIC for several years to educate and request enforcement of law.
  • Unsuccessful until….

AG Informal Opinion

• Attorney General informal opinion confirmed:
  “Pharmacists are health care providers and must be compensated for services included in the basic health plan that are within the scope of the pharmacist’s practice if the pharmacist agrees to abide by stated standards related to cost containment, management, and clinically efficacious health services.”

AG Informal Opinion

• Reinforced our long held belief that payers must credential, privilege and contract with pharmacists for services.
  • However, the informal opinion was not a silver bullet.
  • OIC tried to enforce law
  • Health Plans response was that pharmacists were included in their networks as part of the contract entity Pharmacy Benefit Managers network of pharmacies.
Legislative Fix

- Identified loophole in the law that allowed health plans to justify not including pharmacists in their provider networks.
- We worked with OIC to address loophole.
- Resulted in a legislative fix: SB 5557

Legislative History

- January 2015
  - Introduced by Senator Linda Evans Parlette (R-12)
- May 2015
  - Governor Jay Inslee (D) signed bill into law.

Legislative Intent of SB 5557

- Fixes the loophole in Every Category Provider law.
- Recognition of pharmacists as healthcare providers in Insurance Code.
- Requires inclusion of pharmacists within health plan provider networks as patient care providers within scope of practice.
- Does not change pharmacists' scope of practice

SB 5557 Misconceptions

- Patients can skip physicians completely and receive medical services from pharmacists.
- Changes pharmacists' scope of practice.
- Health carriers must include ALL pharmacists in their participating provider networks.
- Pharmacists' provider status will change immediately after the legislation is signed into law.
- Health carriers must cover ALL services provided by pharmacists in their participating provider networks.

SB 5557 Highlights: Pharmacists as Patient Care Providers

- Health plans recognize pharmacists as patient care providers for covered benefits.
  - Health plans required to include adequate number of pharmacists in their participating provider networks.
  - Includes services covered as essential health benefits requirements.
  - Inclusion of pharmacies in health plans’ drug benefit networks does not satisfy new requirements.
  - In short, pharmacists will be treated the same as other providers.

SB 5557 Highlights: Tiered Implementation Dates

- Health carriers who delegate credentialing to health facilities must accept pharmacists employed or contracted by those facilities in their participating provider networks.
- Health facilities reimbursed for covered services based on negotiated contracts.

Health carriers must accept pharmacists in their participating provider networks.
**SB 5557 Highlights: Advisory Committee Process**

- OIC designates a lead organization.
- Lead organization forms Advisory Committee.
- Advisory Committee develops best practice recommendations for standards on credentialing, privileging, billing and payment.
- Advisory Committee provides best practice recommendations to OIC and DOH by December 1, 2015.
- If needed, OIC and DOH develops rules based on recommendations.

**Advisory Committee Work**

- **INTENT**
  - To ensure that pharmacists will be regarded as any other provider, in accordance with relevant state law, as it relates to health plan billing, processing, and payment of claims for medical services that are provided.
- **SCOPE OF WORK**
  - Recommend guidelines for payment-dependent interactions between health plans and pharmacists/provider organizations

**FAQ Document**

- Document reflects industry information, gathered during a discovery process that offers understanding and context for the recommended *Policy Directives and Provider Expectations*.
  - Clarifications about legislation SB 5557
  - Pharmacist's scope of practice, licensure requirements, training, education, and certifications
  - Collaborative Drug Therapy Agreements (CDTA)
  - Credentialing and Privileging

**Health Plan Policy Directives**

- Identifies policy conditions/requirements that health plans will have in place to enable the billing and appropriate reimbursement of medical services provided by pharmacists.
  - Contracting
  - Credentialing
  - Utilization Management
  - Coding/Billing/Reimbursement

**Provider Expectations**

- Lists and briefly describes the expectations and/or requirements that will need to be met by pharmacists, other providers, and other stakeholders in order to operationalize, within their respective organizations, the reimbursement of pharmacist-provided services.
  - Applicability
  - Contracting
  - Credentialing
  - Privileging
  - Utilization Management
  - Coding/Billing/Reimbursement
Key Issues

Does this legislation require all health plans to reimburse pharmacists for medical services that they deliver?

**NO**

- The 5557 legislation only requires Washington State licensed insured large group, small group, individual, and family plans to reimburse for pharmacist provided medical services.
- These reimbursement requirements may not apply to Federal plans such as Medicare, Tricare, Taft-Hartley AND to other State plans, e.g. PEBB/Uniform Medical plans, Washington State Medicaid and related plans, commercial self-insured plans, etc.

