TREATING DANGEROUS PATIENTS & CLOSING A PRACTICE

Psychiatric Society of Westchester County
January 27, 2021

Charles D. Cash, JD, LLM
Associate Director of Risk Management
Professional Risk Management Services (PRMS)

CME DISCLOSURE

I have no financial relationships with any commercial interest

DISCLAIMER

Nothing I say today is legal advice.

Donna Vanderpool, MBA, JD, contributed to a chapter in Gun Violence and Mental Illness (APPI, 2015).

PRMS funded the initial distribution of the SAFE-T cards to residency programs years ago.

OBJECTIVES

At the conclusion of this program, attendees will be able to:

- Explain the importance of documentation of initial and ongoing risk assessments
- Evaluate when to communicate with the family of a patient with suicidal behavior, even if the patient did not give consent for such communication
- Explain the standard of care factors that will be assessed in a medical malpractice lawsuit involving patient suicide
- Recognize online activity and its potential impact on patients
- Implement at least one strategy to minimize risks inherent in treating dangerous patients

OBJECTIVES

At the conclusion of this program, attendees will be able to (*cont'd*):

- Explain the importance of knowing the legal standard of "duty to warn" in the state(s) where he/she practices
- Recognize when to withdraw from care while protecting patient safety and minimizing liability
- Identify steps necessary to close their medical practices upon retirement
- Describe the appropriate procedure for terminating the physician-patient relationship

RESOURCES

www.prms.com/RMtalks

www.prms.com/faq

DANGEROUS PATIENTS

PATIENTS AT RISK FOR SUICIDE

Cannot predict suicide

but

risk of suicide may be foreseeable

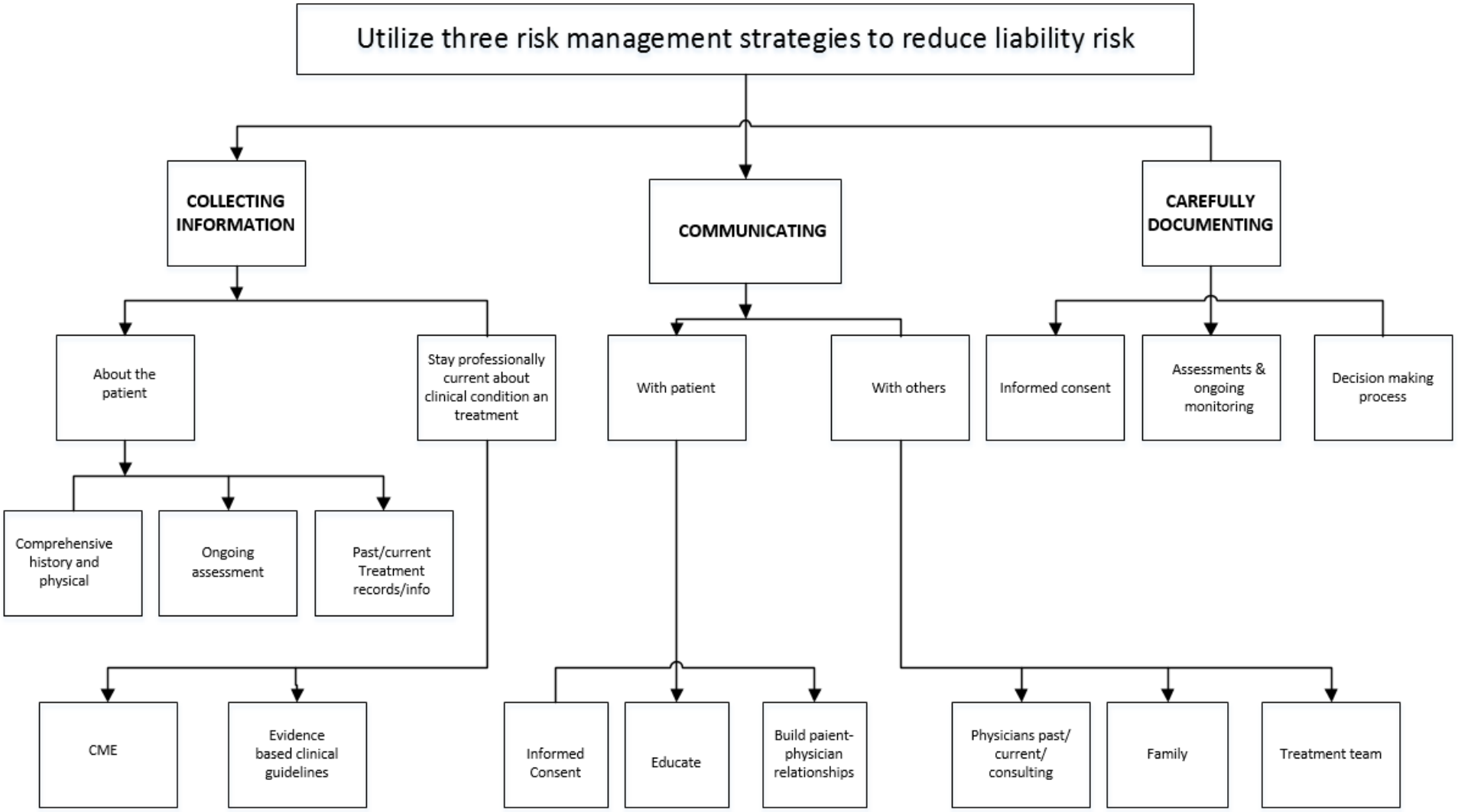
STANDARD OF CARE – SUICIDE CASES

* Suicide risk is identified and treated appropriately *

Standard of care factors:

