

RISK MANAGEMENT PLAN: PREPARING FOR PRIVATE PRACTICE



PREPARING FOR PRIVATE PRACTICE: DEVELOP A RISK MANAGEMENT PLAN FOR YOUR PRACTICE

As you begin your career in the practice of psychiatry, we invite you to develop – based on your individual practice – a risk management plan using strategies that support improved patient care and decreased professional liability.

Preparing for Private Practice covers eight vital risk management issues to consider. For each issue, there is an accompanying self-assessment. We have also included several tools for practical assistance, such as a model form, to further assist you in implementing the risk management strategies. *Preparing for Private Practice* is designed to be a resource that you can refer to over the years as your practice evolves.

Of course, the information presented in this resource is for your consideration only. As with any guidelines, there may be suggestions that in your professional judgment are not appropriate for you, for your patients, or for your practice. This information should not be considered a standard of medical care.

We hope you find this risk management resource useful!

The content of this booklet ("Content") is for informational purposes only. The Content is not intended to be a substitute for professional legal advice or judgment, or for other professional advice. Always seek the advice of your attorney with any questions you may have regarding the Content. Never disregard professional legal advice or delay in seeking it because of the Content.

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GETTING STARTED

I. BUILD GOOD RELATIONSHIPS

For any psychiatrist entering into, or already in, private practice, there are a variety of professionals and entities with which it is advisable to forge and maintain relationships. There are multiple benefits to having these types of relationship, but primarily, they provide support that allows the psychiatrist to remain as focused as possible on meeting patients' clinical needs, which leads to the secondary benefit of helping to minimizing professional liability risk. They are:

An experienced colleague

An attorney

An accountant

Professional organizations

Trusted insurance professionals

An Experienced Colleague

Having a relationship with an experienced colleague who is willing to serve as mentor, consultant, advisor, and perhaps cover your practice occasionally, can go a long way toward helping you provide the best care for patients and, thus, reduce your professional liability risk.

In a malpractice lawsuit, the standard of care – the care that should have been delivered – largely is determined by other psychiatrists in the role of expert witnesses. The standard of review is reasonableness – what would a reasonable psychiatrist do under similar circumstances. Each time a second psychiatrist consults on or reviews a patient's clinical treatment, the treatment course tends toward reasonableness.

When a complex case presents itself, or a case calls for difficult clinical judgments, or a patient does not seem to be progressing, the need for a "second set of eyes" to review the case becomes even more acute. Many psychiatrists who find themselves as defendants in a lawsuit might have benefited from either a formal or "curbside" consultation on a patient.

An Attorney

An attorney experienced in healthcare law, reimbursement matters, and organizing physician practices can be an invaluable resource throughout any career. Spending an

hour with an attorney so that he can get to know you and your practice may be well-worth the fee. After questions arise, it may be difficult to start searching for an experienced attorney. Knowing an attorney before a problem arises can help you sleep at night.

For example: Laws inevitably change, and many attorneys will periodically update their clients on changes in the law that might affect their clients' practices.

An Accountant

An accountant with experience in healthcare reimbursement and business management is extremely important for those entering private practice, especially for those without experience running a business.

Professional Organizations

Join and participate in professional organizations. Psychiatry can be a lonely practice, especially for solo practitioners. Get out and rub elbows with colleagues. A major advantage to personally attending meetings is the opportunity to speak with colleagues and compare approaches. Talking about and comparing notes on cutting edge technologies, new treatment approaches, and the latest research can help you stay up-to-date with the latest medicine.

Trusted Insurance Professionals

Finally, have good insurance. Most psychiatrists will need at least a general liability policy and a medical malpractice policy. No matter which carrier you choose, the insurance professionals you interact with should help you understand your insurance needs and answer your questions. Having a good general liability policy and a good medical malpractice policy will allow you to focus on providing good patient care with one less worry.

II. UNDERSTAND THE STANDARD OF CARE

The psychiatrist owes a legal duty of care to her patients, but the obligation is not simply to care for them in any way she sees fit. The psychiatrist must care for patients in accordance with the standard of care.

The exact definition of standard of care varies by state, but generally, it is the degree of skill, care, and diligence exercised by members of the same profession or specialty practicing in light of the present state of medical science. It is important to keep in mind that **the standard of care does not mean optimal care**, but includes a range of acceptable treatment options.

