OPPA VIRTUAL SUMMER CONFERENCE

Professional Risk Management Services (PRMS)

Oregon Psychiatric Physicians Association
August 1, 2020

CME DISCLOSURES

Ms. McNary has no relevant financial relationships with any commercial interest.

Mr. Pope has no relevant financial relationships with any commercial interest.

Ms. Vanderpool has no relevant financial relationships with any commercial interest.

Mr. Cash has no relevant financial relationships with any commercial interest.

TO CLAIM YOUR CME CREDITS

At the completion of this course, you will need to submit the CREDIT APPLICATION and EVALUATION online at:

www.surveymonkey.com/r/HCXJHD5

If you would prefer to request and submit these forms by email, you can send the request to seminars@prms.com

HANDOUTS

www.prms.com/RMtalks

AGENDA

- Geriatric Psychiatry
- Minors – Psychopharmacology and Other Treatment Issues
- Psychopharmacology
- What Would You Do?

GERIATRIC PSYCHIATRY

Ann McNary, JD
Senior Risk Manager
Professional Risk Management Services (PRMS)

OBJECTIVES

- Identify potential barriers to obtaining informed consent when treating elderly patients and utilize strategies to overcome these barriers
- Recognize signs of abuse and neglect in elderly patients

WHAT WE'LL COVER

- Communication
- Capacity
- Prescribing
- Abuse and Neglect
- Suicide Risk
- Driving Issues
- Managing Risk

COMMUNICATION

Be prepared to navigate around communication barriers and involve others in treatment

COMMUNICATION

Communication barriers

- Vision/hearing deficiencies
- Lower health literacy
- Fear of resulting lifestyle changes
- Stoicism
- Reduced cognitive ability / lack of capacity

COMMUNICATION

Risk Management Advice

- Try to involve family
- Educate caregivers
  - Condition
  - Medication
  - Side-effects
- Other providers
- Safety trumps confidentiality
- You can always listen

COMMUNICATION

Consider small changes to enhance comfort

- Space for walkers/wheelchairs
- Consider seating
- Utilize low-glare lighting
- Use 14 point readable font
- Avoid placing chairs in draft

CAPACITY

Recognize that an elderly patient's capacity to give informed consent to treatment may be impaired

CAPACITY

Capacity = ability to:

- Communicate a choice
- Understand relevant information
- Appreciate medical consequences
- Reason about treatment choices

(Assessment of Patients' Competence to Consent to Treatment. N Engl J Med 2007; 357:1834-1840)

CAPACITY

- Fluid concept
- Different requirements for different decisions
- Try to identify and reduce factors that may diminish capacity

CAPACITY

Two ways to assess:

- Formal assessment tool
- Clinical interview – determining patient's ability to:
  - Understand proposed treatment and treatment alternatives
  - Apply this information to his own medical situation
  - Reason with the information
  - Communicate and express a choice clearly

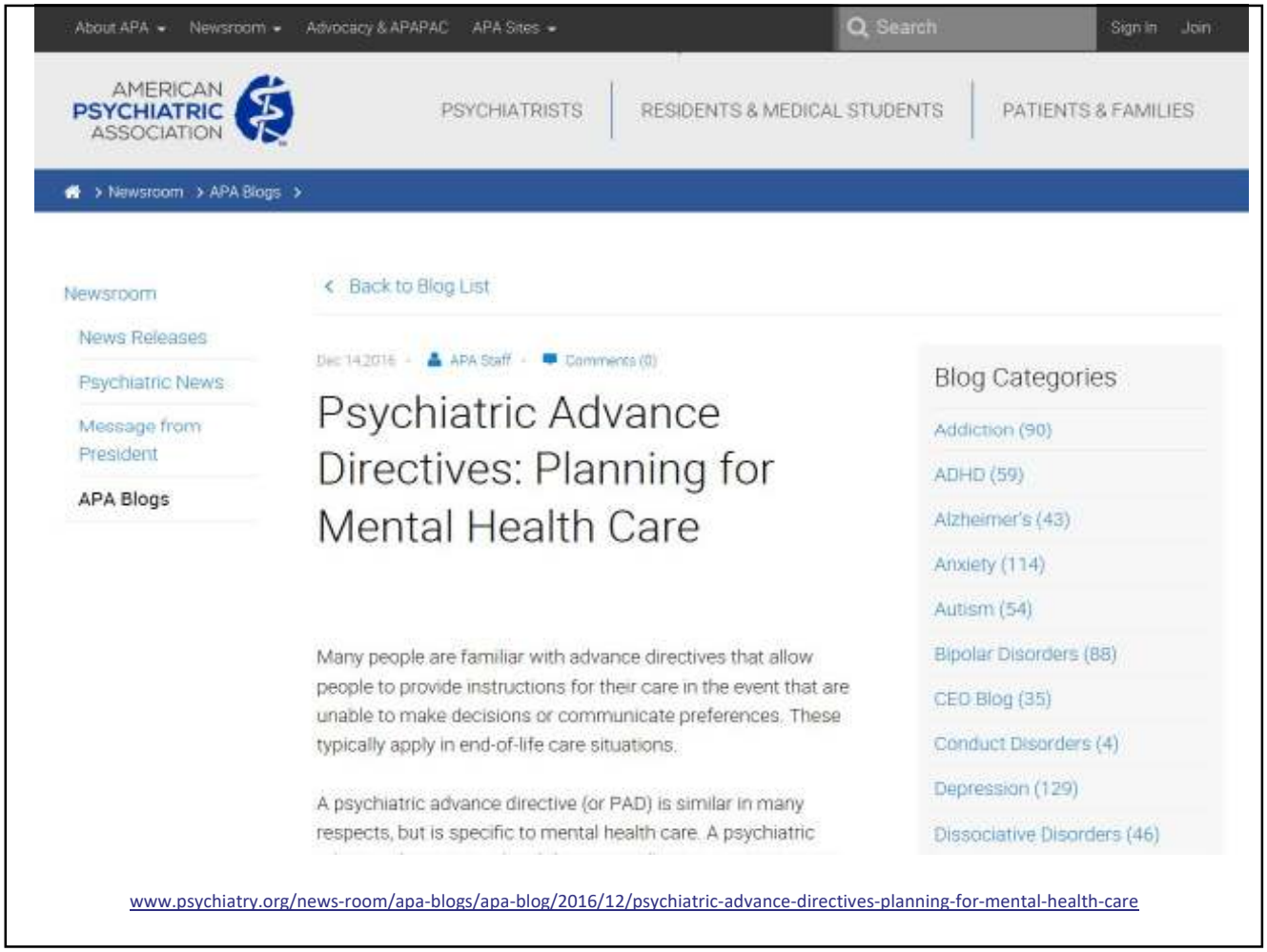
(Appelbaum, Clinical issues in the assessment of competency. Am J Psychiatry. 1981;138(11):1462–1467)

CAPACITY

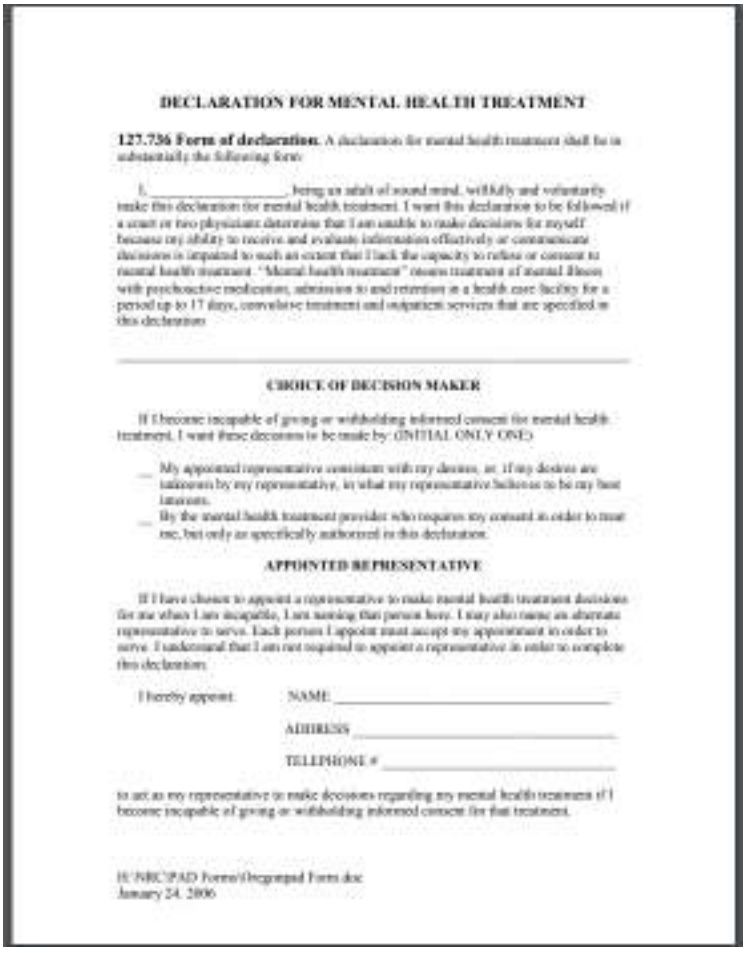
Surrogate decision makers:

- Guardian
- Healthcare Power of Attorney

* Get copy of the document *



www.psychiatry.org/news-room/apa-blogs/apa-blog/2016/12/psychiatric-advance-directives-planning-for-mental-health-care



DECLARATION FOR MENTAL HEALTH TREATMENT

127.736 Form of declaration. A declaration for mental health treatment shall be in substantially the following form:

I, _____, being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment. I want this declaration to be followed if a court or two physicians determine that I am unable to make decisions for myself because my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. "Mental health treatment" means treatment of mental illness with psychoactive medications, admission to and retention in a health care facility for a period up to 17 days, convulsive treatment and outpatient services that are specified in this declaration.

_____

CHOICE OF DECISION MAKER

If I become incapable of giving or withholding informed consent for mental health treatment, I want those decisions to be made by: (INITIAL ONLY ONE)

___ My appointed representative consistent with my desires, or, if my desires are unknown by my representative, in what my representative believes to be my best interests.

___ By the mental health treatment provider who requires my consent in order to treat me, but only as specifically authorized in this declaration.

APPOINTED REPRESENTATIVE

If I have chosen to appoint a representative to make mental health treatment decisions for me when I am incapable, I am naming that person here. I may also name an alternate representative to serve. Each person I appoint must accept my appointment in order to serve. I understand that I am not required to appoint a representative in order to complete this declaration.

I hereby appoint: NAME: _____

ADDRESS: _____

TELEPHONE #: _____

to act as my representative to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment.

H:\NRC\PAD Forms\Unsigned Form.doc
January 24, 2006

www.nrc-pad.org/states/

PRESCRIBING

Recognize that prescribing medication requires special attention to ensure the safety of elderly patients

PRESCRIBING

Before prescribing:

- Be current
- Be aware of all meds your patient currently takes
- Check the PMP
- Communicate with other prescribers
- Be aware of the ↑ risk of falls
- Discuss risks, including
  - Falls
  - Driving impairment

PRESCRIBING

After prescribing:

- Provide written instructions
- Simplify dosing
- One pharmacy
- Risks of under- and over-medicating
- Document clinical basis for your prescribing decisions

ABUSE AND NEGLECT

Understand your state's law regarding reporting of elder abuse or neglect

Oregon Department of Human Services / Seniors & People with Disabilities / Adult Abuse

Adult Abuse Prevention, Investigations and Initiatives

- ▶ADULT ABUSE
- ⊞ CENTRALIZED ABUSE MANAGEMENT SYSTEM (CAM)
- COVID-19 AND LTC FACILITIES
- REPORTS & PUBLICATIONS
- PREVENTION & INVESTIGATIONS
- PROVIDER RESOURCES
- WARNING SIGNS & DEFINITION

Protecting vulnerable Oregonians

Abuse of older people and adults with disabilities is a societal problem that is getting worse with the aging of the population. Education about the risks, along with effective investigation of abuse, is essential to prevent abuse of vulnerable Oregonians.

What is elder abuse?

Elder abuse includes physical harm, failure to provide basic care, abandonment or involuntary seclusion, unwanted sexual contact, verbal or emotional abuse, neglect, self-neglect, wrongful restraint and financial exploitation. Abuse can happen in a person's own home or the home of family or friends. It can also occur in a professional care setting such as a nursing facility, a residential care facility, an assisted living facility, an adult foster home, a retirement home or a room and board home. Learn more about types of abuse and warning signs.

ABUSE AND NEGLECT

As used in ORS **124.005 (Definitions for ORS 124.005 to 124.040)**

(1) "Abuse" means one or more of the following:

(a) Any **physical injury** caused by other than accidental means

(b) Neglect that leads to physical harm

(c) Abandonment, including desertion or willful forsaking of an elderly person or a person with a disability

(d) Willful **infliction of physical pain or injury**.

(e) Use of derogatory or inappropriate names, phrases or profanity, ridicule, harassment, coercion, threats, cursing, intimidation or inappropriate sexual comments or conduct of such a nature as to threaten significant physical or emotional harm to the elderly person or person with a disability.

(f) Causing any sweepstakes promotion to be mailed to an elderly person or a person with a disability who had received sweepstakes promotional material in the United States mail, spent more than $500 in the preceding year on any sweepstakes promotions.

(g) Wrongfully taking or appropriating money or property, or knowingly subjecting an elderly person or person with a disability to alarm by conveying a threat to wrongfully take or appropriate money or property,

(h) Sexual contact with a nonconsenting elderly person or person with a disability or with an elderly person or person with a disability considered incapable of consenting to a sexual act

ABUSE AND NEGLECT

Recognizing signs of abuse

- Physical abuse
  - Fractures, cuts, suspicious burns
  - Bruises on arms consistent with grabbing or shaking
  - Other bruises not readily explainable
  - Bite marks

ABUSE AND NEGLECT

- Neglect
  - Poor general and/or poor oral hygiene
  - Unexplained weight loss
  - Dehydration and/or malnutrition
  - Unkempt clothing
  - Absence of eyeglasses or hearing aid
  - Signs of overdrugging

ABUSE AND NEGLECT

- Emotional abuse
  - Confusion
  - Dramatic changes in sleep patterns
  - Unusual or excessive fear
  - Loss of interest in self and surroundings
  - Unexplained weight changes
  - Deprivation of personal property
  - Seclusion

ABUSE AND NEGLECT

- Financial Abuse
  - Significant disparity between assets/income and lifestyle
  - Sudden failure to pay bills
  - Lack of knowledge of personal finances
  - Sudden appearance of caretaker upon whom patient seems abnormally dependent

ABUSE AND NEGLECT

Signs of caregiver mistreatment:

- Anger / frustration toward patient
- Lack of knowledge / indifference re: patient's condition
- History of doctor-hopping by caregiver
- Implausible explanations of patient's condition
- Attempts to keep patient from speaking to you

ABUSE AND NEGLECT

Signs of caregiver mistreatment:

- Failing to visit patient in hospital
- Inappropriate display of affection toward patient
- Apparent financial dependence on patient
- Excessive concern of treatment costs
- Caregiver has substance abuse / mental health issues

(Read, 2016)

ABUSE AND NEGLECT REPORTING – ORS 124.060

Duty of officials to report

(1) Any public or private official having **reasonable cause to believe** that any person 65 years of age or older **with whom the official comes in contact** has suffered abuse, or that any person with whom the official comes in contact has abused a person 65 years of age or older, **shall report or cause a report to be made** in the manner required in ORS 124.065

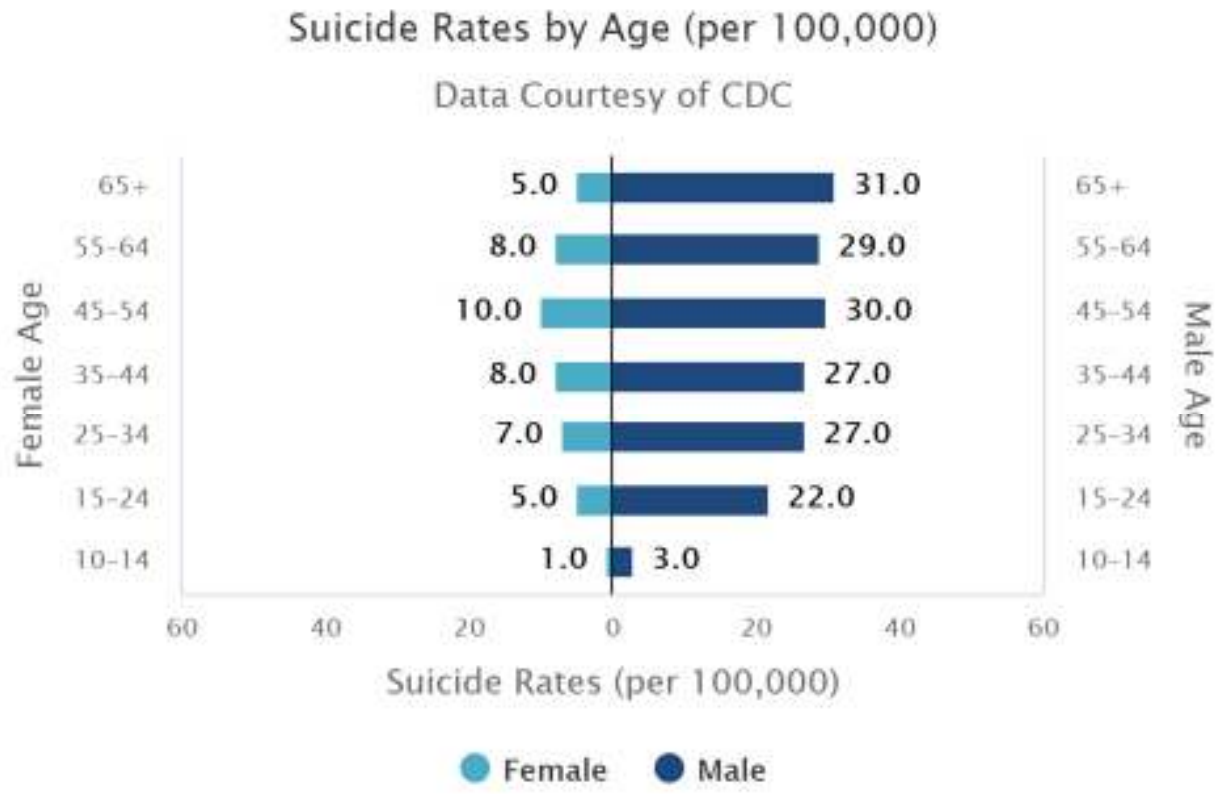
(2) Nothing contained in ORS 40.225 to 40.295 affects the duty to report imposed by this section, except that a **psychiatrist**, psychologist, member of the clergy or attorney **is not required to report such information communicated by a person if the communication is privileged under** ORS 40.225 to 40.295

ABUSE AND NEGLECT REPORTING – RISK MANAGEMENT ADVICE

Call your carrier or personal attorney!!