- Whether there was adequate identification and evaluation of suicide risk indicators and protective factors for the patient with suicidal behaviors
- Whether a reasonable treatment plan was developed based on the assessment of the patient's clinical needs
- Whether the treatment plan was appropriately implemented and modified based on an ongoing assessment of the patient's clinical status
- Whether the provider was professionally current regarding the assessment and treatment of patients with suicidal behaviors
- Whether documentation was adequate to support that appropriate care was provided in terms of the assessment, treatment, and ongoing monitoring of the patient

3 Cs of RISK MANAGEMENT



COLLECTING INFORMATION *ABOUT THE PATIENT*

- Assess patients at significant points in treatment
- Assessment is ongoing
  - Consider the possibility of comorbid conditions
    - Substance use
    - Medical conditions
- Try to get prior records; if can't, document attempts
- Obtain collateral information from family and significant others
- Inquire about access to weapons
- Consistently utilize specific, reputable suicide assessment and treatment methodology/resource

ASSESSING RISK

- No one can predict future dangerous behavior with absolute certainty
- Approaches to risk assessment:
  - **Actuarial**
    - Uses information derived from group data instead of an individualized assessment of dangerousness
  - **Clinical**
    - Individualized assessment based solely on psychiatrists' intuition, experience, and clinical orientation
  - **Structural clinical judgment (preferred)**
    - Psychiatrist uses a list of empirically validated risk factors known to be associated with violence
    - Psychiatrist uses clinical judgment to weigh importance of risk factors

(Phillips, 2012)

ASSESSING RISK

- You have to ask about access to firearms
  - APA Guidelines: because of the increased risk, mental health providers should routinely ask patients about suicidal thoughts, intents, or plans, including this question:
    - "Do you have any guns or weapons available to you?"
  - "Evidence indicates that the presence of firearms in the home is a risk factor for suicide"
  - "Miller and Hemmenway suggested that the availability of firearms increases the risk of suicide for three reasons:
    - Many suicidal acts are impulsive
    - Many suicide crises are self-limiting
    - And guns are common in the US and lethal
  - They contend 'restriction of access to lethal means is one of the few suicide prevention policies with proven effectiveness'"

(Cook et al, 2012)

CRITICAL COMPONENTS – SUICIDE RISK ASSESSMENT

- Identify risk factors
  - Note those that can be modified
- Identify protective factors
- Inquire as to the patient's suicidal ideation, intent, plan
- Document the assessment
- Use the information gathered to determine the risk level and treatment plan

COMMON PITFALLS – SUICIDE RISK ASSESSMENT

- No assessment
- Delegating risk assessment
- Documenting assessment
- “Gut” assessments
- Risk assessment forms
- “No harm contract”

(Simon, 2011)

COMMON PITFALLS – SUICIDE RISK ASSESSMENT

- Assuming self report is accurate
- Using black and white thinking

(Nau, 2014)

COLLECTING INFORMATION
STAYING PROFESSIONALLY CURRENT

- Know the criteria for involuntary hospitalization
- Be familiar with reputable treatment guidelines
  - Document reasons for deviating

COMMUNICATING

- Do not rely solely on “no harm contracts”
  - No legal force
  - But … may be one part of a comprehensive treatment plan
- Consider discussing patient internet activities
- Risk reduction planning should be completed with patient involved
- Educate patient on services available

COMMUNICATING

- Communicate with other healthcare professionals
  - Do not hesitate to seek consultation or second opinion
  - Other treating providers, covering providers

- Communicate with family and significant others
  - Involve and educate
  - Stress responsibility
  - Access to weapons

COMMUNICATING

- Remember: patient safety is *exception* to confidentiality

- Consider alerting family members / significant others to risk of suicide without patient authorization when:
  - The risk is significant
  - They do not seem to be aware of the risk
  - They might contribute to patient's safety

DOCUMENTING

Sample suicide risk assessment note

- Suicide risk factors identified and weighed (low, moderate, high)
    - *Identify modifiable factors*
- Protective factors identified and weighed (low, moderate, high)
- Overall assessment rated (low, moderate, high, or range)
- Treatment and management intervention informed by the assessment
- Effectiveness of interventions evaluated

(Simon and Hales, 2006)

DOCUMENTING

Critical junctures for documentation:

- At first psychiatric assessment or admission
- With occurrence of any suicidal behavior or ideation
- Whenever there is any noteworthy clinical change
- For inpatients, before increasing privileges or giving passes and before discharge

PATIENTS AT RISK FOR VIOLENCE

Alleged negligence in:

- Assessing potential for violence
- Executing proper treatment plan to prevent/reduce risk to patient and others
- Properly warning potential victims
- Complaints to licensing board related to patient's behavior

CRITICAL COMPONENTS – VIOLENCE RISK ASSESSMENT

- Identify risk factors
- Assess overall risk of violence based on risk factors
- Document the assessment
- Use the information gathered to determine the risk level, treatment plan, and preventative interventions

APA PRACTICE GUIDELINES FOR THE PSYCHIATRIC EVALUATION OF ADULTS

ASSESSMENT OF RISK FOR AGGRESSIVE BEHAVIORS

Statement 1: contents of initial psychiatric evaluation

Statement 2: contents to include if aggressive ideas are reported

Statement 3: document estimation of patient's aggressive behavior risk

(APA, 2016)

VIOLENCE RISK FACTORS

Past history
Prior violence
Prior arrest
Young age at time of first arrest
Drug and/or alcohol abuse
Cruelty to animals and people
Fire setting
Risk taking
Behavior suggesting loss of control or impulsivity
Lack of concern over consequences of or violent acts

Present circumstances and mental state
Male under 40
Noncompliance with treatment
Access to weapons
Role of significant other and/or caretaker
Sees self as victim
Lack of compassion/empathy
Intention to harm

(APA, 2011)

VIOLENCE RISK ASSESSMENT

"The most common mistake made by clinicians is to base a violence risk assessment on insufficient information"

- Ask about violence

(Simon, 2001)

ASSESSING VIOLENCE RISK

Options:

- Look for the presence of factors associated with violence
- Combine your understanding of the patient's personality, symptoms, and environment with your understanding of the likely causes of violence
- Structured professional judgment
    - Ex: HCR-20

(APA, 2011)

ASSESSING VIOLENCE RISK - SPJ

Structured Professional Judgment:

- HCR-20: Most widely used and researched violence risk assessment approach using SPJ model
- Key considerations:
  - No single structured violence risk assessment is always best
  - All structured violence risk assessment approaches have limitations
  - The value lies in prevention, not prediction of violence

(Gold and Simon, 2015)

PRINCIPLES OF RISK AND RISK ASSESSMENT

- “Clinicians must be aware of the possibility of risks at multiple junctures in their patient’s life
- Critical appraisal of essential information plays an important role in influencing clinical (and legal) decision making about a person’s “dangerousness”
- Risk assessments should be carried out under circumstances that are comfortable to both client and assessor (who must ensure the safety and security of all involved in the process)
- Assessors should have a working familiarity with the literature on violence risk assessment and management as well as its limitations
- A thorough history is essential for the completion of risk assessments
- Although actuarial information is not often available to psychiatrists who practice outside mental hospitals and prisons, it should not be ignored if it has been properly consolidated”

(Webster et al, 2009)

PRINCIPLES OF RISK AND RISK ASSESSMENT

- “Structured professional judgment scales may assist in the assessment
- Client strengths are important in creating plans for risk management
- Risk of violence against others usually provides a focus for assessment, but there are other interrelated issues that may need to be taken into account
- Signature risk signs should be documented
- All propensity for violence is not entirely inherent within the individual; rather, circumstances and situational effects also exert powerful influences
- It is often vital and reassuring to obtain a second opinion from a trusted and experienced colleague”

(Webster et al, 2009)

PATIENTS AT RISK FOR VIOLENCE

- Be candid about confidentiality
- Commit if necessary
- Warn where appropriate

DOCUMENTING

Sample violence risk assessment note

- Risk factors identified and weighed (low, moderate, high)
    - Including collateral source info
- Protective factors identified and weighed (low, moderate, high)
- Overall assessment rated (low, moderate, high, or range)
- Treatment and management intervention informed by the assessment
- Effectiveness of interventions evaluated

(Adapted from Simon and Hales, 2006)

COMMON PITFALLS – VIOLENCE RISK ASSESSMENT

- Overgeneralizations
- Ignoring context
- Failing to get collateral information
- Inadequate communication of risk to police and potential victims

(Nau, 2014)

The School Shooter: A Quick Reference Guide

BAU-1 (703) 632-4333

REMEMBER

- There is not a "profile" of a school shooter-instead the students who carried out the attacks differed from one another in numerous ways.
- School shootings are rarely impulsive acts.
- They are typically thought out and planned in advance.
- Prior to most school shootings other students knew the shooting was going to occur but failed to notify an adult.
- Very few of the attackers ever directed threats to their targets before the attack.
- The most common goal was retribution. The justifications and excuses offered indicated this stemmed not from an absence of values but from a well-developed value system in which violence was acceptable.
- In many cases, other students were involved in the attack in some capacity.
- Many offenders experienced a significant personal loss in the months leading up to the attack, such as a death, breakup, or divorce in the family.
- Many offenders engaged in repetitive viewing of violent media and were often fascinated with previous school shootings. Repeated viewing of movies depicting school shootings, such as "Zero Day" and "Elephant," may indicate a fascination with campus attacks.
- Be aware of the subject's online videos, blogs, and social networking activities.