There are many factors that could be used as evidence of the applicable standard of care for a particular patient care issue. These factors that determine the applicable standard of care include, but are not limited to, the following:

- Federal and state statutes – such as federal and state prescribing laws
- Federal and state regulations – such as regulations from your state medical board, the Food and Drug Administration, and the Drug Enforcement Agency
- Caselaw – federal and state
- Other statements from federal and state regulatory agencies – such as guidance documents or policy statements from your state medical board
- **Authoritative** clinical guidelines – such as the American Psychiatric Association’s practice guidelines
- Policies and guidelines from professional organizations – such as the *PhysiciansMedGuide*, a joint statement by the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry, which addresses the treatment of children with depression
- Treatises
- Journal articles
- Accreditation standards – such as Joint Commission standards
- A facility’s own policies and procedures
- *Physicians’ Desk Reference*

In psychiatric malpractice litigation, the standard of care is established primarily by psychiatrists in the role of the expert witness. The expert witness will offer an opinion whether the treating psychiatrist met the standard of care based on the items mentioned above evidencing the applicable standard of care, the expert witness’ own clinical experience and education, and the clinical record.

The failure to meet the standard of care can be a result of unintentional negligence, but it does not include the exercise of professional judgment. In other words, a psychiatrist

can use proper professional judgment and there may still be a bad outcome (e.g., a bad reaction to a medication). A bad outcome is not itself evidence of malpractice, as exemplified in the adage "the operation was a success, but the patient died anyway." Accordingly, the psychiatrist's documentation should support the care that was given and should enable someone else – such as an expert witness – to read the record and know what happened and why. One way to accomplish this is to document not only what happened in treatment and why, but also what actions were considered but rejected and why.

Ultimately, the best risk management approach is to provide thoughtful care and treatment that meets or exceeds the standard of care.

III. KNOW YOUR RISK TOLERANCE

Each time a psychiatrist is faced with the dilemma of reconciling the standard of care with the quality of care actually delivered, it is imperative that she, as a professional, not only identify and evaluate the associated risks, but also recognize her tolerance for those risks. A good analogy to this process is driving. Most drivers exceed the speed limit occasionally, despite the risks associated with doing so (e.g., tickets, an increased likelihood of accidents).

Some drivers, however, never exceed the speed limit; they have a low tolerance for the risks. Other drivers always exceed the speed limit; they have a high tolerance for the risks. Most drivers fall somewhere in-between.

Some psychiatrists emphasize risk management and incorporate numerous risk management strategies into their practices (e.g., always send a follow-up letter for missed appointments, compose extensive and detailed documentation); they have a low tolerance for the risks. Other psychiatrists are less focused on risk management and incorporate few or no risk management strategies into their practices (e.g., never send follow-up letters for missed appointments, little or minimal documentation); they have a high tolerance for the risks. Most psychiatrists fall somewhere in-between. It is important for each psychiatrist to know where she falls on the spectrum.

ESTABLISHMENT OF THE TREATMENT RELATIONSHIP ASSESSMENT

I understand that once I have established a treatment relationship with a patient, the duty of care exists, and I am legally and ethically obligated to continue treating the patient until the relationship has been properly terminated.

I am aware that I can create a physician-patient relationship either intentionally or inadvertently.

I understand that clear indicators of the existence of a treatment relationship include:

- prescribing medication
- ordering tests
- receiving payment for services

I understand that other ways a treatment relationship may be established include:

- employment situations
- contracts
- EMTALA

I understand that ways in which a treatment relationship can be created inadvertently include, but are not limited to:

- cyber activity (e.g., e-mail)
- prescribing for family and friends (AMA Ethics Opinion E-8.19)

I understand that non-treatment relationships (including consultation and independent medical examinations) contain different legal and ethical obligations than a treatment relationship.

I clarify and manage expectations about my role in any professional relationship at the beginning of that professional relationship.

I try to avoid assuming dual roles with current patients (e.g., avoid being both an expert witness and a treating provider).

TERMINATION OF THE TREATMENT RELATIONSHIP ASSESSMENT

I do not terminate with a patient who is in crisis (imminently suicidal or homicidal).

If I terminate while a patient is hospitalized (transferring care), I inform the inpatient provider that I will not be available to treat the patient upon discharge.

I have checked with my state licensing board (contact information on page 31) to determine if there are laws, policies, or position statements related to termination.

Termination is not my first response to an outstanding patient balance.