SUICIDE RISK

Understand that older patients have high suicide rates that other age groups



www.nimh.nih.gov/health/statistics/suicide.shtml


psychiatryonline
Lifelong Learning in Psychiatry
American Psychia
Practice Gu
American Psychiatric Association (APA) practice g
recommendations for the assessment and treatm
guidelines are intended to assist in clinical decisi
developed patient care strategies in a standardiz
In 2011, APA adopted a new guideline developme
of the Institute of Medicine published in March 20
include establishing transparency, managing conflicts of interest, composing work groups,
using systematic reviews of evidence, articulating and rating recommendations in guidelines,
obtaining external review, and updating. For additional information regarding the new
process and a list of the current membership of the APA Steering Committee on Practice
Guidelines, please visit the American Psychiatric Association.
Recently Published
THE AMERICAN PSYCHIATRIC ASSOCIATION
PRACTICE GUIDELINES FOR THE
Psychiatric Evaluation
of Adults
THIRD EDITION
APA Work Group on Psychiatric Evaluation
Joel J. Silverman, M.D., Chair
Marc Galanter, M.D.
Mega Jackson-Triche, M.D., M.S.H.S.
Douglas G. Jacobs, M.D.
James M. Lomax II, M.D.
Michelle B. Riba, M.D.
Lowell D. Tong, M.D.
Katherine E. Watkins, M.D., M.S.H.S.
Systematic Review Group
Laura J. Fochtmann, M.D., M.B.I.
Richard S. Miranda, M.D.
Joel Yager, M.D.
APA Steering Committee on Practice Guidelines
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Marcia Kraft, M.D. (Area II)
William M. Greenberg, M.D. (Area III)
John Fitz Sheeks, D.E.D. (Area V)
Robert M. McCarron, D.O. (Area VI)
Joann M. Hunstein, M.D. (Area VII)
GUIDELINE III. Assessment of Suicide Risk
Clinical Questions
Development of this guideline was premised on the following clinical questions:
For patients who present with a psychiatric symptom, sign, or syndrome in any setting, is identification of risk for suicide improved when the initial psychiatric evaluation typically (i.e., almost always) includes assessment of the following?
• Current suicidal ideas, including active or passive thoughts of suicide or death
• Current suicide plans
• Current suicide intent
• Intended course of action if current symptoms worsen
• Prior suicidal ideas or suicide plans
• Prior suicide attempts
The APA Practice Guidelines for the Psychiatric Evaluation of Adults, Third Edition
87

(APA, 2016)

SUICIDE RISK ASSESSMENTS

SAFE-T

- https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/sma09-4432

Columbia scale

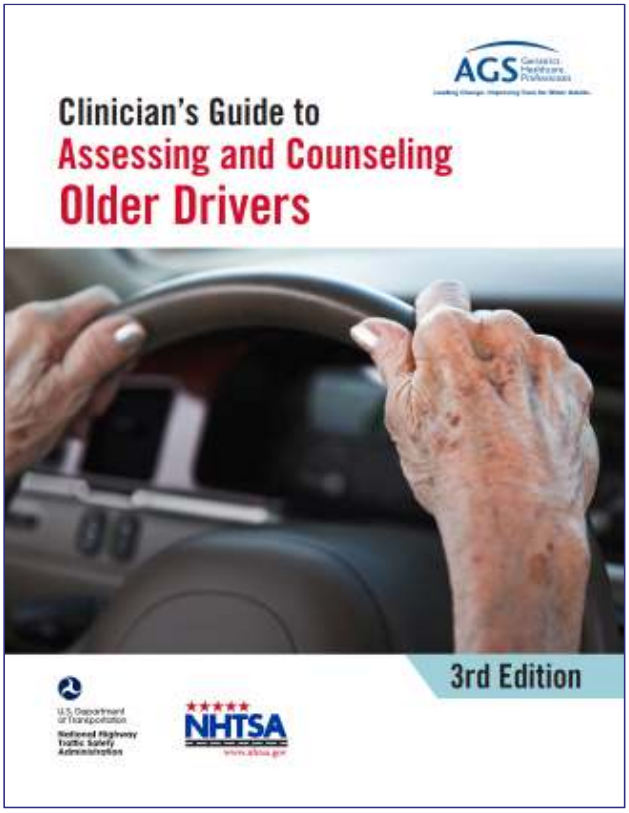
- https://suicidepreventionlifeline.org/wp-content/uploads/2016/09/Suicide-Risk-Assessment-C-SSRS-Lifeline-Version-2014.pdf

APA Practice Guidelines

- https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890426760

DRIVING ISSUES

Be prepared to deal with concerns about your patient's ability to drive safely



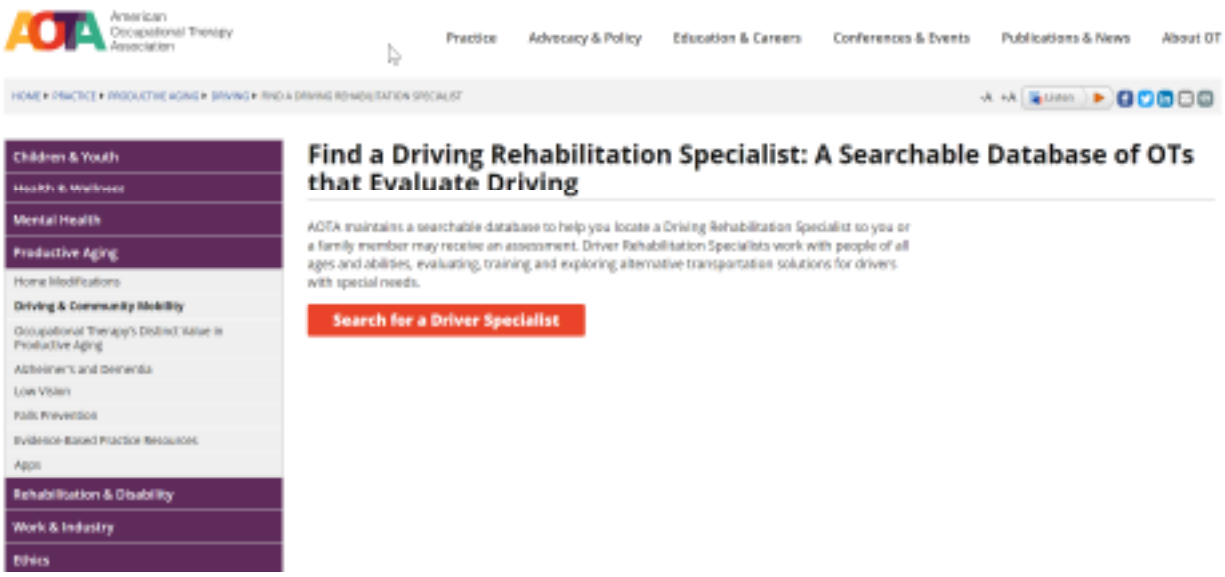
www.nhtsa.gov/sites/nhtsa.dot.gov/files/812228_cliniciansguidetoolderdrivers.pdf

DRIVING ISSUES

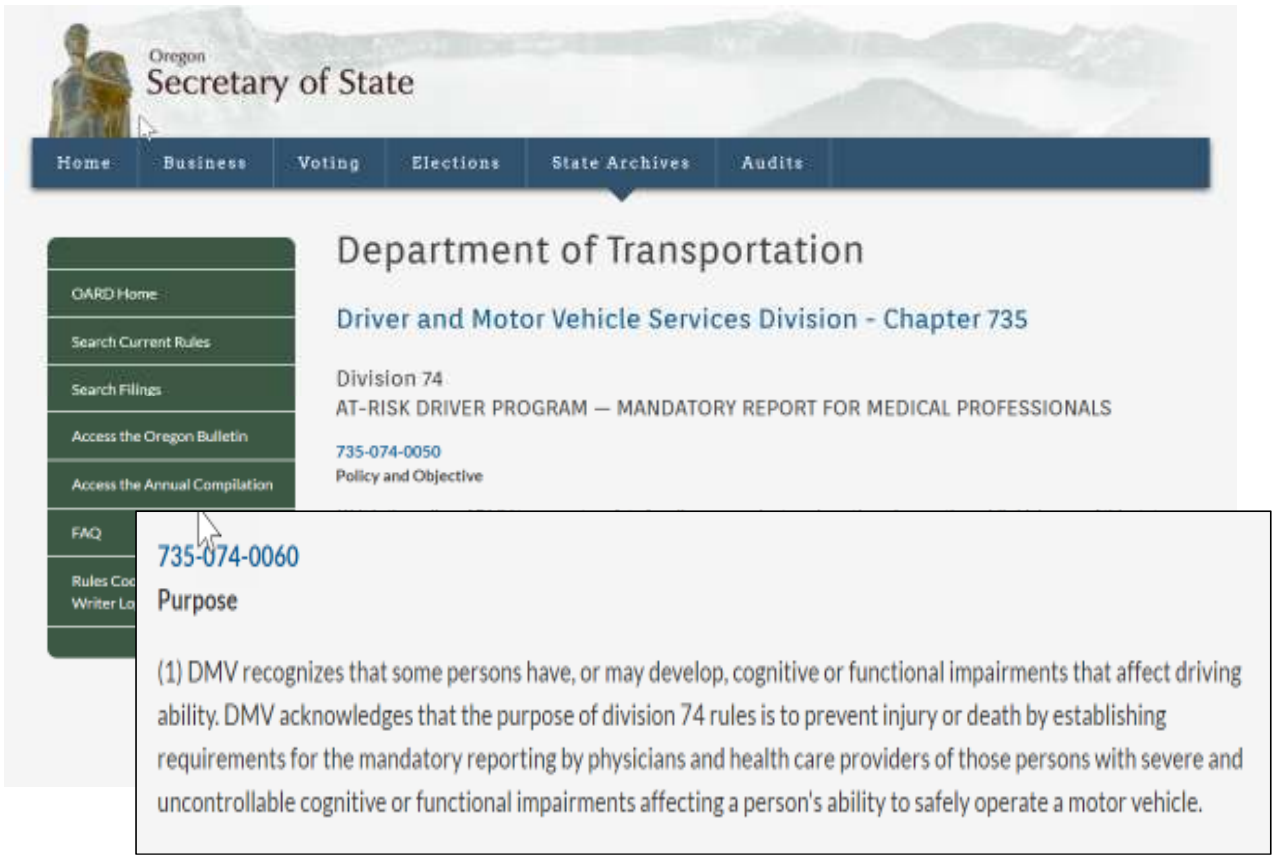
- What is the cause
- Can it be minimized/removed?
- Does impairment vary?
- Medication changes
- Utilize other providers

DRIVING ISSUES

- Be familiar with consensus recommendations on counseling patients
- Educate patient / family / caregiver
- Consider referral to other physician or DRS
- Discuss potential for impairment during informed consent process
- Document discussions and recommended interventions along with patient compliance
- Be familiar with state reporting laws


American Occupational Therapy Association
Practice
Advocacy & Policy
Education & Careers
Conferences & Events
Publications & News
About OT
Children & Youth
Mental Health
Productive Aging
Home Modifications
Driving & Community Mobility
Rehabilitation & Disability
Work & Industry
Ethics
Find a Driving Rehabilitation Specialist: A Searchable Database of OTs that Evaluate Driving
AOTA maintains a searchable database to help you locate a Driving Rehabilitation Specialist so you or a family member may receive an assessment. Driver Rehabilitation Specialists work with people of all ages and abilities, evaluating, training and exploring alternative transportation solutions for drivers with special needs.
Search for a Driver Specialist

www.aota.org

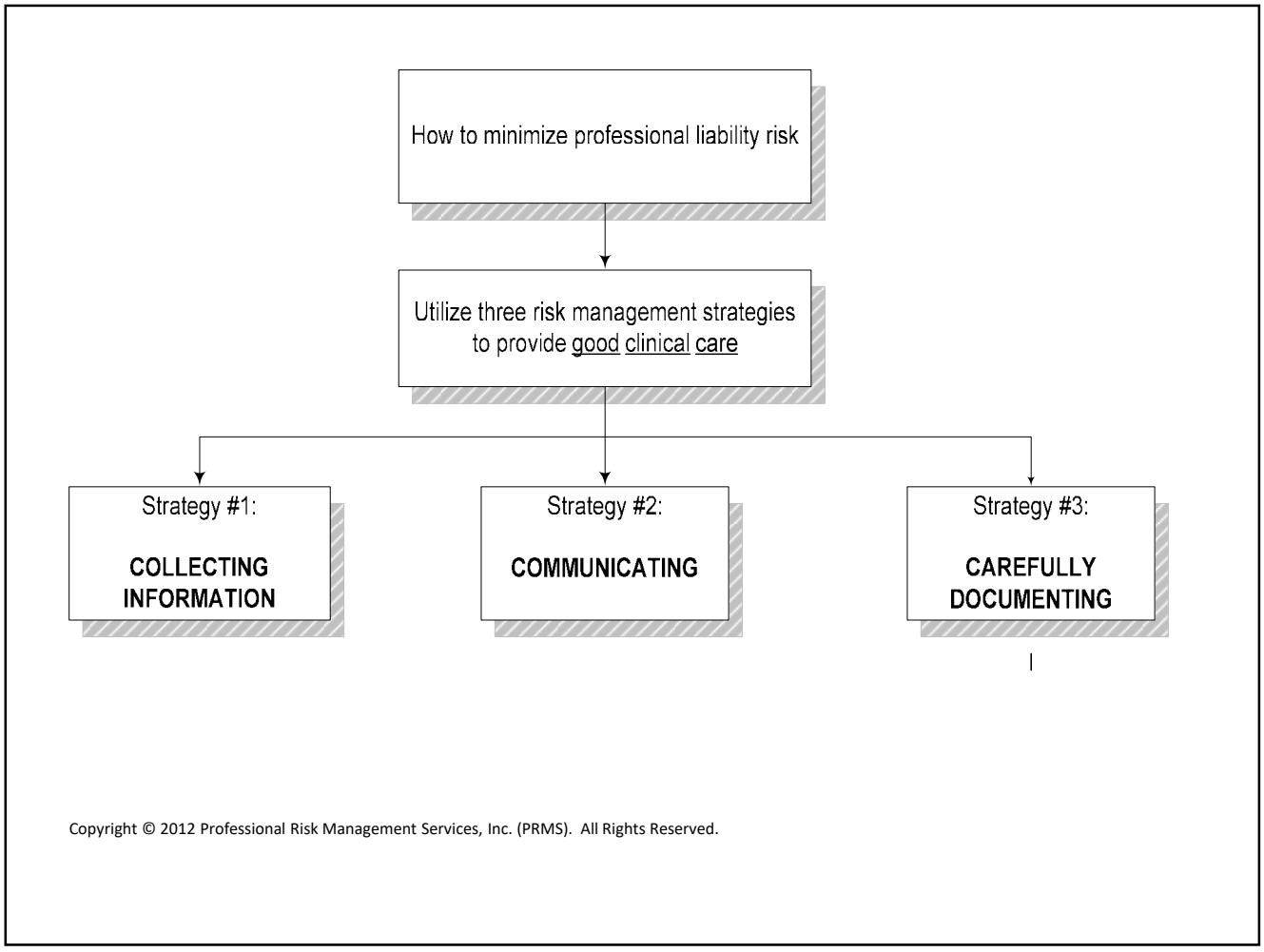


https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=3368


Oregon
Secretary of State
Home
Business
Voting
Elections
State Archives
Audits
OARD Home
Search Current Rules
Search Filings
Access the Oregon Bulletin
Access the Annual Compilation
FAQ
Rules Coordinator / Rules Writer Login
Department of Transportation
Driver and Motor Vehicle Services Division - Chapter 735
Division 76
AT-RISK DRIVER PROGRAM — NON-MANDATORY REPORTING
735-076-0000
Policy, Objective and Purpose of the At-Risk Program — Non-Mandatory Reporting
(1) It is the policy of DMV to promote safety for all persons who travel or otherwise use the public highways of this state.
(2) The underlying policy of the Department's rules on at-risk drivers is to preserve the independence, dignity, and self-esteem that result from providing one's own mobility, so long as it is possible to do so without risk to oneself or to others.
(3) It is therefore an objective of these division 076 rules to establish a program for the non-mandatory reporting to DMV of those drivers who have a mental or physical condition or impairment that may affect driving ability, or drivers who have demonstrated unsafe or dangerous driving behaviors.
(4) DMV may receive information that indicates a person may no longer be qualified to hold a driver license, driver permit or endorsement or may no longer be able to drive safely. This information may come from many sources, including a report from any of the following:
(a) A physician or health care provider.

DRIVING ISSUES – RISK MANAGEMENT TIPS

- Discuss reporting obligations with patient
  - Explain state not you who determines restrictions/revocations
  - Minimum necessary info will be released
- Seek guidance from malpractice insurer before reporting
- Document basis for need to report
- Disclose minimum necessary
- Place copy of report in patient's record



RISK MANAGEMENT STRATEGIES TO ↑ INCREASE PATIENT SAFETY AND ↓ PROFESSIONAL LIABILITY

Strategy #1: COLLECT INFORMATION

- About the patient
  - History (including medication reconciliations)
  - Examination
  - Check the PMP
- About the medication
  - FDA.gov
- About treatment standards
  - APA assessment and treatment guidelines
  - AAFP
  - AAGP

RISK MANAGEMENT STRATEGIES TO ↑ INCREASE PATIENT SAFETY AND ↓ PROFESSIONAL LIABILITY

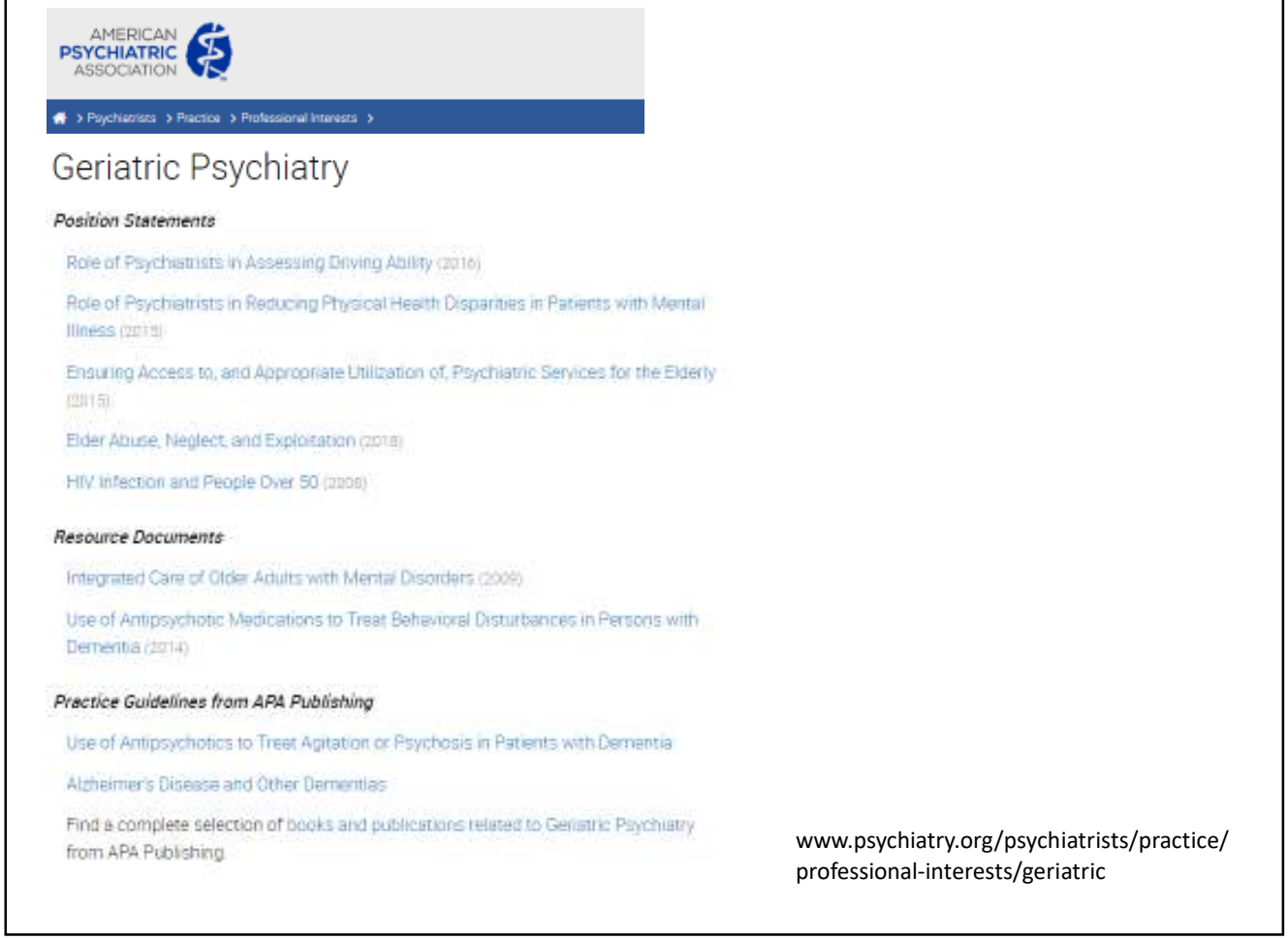
Strategy #2: COMMUNICATE

- With patient
  - Risks and benefits
    - Falls
    - Adverse drug events related to somatic conditions
  - Driving concerns
- With others
  - Other prescribers and consultants
  - Significant others and caregivers