Motives

- 24% motivated by desire for attention or recognition.
- 27% motivated by suicide or desperation.
- 34% motivated by attempt to solve a problem.
- 54% had multiple motives.
- 61% motivated by desire for revenge.
- 75% felt bullied/persecuted/threatened by others.

Statistics

- 27% of attackers exhibited interest in violent movies.
- 37% of attackers exhibited interest in violence in their own writings, poems, essays, and journal entries.
- 59% of attacks occurred during the school day.
- 63% of attackers had a known history of weapons use.
- 68% acquired the weapon used from their own home or that of a relative.
- 93% of attackers engaged in some behavior prior to the attack that caused others to be concerned.
- 93% of attackers planned out the attack in advance.
- 95% of attackers were current students.
- Odds are one in 1 million that a student will die at school as a result of a violent act.

Warning Signs

- Investigators should probe to discover if the subject has engaged in research, planning, or preparation (e.g.,

Preventing School Shootings

A Summary of a U.S. Secret Service Safe School Initiative Report




Photo sources: AP Photo Archive, Rockdale Citizen, Ralph Wilson, and PhotoDisc

THE FINAL REPORT AND FINDINGS OF THE *SAFE SCHOOL INITIATIVE:*

IMPLICATIONS FOR THE PREVENTION OF SCHOOL ATTACKS IN THE UNITED STATES

UNITED STATES SECRET SERVICE AND
UNITED STATES DEPARTMENT OF EDUCATION

WASHINGTON, D. C.
July 2004

ASSESSING RISK FOR GUN OWNERSHIP

- Patient may need clearance to carry concealed weapon
- Patient may need clearance to have gun rights restored
  - Ex: federal law prohibits individuals who have been involuntarily committed (IP) to own firearms
    - Individual can petition to have "relief from disability"
      - "disability" = inability to own firearms
- Physicians are uncomfortable certifying a patient is cleared for gun ownership
  - Study (Pierson et al, 2014): The majority of physicians felt they could not assess their patient's physical capability to carry concealed weapons, and a sizable minority did not feel comfortable assessing mental capacity to carry concealed weapons

PRINCIPLES OF RISK ASSESSMENT IN RELIEF FROM DISABILITY EVALUATIONS

- Identification of the risk
- Specification of context
- Specification of outcome
- Identification of the population
- Identification of risk factors and protective factors
- Individualization of assessment
- Formulation of risk assessment
- Communication of risk

(Gold and Simon, 2015; adapted from Heilbrun 2009)

TAKE AWAY POINTS

- Psychiatrists are not responsible for perfectly predicting patient behavior when working with patients at risk of suicide and violence
- Psychiatrists are expected to meet the standard of care
- The best risk management strategy = good clinical judgment
  - Weight the pros and cons, then choose what you believe is the best course of action

UNEXPECTED CLOSURE OF YOUR PRACTICE

CALLS TO RISK MANAGEMENT

- I’m planning to retire in the next year or so, I’d like some information on closing my practice.
- Another psychiatrist in town with whom I share call has had a stroke and cannot work.
- A psychiatrist with whom I share space has just been arrested.
- I have some urgent health concerns and need to shut down my practice.

CALLS TO RISK MANAGEMENT

- My husband just died and I don’t know what to do.

"When he died, I was forced to handle closing his practice. My mother had mostly been kept in the dark about my father's medical practice and his financial affairs but, at her age, even if she were in the know, it would have been difficult for her. It was difficult for me, and I'm a financial professional, an estate planning attorney."

Jan Copley

Closing My Father's Medical Practice: Lessons Learned

IN AN EMERGENCY

Does your staff know:

- All of your contact info?
- Contact info of spouse, significant others?
- Under what circumstances to reach out?
- How long to wait to do so?

IN AN EMERGENCY

Does someone know:

- Where to find your office key?
- Where to find your voicemail password?
- How to login to your computer?
- How to access your appointment schedule?
- How to access patient records?
- What should patients be told?
- What to put on outgoing message?

IN AN EMERGENCY

Who is in charge?

- Office manager?
- Covering psychiatrist?
- Spouse?
- Significant other?
- Family member?
- Personal attorney?

FAILING TO PLAN, IS PLANNING TO FAIL

Developing an “Advance Directive” for your practice

CREATING AN ADVANCE DIRECTIVE

Initial Steps:

- Ensure staff and significant others have contact info
- Develop written plan
  - Decide who will be in charge
    - Inform others
  - Provide access instructions
  - Colleague(s) who can assist in emergency
  - Others to call for advice – malpractice carrier, attorney, etc.