If I terminate treatment with a patient, I utilize the formal termination process:

- I discuss the termination with the patient,

- I provide reasonable notice (usually 30 days),

- I make clinical recommendations – for further treatment, stopping medications abruptly, etc.,

- I provide referral resources,

- I give a specific termination date, after which I will no longer be available to treat the patient,

- I offer to forward the record to the new provider, and

- I send a follow-up letter confirming the above, unless clinically contraindicated.

If a patient who is not in crisis “fires” me, I consider sending a letter to the patient confirming that the patient has terminated the treatment relationship and that I am no longer available to treat the patient.

The termination letters that I send are sent both certified (for proof of mailing) and first class (to ensure patient receives), unless clinically contraindicated.

I try to avoid prescribing past the termination date.

TOOL: MODEL LETTER

TERMINATION OF THE PSYCHIATRIST- PATIENT RELATIONSHIP

PERSONAL & CONFIDENTIAL

Date

Address

Dear [Name of Patient]:

This is to inform you that I believe it is necessary to terminate our professional relationship. [Psychiatrist may wish to specify reason.]

I have been serving as your psychiatrist since [specify date] and am currently treating you for [indicate diagnosis] with a program of [specify treatment modality, including drugs]. In my view, you [would/would not] benefit from continued treatment.

If you decide to continue to receive treatment, you are, of course, free to choose any psychiatrist. However, you may wish to call one of the following [psychiatrists/facilities/ERs/referral services], who may be willing to accept you as a patient. [Indicate specific referrals with telephone numbers.]

If you find that none of these choices is acceptable, please call me. I will make every effort to suggest other alternatives. If you decide to continue treatment, I will forward copies of your clinical record to your new doctor when I have received your written authorization. [Psychiatrist may want to include a blank authorization form for the patient's convenience.]

Finally, be assured that I will be available to treat you until [specify date]. After that date, I will not be available. Remember that you can always contact the local mental health clinic or the emergency room for assistance. [The following factors, among others, may be used to determine what is a reasonable length of time for continued availability in a particular situation: condition of the patient, availability of other psychiatric services in the community, reason for termination, and length of the psychiatrist-patient relationship.]

Sincerely,

[Psychiatrist]

[This model letter is intended as a general guideline. You may need to make adjustments in order to tailor this letter to your needs. You may also wish to check with your professional liability insurance carrier to obtain a model termination letter.]

INFORMED CONSENT ASSESSMENT

I understand that informed consent is actually an on-going communication process between me and my patient, rather than merely a form signed by the patient.

I consider all five steps of the informed consent process:

- I determine who may legally consent

- I discuss the informed consent issues with the patient or the party with authority to consent

- The treatment decision is made by the patient or patient's decision-maker

- I document the process

- I periodically re-evaluate consent to ensure it remains relevant and meaningful

The following are included in my informed consent discussion (unless there are reasonable exceptions):

- The nature of the proposed treatment

- The risks and benefits of the proposed treatment

- The alternatives to the proposed treatment

- The risks and benefits of the alternative treatments

- The risks and benefits of doing nothing

I discuss the informed consent issues with my patient, rather than delegating that task to my staff.

I understand that the patient has the right to refuse treatment - even if I disagree with that decision - after being educated about the possible consequences of doing nothing.

For minor patients with parents who are divorced or separated, I obtain a copy of the legal document (separation agreement or custody agreement) that sets out the rights of each parent in terms of making treatment decisions and obtaining treatment information.

For adult patients with substitute decision-makers (such as guardians), I obtain a copy of the legal document providing medical decision making authority (such as the court order appointing the guardian).

I avoid relying on the “therapeutic privilege” exception to obtaining informed consent.

If I only obtain verbal consent, I write an entry in the record indicating what the patient was told, the patient’s understanding, and the patient’s consent. I may also personalize the entry with specific issues and/or questions addressed with the particular patient.

If I use consent forms signed by the patient:

I realize that such forms cannot replace the consent discussions between me and my patient.

I review the forms and update, as needed, periodically

I am clear on when utilization of a consent form is legally required (such as when performing research, ECT, etc.)

I have checked with my state licensing board (contact information on page 31) to determine if there are guidelines or policy statements relating to informed consent.

Even if not required, I consider using consent forms when:

Recommending medications with known serious side effects (such as tardive dyskinesia, lithium toxicity, neuroleptic malignant syndrome, etc.)

Recommending an off-label use of a medication – to educate about the nature and the risk of the off-label use

If I recommend treatment that is considered controversial, experimental, complementary or alternative, the information I disclose is expanded and very specific written consent is obtained. The additional information includes the scientific basis for the treatment, if it is considered the standard of care, and why more conventional therapies are not being used.