Key Issues

Are pharmacists being regarded as all other provider types?

**YES**

- The intent of this document is that pharmacists fall under the “Every Category of Provider” law.

Key Issues

For a given type of provider, e.g. pharmacists, do the credentialing requirements of a health plan vary depending upon the services to be provided by that pharmacist, i.e. is credentialing service-specific?

**NO**

Example

- For health plans, the defined set of credentials gathered and verified for a provider, e.g. PA, ARNP, Pharmacist, to deliver services to that health plan’s members **do not vary** based on the specific services that a provider of that type delivers in the course of their work.

Example

- For organizations that are both a provider organization AND a health plan i.e. provide patient care and take on financial risk for providing care
  - the defined set of credentials gathered and verified for a provider, e.g. PA, ARNP, Pharmacist, **may vary** based on the specific services that a provider of that type delivers in the course of their work.
  - Similar to provider organizations, these organizations have a baseline set of credentials that apply to all providers of a given type AND they may have additional training and certification standards depending upon the services that the provider delivers.

Key Issues

Might health plans change credentialing requirements over time for all providers of a given type (including pharmacists)?

**YES**

- Health plans may, at some point in the future, require additional certifications and/or advanced training in order for pharmacists to be credentialed.
  - They may require advanced certifications for all pharmacists or may define different types of pharmacists and vary credentialing requirements by type. This practice will not be uniquely directed towards pharmacists as health plans manage all provider types in this manner.
**Key Issues**

Are pharmacists required to get a diagnosis from a medical provider in order to bill a health plan for preventive care and related services?

**NO**

- Though a diagnosis is ALWAYS required on any/all claim forms, pharmacists are not required to get a diagnosis from a medical provider *if* when they are billing for medical services that are *not* related to injury or illness.
- Specific ICD10 diagnosis codes (Z series codes) are available to pharmacists for billing preventive care and associated services that are *not* related to injury or illness.

**Out of the Committee's Scope**

- Guidelines for internal capabilities required of organizations to perform those interactions are not the focus of this work.
- Similar to other providers, the capability to interact with health plans must be in place.
- Business processes/work flows, coding, education/training, and clinical record management/billing systems are pre-requisites for:
  - Submitting claims to health plans for medical services delivered by pharmacists and
  - Appropriately billing and collecting patient cost-share.

**Next Steps**

- The WSPA will be working with members and partners.
  - Content experts to support advisory committee work
  - Advocating for appropriate integration of pharmacists into provider networks

**Identified Knowledge Gaps**

- Tailoring and transitioning care to recognition within the medical benefit coverage
- Inclusion in participating provider networks
  - Credentialing processes
    - Delegated credentialing vs. Direct credentialing
  - Privileging Processes
  - Contracting with Health Plans vs PBMs
  - Network Adequacy
  - Liability

**Billing processes**

- Retrospective Billing
- Documentation
- Identifying Covered Services
- Coding ICD 10, CPT, HCPCS etc
- Referrals
- Avoidance of Duplication

- Patient Billing: Co-pays/Co-insurance identification and collection
- Pre-Auth, Referral and other Pre-Service requirements
- Payment adjustments – take backs
- Audit protection

**Health information technology**

- Health Information Exchange (HIE)
  - Clinical data sharing
- Electronic Health Record for Documentation & Reporting
  - Electronic Medical Record – patient clinical record
  - Practice Management Software – scheduling, billing, business management
Next Steps

- The WSPA will be working with members and partners.
  - Content experts to support advisory committee work
  - Advocating for appropriate integration of pharmacists into provider networks
  - Addressing knowledge gaps
  - Sharing with colleagues throughout the country

WSPA Implementation Workgroups

- Credentialing and Privileging
- Billing, Coding, Contracts, Documentation
- Technology and Communication
- Outcomes and Research

Credentialing and Privileging

- **Scope**
  - Determine best practices and tools for credentialing and privileging pharmacists.
- **Potential Tasks**
  - Develop credential tools or best practices for pharmacists.
  - Compare and contrast provider credential requirements.
  - Identify and review existing national guidelines.
  - Provide guidance on privileging pharmacists in different settings.
  - Identify gaps in education or training that hinders obtaining credentials.