CREATING AN ADVANCE DIRECTIVE

The plan should address:

- Patient notification
  - Scheduled patients
  - Message on outgoing voicemail
    - Who is covering
    - How to obtain refills
  - Sign on door
  - Death notice for newspaper
  - Letter to active patients*
    - Maintain list with contact info
    - Who is covering
    - How to get records

ACTIVE PATIENTS

- Varies by state
- Clarify status now
- List of terminated patients

CREATING AN ADVANCE DIRECTIVE

Patient Records

- Staff should be trained regarding appropriate record release, retention, etc.
- If no staff, plan should direct person in charge to malpractice carrier for advice.
- Plan should include location of any off-sight storage
- Plan should include list of all patients seen in practice

MEDICAL RECORDS

AMA Ethics Opinion 3.3.1: Management of Medical Records

"In keeping with the professional responsibility to safeguard the confidentiality of patients' personal information, physicians have an ethical obligation to manage medical records appropriately.

This obligation encompasses not only managing the records of current patients, but also retaining old records against possible future need, and providing copies or transferring records to a third party as requested by the patient or the patient's authorized representative, when the physician leaves a practice, sells his or her practice, retires, or dies."

CREATING AN ADVANCE DIRECTIVE

Plan should include list of others to notify with contact info:

- Other providers with whom you share patients
- Other employment
- Hospitals
- Third Party Payers
- State PMP
- DEA – federal and state
  - certificate number

CREATING AN ADVANCE DIRECTIVE

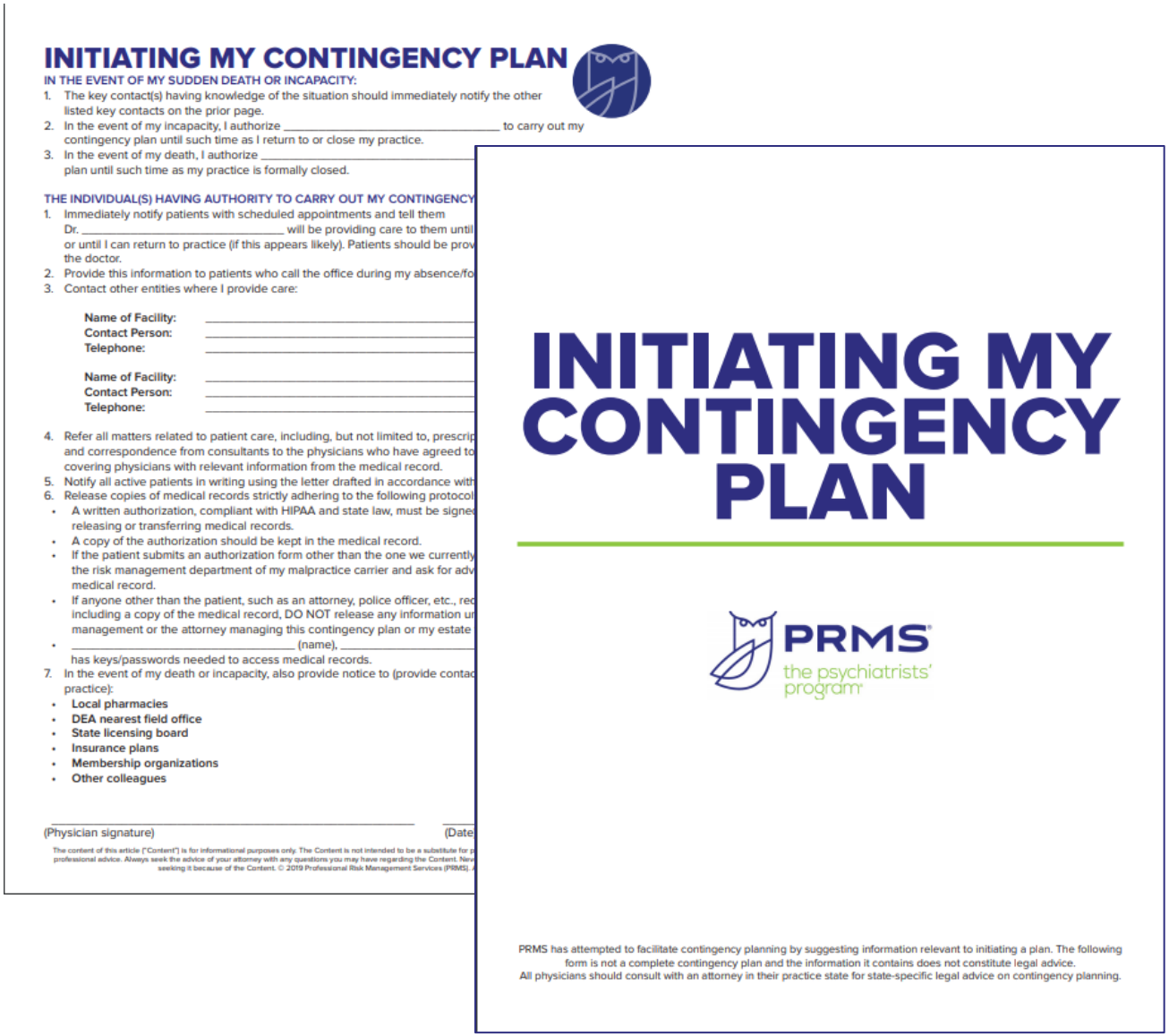
- Local pharmacies
- Medical Board
  - license number
- Landlord
- Utility companies
- Phone service
- Internet provider
- EHR/e-prescribing vendor