RISK MANAGEMENT STRATEGIES TO ↑ INCREASE PATIENT SAFETY AND ↓ PROFESSIONAL LIABILITY

Strategy #3: CAREFULLY DOCUMENT

- Assessments performed
- Consent discussions
- Documents related to surrogate decision-makers, powers of attorney, psychiatric advance directives
- Consultations obtained
- Discussions of driving & fall concerns
- Reasoning behind prescribing decisions



www.psychiatry.org/psychiatrists/practice/professional-interests/geriatric

RESOURCE PAGE

- Geriatric Psychiatry
- American Psychiatric Association – Geriatric Psychiatry
  https://www.psychiatry.org/psychiatrists/practice/professional-interests/geriatric
- American Psychiatric Association – Psychiatric Advance Directives: Planning for Mental Health Care
  www.psychiatry.org/news-room/apa-blogs/apa-blog/2016/12/psychiatric-advance-directives-planning-for-mental-health-care
- National Resource Center on Psychiatric Advance Directives - State by State Info
  https://www.nrc-pad.org/states/
- U.S. Department of Justice - State Statute Topics
  https://www.justice.gov/elderjustice/elder-justice-statutes-0
- Stetson Law – Mandatory Reporting Statutes-for Elder Abuse
  https://www.stetson.edu/law/academics/elder/home/media/Mandatory-reporting-Statutes-for-elder-abuse-2016.pdf
- National Institute of Mental Health – Statistics
  www.nimh.nih.gov/health/statistics/suicide.shtml
- Geriatrics Healthcare Professionals - Assessing and Counseling Older Drivers
  https://www.nhtsa.gov/sites/nhtsa.dot.gov/files/812228_cliniciansguidetoolderdrivers.pdf

MINORS – PSYCHOPHARMACOLOGY AND OTHER TREATMENT ISSUES

Justin Pope, JD
Associate Risk Manager
Professional Risk Management Services (PRMS)

Schools Face the Teen Cutting Problem

Cyberbullying on Social Media Linked to Teen Depression

CDC warns that Americans may be overmedicating youngest children with ADHD

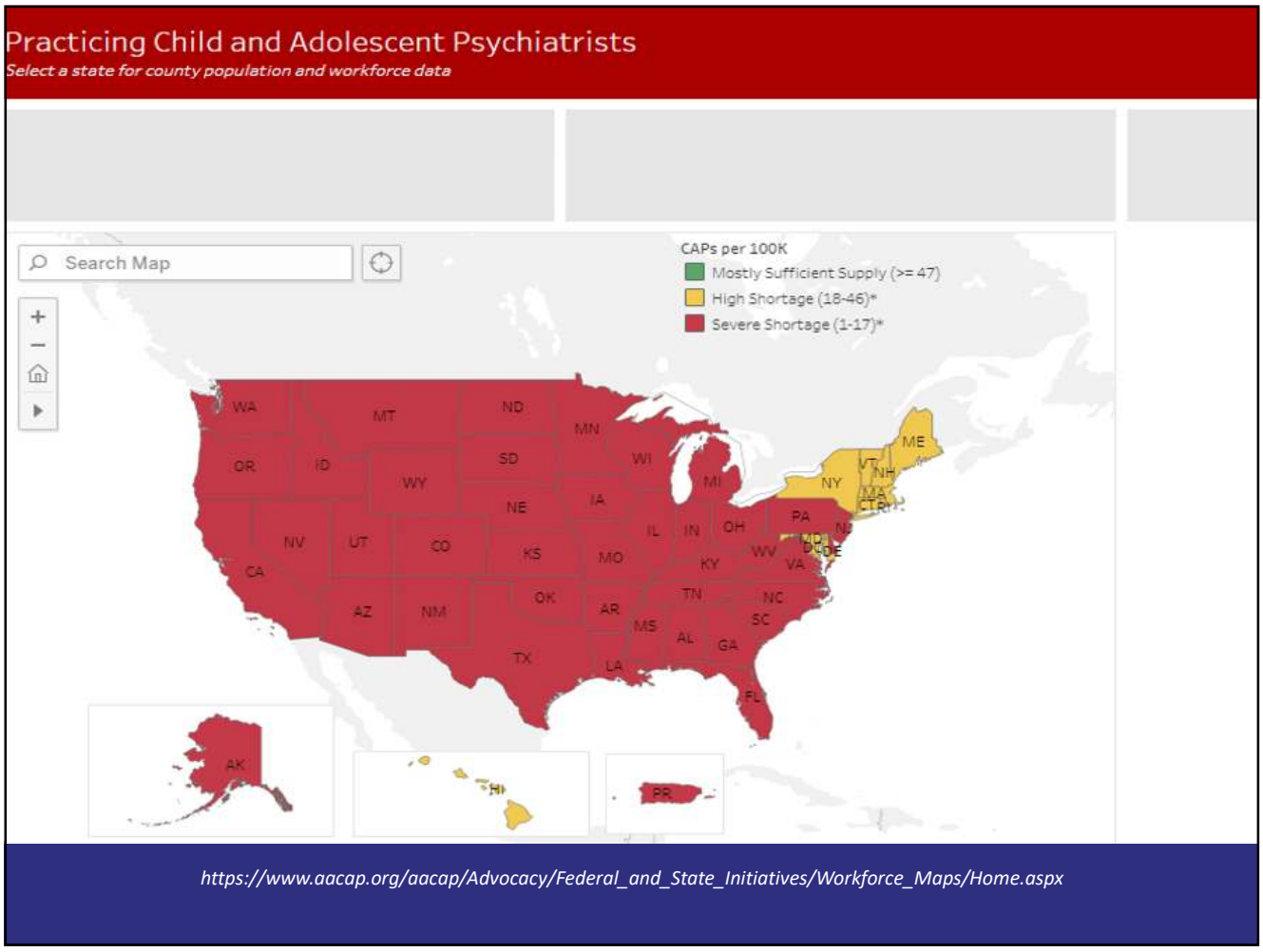
There's a shortage of child psychiatrists, and kids are hurting

Suicide on Campus and the Pressure of Perfection

Teenagers, Medication and Suicide

Suicide Rates Climb In U.S., Especially Among Adolescent Girls

Still in a Crib, Yet Being Given Antipsychotics


Practicing Child and Adolescent Psychiatrists
Select a state for county population and workforce data
Search Map
CAPs per 100K
Mostly Sufficient Supply (>= 47)
High Shortage (18-46)*
Severe Shortage (1-17)*
WA
MT
ND
MN
OR
ID
SD
WI
MI
WY
NY
ME
VT
NH
MA
CT
RI
NE
IA
IL
IN
OH
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NV
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CO
KS
MO
WV
VA
KY
CA
TN
NC
SC
AZ
NM
OK
AR
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GA
TX
LA
FL
AK
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PR
https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx

OBJECTIVES

- Compare and contrast liability when treating adult patients versus minor patients
- Implement three strategies for minimizing risk associated with prescribing controlled substances
- Reconcile a parent's demand for information with a minor patient's right to confidentiality

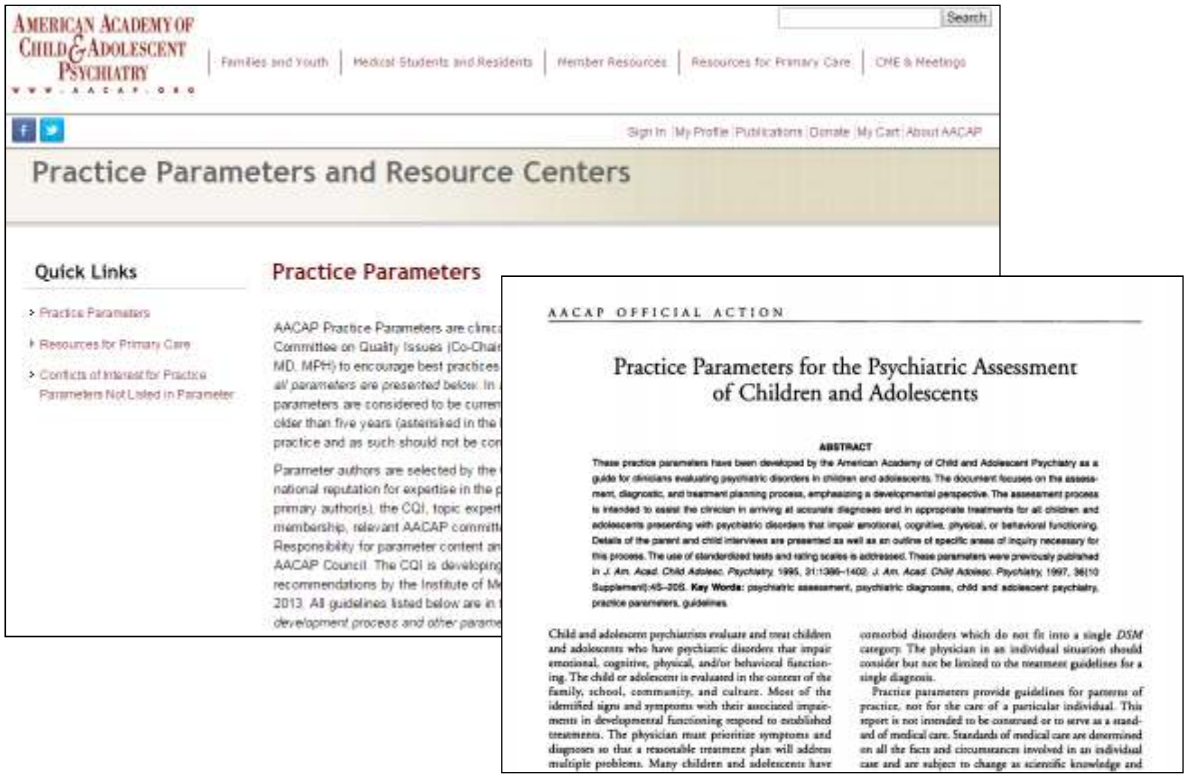
PROFESSIONAL LIABILITY EXPOSURE WHEN TREATING MINORS

ELEMENTS OF A LAWSUIT

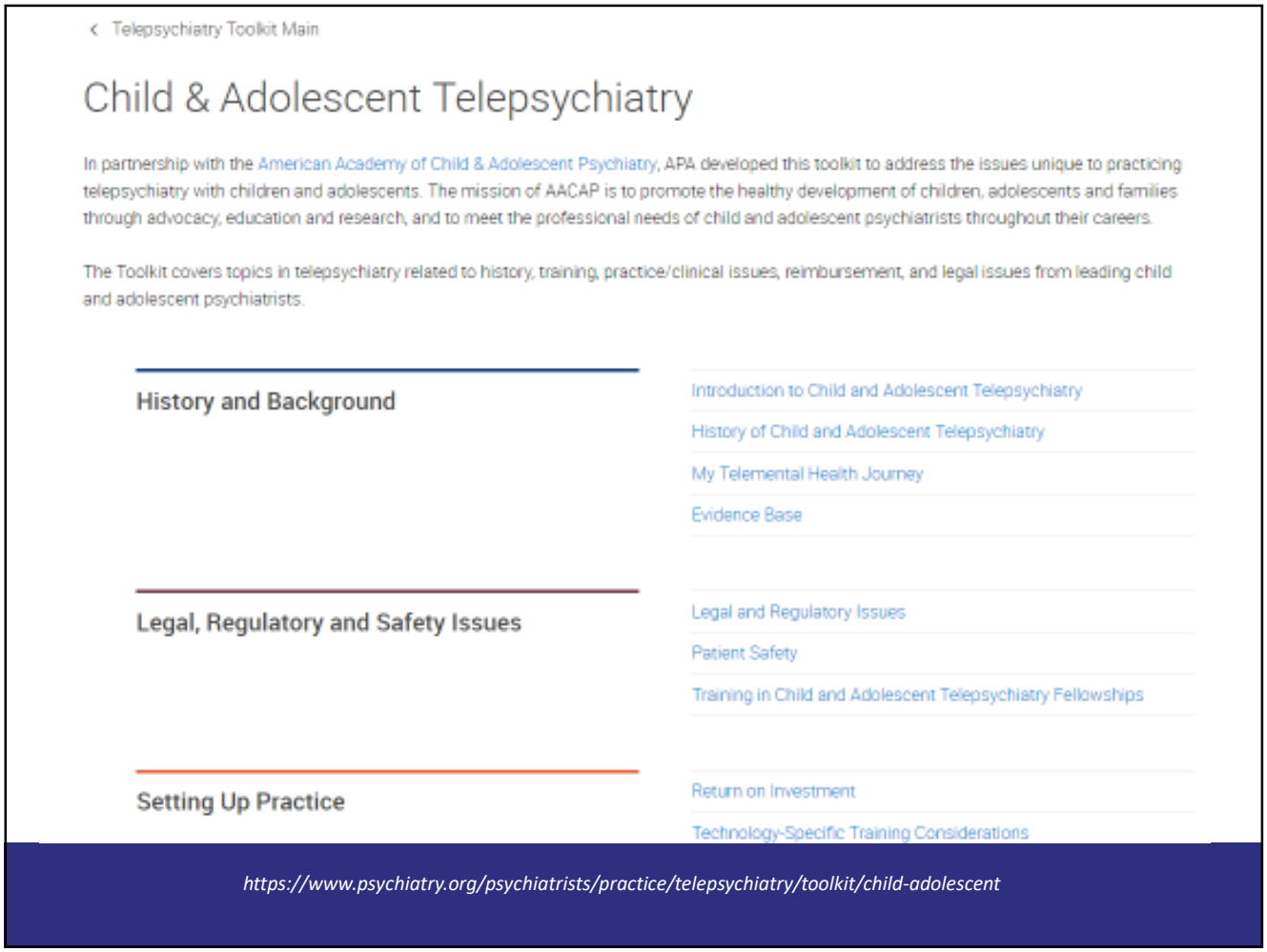
- Duty of Care
  - The psychiatrist owed a duty to the patient
  - To meet the standard of care
- Breach of Duty
  - The psychiatrist was negligent (the care provided fell below the standard of care)
- Damages
  - The psychiatrist suffered an adverse outcome (injury)
- Proximate Cause
  - The patient's damages were a direct result of the psychiatrist's negligence

DETERMINING THE APPLICABLE STANDARD OF CARE

- Authoritative clinical guidelines
- Policies and guidelines from professional organizations
- Learned treatises
- Journal articles
- Research reports
- Accreditation standards
- Facility's own policies and procedures
- PDR recommendations
- Drug manufacturer recommendations
- Other items



www.jaacap.com/article/S0890-8567(09)62591-0/pdf



https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit/child-adolescent

Psychopharmacology Issues During COVID-19

Introduction

The COVID-19 pandemic has had a profound impact on nearly every aspect of life for children and families across the globe, and many of our patients may be experiencing worsened psychiatric distress as a result. The sources of emotional stress during the pandemic are diverse and range widely from cancellation of anticipated summer programs or events, having to leave school and transition to less structured settings, fear of becoming ill, financial stress, more time spent among families and less time with peers, uncertainty about the future, and increased anxiety as communities begin to relax social distancing standards. The loss of structure, direct peer support, and limited special education services related to school closures can also worsen or unmask underlying behavioral conditions in children and adolescents with mental illness or developmental disabilities. Additionally, therapy alone may not be enough to treat patients with new or worsened psychiatric symptoms due to the many changes and stressors caused by the current pandemic. Given the high levels of stress for children and families coupled with decreased services, there is an unprecedented need for outpatient child and adolescent psychopharmacology, much of which is now being delivered virtually. Over the past two months, child and adolescent psychiatrists have had to make a rapid transition to virtual care. During this time, we have learned that it is possible to provide psychopharmacologic care to children and families through virtual care. However, as a field we still have much to learn about best practices for virtual psychopharmacology, some of which may shift as the pandemic evolves. Based on the AACAP Psychopharmacology and Neurotherapeutics Committee

www.aacap.org/App_Themes/AACAP/Docs/resource_libraries/covid-19/COVID-Psychopharm-Guidelines.pdf

GREATEST EXPOSURE

- Greatest Professional Liability Exposure
- When treating minor patients:
  - Patient suicide / attempted suicide
  - Psychopharmacology

THE PSYCHIATRISTS' PROGRAM LAWSUITS INVOLVING MINOR PATIENTS BY CAUSE OF LOSS (SINCE 1986)

- Top Allegations:
  - Incorrect Treatment (Approximately 30%)
  - Suicide/Attempted Suicide (Approximately 16%)
  - Medication Issues (Approximately 15%)

- Other Allegations Include:
  - Incorrect Diagnosis
  - Improper Supervision
  - Unnecessary Commitment

THE PSYCHIATRISTS' PROGRAM LAWSUITS INVOLVING MINOR PATIENTS BY AGE

- Percentage of Lawsuits:
  - Age 5 and Under (Approximately 6%)
  - Age 6-7 (Approximately 6%)
  - Age 8-9 (Approximately 8%)
  - Age 10-11 (Approximately 10%)
  - Age 12-13 (Approximately 19%)
  - Age 14-15 (Approximately 20%)
  - Age 16-17 (Approximately 31%)

THE PSYCHIATRISTS' PROGRAM LAWSUITS INVOLVING MINOR PATIENTS BY CAUSE OF LOSS (AGE 5 AND UNDER)