Billing, Coding, Contracts, Documentation

- **Scope**
  - Determine best practices to ensure pharmacists meet billing and documentation standards, and provide tools to facilitate the billing of services through contracts with health plans.
- **Potential Tasks**
  - Compile and review list of ICD-10 and CPT/HCPCS codes pharmacists can use for billing purposes.
  - Identify gaps in billing codes.
  - Review existing contracts and develop best practice resources for pharmacists.
  - Complexity vs. time-based billing (complexity algorithms).
  - Provide guidelines on documentation and coding standards for medical services.

Outcomes and Research

- **Scope**
  - Determine the metrics to measure and report quality and outcomes of using pharmacists in providing patient care.
- **Potential Tasks**
  - Review national and state quality metrics.
  - Determine metrics that should be collected.
  - Develop a strategy for research and publications.

Technology and Communication

- **Scope**
  - Determine guidelines to integrate technology in pharmacy practices to ensure interoperability, billing and payments, practice management, and documentation.
- **Potential Tasks**
  - Identify technological gaps in pharmacy practices.
  - Develop best practice resources for technology.
  - Compile list of vendors that can provide customize or bundled technological software.
Case Study #1 – Case Summary

- The consultant pharmacist was employed by an endoscopy center to monitor the management of drugs in the center’s pharmacy.
- The agreed-upon scope of the consultant pharmacist’s responsibilities included:
  - Verifying that drugs in the pharmacy were stored properly and at the correct temperature
  - Ensuring that drugs, including Class II narcotics, were properly stored, double-locked, logged, and tracked
  - Removing outdated drugs from stock
  - Disposing of expired drugs

Case Study #1 – Case Summary (continued)

- The pharmacist further offered to lead in-service educational sessions for the staff regarding clinical pharmaceutical issues, but the center declined this proposal.
- The pharmacist was aware that Propofol in both 20cc and 50cc single-dose vials was purchased and maintained in the facility for patients requiring anesthesia, but because Propofol is not a Class II drug, she was not responsible to monitor or track its use.

Case Study #1 – Case Summary (continued)

- Center policies and protocols specifically indicated that the center’s physician and director of nursing were directly responsible for:
  - Hiring, supervising, and evaluating all clinical staff
  - Developing, implementing, and monitoring staff compliance with facility clinical and administrative policies, procedures, and protocols
  - Overseeing the clinical management and tracking of all drugs
  - Complying with the facility’s infection control policies and procedures
- Many patients require Propofol in dosages other than 20cc or 50cc.

Case Study #1 – Allegations Against the Pharmacist

- Failure to follow proper sterile technique, resulting in multiple patients being exposed to and/or contracting Hepatitis C
- Negligent hiring
- Negligent training and supervision of center staff

Case Study #1 – Allegations Against the Pharmacist (continued)

- The physician owner required the nursing and anesthetist staffs to draw up the unused amount of Propofol after injection for subsequent use, even though the vials were designed for single patient use.
- Some staff left a needle in the Propofol vial and attached a new syringe to draw up any remaining Propofol. Others used the same syringe but changed the needle between patients. Both techniques breached the standard of care for single-dose vials and violated infection control standards.
- The consulting pharmacist had no knowledge of these practices.
Case Study #1 – Was the Consultant Pharmacist Deemed Negligent?

- Do you think the consultant pharmacist was negligent?
- Do you think any other practitioners were negligent?
- Do you think any indemnity and/or expense payment was made on behalf of the pharmacist?
- If yes, how much?

Case Study #1 – Was the Consultant Pharmacist Negligent?

- Based on the consulting pharmacist’s role, none of the allegations were initially deemed to be her responsibility and the plan was to fully defend the consultant pharmacist’s actions and take the case to trial.

Case Study #1 – Additional Considerations

- As discovery progressed, however, several additional factors were identified, altering that initial decision including:
  - The pharmacist’s contract contained a provision that stated that she was “responsible for all matters pertaining to the use of drugs in the center”. This sentence greatly expanded the consultant pharmacist’s scope of responsibility beyond her agreed-upon duties.
  - The use of the same needle or syringe to withdraw Propofol from single-dose vials for use in multiple patients violated infection control standards of care resulting in the potential exposure of thousands of patients to disease. Several hundred lawsuits were filed. Many plaintiffs settled for significant sums, and 43 patients instituted allegations against the consultant pharmacist.

Case Study #1 – Additional Considerations

- The state where the consultant pharmacist was employed had enacted medical professional liability reform laws that protected physicians and nurses from noneconomic damages of more than $350,000 for any individual claimant. Pharmacists were excluded from that protection.
  - The center’s physician, nurse anesthetists and others settled their portions of the claims quickly and subsequently filed for bankruptcy protection.
  - The physician and two nurse anesthetists have been indicted on criminal charges with trials pending.
  - Numerous staff members have been called to testify before a grand jury and the state medical licensing board.