CREATING AN ADVANCE DIRECTIVE

- Insurance carriers
- Billing service
- Business bank accounts
- Professional associations

CREATING AN ADVANCE DIRECTIVE

- Periodically review plan and update as needed
- Use as a template for closure upon retirement
- Safe but accessible



INITIATING MY CONTINGENCY PLAN

IN THE EVENT OF MY SUDDEN DEATH OR INCAPACITY:

1. The key contact(s) having knowledge of the situation should immediately notify the other listed key contacts on the prior page.
2. In the event of my incapacity, I authorize _____ to carry out my contingency plan until such time as I return to or close my practice.
3. In the event of my death, I authorize _____ plan until such time as my practice is formally closed.

THE INDIVIDUAL(S) HAVING AUTHORITY TO CARRY OUT MY CONTINGENCY

1. Immediately notify patients with scheduled appointments and tell them Dr. _____ will be providing care to them until or until I can return to practice (if this appears likely). Patients should be prov the doctor.
2. Provide this information to patients who call the office during my absence/fo
3. Contact other entities where I provide care:

Name of Facility: _____
Contact Person: _____
Telephone: _____

Name of Facility: _____
Contact Person: _____
Telephone: _____

4. Refer all matters related to patient care, including, but not limited to, prescrip and correspondence from consultants to the physicians who have agreed to covering physicians with relevant information from the medical record.
5. Notify all active patients in writing using the letter drafted in accordance with
6. Release copies of medical records strictly adhering to the following protocol
   - A written authorization, compliant with HIPAA and state law, must be signe releasing or transferring medical records.
   - A copy of the authorization should be kept in the medical record.
   - If the patient submits an authorization form other than the one we currently the risk management department of my malpractice carrier and ask for adv medical record.
   - If anyone other than the patient, such as an attorney, police officer, etc., re including a copy of the medical record, DO NOT release any information u management or the attorney managing this contingency plan or my estate
   - _____ (name), _____ has keys/passwords needed to access medical records.
7. In the event of my death or incapacity, also provide notice to (provide contac practice):
   - **Local pharmacies**
   - **DEA nearest field office**
   - **State licensing board**
   - **Insurance plans**
   - **Membership organizations**
   - **Other colleagues**

_____ _____
(Physician signature) (Date)

INITIATING MY CONTINGENCY PLAN

PRMS the psychiatrists' program

PRMS has attempted to facilitate contingency planning by suggesting information relevant to initiating a plan. The following form is not a complete contingency plan and the information it contains does not constitute legal advice.
All physicians should consult with an attorney in their practice state for state-specific legal advice on contingency planning.

www.prms.com/media/2497/contingency-planning-tool_2020-v2.pdf

PRACTICE CLOSURE UPON RETIREMENT

BEGIN THE COUNTDOWN

- Determine practice closure date
  - Ideally 12 months or more away
- Consult with advisors
  - Business attorney
  - Accountant
  - Malpractice carrier
- Limit/stop acceptance of new patients
- Determine status of patients*
  - Send letters as appropriate

BEGIN THE COUNTDOWN

- Review contracts
  - Lease
  - Employment
  - Vendors
    - EHR/E-prescribing
  - Managed Care
  - Malpractice Insurance
    - How long should you keep?
    - Tail coverage?