- Top Allegations:
  - Incorrect Treatment (Approximately 48%)
  - Improper Supervision (Approximately 13%)
  - Medication Issues (Approximately 13%)

THE PSYCHIATRISTS' PROGRAM LAWSUITS INVOLVING MINOR PATIENTS BY CAUSE OF LOSS (AGE 6-9)

- Top Allegations:
  - Incorrect Treatment (Approximately 38%)
  - Medication Issues (Approximately 17%)
  - Improper Supervision (Approximately 12%)

THE PSYCHIATRISTS' PROGRAM LAWSUITS INVOLVING MINOR PATIENTS BY CAUSE OF LOSS (AGE 10-11)

- Top Allegations:
  - Incorrect Treatment (Approximately 42%)
  - Medication Issues (Approximately 11%)
  - Incorrect Diagnosis (Approximately 11%)

THE PSYCHIATRISTS' PROGRAM LAWSUITS INVOLVING MINOR PATIENTS BY CAUSE OF LOSS (AGE 12-13)

- Top Allegations:
  - Incorrect Treatment (Approximately 28%)
  - Incorrect Diagnosis (Approximately 21%)
  - Suicide/Attempted Suicide (Approximately 14%)

THE PSYCHIATRISTS' PROGRAM LAWSUITS INVOLVING MINOR PATIENTS BY CAUSE OF LOSS (AGE 14-15)

- Top Allegations:
  - Incorrect Treatment (Approximately 33%)
  - Suicide/Attempted Suicide (Approximately 17%)
  - Medication Issues (Approximately 17%)

THE PSYCHIATRISTS' PROGRAM LAWSUITS INVOLVING MINOR PATIENTS BY CAUSE OF LOSS (AGE 16-17)

- Top Allegations:
  - Suicide/Attempted Suicide (Approximately 31%)
  - Incorrect Treatment (Approximately 19%)
  - Medication Issues (Approximately 17%)

THE PSYCHIATRISTS' PROGRAM
LAWSUITS, CLAIMS, AND ADMINISTRATIVE ACTIONS INVOLVING MINOR PATIENTS

- Since 1986:
  - Lawsuits (Approximately 53%)
  - Administrative Actions (Approximately 39%)
  - Claims (Approximately 8%)

- Since 2004:
  - Administrative Actions (Approximately 55%)
  - Lawsuits (Approximately 36%)
  - Claims (Approximately 9%)

PRMS DATA: ADMINISTRATIVE ACTIONS

Overlapping themes:

- Divorced parents
- Psychopharmacology
- Child abuse
- Termination

ADDITIONAL LIABILITY RISK WHEN TREATING MINORS

Unique characteristics of patient population:

- Off-label prescribing
- Many parties can complain
- Statute of limitations
- Vulnerable population

THINGS TO KEEP IN MIND

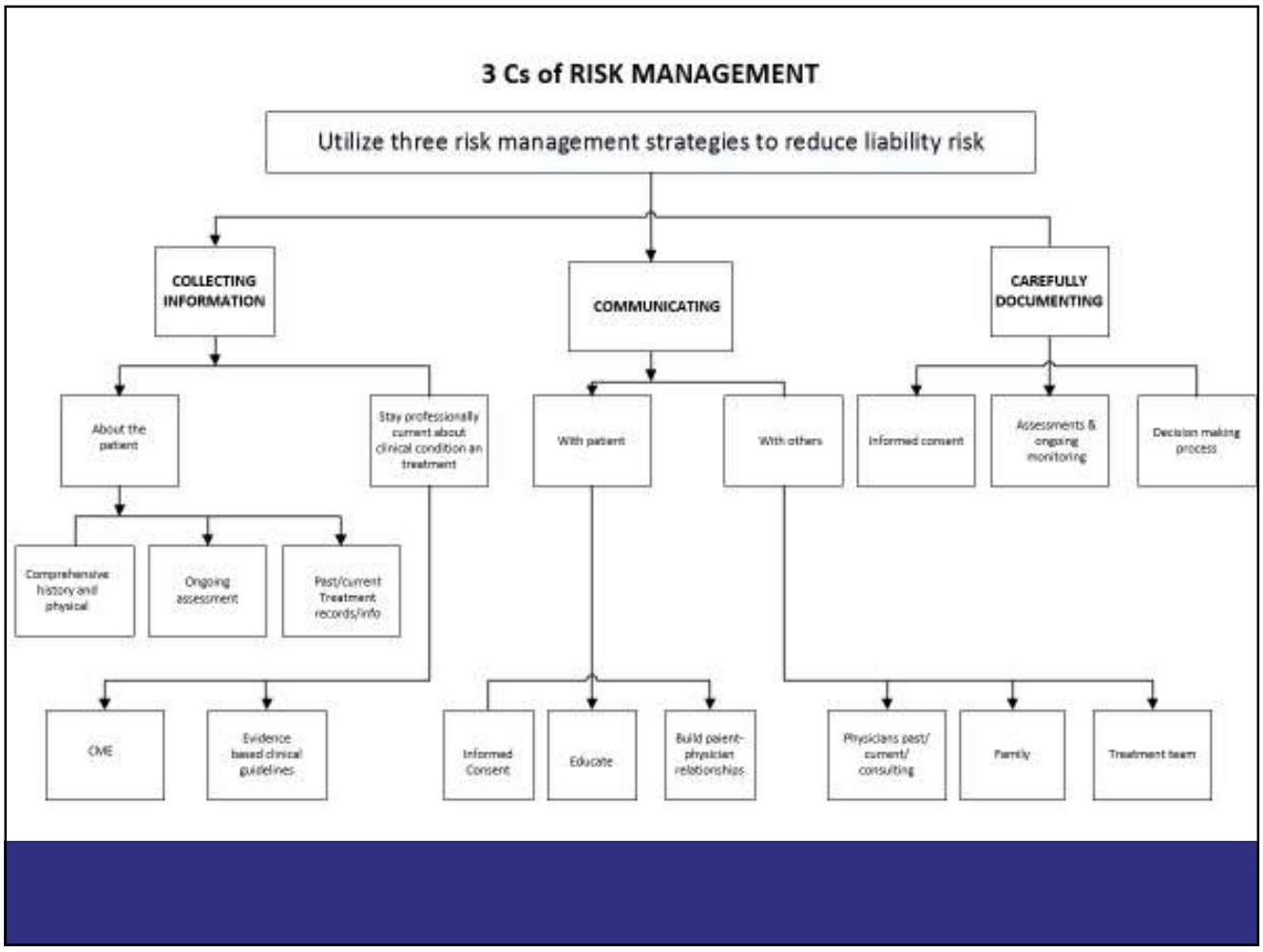
- Payouts are lower for minor patients' cases vs. adult patients
- Psychiatry – one of the least often sued medical specialties

THE PSYCHIATRISTS' PROGRAM LAWSUITS INVOLVING MINOR PATIENTS BY DISPOSITION

- Dismissed/Not Pursued (44%)
- Settled Prior to Trial (35%)
- Summary Judgment/Motion to Dismiss (14%)
- Settled During or After Trial (3%)
- Defense Verdict (3%)
- Plaintiff’s Verdict (1%)

THREE KEY RISK MANAGEMENT STRATEGIES (THE THREE Cs)

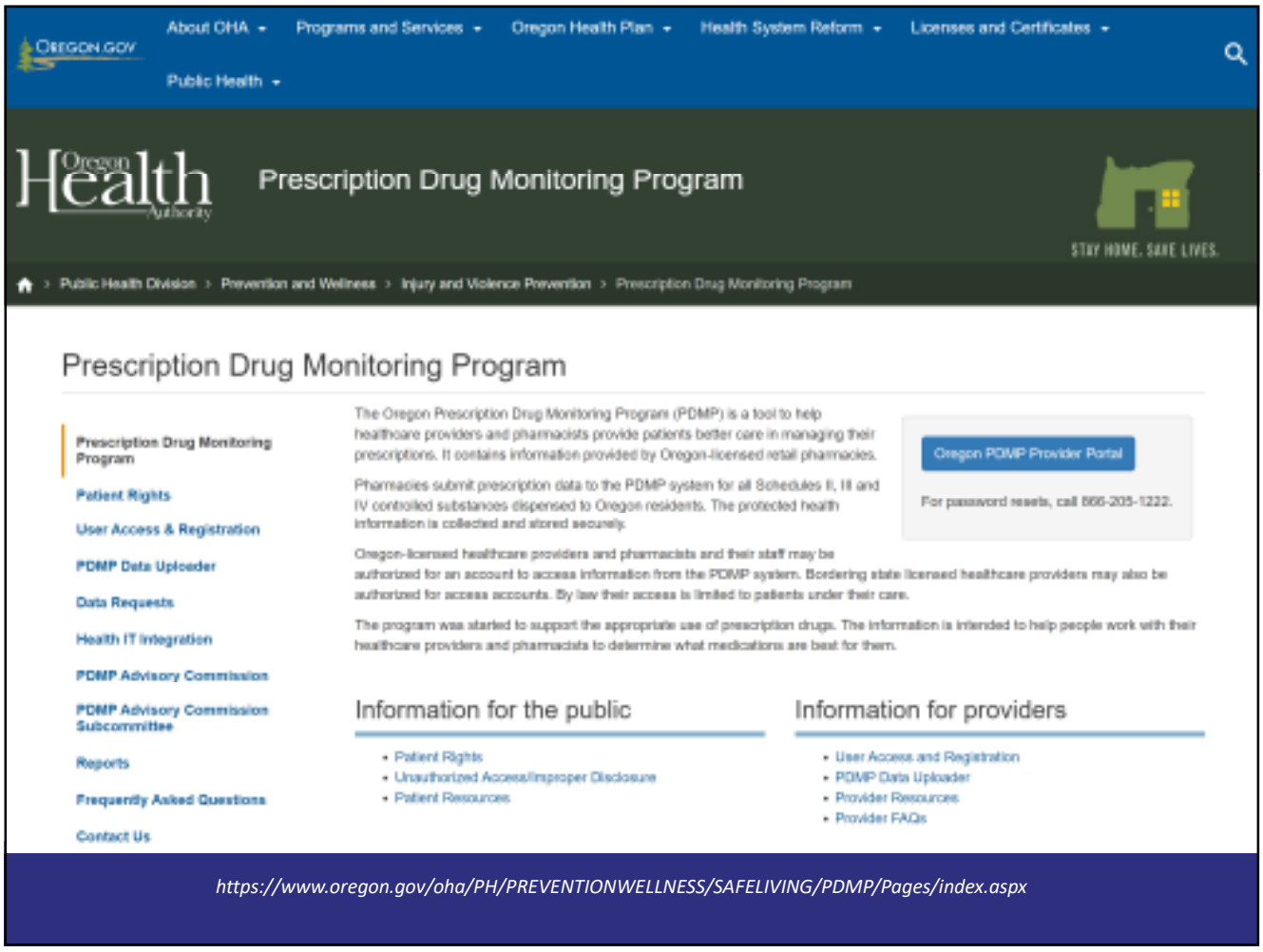
1. Collect Information
2. Communicate
3. Carefully Document


3 Cs of RISK MANAGEMENT
Utilize three risk management strategies to reduce liability risk
COLLECTING INFORMATION
COMMUNICATING
CAREFULLY DOCUMENTING
About the patient
Stay professionally current about clinical condition an treatment
With patient
With others
Informed consent
Assessments & ongoing monitoring
Decision making process
Comprehensive history and physical
Ongoing assessment
Past/current Treatment records/info
CME
Evidence based clinical guidelines
Informed Consent
Educate
Build paient-physician relationships
Physicians past/ current/ consulting
Family
Treatment team

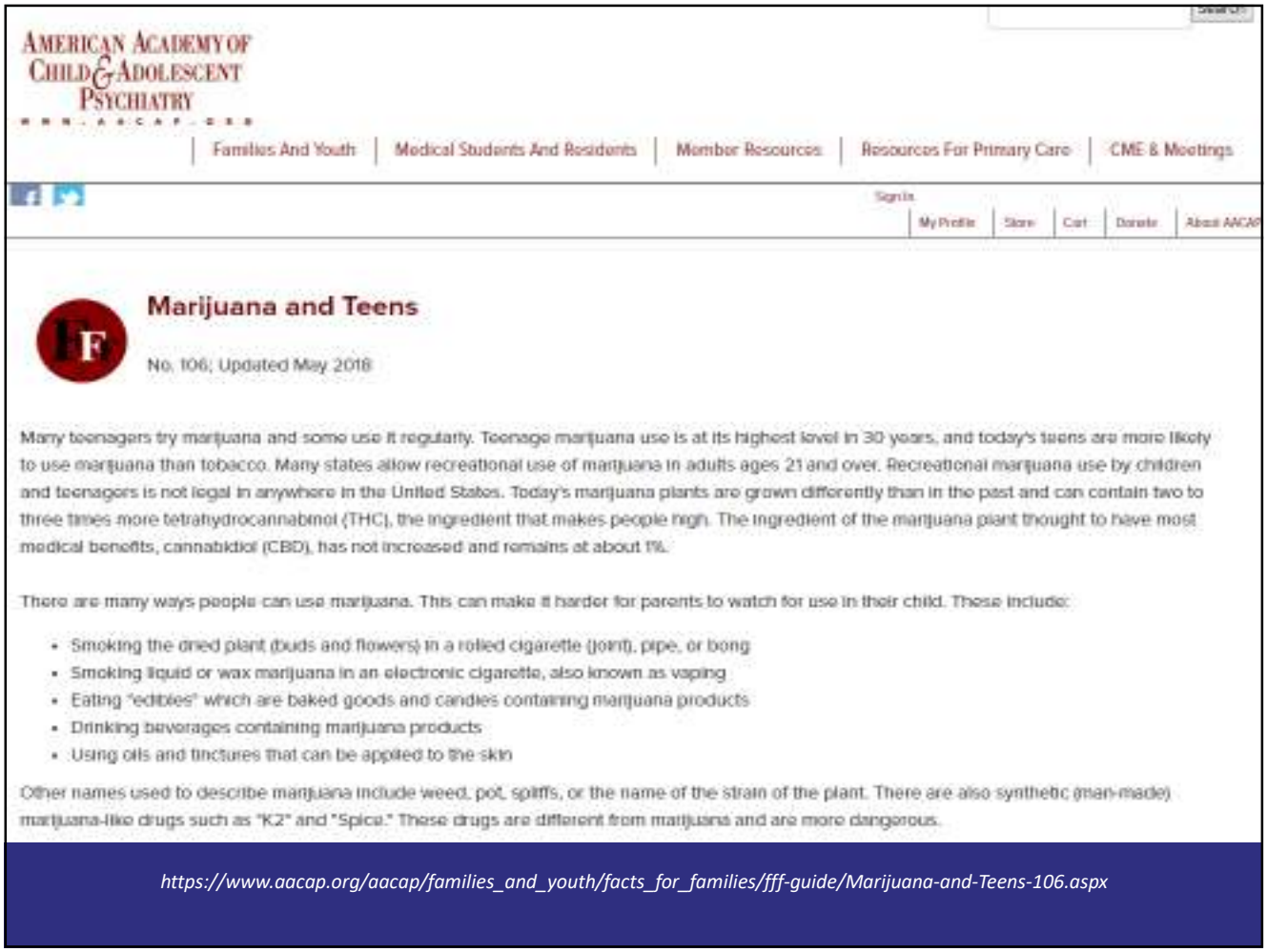
RISK MANAGEMENT STRATEGY #1: COLLECTING INFORMATION

COLLECTING INFORMATION – ABOUT THE PATIENT

- Assess patients at significant points in treatment
- Assessment is ongoing
  - Consider possibility of comorbid conditions
    - Substance abuse
    - Medical conditions
- Obtain prior records / document efforts
- Collateral information from family and others
- Inquire about access to weapons



https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SAFELIVING/PDMP/Pages/index.aspx



AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

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Marijuana and Teens

No. 106; Updated May 2018

Many teenagers try marijuana and some use it regularly. Teenage marijuana use is at its highest level in 30 years, and today's teens are more likely to use marijuana than tobacco. Many states allow recreational use of marijuana in adults ages 21 and over. Recreational marijuana use by children and teenagers is not legal in anywhere in the United States. Today's marijuana plants are grown differently than in the past and can contain two to three times more tetrahydrocannabinol (THC), the ingredient that makes people high. The ingredient of the marijuana plant thought to have most medical benefits, cannabidiol (CBD), has not increased and remains at about 1%.

There are many ways people can use marijuana. This can make it harder for parents to watch for use in their child. These include:

- Smoking the dried plant (buds and flowers) in a rolled cigarette (joint), pipe, or bong
- Smoking liquid or wax marijuana in an electronic cigarette, also known as vaping
- Eating "edibles" which are baked goods and candies containing marijuana products
- Drinking beverages containing marijuana products
- Using oils and tinctures that can be applied to the skin

Other names used to describe marijuana include weed, pot, spliffs, or the name of the strain of the plant. There are also synthetic (man-made) marijuana-like drugs such as "K2" and "Spice." These drugs are different from marijuana and are more dangerous.