Case Study #1 – Additional Considerations (continued)

- The state where the pharmacist was employed had “joint and several” liability responsibility for all named parties. This meant that the consultant pharmacist could theoretically have been held liable for any unpaid verdict amount if the jury apportioned a percentage of the liability to her.
  - Because the physician, center and several nurse anesthetists had declared bankruptcy, patients and their attorneys sought out other potential defendants, including the consultant pharmacist.
  - This combination of factors made it necessary to settle the claim on behalf of the consultant pharmacist, despite multiple expert opinions supporting the pharmacist’s actions.

Case Study #1 – Resolution

- Settlement on behalf of the consultant pharmacist required the full limits of her policy which was divided among the 43 patients.
  - Indemnity Paid: Full policy limits
  - Expenses Paid: High five-figure range
Case Study #1 – Risk Control Recommendations

- Understand and comply with state regulations regarding the consultant pharmacist role within the particular healthcare delivery model.
- Ensure that the description of the position accurately reflects the scope of practice, as well as scope of services and specific job duties to be performed.
- Engage an attorney to review all contracts involving consulting services for a clinical facility prior to signing and executing such contracts.
- Read the employment contract carefully to determine the full extent of responsibility being assumed, and request legal counsel to negotiate removal of inappropriate, overly broad or undesirables descriptions of duties and responsibilities.

- Review facility infection control and medication administration manuals to determine if policies and procedures comply with required standards of care.
- If agreeing to a contract that includes overall responsibility for supervising the use of drugs in the facility, ensure that the contract provides for the following:
  - Mandatory education regarding all aspects of medication management, including infection control techniques
  - Policies and protocols related to proper medication management, including infection control
  - A requirement that unused portions of medications in single-dose packaging be disposed of in the proper manner
  - Direct observation of the preparation and administration of drugs within the facility on a regular basis
  - Immediate training for staff who are not performing within standards and/or complying with protocols
- Document all actions taken to ensure the safe and appropriate dispensing, administration, storage and disposal of drugs within the facility.

### Survey Distribution Methodology

- Purpose: to examine the relationship between professional liability exposure and a variety of demographic and workplace factors.
- Responding Pharmacists were divided into two groups:
  - HPSO/CNA pharmacist customers who had experienced a professional liability claim resulting in loss that had closed between 2002 and 2011, and
  - HPSO/CNA pharmacist customers who had never experienced a claim.
- Survey sent via U.S. mail and email
- Interpretation of Results
  - The survey findings are based on self-reported information and thus may be skewed due to the respondents’ personal perceptions and recollections of the requested information.
  - Our general guideline is to use a 95% confidence level as the basis for estimating statistical error and the significance of differences between two or more statistical results.

### Claims Survey - What We Considered

- Inclusion criteria were applied to 1,409 reported claims, incidents and adverse events
- Claim was against a pharmacist or pharmacy technician
  - Claim closed between January 1, 2002, and December 31, 2011
  - Claim was not for deposition assistance only
  - Claim was not for license protection or defense only (addressed separately)
  - Claim indemnity payment was ≥ $1.00
- Total paid expenses for closed claims with indemnity payment of $0.00 but with expenses of $1.00 or more are shown separately.
- 162 closed claims in the study
### Claims Survey

#### Pharmacist Demographics–Years in Practice

**Q: How many years have you been a pharmacist?**

<table>
<thead>
<tr>
<th>Years</th>
<th>Non-claims</th>
<th>Claims</th>
<th>Average total paid (Indemnity plus expense)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 2</td>
<td>13.3%</td>
<td>1.1%</td>
<td>$1,0374</td>
</tr>
<tr>
<td>2-5</td>
<td>23.1%</td>
<td>0.1%</td>
<td>$1,0374</td>
</tr>
<tr>
<td>6-10</td>
<td>11.3%</td>
<td>1.5%</td>
<td>$1,0374</td>
</tr>
<tr>
<td>More than 15</td>
<td>39.3%</td>
<td>7.2%</td>
<td>$1,0374</td>
</tr>
</tbody>
</table>