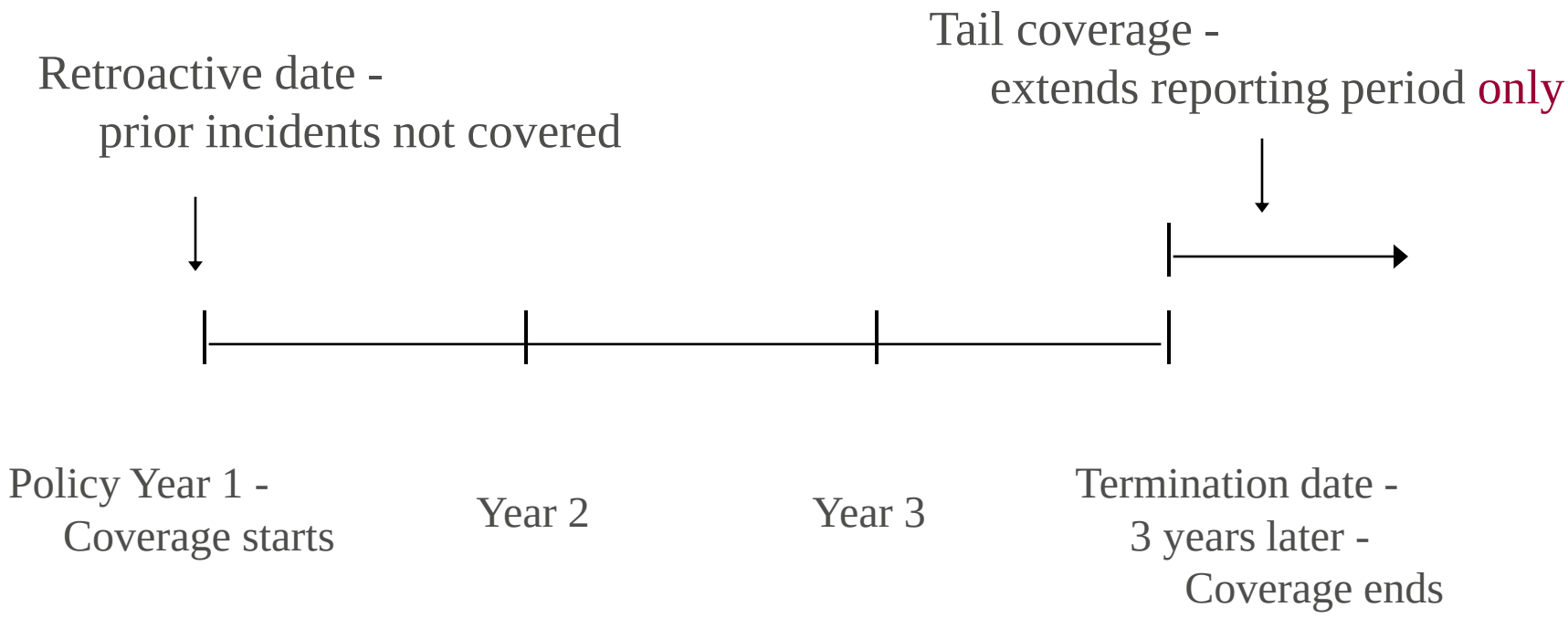
MALPRACTICE INSURANCE

Type of policy

- Occurrence
  - Covers claims arising from events that **occur** during policy period

- Claims-made
  - Covers claims **reported** during policy period arising from events that occur during policy period

EXTENDED CLAIM REPORTING ENDORSEMENT – TAIL COVERAGE



BEGIN THE COUNTDOWN

- Notify staff
  - Prior to notifying patients
  - Prepare to hire temps
  - Consult business attorney re: compensation issues, e.g., payment for unused leave, etc.
- Notify NPs and PAs you supervise/collaborate with

MEDICAL RECORDS

- Get a handle on medical records
  - Destroy per policies and procedures
    - Shred, incinerate
  - Maintain log
    - Patient name
      - DOB, patient number
    - Dates covered
    - How destroyed
      - Person or company
    - Date
    - Witness

MEDICAL RECORDS

- Explore storage options
  - Document storage facility
  - Psychiatrist's home
  - Other custodian
- Must ensure:
  - Privacy
  - Safety – theft, damage
  - Accessibility

MEDICAL RECORDS

- Document storage facility
  - Medical records experience
  - Contract
    - Destruction for non-payment
    - Timely access
  - BAA or confidentiality agreement

HIPAA for Professionals
Privacy +
Security +
Breach Notification +
Compliance & Enforcement –
Enforcement Rule
Enforcement Process
Enforcement Data
Resolution Agreements

No Business Associate Agreement? $31K Mistake – April 20, 2017

The Center for Children's Digestive Health (CCDH) has paid the U.S. Department of Health and Human Services (HHS) $31,000 to settle potential violations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule and agreed to implement a corrective action plan. CCDH is a small, for-profit health care provider with a pediatric subspecialty practice that operates its practice in seven clinic locations in Illinois.

In August 2015, the HHS Office for Civil Rights (OCR) initiated a compliance review of the Center for Children's Digestive Health (CCDH) following an initiation of an investigation of a business associate, FileFax, Inc., which stored records containing protected health information (PHI) for CCDH. While CCDH began disclosing PHI to Filefax in 2003, neither party could produce a signed Business Associate Agreement (BAA) prior to Oct. 12, 2015.

MEDICAL RECORDS

- Psychiatrist's home
  - Secure storage
    - Privacy
    - Safety -fire/flood proof
  - Responsible for honoring requests
  - May destroy when meet retention requirement
    - Maintain log
  - May scan and destroy paper

MEDICAL RECORDS

- Other custodian
  - Written agreement
    - Maintain privacy/safety
    - Allow access
    - Patient record requests
    - Follow retention period
    - Destruction
    - Commingling
    - Notification of change of address
  - Maintain log

MEDICAL RECORDS

- EHRs
  - Consult vendor contract
    - Hard copies
    - Cloud-based storage
    - Mixed records
    - Maintain software?
  - Destroy per NIST
- Computers
- Copiers???