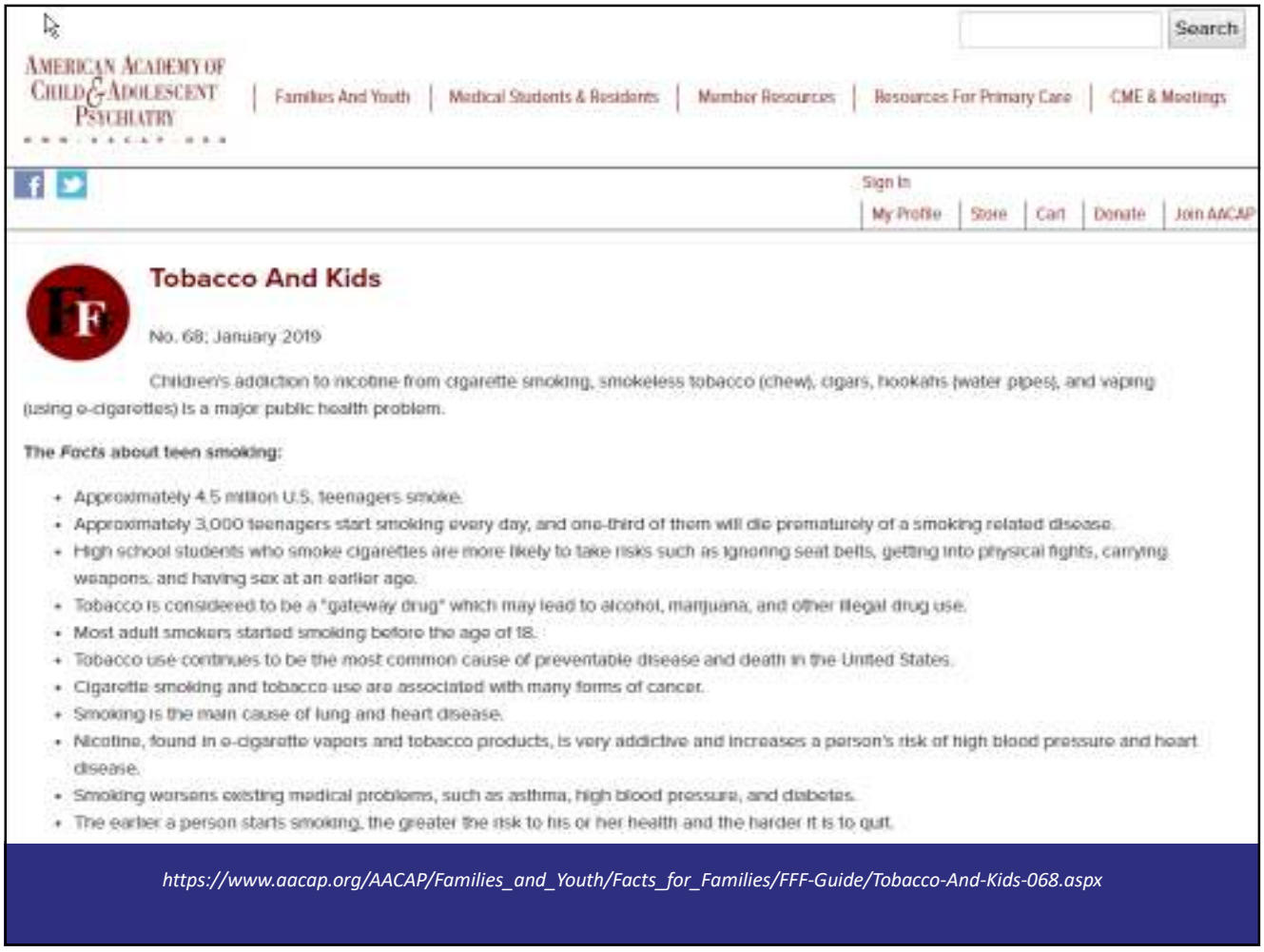
https://www.aacap.org/aacap/families_and_youth/facts_for_families/fff-guide/Marijuana-and-Teens-106.aspx

The New York Times

Addicted to Vaped Nicotine, Teenagers Have No Clear Path to Quitting

Dr. Susanne Tanski, a pediatrics professor at Dartmouth, holding pieces of a vape pen that can be worn on a lanyard. Elizabeth Frantz for The New York Times

https://www.nytimes.com/2018/12/18/health/vaping-nicotine-teenagers.html



https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Tobacco-And-Kids-068.aspx

COLLECTING INFORMATION – ABOUT PATIENTS IN THE DIGITAL AGE

- "Digital native" vs. "digital immigrants"
- Today's average university graduate:
  - < 5,000 hours of their lives reading
  - > 10,000 hours of their lives playing video games
  - 20,000 hours watching TV
- They think and process information fundamentally different from their predecessors

https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.5a17

COLLECTING INFORMATION – ABOUT PATIENTS IN THE DIGITAL AGE

Consider what patients may be doing in the digital age:

- Social Networking
- Bullying and Being Bullied
- Sexting
- Posting Nude Photos
- Gambling
- Masking Online Identities
- Researching Dangerous behaviors

THEY CAN BULLY AND BE BULLIED ONLINE

Instagram Has a Massive Harassment Problem

The platform has cast itself as the internet's kindest place. But users argue harassment is rampant, and employees say efforts to stem it aren't funded well or prioritized.

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TEXT SIZE − +

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Email SIGN UP

WHEN Brandon Farbstein first joined Instagram in 2014, he was 14 and optimistic. Farbstein was born with a rare form of dwarfism, and he wanted to use the photo-sharing site to educate people about his condition—to, as he told me, "show people a glimpse into my life and inspire people."

Soon enough, though, the hateful messages started coming: death threats, expletive-laden comments about his appearance, worse. A meme page put his

https://www.theatlantic.com/technology/archive/2018/10/instagram-has-massive-harassment-problem/572890/

Bullying Found to Increase Risk for Adolescent Suicide Attempts Worldwide

LINDA M. RICHMOND

Published Online: 2 May 2019| https://doi.org/10.1176/appi.pn.2019.5a17

Psychiatrists should consider asking their adolescent patients about whether they are being bullied.

Adolescents who are bullied have a threefold higher risk of suicide attempts globally, according to a study published in March in the *Journal of the American Academy of Child & Adolescent Psychiatry*. The findings emphasize the importance of screening youth for exposure to bullying, assessing suicidality in youth who have been bullied, as well as enhancing youth coping and problem-solving skills.

"Bullying victimization may be an important risk factor of suicide attempts among adolescents globally," wrote Ai Koyanagi, M.D., Ph.D., of the Research and Development Unit at the Universitat de Barcelona in Barcelona, Spain, and the Centro de Investigación Biomédica en Red de Salud Mental in Madrid, Spain, and colleagues. "Thus, there is an urgent need to implement effective and evidence-based interventions to address bullying in order to prevent suicides and suicide attempts among adolescents worldwide."

Self-harm is the third-leading cause of death among adolescents worldwide, resulting in about 67,000 deaths a year, according to the World Health Organization. For this

https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.5a17

THEY MAY BE ENGAGING IN ONLINE SEXUAL ACTIVITIES

ONLINE SEXUAL ACTIVITY STATISTICS

- Pornography –
  - The largest group of internet pornography consumers is children ages 12-17.
  - 90% of kids ages 8-16 have seen online pornography.
- Sexting –
  - 37% of teen girls, 40% of teen boys say they have sexted.
  - 48% of teens say they received sexts.
- Posting –
  - 22% of teenage girls, 18% of teen boys report posting nude or semi-nude photos or videos of themselves online.

www.guardchild.com/statistics/

Minors & Sexting: Serious Consequences

Published on November 7, 2016

Donna Vanderpool, MBA, JD
VP, Risk Management at PRMS, Specialists in Professional Liability Insurance Programs

148 articles ✓ Following

Sexting is basically using a cell phone to send sexually explicit photos or videos. When minors engage in sexting, multiple issues arise, including:

1. The extent to which minors are sexting,
2. The significant legal consequences,
3. The potential for significant personal consequences.

There's a great recent article by Drs. Lorang, McNiel, and Binder on minors and sexting. The article first addresses the research on rates of sexting among minors. Depending on the individual study reviewed, approximately 4% - 20% of minors reported having sent sexually explicit texts, and 7%-40% reported having received a sext. In one study, of the almost 40% that reported having received a sext, more than 25% reported forwarding it. The authors also report on a study that provides insight into this trend, saying the following: "…the teens who completed the survey described the pressure they feel to share sexually suggestive images

https://www.linkedin.com/pulse/minors-sexting-serious-consequences-donna-vanderpool-mba-jd/

Current PSYCHIATRY

Sexting: What are the clinical and legal implications?

To best help teens, ask them about sexting and educate them about potential consequences

Sexting includes sending sexually explicit (or sexually suggestive) text messages and photos, usually by cell phone. This article focuses on sexts involving photos. Cell phones are almost ubiquitous among American teens, and with technological advances, sexts are getting easier to send. Sexting may occur to initiate a relationship or sustain one. Some teenagers are coerced into sexting. Many people do not realize the potential long-term consequences of sexting—particularly because of the impulsive nature of sexting and the belief that the behavior is harmless.

Media attention has recently focused on teens who face legal charges related to sexting. Sexting photos may be considered child pornography—even though the teens made it themselves. There are also social consequences to sexting.

https://www.mdedge.com/psychiatry/article/152842/sexting-what-are-clinical-and-legal-implications

ONLINE SEXUAL ACTIVITY STATISTICS (CONT.)

- Solicitation –
  - Law enforcement estimates that more than 50,000 sexual predators are online at any given moment.
  - 69% of teens regularly receive online communications from strangers and don't tell a parent or caretaker.
  - 20% of teenaged internet users have been the target of unwanted sexual solicitation.
  - 1 in 33 youth received an aggressive sexual solicitation (meaning predator asked to meet youth, called youth, or sent youth correspondence, money, or gifts.

www.guardchild.com/statistics/

THEY CAN MASK THEIR IDENTITY

GENERAL OBSERVATIONS

The virtual social world:

- Difficult to determine true identities
- You can be whomever you want
- “Online disinhibition effect”

ONLINE DISINHIBITION EFFECT

"Loosening / abandonment of social restrictions and inhibitions that would otherwise be present in normal face-to-face interaction during interactions with others on the internet."

Suler J. The online disinhibition effect. CyberPsychology & Behavior 7(3):321-326

THEY CAN SEARCH FOR INFORMATION ON DANGEROUS BEHAVIORS

Anorexia is a lifestyle, not a disease.

10/01/2012

How are you all doing?

Labels: Diary, Info

We'll the tittle says it all...
I'm just wondering, how are you all doing?
Are there already some buddy matches made by yourself?
And how are you holding up?

I'm extremely busy by answering your emails, but I love to do so. And same time trying to make something of the forum, which does excist, but I don't understand it yet. But we are getting closer every day.

The safety settings are back to what they were, cause there was no way to keep up for me with all the busy traffic. What still remains is that all reactions have to be moderated by me first.

I'm also busy matching you all as buddy's together, looking for who I think are going to be good couples, but you all understand that its all a lot of work I hope.

Just know, I'm working a daytime job for ya'll. And I do it with all my love!

Love Jade

Thin Commandments

1) If you aren't thin, you aren't attractive
2) Being thin is more important than being healthy
3) You must but clotes, cut your hair, take laxatives, anything to make yourself look thinner
4) Thou shall not eat without feeling guilty
5) Thou shall not eat fattening food without punishing afterwards
6) Thou shall count calories and restrict intake accordingly
7) What the scale says is the most important thing
8) Losing weight is good, gaining weight is bad
9) You can never be to thin
10) Being thin and not eating are signs of true will power and succes.

http://proanalifestyle.blogspot.com

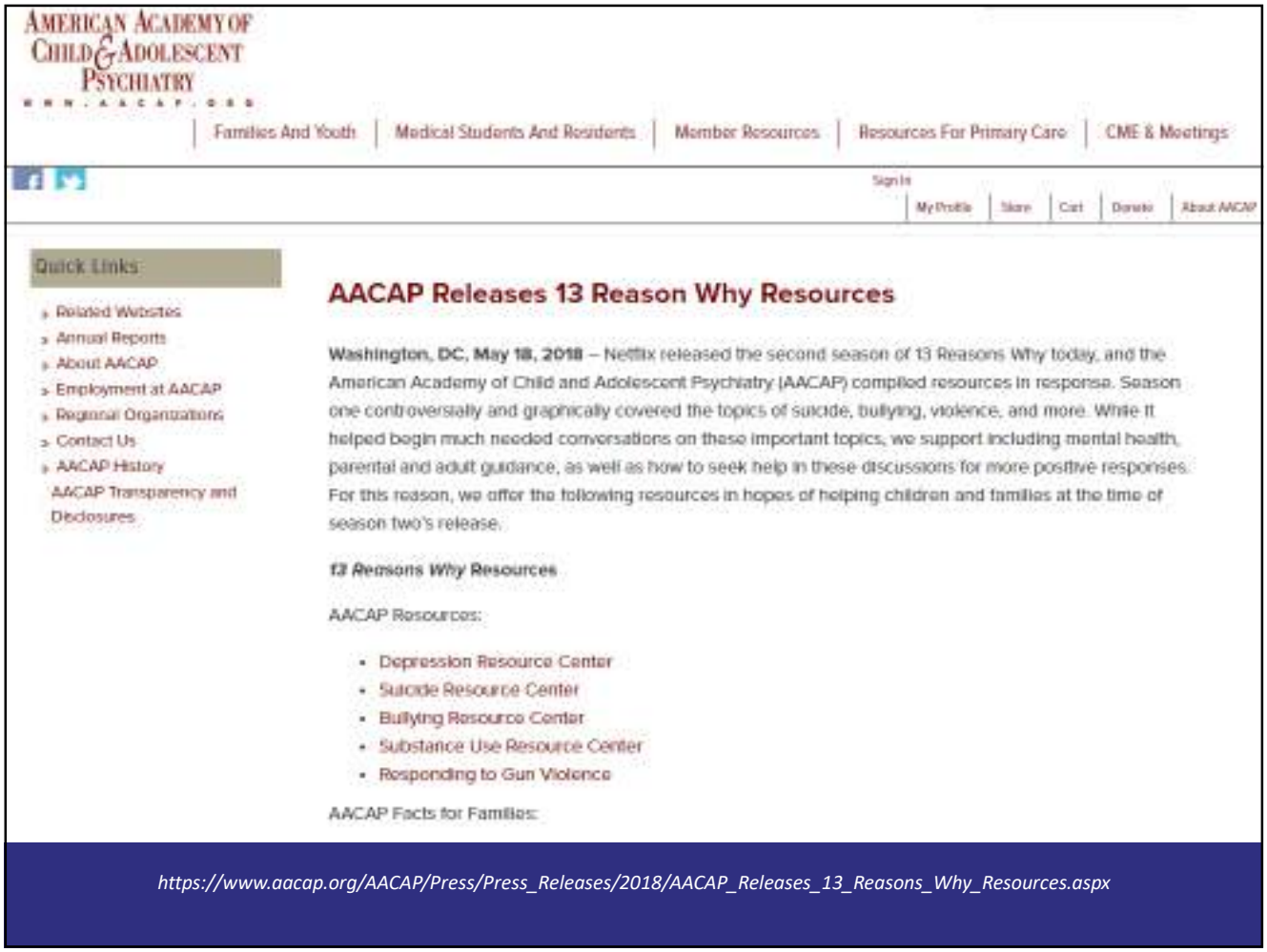
A VIRTUAL PATH TO SUICIDE / Depressed student killed herself with help from online discussion group

Julia Scheeres, Special to The Chronicle Published 4:00 am PDT, Sunday, June 8, 2003

Photo: HANDOUT

www.sfgate.com/news/article/a-virtual-path-to-suicide-depressed-student-2611315.php

https://www.washingtonpost.com/technology/2019/02/24/pediatrician-exposes-suicide-tips-children-hidden-videos-youtube-youtube-kids/?utm_term=.47fd3a341afc



https://www.aacap.org/AACAP/Press/Press_Releases/2018/AACAP_Releases_13_Reasons_Why_Resources.aspx

Association Between the Release of Netflix's *13 Reasons Why* and Suicide Rates in the United States: An Interrupted Times Series Analysis

Jeffrey A. Bridge, PhD[a,b,*], Joel B. Greenhouse, PhD[d], Donna Ruch, PhD[a], Jack Stevens, PhD[a,b], John Ackerman, PhD[b,c], Arielle H. Sheftall, PhD[a,b], Lisa M. Horowitz, PhD, MPH[e], Kelly J. Kelleher, MD[a,b], John V. Campo, MD[f]

PlumX Metrics

DOI: https://doi.org/10.1016/j.jaac.2019.04.020

Article Info

Abstract | Full Text | Images | References | Supplemental Materials

Objective

To estimate the association between the release of the Netflix series *13 Reasons Why* and suicide rates in the United States.

Method

Using segmented quasi-Poisson regression and Holt-Winters forecasting models, we assessed monthly rates of suicide among individuals aged 10 to 64 years grouped into 3 age categories (10–17, 18–29, and 30–64 years) between January 1, 2013, and December 31, 2017, before and after the release of *13 Reasons Why* on March 31, 2017. We also assessed the impact of the show's release on a control outcome, homicide deaths.

https://www.jaacap.org/article/S0890-8567(19)30288-6/fulltext

This Issue | Views 16,703 | Citations 0 | Altmetric 66

Medical News & Perspectives

July 24, 2019

Mounting Evidence and Netflix's Decision to Pull a Controversial Suicide Scene

Rebecca Voelker, MSJ

JAMA. 2019;322(6):490-492. doi:10.1001/jama.2019.9492

Related Articles

Original Investigation
Association of Increased Youth Suicides With *13 Reasons Why*
Thomas Niederkrotenthaler, MD, PhD, MMSc; Steven Stack, PhD; Benedikt Till, DSc; Mark Sinyor, MSc, MD; Jane Pirkis, PhD; David Garcia, DSc; Ian R. H. Rockett, PhD, MPH; Ulrich S. Tran, DSc

With perhaps millions of viewers awaiting the season 3 premiere of Netflix's *13 Reasons Why* series, the streaming service made a somewhat unusual decision. A graphic suicide scene that generated 2 years of debate and at least a half-dozen published studies on suicide trends was edited out of the first season's final episode. A Netflix statement indicated that the decision was made "on the advice of medical experts."

https://jamanetwork.com/journals/jama/article-abstract/2739494

Table 1
Screening questions for further study

Interview Domain	Screening Questions
Chief complaint	• Do you think your main concern today is related to something that happened online?
History of presenting illness/psychiatric review of systems	• Do you ever post online about your current problem? How so, and where? • Have you been involved in any online bullying or "drama"? • Do you think using the Internet has been helpful or harmful to your current situation? • Do you ever go online to learn about the problems you've been experiencing?
Past psychiatric history	• Have you/has your child ever been diagnosed with or treated for Internet addiction or problematic Internet use?
Past medical history	• Do you go online before you fall asleep? • Would you say your (media use) affects your sleep? • Do you go online to learn about physical health?
School history	• Do you use your cell phone in the classroom? • Would you say your media use affects your ability to get your schoolwork done?
Social history	• Who do you talk to online, and how do you interact with them? • What are your favorite Web sites and apps? • What kind of things do you post online, and what kind of feedback do you get? Have you gotten in trouble for it? • Is anyone bothering you online? Are you bothering anyone online?
Developmental history	• (Caregiver) What kind of screen time was allowed during the early years? How did you supervise this? • (Adolescent) What are you good at online? What is your favorite thing to do online? • (Adolescent) Do you feel like you belong to something online? • (Adolescent) Does going online help you figure out the kind of person you want to be?
Sexual history	(Adolescent only) • Do you go online to start romantic or sexual relationships? Did you meet these people in person? • Have you sent sexually explicit texts to anyone? Were there positive or negative consequences? • Do you go online to view sexual content, such as pornography? If so, how often?