### Claims Study

#### Severity by Pharmacy Type

<table>
<thead>
<tr>
<th>Pharmacy type</th>
<th>Percentage of closed claims</th>
<th>Total paid indemnity</th>
<th>Average paid indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioner or group practice office-based pharmacy</td>
<td>5.2%</td>
<td>$1,032,000</td>
<td>$206,400</td>
</tr>
<tr>
<td>Home care-only pharmacy–oral, intravenous and TPN</td>
<td>1.8%</td>
<td>$1,042,625</td>
<td>$226,116</td>
</tr>
<tr>
<td>Hospital round pharmacy</td>
<td>4.5%</td>
<td>$1,124,000</td>
<td>$238,240</td>
</tr>
<tr>
<td>Telemedicine-only pharmacy</td>
<td>0.5%</td>
<td>$300,000</td>
<td>$60,000</td>
</tr>
<tr>
<td>Ambulatory pharmacy</td>
<td>1.2%</td>
<td>$303,000</td>
<td>$60,608</td>
</tr>
<tr>
<td>Compounding specialty pharmacy</td>
<td>11.2%</td>
<td>$902,300</td>
<td>$111,908</td>
</tr>
<tr>
<td>State-based pharmacy</td>
<td>2.5%</td>
<td>$906,000</td>
<td>$111,908</td>
</tr>
<tr>
<td>Non-regional chain pharmacy</td>
<td>34.5%</td>
<td>$7,923,000</td>
<td>$215,500</td>
</tr>
<tr>
<td>Independent or individually owned pharmacy or pharmacy franchise</td>
<td>40.6%</td>
<td>$4,045,000</td>
<td>$101,308</td>
</tr>
<tr>
<td>Aging services contracted pharmacy</td>
<td>0.8%</td>
<td>$174,300</td>
<td>$42,650</td>
</tr>
<tr>
<td>Mail order pharmacy</td>
<td>0.5%</td>
<td>$25,000</td>
<td>$25,000</td>
</tr>
<tr>
<td>Pharmacy type not specified</td>
<td>3.7%</td>
<td>$27,200</td>
<td>$4,534</td>
</tr>
</tbody>
</table>

### Claims Survey

#### Pharmacy Practice Setting

**Q: At the time of the incident, which best describes your pharmacy practice setting?**

<table>
<thead>
<tr>
<th>Level</th>
<th>Non-claims</th>
<th>Claims</th>
<th>Average total paid (Indemnity plus expense)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community pharmacy</td>
<td>56.6%</td>
<td>67.7%</td>
<td>$8,237,740</td>
</tr>
<tr>
<td>Other</td>
<td>6.1%</td>
<td>7.1%</td>
<td>$8,327,348</td>
</tr>
<tr>
<td>Home infusion pharmacy</td>
<td>14.6%</td>
<td>1.6%</td>
<td>$822,919</td>
</tr>
<tr>
<td>Long term care pharmacy</td>
<td>3.5%</td>
<td>5.1%</td>
<td>$820,487</td>
</tr>
<tr>
<td>Mail order pharmacy</td>
<td>1.8%</td>
<td>5.1%</td>
<td>$3,903</td>
</tr>
<tr>
<td>Hospital/health system</td>
<td>27.8%</td>
<td>4.0%</td>
<td>$3,903</td>
</tr>
<tr>
<td>Home health care pharmacy</td>
<td>0.3%</td>
<td>0.3%</td>
<td>$3,903</td>
</tr>
<tr>
<td>Compounding pharmacy</td>
<td>1.1%</td>
<td>2.0%</td>
<td>$2,205,195</td>
</tr>
<tr>
<td>Practitioner, office-based</td>
<td>1.6%</td>
<td>1.0%</td>
<td>$85,000</td>
</tr>
<tr>
<td>Non-regional pharmacy</td>
<td>1.2%</td>
<td>2.0%</td>
<td>$85,000</td>
</tr>
</tbody>
</table>