HIPAA for Professionals

Privacy +

Security +

Breach Notification +

Compliance & Enforcement −

Enforcement Rule

Enforcement Process

Enforcement Data

Resolution Agreements

Case Examples

Audit

Reports to Congress

State Attorneys General

HHS Settles with Health Plan in Photocopier Breach Case

Under a settlement with the U.S. Department of Health and Human Services (HHS), Affinity Health Plan, Inc. will settle potential violations of the HIPAA Privacy and Security Rules for $1,215,780. OCR's investigation indicated that Affinity impermissibly disclosed the protected health information of up to 344,579 individuals when it returned multiple photocopiers to a leasing agent without erasing the data contained on the copier hard drives. In addition, the investigation revealed that Affinity failed to incorporate the electronic protected health information stored in copier's hard drives in its analysis of risks and vulnerabilities as required by the Security Rule, and failed to implement policies and procedures when returning the hard drives to its leasing agents.

- Read the Resolution Agreement - PDF
- For Information on OCR's Enforcement Activities
- Read the Press Release
- To File a Health Information Privacy or Security Complaint
- View the Federal Trade Commission's guidance on safeguarding sensitive data stored in the hard drives of digital copiers
- The National Institute of Standards and Technology has issued guidance on assessing the security of multipurpose office machines - PDF

OKLAHOMA BOARD OF MEDICINE

Closing or Relocating the Physician's Office:

"Whenever a medical office is closing and it has patient health information stored on its computers, it is recommended that the hard drives be removed from the machines and physically destroyed. Computer technicians say that erasing a hard drive does not remove the information stored on it and it is possible to recover much of the data. The only way to prevent this is to break-up the disks in the hard drive. (National security experts say that a used computer should never be sold, given away, or thrown away with its hard drive intact.)"

PATIENT NOTIFICATION

- Whom?
- When?
- How?
- What?

PATIENT NOTIFICATION

Whom?

- “Active” patients
- Former patients?

PATIENT NOTIFICATION

Overview of State Licensing Board Requirements

- **Which patients to notify of practice closure?**
  - "Active" patients must be notified sufficiently in advance of practice closure to ensure minimal disruption to the continuity of care
    - State examples of "active"
      - Seen in last 6 months: NJ
      - Seen within past 2 years: IN, TX, VA
      - Seen within past 3 years: NM
      - Other: TN – Seen within 3 years, unless patient has visited fewer than two times within the past 18 months

PATIENT NOTIFICATION

Overview of State Licensing Board Requirements

- **When to notify?**
  - States vary
    - 3 months prior to closure (preferred)
    - 90 days prior to closure
    - 30 days prior to closure
  - *Knowing your jurisdiction's requirement is vital to avoiding a patient abandonment claims*

PATIENT NOTIFICATION

Overview of State Licensing Board Requirements

- **How to notify?**
  - Letter
  - Newspaper announcement
    - Requirements vary; can be very specific
  - Electronic communication
  - Sign (to supplement, not replace, actual notice to patients)

PATIENT NOTIFICATION

What should you send?

- Notice of practice closure?
- Termination letter?

AMA Ethics Opinion 1.1.5: Terminating a Patient-Physician Relationship

Physicians' fiduciary responsibility to patients entails an obligation to support continuity of care for their patients. At the beginning of patient-physician relationship, the physician should alert the patient to any foreseeable impediments to continuity of care. When considering withdrawing from a case, physicians must : (a) Notify the patient (or authorized decision maker) long enough in advance to permit the patient to secure another physician. (b) Facilitate transfer of care when appropriate.

TERMINATING TREATMENT

- Send/distribute letter to all active patients
  - Clear statement of termination
  - Recommendations for further care
  - Referrals
    - General vs. specific
  - Definite closure date
  - How to obtain records

PATIENT NOTIFICATION

Risk management advice:

- Comply with state law!
- Give 3 months notice
  - Prepare patients for transition
  - Speak with shared treatment providers
- Post sign in waiting area
- Notification on practice website
- Newspapers?

TERMINATING TREATMENT

- Terminate or transfer?
- Do not prescribe beyond closure date
- Use caution with continued contact

CLOSING THE OFFICE

- Arrange to have mail forwarded for 6-12 months
- Outgoing voicemail message for 6-12 months
- Update profile on state licensing board site
- LinkedIn/social media profile
- Discuss licensure status with medical board

CLOSING THE OFFICE

- Medication disposal
- Prescription pads
- Letterhead
- Licenses and diplomas

DON'T FORGET TO NOTIFY

- DEA
- Local DEA
- PMP
- 3rd party payers
- Professional societies

DOCUMENT

- Keep copies of all letters and emails related to your practice closure – particularly those involving required notices.
- Lists of letter recipients
- Newspaper announcements
- Etc.

RESOURCES

www.prms.com/RMtalks