Carson NJ, Gansner M, Khang J. Assessment of Digital Media Use in the Adolescent Psychiatric Evaluation. Child Adolesc Psychiatric Clin N Am 27 (2019) 133-143

https://www.aacap.org/aacap/resources_for_primary_care/practice_parameters_and_resource_centers/practice_parameters.aspx

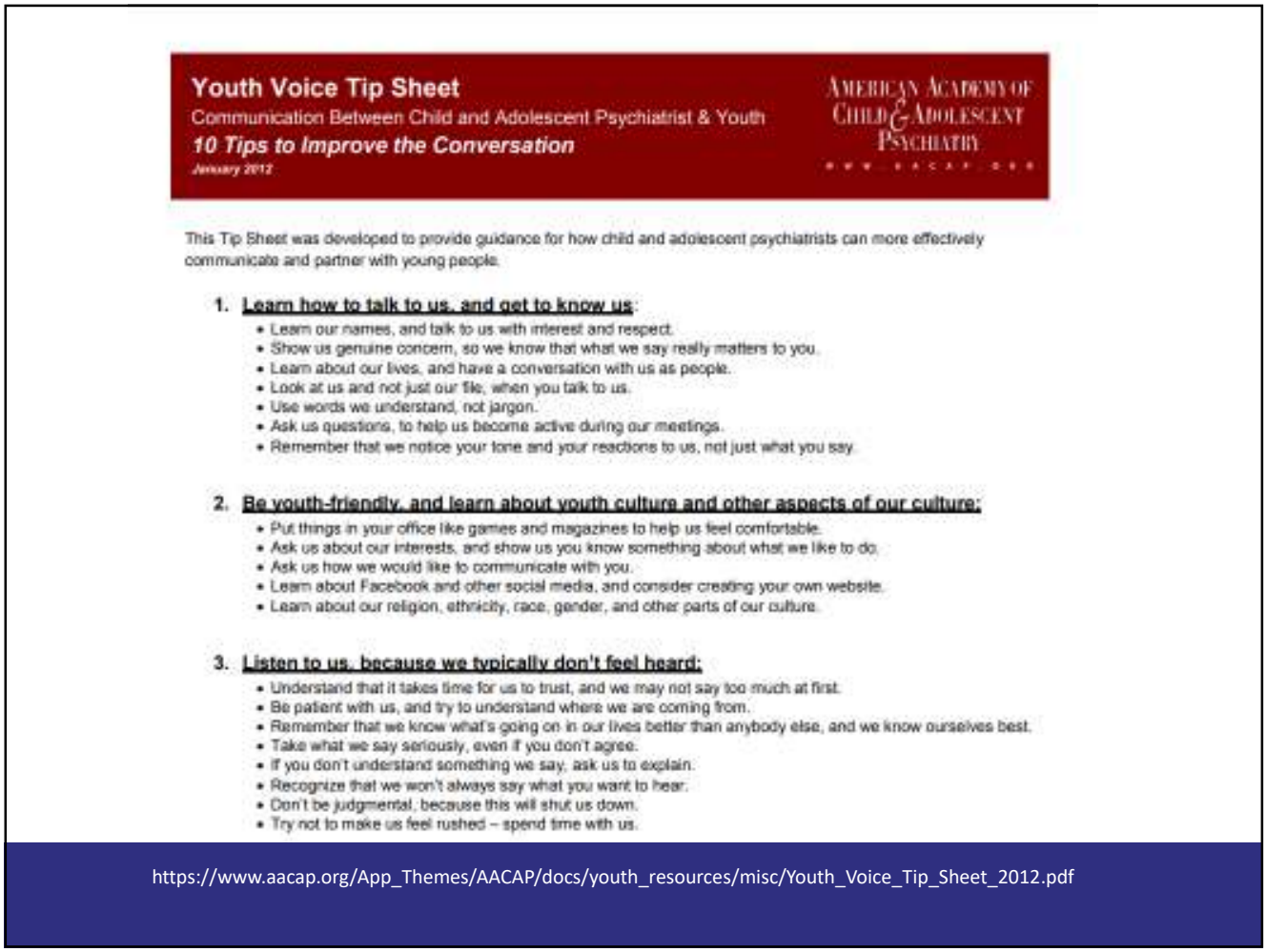
RISK MANAGEMENT STRATEGY #2: COMMUNICATE

COMMUNICATION

- With patients
- With parents
- With other treatment providers

COMMUNICATING – WITH PATIENTS AND PARENTS

- Improving the Conversation with Minors
- Informed Consent
- Minor's Confidentiality vs Parent's Right to Know



Youth Voice Tip Sheet

Communication Between Child and Adolescent Psychiatrist & Youth

10 Tips to Improve the Conversation

January 2012

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

www.aacap.org

This Tip Sheet was developed to provide guidance for how child and adolescent psychiatrists can more effectively communicate and partner with young people.

1. **Learn how to talk to us, and get to know us:**
   - Learn our names, and talk to us with interest and respect.
   - Show us genuine concern, so we know that what we say really matters to you.
   - Learn about our lives, and have a conversation with us as people.
   - Look at us and not just our file, when you talk to us.
   - Use words we understand, not jargon.
   - Ask us questions, to help us become active during our meetings.
   - Remember that we notice your tone and your reactions to us, not just what you say.

2. **Be youth-friendly, and learn about youth culture and other aspects of our culture:**
   - Put things in your office like games and magazines to help us feel comfortable.
   - Ask us about our interests, and show us you know something about what we like to do.
   - Ask us how we would like to communicate with you.
   - Learn about Facebook and other social media, and consider creating your own website.
   - Learn about our religion, ethnicity, race, gender, and other parts of our culture.

3. **Listen to us, because we typically don't feel heard:**
   - Understand that it takes time for us to trust, and we may not say too much at first.
   - Be patient with us, and try to understand where we are coming from.
   - Remember that we know what's going on in our lives better than anybody else, and we know ourselves best.
   - Take what we say seriously, even if you don't agree.
   - If you don't understand something we say, ask us to explain.
   - Recognize that we won't always say what you want to hear.
   - Don't be judgmental, because this will shut us down.
   - Try not to make us feel rushed – spend time with us.

https://www.aacap.org/App_Themes/AACAP/docs/youth_resources/misc/Youth_Voice_Tip_Sheet_2012.pdf

CONSENT

General Rule

- < 18 incompetent to consent
- Parent or legal guardian
- No legal authority = NO Consent

CONSENT VARIES ACROSS STATES

MINOR CONSENT TO TREATMENT – OREGON

O.R.S. § 109.675

1) A minor 14 years of age or older may obtain, without parental knowledge or consent, outpatient diagnosis or treatment of a mental or emotional disorder or a chemical dependency, excluding methadone maintenance, by a physician…licensed by the Oregon Medical Board…

MINOR CONSENT TO TREATMENT – OREGON

O.R.S. § 109.675

2) However, the person providing treatment shall have the parents of the minor involved before the end of treatment unless the parents refuse or unless there are clear clinical indications to the contrary, which shall be documented in the treatment record. The provisions of this subsection do not apply to:

(a) A minor who has been sexually abused by a parent; or

(b) An emancipated minor, whether emancipated under the provisions of ORS 109.510 and 109.520 or 419B.550 to 419B.558 or, for the purpose of this section only, emancipated by virtue of having lived apart from the parents or legal guardian while being self-sustaining for a period of 90 days prior to obtaining treatment as provided by this section.

MINOR'S ASSENT TO TREATMENT

American Academy of Child and Adolescent Psychiatry Code of Ethics, Principle IV: Assent and Consent (Autonomy)

"Guardians are responsible for the health and welfare of their children. Children and adolescents, however, should play a role in determining the services they receive and their participation in treatments to the extent of their capacities to understand options and act rationally. The right of assent to or dissent from treatment belongs to the individual child or adolescent of minor age. ***The child and adolescent psychiatrist shall, whenever reasonably possible, obtain the assent of the minor and the consent of the legal guardian prior to engaging in actions involving the child or adolescent."***

CONSENT

Risk Management Tips:

- Require parent/guardian at first appointment
- If guardian consents, obtain proof of guardianship
- Signed authorization for other caregiver
- Agreement as to when parents must attend
- Communication re: meds

CONSENT

Children of Divorced Parents

- Obtain custody agreement or divorce decree!!!!
- Consider involving other parent
- Involvement of other caregivers

INFORMED CONSENT – OREGON

O.R.S. § 677.097

(1) In order to obtain the informed consent of a patient, a physician or physician assistant shall explain the following:

(a) In general terms the procedure or treatment to be undertaken;

(b) That there may be alternative procedures or methods of treatment, if any; and

(c) That there are risks, if any, to the procedure or treatment.

INFORMED CONSENT – OREGON

O.R.S. § 677.097

2) After giving the explanation specified in subsection (1) of this section, the physician or physician assistant shall ask the patient if the patient wants a more detailed explanation. If the patient requests further explanation, the physician or physician assistant shall disclose in substantial detail the procedure, the viable alternatives and the material risks unless to do so would be materially detrimental to the patient. In determining that further explanation would be materially detrimental the physician or physician assistant shall give due consideration to the standards of practice of reasonable medical or podiatric practitioners in the same or a similar community under the same or similar circumstances.

CONSENT - OFF-LABEL PRESCRIBING

- Per the FDA:

  "Good medical practice and the best interests of the patient require that physicians use legally available drugs, biologics and devices according to their best knowledge and judgment. If physicians use a product for an indication not in the approved labeling, they have the responsibility to be well informed about the product, to base its use on firm scientific rationale and on sound medical evidence, and to maintain records of the product's use and effects."

- Should be part of informed consent discussion.

www.fda.gov/RegulatoryInformation/Guidances/ucm126486.htm.

CONSENT - MEDICATION RESOURCES

ParentsMedGuide.org:

Medication guides

- ADHD
- Depression
- Bipolar Disorder

Minors' Confidentiality vs. Parents' Right to Know

Published on May 25, 2016

Donna Vanderpool, MBA, JD | Follow
VP, Risk Management at PRM...

12 0 0

One of the more complicated confidentiality issues involves a minor patient's right to confidentiality versus the parents' right to know what is going on in their child's treatment. There are at least these three competing interests:

The ethical piece: To the extent possible, minors should be accorded the same confidentiality rights as adults. From AACAP's code of ethics:

"Respect for the patient's privacy is of great importance to the establishment and maintenance of that trust. Thus the child or adolescent's right to privacy of communication is essential in the practice of child and adolescent psychiatry. Certainty that their verbal expressions are protected as confidential allows minor patients to reveal their feelings and thoughts to the clinicians providing care, with the assurance that the contents of their discussions will not be communicated to others without their permission…"

The clinical piece: Minors need treatment, but will not get treatment without confidentiality, or if they get treatment, without confidentiality, the diagnosis may not be accurate, which can lead to ineffective or even harmful treatment.

And the legal piece: Parents generally have the right to information about treatment as well as the right to access the records of their minor children.

https://www.jaacap.org/article/S0890-8567(19)30288-6/fulltext

MINORS' CONFIDENTIALITY VS. PARENTS' RIGHT TO KNOW

Three Competing Interests:

- Ethical – AACAP Code of Ethics
- Clinical – Confidentiality necessary for treatment.
- Legal – Parents generally have right to access information.

MINORS' CONFIDENTIALITY VS. PARENTS' RIGHT TO KNOW

Key Concepts -

1. Manage expectations of all parties.
2. There are exceptions to confidentiality.
3. Even if they say they won't, parents can always change their minds and demand a copy of your record.
4. With few exceptions, parents generally have the right to access the record of their minor child.
5. Document knowing that the record may have to be released to the parent(s).
6. What you believe is the "right" approach may be considered the "wrong" approach by other child and adolescent psychiatrists.
7. Your clinical judgment is the determining factor.

GENERAL THOUGHTS

Protect minor patient's confidentiality, unless:

- Mandated report
- Safety of patient
- Safety of third party
- Valid legal compulsion
  - Authorization
  - Court order

COMMUNICATING WITH PARENTS – DUAL ROLES

Custody disputes – Manage parents' expectations.

- Treating vs. forensic
  - Conflicting obligations
    - Child's clinical needs vs. parent's legal needs
  - Avoid opinions
    - Facts Only
  - Possible scapegoat

COMMUNICATE WITH OTHER PROVIDERS – SPLIT TREATMENT

- **Collaboration:** mutually shared responsibility for patient's care in accordance with the qualifications and limitations of each professional's discipline and abilities.
- **Split Treatment:** one psychiatrist (or physician) provides medication management and another is responsible for psychotherapy.
  - No change in psychiatrist's duty to the patient – always liable for ensuring that patient receives appropriate care.

COMMUNICATE WITH OTHER PROVIDERS – SPLIT TREATMENT

Split Treatment – Risk Management Advice:

- Communication among all parties
  - Patient MUST allow
- Clarify division of treatment responsibilities
  - Example: who will patient contact for what?
- Split treatment agreement to clarify relationship

COMMUNICATE WITH OTHER PROVIDERS – CONSULTATION

Give and get consults:

- Never hesitate to obtain a consult with a more experienced C&A psychiatrist.
- If you are an experienced C&A psychiatrist, please give consults when asked.
- Consults are low-risk and will be key in addressing shortage of C&A psychiatrists!

RISK MANAGEMENT STRATEGY #3: CAREFULLY DOCUMENT

CAREFULLY DOCUMENT

Critical junctures for documentation:

- First psychiatric assessment / End of treatment
- Informed consent process
- Monitoring
- Significant clinical changes
  - Such as occurrence of suicidal behavior or ideation

CAREFULLY DOCUMENT

Suicide Risk Assessment

- Assess and document after initial assessment
- Formal assessment tool is recommended
  - Ex: SAFE-T
- Do not rely solely on “no harm contracts”
- AACAP Suicide Resource Center

CAREFULLY DOCUMENT

Thought process:

- Treatment options/actions considered
- Options/actions were chosen and why
- Options/actions were rejected and why

PSYCHOPHARMACOLOGY

Donna Vanderpool, MBA, JD
Director of Risk Management
Professional Risk Management Services (PRMS)

OBJECTIVES

Upon completion of this course, learners will be able to:

- Explain the risks when prescribing controlled substances
- Implement at least two strategies to minimize the risk associated with prescribing controlled substances

THE OPIOID EPIDEMIC

- Focus is on opioids
- But it's not just opioids
  - Benzos
  - Stimulants

THE RESPONSE: VARIOUS INITIATIVES

- State
  - Opioid task forces
  - Restrictions on opioid prescribing
  - Prescribing guidelines
  - Mandated use of PMPs
  - Lawsuits against Pharma
  - Enforcement
- Federal
  - Public Health Emergency declaration
  - Guidelines
  - CMS initiatives
  - Enforcement

FEDERAL V. STATE

- DEA works closely with state licensing boards and state local law enforcement
- Majority of investigations of controlled substance laws are done by state authorities
- DEA will also conduct investigations of federal law

FEDERAL

FDA

- Can require REMS when potential risks of a drug outweigh the benefits
- Seeking prescribers' help in curtailing opioid epidemic by:
  - Ensuring adequate training
  - Knowing the content of the most current opioid drug labels
  - Educating patients

FEDERAL

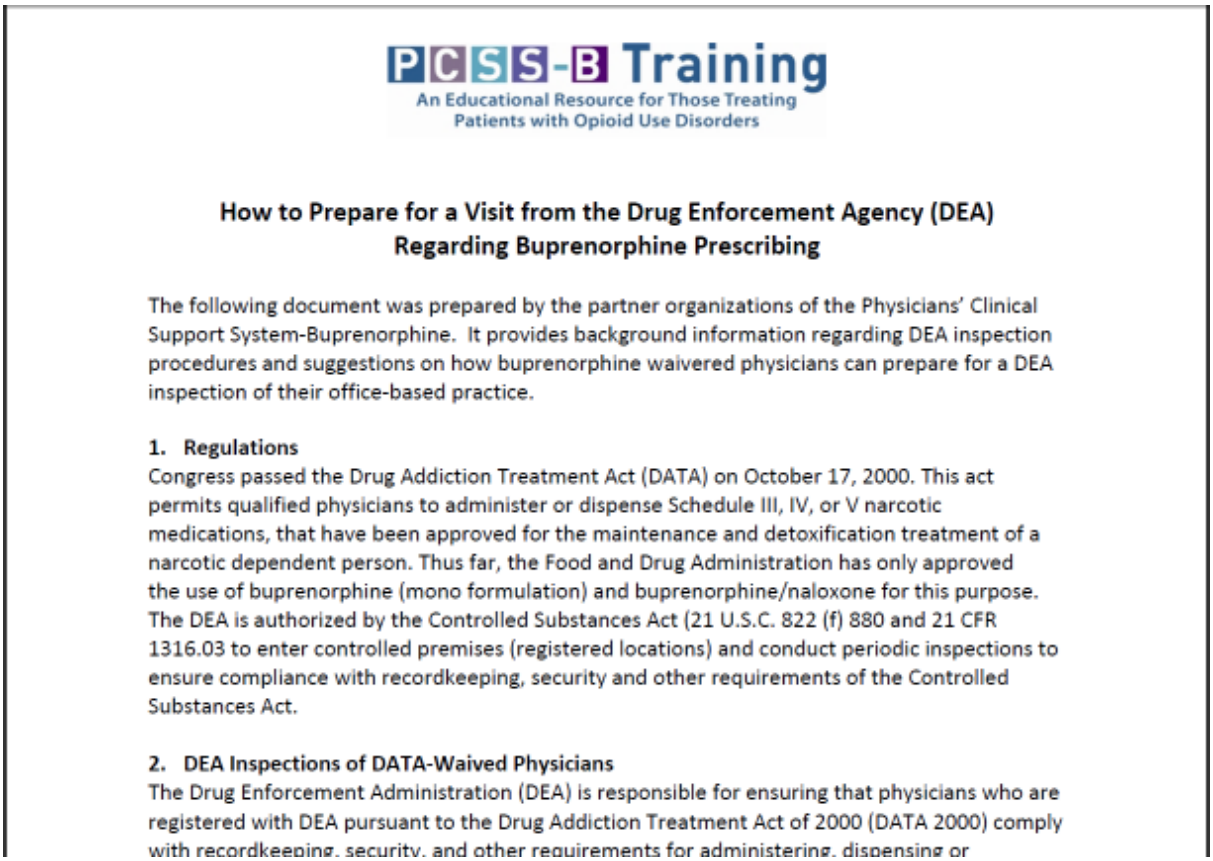
DOJ / DEA

- Primary agency charged with policing the issuance and dispensing of controlled substances
- ~ 5,000 Special Agents, ~ 600 Diversion Investigators
- Per CSA: must be a legitimate medical purpose and must be acting in usual course of practice
- Penalties: imprisonment, fines, loss of DEA license

FEDERAL

DEA VISITS

- CSA authorizes DEA to enter controlled premises and conduct periodic inspections
- Buprenorphine prescribers:
  - "Inspection" – investigators look at records for buprenorphine patients
    - Need log of buprenorphine patients and prescriptions in location listed on DEA registration
  - "Audit" – if also dispenses, will look at meds received and dispensed



PCSS-B Training
An Educational Resource for Those Treating Patients with Opioid Use Disorders

How to Prepare for a Visit from the Drug Enforcement Agency (DEA) Regarding Buprenorphine Prescribing

The following document was prepared by the partner organizations of the Physicians' Clinical Support System-Buprenorphine. It provides background information regarding DEA inspection procedures and suggestions on how buprenorphine waivered physicians can prepare for a DEA inspection of their office-based practice.