### Claims Study

#### Severity by Allegation Category

<table>
<thead>
<tr>
<th>Allegation</th>
<th>Percentage of closed claims</th>
<th>Total paid indemnity</th>
<th>Average paid indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection control error–contamination of drug/container/equipment</td>
<td>0.6%</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Compounding calculation and/or preparation error</td>
<td>3.7%</td>
<td>$2,240,500</td>
<td>$373,417</td>
</tr>
<tr>
<td>Failure to counsel patient</td>
<td>0.2%</td>
<td>$3,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Failure to identify drug allergy</td>
<td>1.9%</td>
<td>$372,500</td>
<td>$124,167</td>
</tr>
<tr>
<td>Failure to identify overdosing</td>
<td>3.1%</td>
<td>$567,399</td>
<td>$113,480</td>
</tr>
<tr>
<td>Wrong strength</td>
<td>0.6%</td>
<td>$79,167</td>
<td>$79,167</td>
</tr>
<tr>
<td>Inappropriate/improper substitution</td>
<td>0.6%</td>
<td>$79,167</td>
<td>$79,167</td>
</tr>
<tr>
<td>Failure to consult with prescribing practitioner for any question/concern</td>
<td>4.9%</td>
<td>$519,241</td>
<td>$64,905</td>
</tr>
<tr>
<td>Wrong drug</td>
<td>43.8%</td>
<td>$4,125,000</td>
<td>$58,167</td>
</tr>
<tr>
<td>Failure to identify drug interactions</td>
<td>0.6%</td>
<td>$79,167</td>
<td>$79,167</td>
</tr>
<tr>
<td>Wrong dose</td>
<td>31.5%</td>
<td>$3,791,807</td>
<td>$74,349</td>
</tr>
<tr>
<td>Inappropriate use of narcotic</td>
<td>0.6%</td>
<td>$79,167</td>
<td>$79,167</td>
</tr>
<tr>
<td>Failure to provide child-resistant cap</td>
<td>0.6%</td>
<td>$15,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>Prescription given to wrong patient</td>
<td>3.1%</td>
<td>$17,500</td>
<td>$3,500</td>
</tr>
</tbody>
</table>

### Claims Survey

#### Pharmacist Demographics–Bar Coding Usage

**Q: Does your pharmacy utilize bar-coding to scan for correct drug products?**

<table>
<thead>
<tr>
<th>Y/N</th>
<th>Non-claims</th>
<th>Claims</th>
<th>Average total paid (Indemnity plus expense)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>76.7%</td>
<td>66.9%</td>
<td>$289,962</td>
</tr>
<tr>
<td>No</td>
<td>23.3%</td>
<td>34.1%</td>
<td>$102,453</td>
</tr>
</tbody>
</table>

### Claims Survey

#### Pharmacist Demographics–Robotic and/or Automation Usage

**Q: Does your pharmacy utilize robotics/automation?**

<table>
<thead>
<tr>
<th>Y/N</th>
<th>Non-claims</th>
<th>Claims</th>
<th>Average total paid (Indemnity plus expense)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>42.1%</td>
<td>32.1%</td>
<td>$94,148</td>
</tr>
<tr>
<td>No</td>
<td>57.9%</td>
<td>67.9%</td>
<td>$38,150</td>
</tr>
</tbody>
</table>
Case Study #2 – Case Summary

- The patient was a 55 year old man who sought treatment at a walk-in clinic with a nurse practitioner.
- The patient was complaining of shortness of breath, fatigue and lower extremity swelling.
- He had a medical history that included asthma, hypercholesterolemia, diabetes and hypertension.
- He was non-compliant with dietary guidelines and medication regimens and both his blood pressure and blood sugar were significantly elevated.
- The NP reviewed the chest x-ray and diagnosed the patient as having acute congestive heart failure.
- She changed the patient’s heart, hypertension and diabetes medications, added a diuretic and ordered baseline blood tests.

Case Study #2 – Case Summary

- Following the NP’s instructions, the patient returned in a week claiming to feel a bit better.
- He remained short of breath, his legs were still swollen, his blood pressure and blood sugar still elevated, but his chest x-ray showed some improvement.
- Even though the lab tests that the NP had ordered after the first visit had not been performed she did not note this in the chart during the patient’s second visit. Nor did she collaborate or consult with a physician regarding any aspect of this patient’s care.
- The NP believed she had corrected the patient’s congestive heart failure and focused on his pulmonary and diabetic status during his second visit.
- Believing the patient had asthma, she discontinued the diuretic and ordered asthma meds instead.

Case Study #2 – Allegations Against the Nurse Practitioner

- The patient’s wife, as representative of the patient’s estate, filed suit against the nurse practitioner.
- The lawsuit alleged that the NP failed to:
  - Obtain an Electrocardiogram
  - Obtain an Echocardiogram
  - Request a Cardiology Consult
  - Perform Appropriate Lab Tests
- Resulting in:
  - Wrongful death
  - Pain and suffering
  - Loss of consortium
  - Medical and funeral expenses
  - Loss of earnings

Case Study #2 – Was the Nurse Practitioner Deemed Negligent?

- Do you think the nurse practitioner was negligent?
- Do you think any other practitioners were negligent?
- Do you think any indemnity and/or expense payment was made on behalf of the nurse practitioner?
- If yes, how much?