1. Regulations

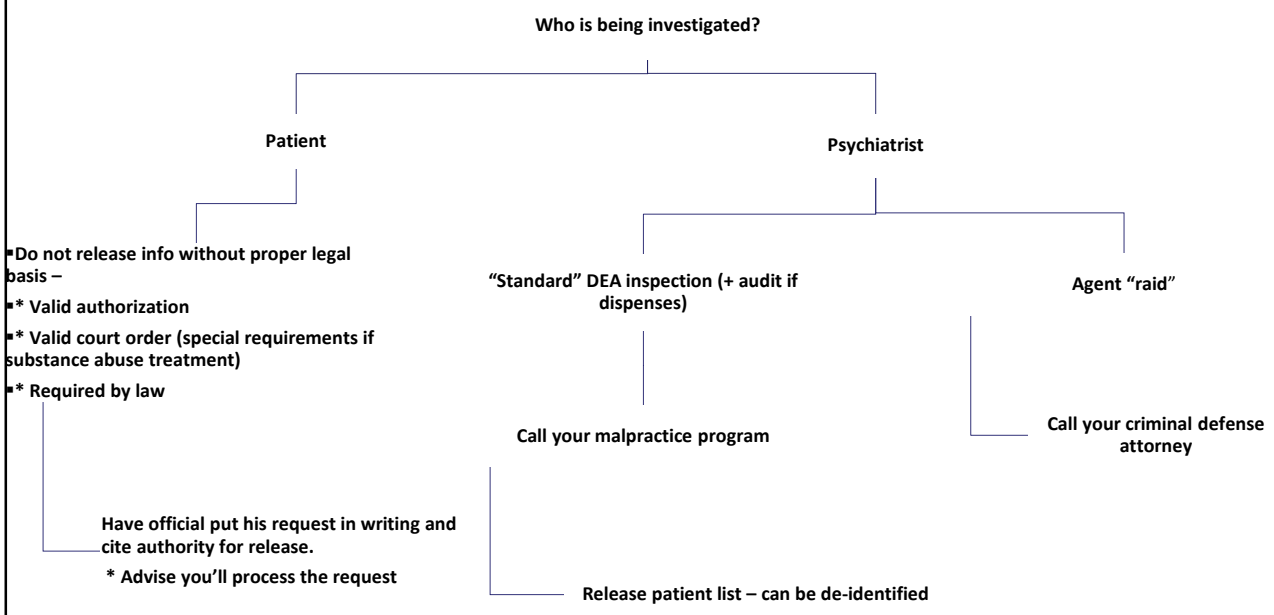
Congress passed the Drug Addiction Treatment Act (DATA) on October 17, 2000. This act permits qualified physicians to administer or dispense Schedule III, IV, or V narcotic medications, that have been approved for the maintenance and detoxification treatment of a narcotic dependent person. Thus far, the Food and Drug Administration has only approved the use of buprenorphine (mono formulation) and buprenorphine/naloxone for this purpose. The DEA is authorized by the Controlled Substances Act (21 U.S.C. 822 (f) 880 and 21 CFR 1316.03 to enter controlled premises (registered locations) and conduct periodic inspections to ensure compliance with recordkeeping, security and other requirements of the Controlled Substances Act.

2. DEA Inspections of DATA-Waived Physicians

The Drug Enforcement Administration (DEA) is responsible for ensuring that physicians who are registered with DEA pursuant to the Drug Addiction Treatment Act of 2000 (DATA 2000) comply with recordkeeping, security, and other requirements for administering, dispensing or

http://pcssmat.org/wp-content/uploads/2014/02/FINAL-How-to-Prepare-for-a-DEA-Inspection.pdf

Government Official Comes to Your Office Wanting Patient Information



STATE

LAWS

- Required use of PDMP
- Prescribing for pain
- Etc.

PROFESSIONAL RISK MANAGEMENT SERVICES (PRMS)
CAUSE OF LOSS – CLAIMS AND LAWSUITS
1986 – 2019

Primary Allegation	Patients of All Ages	Adult Patients	Minor Patients
Incorrect Treatment	33%	35%	33%
Suicide/Attempted Suicide	16%	16%	16%
Medication Issues	13%	18%	9%
Other	11%	5%	13%
Incorrect Diagnosis	9%	7%	11%
Hospital Commitment / Discharge	6%	6%	7%
Breach of Confidentiality	3%	4%	2%
Improper Supervision	6%	4%	7%
Abandonment	1%	1%	1%
Vicarious Liability	1%	2%	<1%
Forensic (expert testimony, IMEs, etc.)	<1%	<1%	<1%
Duty to Warn / Protect	<1%	<1%	<1%
Boundary Violation	<1%	1%	-

Notes:
"Primary allegation" is the main allegation by plaintiffs' attorneys of what the psychiatrist did wrong
"Incorrect treatment" will represent a high percentage of cases because plaintiffs' attorneys often use a broad, general allegation initially; this category includes all types of cases, including suicide and psychopharmacology
The category labeled "Improper Supervision" refers to supervision of patients as well as of other providers

ELEMENTS OF A LAWSUIT

1) **Duty of Care**

2) **Breach of Duty – negligence – failure to meet the standard of care**

3) **Damages**

4) **Causation**

DETERMINING THE APPLICABLE STANDARD OF CARE

Many items may be admissible, along with expert testimony, to determine the issue of standard of care. The following items could be relied upon as ***evidence of*** the appropriate standard of care:

- Statutes – federal and state
- Regulations – federal and state
- Case law – federal and state
- Other materials from federal and state regulatory agencies – state medical boards, DEA, FDA, etc.
  - Rules / Guidelines / Policy Statements
- Authoritative clinical guidelines

DETERMINING THE APPLICABLE STANDARD OF CARE

- Policies and guidelines from professional organizations
- Learned treatises
- Journal articles
- Research reports
- Accreditation standards
- Facility's own policies and procedures
- Drug label / manufacturer recommendations
- Etc.

FEDERAL STATUTE

- Controlled Substances Act (as amended by the Ryan Haight Act)
  - "Valid prescription means a prescription that is issued for a legitimate medical purpose in the usual course of professional practice by –
    - A practitioner who has conducted at least 1 in-person medical evaluation of the patient, or a covering practitioner
      - In-person medical evaluation means a medical evaluation that is conducted with the patient in the physical presence of the practitioner
      - Very limited exceptions

DEA REGULATIONS

Ex: 21 CFR 1306.04(A):

"A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose…by an individual practitioner…acting in the usual course of his professional practice"

U.S. V. ROSEN, 582 F2D 1032 (1978)

"We are, however, able to glean from reported cases certain recurring concomitance of condemned behavior, examples of which include the following:

1) An inordinately large quantity of controlled substances was prescribed.
2) Large numbers of prescriptions were issued.
3) No physical examination was given.
4) The physician warned the patient to fill prescriptions at different drug stores.
5) The physician issued prescriptions to a patient known to be delivering the drugs to others.

U.S. V. ROSEN, 582 F2D 1032 (1978)

(*CONTINUED*)

6) The physician prescribed controlled drugs at intervals inconsistent with legitimate medical treatment.

7) The physician involved used street slang rather than medical terminology for the drugs prescribed.

8) There was no logical relationship between the drugs prescribed and treatment of the condition allegedly existing.

9) The physician wrote more than one prescription on occasions in order to spread them out.

https://www.deadiversion.usdoj.gov/coronavirus.html

https://www.oregon.gov/omb/Pages/default.aspx

RISKS OF PRESCRIBING CONTROLLED SUBSTANCES

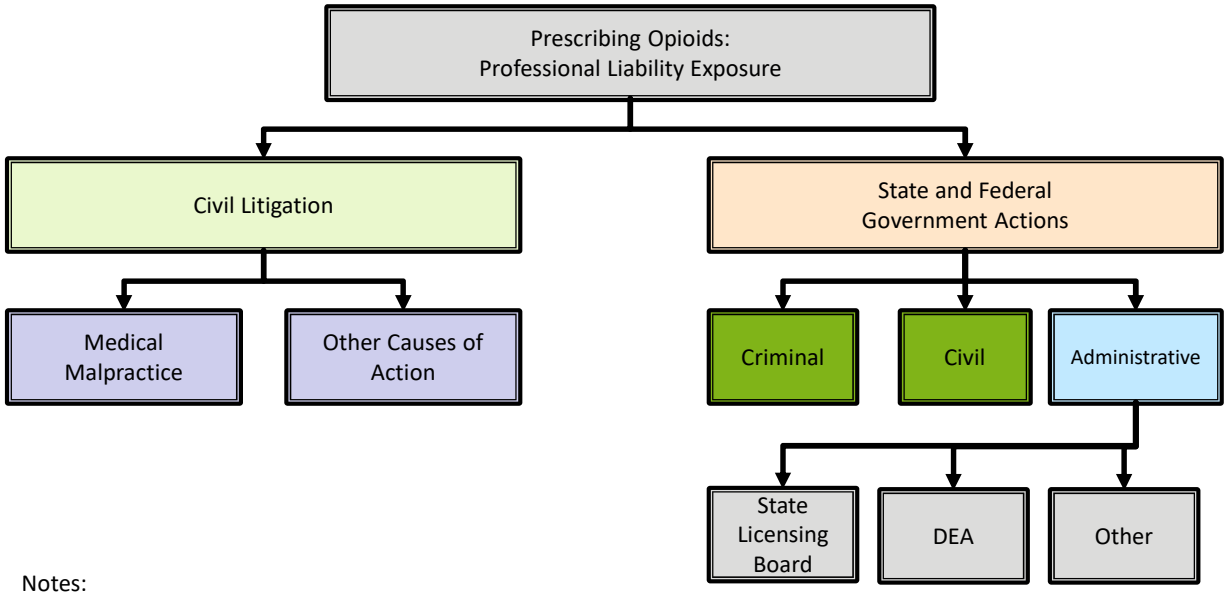
- To patients
- To third parties
- To prescribing physicians

RISKS TO PATIENTS

- Side effects
  - Including withdrawal
- Misuse
  - OD
  - Death
- Addiction
- Diversion

RISKS TO THIRD PARTIES

- Diversion
- Third party injury

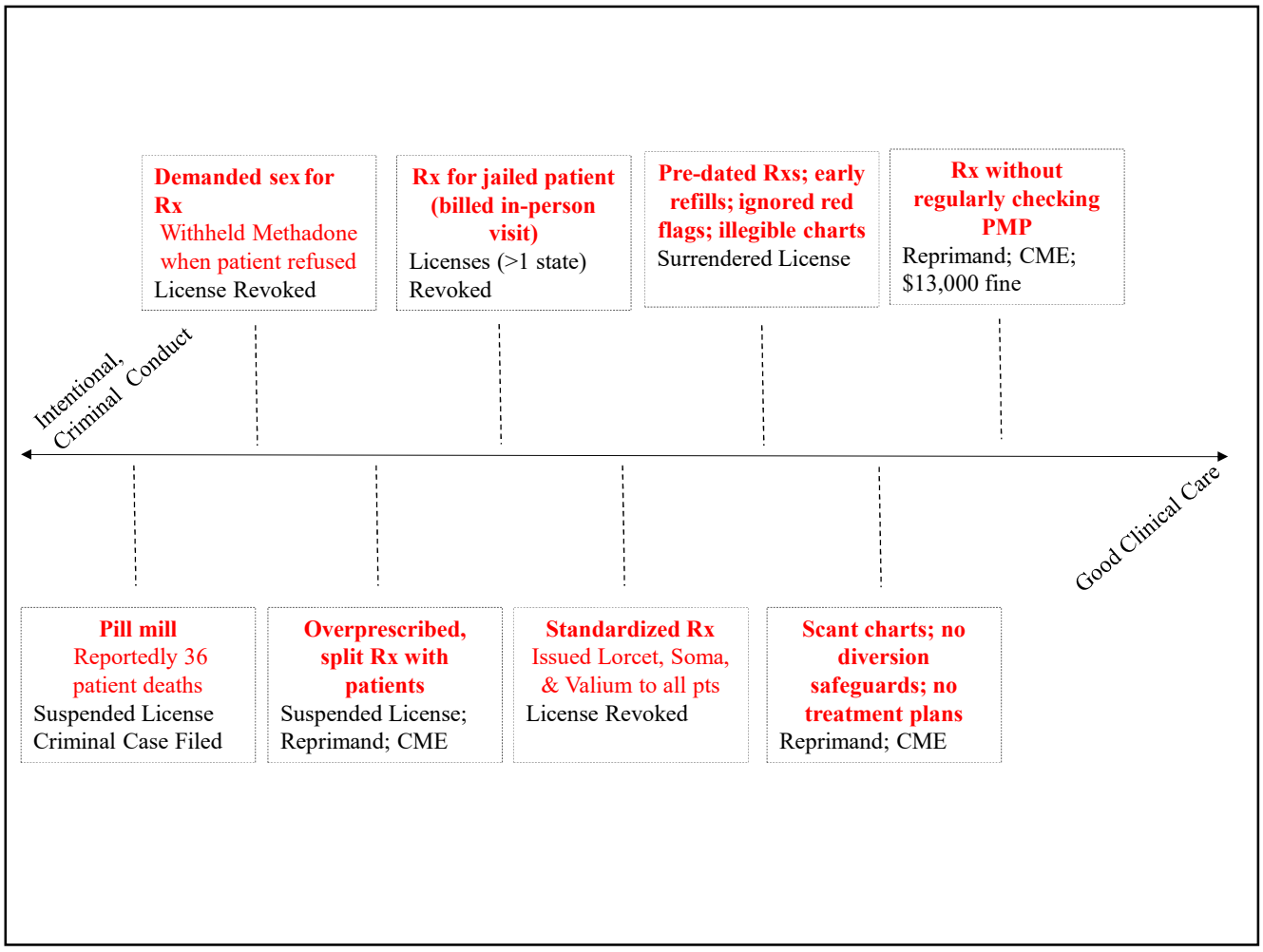


Notes:

* These actions are <u>not</u> mutually exclusive
* Professional liability insurance policies do not cover all of theses actions

RISKS TO PRESCRIBING PSYCHIATRISTS

- Civil lawsuits
- Licensing board action
- DEA action
- Criminal action


Demanded sex for Rx
Withheld Methadone when patient refused
License Revoked
Rx for jailed patient (billed in-person visit)
Licenses (>1 state) Revoked
Pre-dated Rxs; early refills; ignored red flags; illegible charts
Surrendered License
Rx without regularly checking PMP
Reprimand; CME; $13,000 fine
Intentional, Criminal Conduct
Good Clinical Care
Pill mill
Reportedly 36 patient deaths
Suspended License
Criminal Case Filed
Overprescribed, split Rx with patients
Suspended License; Reprimand; CME
Standardized Rx
Issued Lorcet, Soma, & Valium to all pts
License Revoked
Scant charts; no diversion safeguards; no treatment plans
Reprimand; CME

LIABILITY TO THIRD PARTIES

Two lines of cases imposing liability:

1) Controlled substance (usually methadone) was ADMINISTERED despite risks that were known or should have been known
2) Controlled substance was PRESCRIBED without warning patient of known side effects that could impair driving

Importance of Discussing Potential Risks of Pain Medication on Vehicle Operation

By Brittan Durham, M.D.
Health Quality Investigation Unit, Tustin Office

The Medical Board of California (Board) remains vigilant in its mission to protect the public and works with many government entities to identify adverse events, and preventable morbidity and mortality. The Board has partnered with the U.S. Drug Enforcement Administration (DEA) in investigating deaths associated with controlled substances.

The National Transportation Safety Board (NTSB), the federal agency charged with investigating civil aviation accidents in the United States as well as significant accidents on railroads, highways and waterways, is now voicing concerns regarding the use of controlled substances and the potential for impairment in driving, aviation, watercraft operations and accidents associated with working with heavy machinery.

The NTSB has recommended that state medical boards develop guidelines for prescribing controlled substances which include recommendations for health care providers to discuss with patients the effects their medical condition and medication use may have on their ability to safely operate motor vehicles, aircraft, boats, and any ancillary machinery.

The Board adopted the *Guidelines for Prescribing Controlled Substances for Pain* (*Guidelines*) with the intent of helping physicians improve patient care outcomes and prevent morbidity and mortality associated with the use and misuse of controlled substances. The *Guidelines* include an informed consent and treatment agreement for those patients who are taking controlled substances on a medium- and long-term basis. The patient consent and a pain management agreement can be combined into one document for convenience.

When considering long-term use of opioids, physicians should discuss the risks and benefits of the treatment plan with the patient and document this process in the medical records. The risks of medication should be considered in the context of the patient's potential impairment with respect to activities such as driving, flying and working with machinery.

Risks as defined by the *Guidelines* include:

- Potential side effects (both short- and long-term) of the medication, such as nausea, opioid-induced constipation and cognitive impairment.
- The likelihood that some medications will cause tolerance and physical dependence to develop.
- The risk of drug interactions and over-sedation.
- The risk of respiratory depression.
- The risk of impaired motor skills (affecting driving and other tasks).
- The risk of opioid misuse, dependence, addiction and overdose.
- The limited evidence as to the benefit of long-term opioid therapy.

The treatment agreement should outline joint prescriber and patient responsibilities so there is a documented understanding that the patient agrees to use medications safely while performing tasks that might be compromised by impaired motor skills and cognitive function. It should highlight the importance of documented routine discussions regarding a patient's medical condition and the drugs he or she takes with respect to his or her ability to safely operate any transportation vehicle with the goal of preventing accidents and saving lives.

How should I take PROZAC?

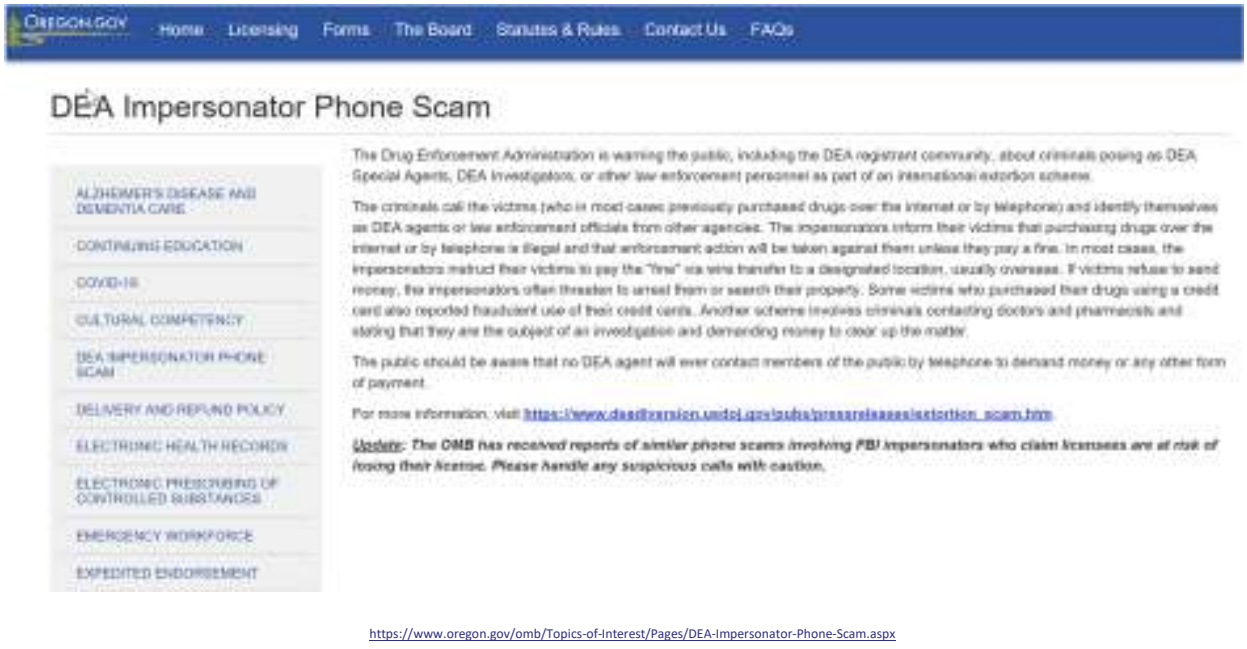
- Take PROZAC exactly as prescribed. Your healthcare provider may need to change the dose of PROZAC until it is the right dose for you.
- PROZAC may be taken with or without food.
- If you miss a dose of PROZAC, take the missed dose as soon as you remember. If it is almost time for the next dose, skip the missed dose and take your next dose at the regular time. Do not take two doses of PROZAC at the same time.
- If you take too much PROZAC, call your healthcare provider or poison control center right away, or get emergency treatment.