Case Study #2 – Expert findings

- No experts could be found to support the NP’s diagnosis or actions.
- Expert review of the chest x-ray and the satisfactory oxygen saturation levels at the patient’s first visit did not support the NP’s diagnosis of congestive heart failure.
- The decision was made to attempt to settle the claim.
### Case Study #2 – Resolution

- The lawsuit was settled without going to trial.
- Indemnity Paid: in excess of $200,000
- Expenses Paid: in excess of $100,000

### Claims Study

#### Most Severe Wrong Drug Closed Claims

<table>
<thead>
<tr>
<th>Drug prescribed</th>
<th>Dose prescribed</th>
<th>Dose dispensed</th>
<th>Resulting injury or adverse effect</th>
<th>Expenses Paid: indemnity</th>
<th>Expenses Paid: expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amaryl*</td>
<td>Coumadin*</td>
<td>$87,500</td>
<td>Gastrointestinal bleeding, requiring hospital treatment</td>
<td>$87,500</td>
<td></td>
</tr>
<tr>
<td>Tarceva*</td>
<td>Tambocor*</td>
<td>$100,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tinzanidine*</td>
<td>Klonapin*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Isosorbide*</td>
<td>Glipizide*</td>
<td>$185,000</td>
<td>Hypoglycemic crisis, resulting in brain damage and ultimately in death</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tegretol*</td>
<td>Theophylline*</td>
<td>$200,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Progesterone*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prednisone*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diamox*</td>
<td>Diabinese*</td>
<td>$275,000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Factors Affecting Wrong Drug Dispensing Errors

<table>
<thead>
<tr>
<th>Factors</th>
<th>Percentage of closed claims</th>
<th>Expenses Paid: indemnity</th>
<th>Expenses Paid: expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to consider patient history/profile/drug therapies</td>
<td>0.6%</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Failure to review prescriptions with patient</td>
<td>0.6%</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Failure to specifically monitor and clarify controlled drug prescriptions</td>
<td>0.6%</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Pharmacy technician acted outside the state-defined scope of practice</td>
<td>0.6%</td>
<td>$6,500</td>
<td>$6,500</td>
</tr>
<tr>
<td>Failure to check drug against label and actual prescription</td>
<td>10.5%</td>
<td>$209,223</td>
<td>$12,307</td>
</tr>
<tr>
<td>Failure to review and check prescription for error/discrepancy/illegibility</td>
<td>2.5%</td>
<td>$68,362</td>
<td>$17,091</td>
</tr>
<tr>
<td>Failure to verify generic equivalency prior to legal substitution</td>
<td>1.9%</td>
<td>$56,000</td>
<td>$18,667</td>
</tr>
<tr>
<td>Failure to separate look-alike drugs using color/separation/tall man letters, etc.</td>
<td>1.2%</td>
<td>$43,250</td>
<td>$21,625</td>
</tr>
<tr>
<td>Failure to specifically monitor and clarify anticoagulant prescriptions</td>
<td>0.6%</td>
<td>$74,188</td>
<td>$74,188</td>
</tr>
<tr>
<td>Failure to question practitioner regarding unusual numbers/amounts of controlled drugs</td>
<td>1.2%</td>
<td>$93,750</td>
<td>$46,875</td>
</tr>
<tr>
<td>Failure to consult with prescribing practitioner to answer questions about an unusual prescription</td>
<td>1.9%</td>
<td>$1,137,500</td>
<td>$379,167</td>
</tr>
<tr>
<td>Failure to provide patient history/profile/drug therapies and make appropriate adjustments</td>
<td>0.6%</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
</tbody>
</table>

### Claims Survey

#### Pharmacist Demographics—Clarifying Drug Substitutions

**Q: Do you clarify with the prescribing practitioner before making substitutions?**

<table>
<thead>
<tr>
<th>Y/N</th>
<th>Non-claims</th>
<th>Claims</th>
<th>Average total paid (indemnity prior settlement)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>52.8%</td>
<td>47.2%</td>
<td>$53,481</td>
</tr>
<tr>
<td>No</td>
<td>7.3%</td>
<td>92.7%</td>
<td>$172,512</td>
</tr>
</tbody>
</table>

### Case Study #2 – Risk Control Recommendations

- Understand and maintain the scope and standard of care that applies to the relevant setting.
- Refer unstable and acutely ill patients to emergency services.
- Discuss the patient’s condition, medication, and care needs with the physician or a collaborating or supervising physician.
- Consult with a pharmacist (as needed) regarding multiple long-term medications prior to making significant changes.
- Perform appropriate diagnostic tests to determine the cause or causes of a patient’s multi-symptom presentation.
- Obtain, review, and document the results of ordered diagnostic tests.
- Refer the patient to his primary care practitioner for ongoing care.
- Document all patient-related discussions.
Claims Study

### Highest Severity by Drug-related Injury/Illness/Adverse Outcome

<table>
<thead>
<tr>
<th>Injury</th>
<th>Percentage of closed claims (%)</th>
<th>Total paid indemnity ($1,000,000)</th>
<th>Average paid indemnity ($1,000,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fetal/infant birth-related brain damage</td>
<td>0.6</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Brain injury other than birth-related brain injury</td>
<td>2.5</td>
<td>$1,250,000</td>
<td>$500,000</td>
</tr>
<tr>
<td>Multisystem failure</td>
<td>1.2</td>
<td>$500,000</td>
<td>$500,000</td>
</tr>
<tr>
<td>Respiratory arrest</td>
<td>1.9</td>
<td>$610,500</td>
<td>$310,314</td>
</tr>
<tr>
<td>Death *</td>
<td>11.7</td>
<td>$1,144,461</td>
<td>$220,236</td>
</tr>
<tr>
<td>Loss of organ or organ function</td>
<td>1.2</td>
<td>$172,920</td>
<td>$143,268</td>
</tr>
<tr>
<td>Nonsurvival failure</td>
<td>1.9</td>
<td>$200,000</td>
<td>$100,000</td>
</tr>
<tr>
<td>Eye injury/vision loss</td>
<td>1.9</td>
<td>$231,821</td>
<td>$123,418</td>
</tr>
<tr>
<td>Overall</td>
<td>100.0</td>
<td>$16,122,154</td>
<td>$87,174</td>
</tr>
</tbody>
</table>

### Severity by Cause of Death for Closed Claims with Injury of Death

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>Percentage of death closed claims (%)</th>
<th>Total paid indemnity ($1,000,000)</th>
<th>Average paid indemnity ($1,000,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>10.9</td>
<td>$1,000,000</td>
<td>$909,091</td>
</tr>
<tr>
<td>Overdose</td>
<td>57.9</td>
<td>$2,052,825</td>
<td>$350,257</td>
</tr>
<tr>
<td>Sepsis</td>
<td>6.3</td>
<td>$185,000</td>
<td>$185,000</td>
</tr>
<tr>
<td>Allergic reaction/anaphylaxis</td>
<td>10.5</td>
<td>$200,000</td>
<td>$200,000</td>
</tr>
<tr>
<td>Loss of organ or organ function</td>
<td>5.3</td>
<td>$95,000</td>
<td>$95,000</td>
</tr>
<tr>
<td>Inflammation or inflammatory response</td>
<td>5.3</td>
<td>$95,000</td>
<td>$95,000</td>
</tr>
<tr>
<td>Overall</td>
<td>100.0</td>
<td>$4,184,491</td>
<td>$220,236</td>
</tr>
</tbody>
</table>

### Pharmacist Self-assessment Checklist

Part I: Understanding Pharmacist Liability also includes a Pharmacist Self-assessment Checklist with claim tips

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### Sample Professional Liability Premiums for Select Healthcare Professionals

<table>
<thead>
<tr>
<th>Occurrence/Claims Made</th>
<th>Self-Employed/Claims Made</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>Claims Made</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>$147</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>$1,521</td>
</tr>
<tr>
<td>Physician Assistants</td>
<td>$4,222</td>
</tr>
<tr>
<td>Nurse (Vac/wild)</td>
<td>$100</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>$100</td>
</tr>
<tr>
<td>Dental</td>
<td>$2,054</td>
</tr>
</tbody>
</table>

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### Self-Assessment Question #1

Provider status success at the federal, state and/or private sector levels will:

- a. Better integrate the pharmacist into the patient’s health care team and help improve patient outcomes
- b. Increase opportunities for pharmacists to contribute to more efficient and coordinated delivery of care
- c. Increase patient access to health care and pharmacists’ opportunities to provide more patient care services
- d. All of the above
Self Test Assessment Question #2

Washington State ESSB 5557:
  a. Changes pharmacists’ scope of practice
  b. Requires health carriers to cover all services provided by pharmacists in their participating provider networks
  c. Requires pharmacists to be treated similar to other providers
  d. All of the above

Self Test Assessment Question #3

The claims study identified two allegations that were both the most frequent and the most severe. These are:
  a. Failure to identify drug allergy and Wrong drug
  b. Wrong dose and Failure to counsel patient
  c. Wrong dose and Wrong Drug
  d. Compounding calculation and Wrong Strength

Questions?