What should I avoid while taking PROZAC?

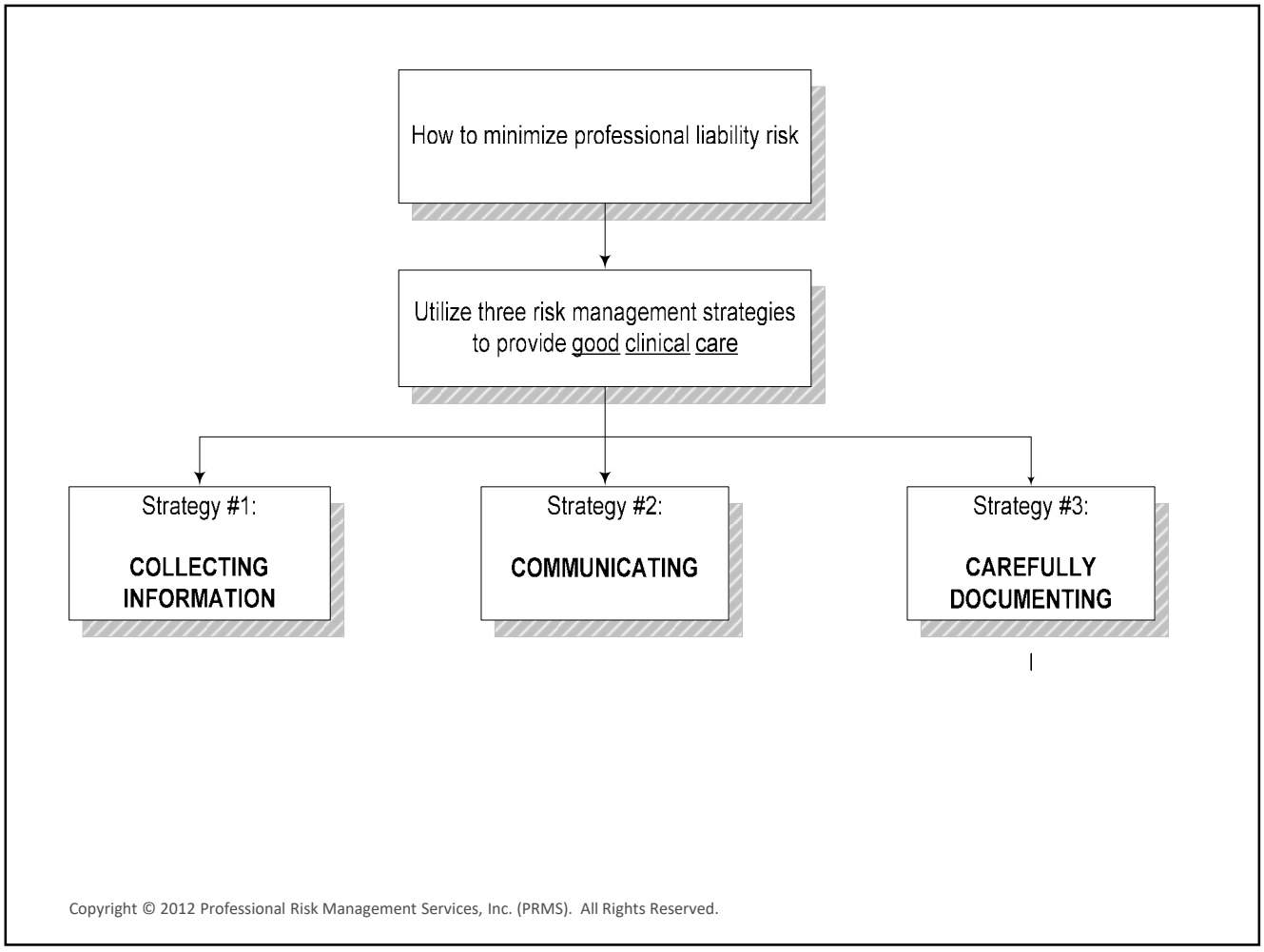
PROZAC can cause sleepiness or may affect your ability to make decisions, think clearly, or react quickly. You should not drive, operate heavy machinery, or do other dangerous activities until you know how PROZAC affects you. Do not drink alcohol while using PROZAC.

What are the possible side effects of PROZAC?

PROZAC may cause serious side effects, including:



https://www.oregon.gov/omb/Topics-of-Interest/Pages/DEA-Impersonator-Phone-Scam.aspx



COLLECT INFORMATION

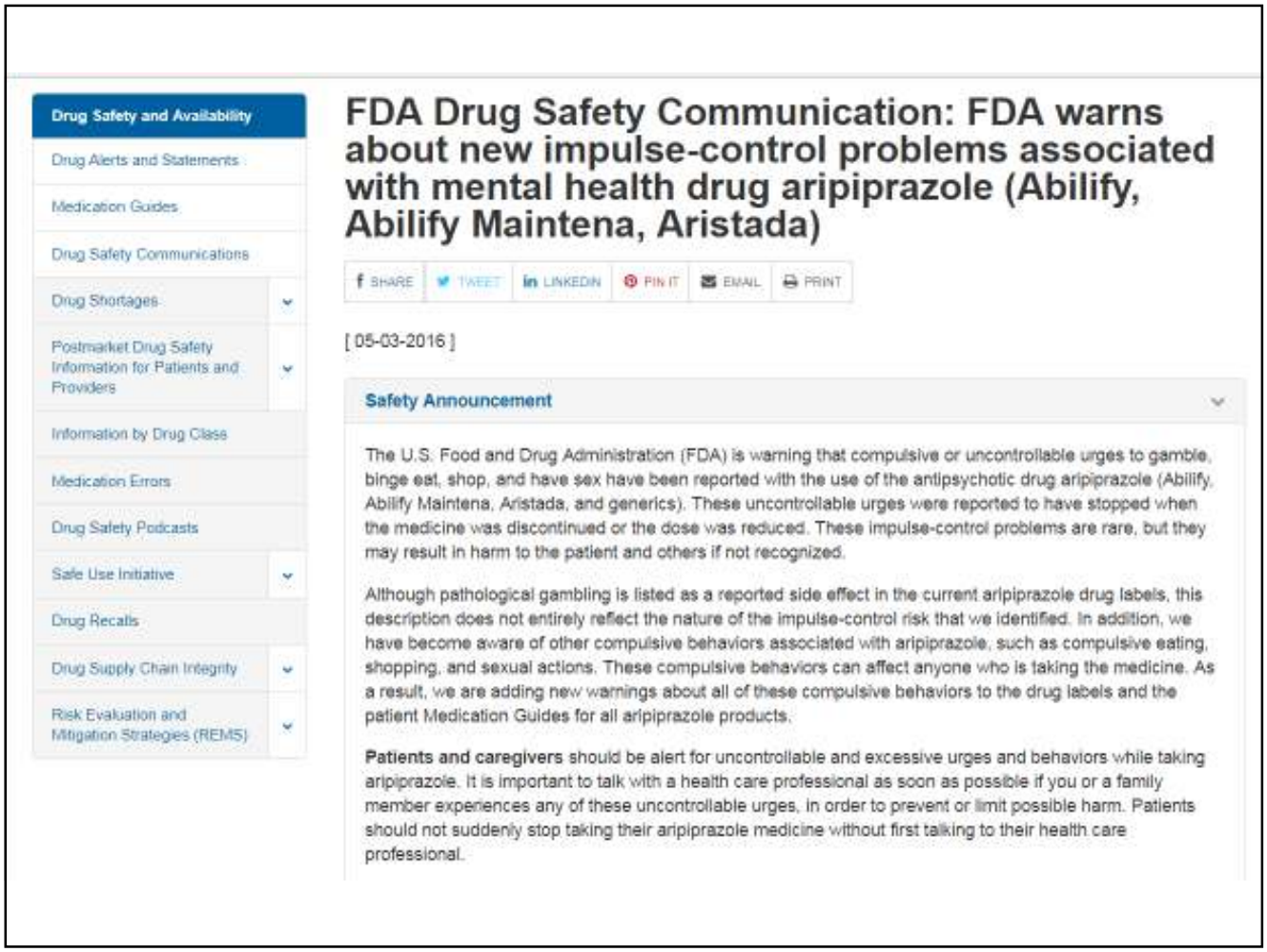
- Patient
- Medications
- Treatment / standard of care
- Abuse / diversion

COLLECT INFORMATION – ABOUT THE PATIENT

- History
- PDMP

COLLECT INFORMATION – ABOUT THE MEDICATIONS

- REMS: Strategy to manage known or potential serious risks associated with a drug product and is required by the FDA to ensure the benefits of a drug outweigh its risks


Drug Safety and Availability
Drug Alerts and Statements
Medication Guides
Drug Safety Communications
Drug Shortages
Postmarket Drug Safety Information for Patients and Providers
Information by Drug Class
Medication Errors
Drug Safety Podcasts
Safe Use Initiative
Drug Recalls
Drug Supply Chain Integrity
Risk Evaluation and Mitigation Strategies (REMS)
FDA Drug Safety Communication: FDA warns about new impulse-control problems associated with mental health drug aripiprazole (Abilify, Abilify Maintena, Aristada)
SHARE
TWEET
LINKEDIN
PIN IT
EMAIL
PRINT
[05-03-2016]
Safety Announcement
The U.S. Food and Drug Administration (FDA) is warning that compulsive or uncontrollable urges to gamble, binge eat, shop, and have sex have been reported with the use of the antipsychotic drug aripiprazole (Abilify, Abilify Maintena, Aristada, and generics). These uncontrollable urges were reported to have stopped when the medicine was discontinued or the dose was reduced. These impulse-control problems are rare, but they may result in harm to the patient and others if not recognized.
Although pathological gambling is listed as a reported side effect in the current aripiprazole drug labels, this description does not entirely reflect the nature of the impulse-control risk that we identified. In addition, we have become aware of other compulsive behaviors associated with aripiprazole, such as compulsive eating, shopping, and sexual actions. These compulsive behaviors can affect anyone who is taking the medicine. As a result, we are adding new warnings about all of these compulsive behaviors to the drug labels and the patient Medication Guides for all aripiprazole products.
Patients and caregivers should be alert for uncontrollable and excessive urges and behaviors while taking aripiprazole. It is important to talk with a health care professional as soon as possible if you or a family member experiences any of these uncontrollable urges, in order to prevent or limit possible harm. Patients should not suddenly stop taking their aripiprazole medicine without first talking to their health care professional.

NEW SAFETY INFORMATION

In response to new safety information, review the appropriateness of your prescriptions

- Communicate new information to patient – and document
- If medication is changed -
  - Document your decision-making process
  - Obtain informed consent
  - Document informed consent discussions
- If not clinically appropriate to change -
  - Document your decision-making process
  - Obtain updated informed consent
  - Document updated informed consent
  - Consider modifying patient monitoring
  - Do not hesitate to seek consultation

COLLECT INFORMATION – ABOUT TREATMENT / STANDARD OF CARE

- Medication-specific
  - Ex: opioids
- Patient-specific
  - Ex: C&A
- Expectations of regulators
  - State
  - Federal

OREGON PRESCRIPTION CONTROLLED SUBSTANCES TOOLKIT

Health System Level Interventions

Strategies	Links	References
1. Integrate PDMP patient data reviews when prescribing a new controlled substance, for early refill requests, and as part of pain management contracts; enroll providers and develop system use protocols.	**Oregon Prescription Drug Monitoring Program** http://www.orpdmp.com	Johnson et al., 2002 [6] GAO 2002 [7] Braidwood 2001 [8] Manchikanti 2007 [4] MITRE 2012 [5]
2. Integrate mental health and substance abuse screening into the health care standard of care for all ages; refer to behavioral health services and detoxification centers.	**Screening, brief intervention, and referral to treatment** http://www.sbirsoregon.org/ **Depression Screening** http://www.ahrq.gov/clinic/uspstf/uspsdepr.htm **Clinical Drug Testing** http://store.samhsa.gov/product/TAP-32-Clinical-Drug-Testing-in-Primary-Care/SMA12-4668 **SAMHSA Mental Health Treatment Locator** http://findtreatment.samhsa.gov/MHTreatmentLocator/faces/quickSearch.jsp **SAMHSA Drug and Alcohol Abuse Treatment Locator** http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jsp	Gordon et al., 2012 [9] Nunes and Mahoney 2003 [3]
3. Look at risk patients who use prescriber and one dispenser	**SAMHSA TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorder** http://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA12-4671	Carroll et al., 2012 [2]

https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SAFELIVING/PDMP/Documents/Oregon_Rx_CS_Toolkit_v5.pdf

Modus Operandi Often Used by the Drug-Abusing Patient Include:

What You Should Do When Confronted by a Suspected Drug Abuser

DO:

DON'T:

Recognizing the Drug Abuser

https://urldefense.proofpoint.com/v2/url?u=https-3A__www.deadiversion.usdoj.gov_pubs__brochures_pdfs_recognizing-5Fdrug-5Fabuser-5Ftrifold.pdf&d=DwIFAg&c=ZeRjgwCO0jrp4rkAtCoSKyq8f3EgikGx7r3AUiZ_4i0&r=nc2PKYF1vSCHtTmMBlo8-dqDsIJVbYVlykADDPcLJiM&m=0c_U4ocylu-HNvyuO6RfgCajdcx0hfpozN56KUX5tzw&s=0VqjSEX7yHmSAPvKAao9eaa9lwY_olf70adeqIHmIPE&e=

COMMUNICATE – ASSESSMENT AND MONITORING

- Conduct thorough patient examination, interview, and assessment
- Consider standardized assessment and documentation tool
  - Especially for pain
    - Ex: PADT from Janssen

COMMUNICATE – INFORMED CONSENT

Standard Elements:

- Nature of proposed medication
- Risks and benefits of proposed medication
  - Including potential for tolerance, dependence, addiction, overdose
- Alternatives to proposed medication
- Risks and benefits of alternative treatments
- Risks and benefits of doing nothing

Plus:

- Prescribing policies
- Reasons for which medication may be changed or stopped

COMMUNICATE – INFORMED CONSENT

"MATERIAL RISK"

- Disclose risk if SEVERE, even if infrequent
- Disclose risk if FREQUENT, even if not severe
- Disclose possible driving impairment
- Golden Rule

COMMUNICATE – INFORMED CONSENT

Medication Guides

- FDA
  - *www.fda.gov/drugs/drugsafety/ucm085729.htm*
- AACAP / ParentsMedGuide - ADHD
  - *www.aacap.org/App_Themes/AACAP/Docs/resource_centers/adhd/adhd_parents_medication_guide_201305.pdf*

COMMUNICATION WITH PATIENTS

Educate the patient on issues such as:

- Restrictions (driving, diet, activity, etc.) associated with the medication
- Monitoring, such as blood work, that is needed
- Purpose, dose, and frequency of the medication
- How to identify side effects, and what to do if patient experiences
- Ensuring patient's other physicians are aware of new prescriptions

COMMUNICATION WITH PATIENTS

Communicate to obtain informed consent:

- Reminders if you choose to use medication information sheets:
  - You are responsible for tailoring them to meet your patient's needs and for ensuring the information is up-to-date
  - Be sure to document in the record that the medication information sheet was reviewed with the patient and the patient was provided a copy

COMMUNICATION WITH PATIENTS

Communicate to obtain informed consent *(continued)*:

- Remember that informed consent is an ongoing communication process
- Know who has decision-making authority - obtain and retain proof of that authority
- Understand that communication is crucial to your patients' understanding of the treatment plan
- Document the informed consent process

COMMUNICATION WITH PATIENTS

Communicate to obtain informed consent *(continued)*:

- If you are prescribing off-label, discuss off-label nature of the use with the patient
  - FDA position
  - All off-label prescribing is NOT the same in terms of medical malpractice risk

COMMUNICATE – TREATMENT AGREEMENT

- Can Cover:
  - Intended benefits of using controlled substances
  - Risks of the treatment – tolerance, dependence, abuse addiction
  - Prescription management – security of meds

COMMUNICATE – TREATMENT AGREEMENT

- Can Cover (*Continued*):
  - Office policies
    - Only one prescriber
    - Only one pharmacy
    - Not replacing lost or stolen prescriptions
    - Prohibiting dose or frequency increased by patient
    - Use of PMP
    - Random pill counts
    - Random urine screening
  - Termination for
    - Failure to adhere to treatment plan
    - Aberrant Behavior
  - Etc.

COMMUNICATE – DISPOSAL OF UNUSED MEDICATIONS

The FDA's

"Disposal of Unused Medicines: What You Should Know"

www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/ensuringsafeuseofmedicine/safedisposalofmedicines/ucm186187.htm

COMMUNICATE – WITH OTHERS

- Other providers:
  - Covering
  - PCP, specialists
  - Consultants
- Family
  - Remember: safety = exception to confidentiality

CAREFULLY DOCUMENT

Generally:

- Medication log
- Evaluation
- Medial indication for prescription
- Treatment plan
  - Initial
  - Updated
- Treatment agreement, if any
  - Subsequent discussions about agreement

CAREFULLY DOCUMENT

Generally (*Continued*):

- Informed consent
  - Patient Education Materials
- Ongoing assessment
  - Adherence to treatment plan
  - Medication monitoring
  - Aberrant behavior
- Referral / consultation, if necessary
- Basis for clinical decision-making

CAREFULLY DOCUMENT

Remember:

- There's no such thing as a perfect record
- Defense attorneys can work with adequate records
- Defense attorneys cannot work with no records or altered records

CAREFULLY DOCUMENT

Professional Judgment – Bottom Line:

- By articulating the basis for medical decisions in the record, the psychiatrist's professional medical judgment will be clear and available to defend the psychiatrist against allegations of malpractice.

Prescribing Controlled Substances

PILL "PUSHER"/ PILL MILL

- No medical history
- Inadequate, or no physical examination
- No informed consent

- Lack of urine screens, or results ignored
- No documentation of prescriptions
- Very large quantities prescribed
- Large number of prescriptions
- PMP not checked, or results ignored
- Lack of monitoring

- No documentation
- No logical relationship between medications prescribed and treatment and alleged condition
- No precautions against abuse or misuse

- No communication with other providers
- Information from third parties (pharmacists, other providers, etc.) ignored
- Patients charged based on number of pills prescribed

LEGITIMATE PATIENT CARE

- Medical history
- Physical examination
- Informed consent obtained, including discussion of applicable driving risks
- Random urine testing
- Prescription details documented
- Clinically appropriate quantities prescribed
- Reasonable number of prescriptions provided
- PMP checked and information incorporated into treatment
- Patient monitoring - drug screens and adequate time spent with patient
- Documentation of decision-making process
- Evidence to support medications for patient's condition

- Treatment agreement including only one pharmacy requirement, prescription rules, termination for non-adherence, etc.
- Communication and coordination with other prescribers
- Information from third parties is considered and treatment is revised accordingly
- Appropriate billing for treatment provided

WHAT WOULD YOU DO?

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