If I use patient information handouts:

I do not rely exclusively on brochures, pamphlets, or articles to provide information about the treatment.

They are reviewed and updated, if needed, periodically

I keep a copy in the patient’s record of informed consent forms, written instructions, and educational information, including medication information sheets, provided to the patient.

DOCUMENTATION

Good documentation supports quality patient care and is your primary means of demonstrating that you practiced responsible medicine during the course of treatment. Courts view a carefully kept treatment record as a psychiatrist's written testimony.

What standard must a record satisfy? There is no simple answer. Requirements vary from state to state and from practice setting to practice setting. The following list presents the suggested major "contents" of a psychiatric record. *Please remember that federal and state laws and regulations may impose additional requirements.*

1. Dates (and length) of service
2. Pertinent history
3. Initial assessment, diagnosis, and subsequent re-assessments of the patient's needs
4. Any signed informed consents for treatment and authorizations for release of information, including releases to third-party payors
5. Names, addresses, and telephone numbers of the patient and designated others, if the patient has granted appropriate authorization to communicate with others
6. Consultations with other health care providers
7. Reports from psychological testing, physical examinations, laboratory data, etc.
8. What treatment options/actions were considered, what options/actions were chosen and why, and what options/actions were rejected and why
9. Prescriptions of medications, adjustments of dosage, etc.
10. Progress notes or other documentation that reflects a patient's reaction to treatment or the need to change treatment
11. Documentation of the termination process
12. A discharge summary (if relevant), including patient's status relative to goal achievement, prognosis, and future treatment considerations
13. Copies of relevant correspondence concerning the patient

There is no such thing as a perfect record. A psychiatric record does not have to be "perfect," but it should be "good enough." What does that mean? While the specific content of a psychiatric record may vary, the purpose of documentation remains constant. A good record accomplishes several things: it substantiates your clinical judgment and choices, demonstrates the knowledge and skill you exercised during treatment, provides a contemporaneous assessment of the patient's needs and behaviors, and documents significant events, revisions to the treatment plan, and explanations of your decisions.

DOCUMENTATION ASSESSMENT

I try to document my decision-making process – the actions I take and why, as well as actions I considered but rejected, and why.

I understand the primary purpose of the record is a clinical purpose – treatment of the patient.

I try to document so that subsequent treaters will understand what happened in my treatment in why.

I understand that if I am a Covered Entity under HIPAA's Privacy Rule, and if I chose to keep "psychotherapy notes" [process notes of no value to anyone else that are kept separate from the rest of the record], that the patient can authorize the release of psychotherapy notes to any third party, even if state law says notes never have to be disclosed.

I understand that if I am not a Covered Entity under HIPAA's Privacy Rule, and I choose to keep personal notes, I may have to release these notes, even if state law says otherwise.

I document discreetly, knowing that whatever I document - even in the form of personal notes – may, under some circumstances, have to be disclosed.

I use abbreviations very carefully – only accepted abbreviations, etc. - so that my documentation, including abbreviations, can be understood by other treaters.

If handwritten, my documentation is legible.

I try to document as soon as possible after the patient encounter.

I try to document telephone calls with patient.

If I need to correct the record, I draw a single line through error (so the error is still readable), mark it "error", and sign and date the correction.

I understand that there is no such thing as a “perfect” record.

I have checked with my state licensing board (see contact information on page 31) to determine if there are specific rules, regulations, or policies related to documentation.

I am aware of requirements for documentation in authoritative clinical guidelines.

I never alter records.

I understand that in the event of future litigation, expert witnesses will base their opinions on whether or not the standard of care was met, in part, on my documentation.

I understand there are serious consequences for failure to document – malpractice cases are much harder to defend, and it may be a violation of state law (which could evidence a breach of the standard of care and subject me to discipline by my licensing board).

CONFIDENTIALITY ASSESSMENT

I and my staff understand I am legally and ethically obligated to maintain the confidentiality of my patients' information.

I and my staff understand the various laws related to confidentiality:

- State confidentiality law

- Federal confidentiality law, including:

 - HIPAA's Privacy and Security Rules

 - 42 CFR Part 2 (relates to confidentiality of substance abuse treatment records)

I and my staff understand that the authorization of the patient or the patient's legally authorized representative is required in order to release confidential patient information, unless an exception applies.

I approve the release of any confidential patient information prior to information being released.

In the case of a government official (police officer, investigative agent, etc) demanding access to patient information without proper written authorization, my staff and I

- Politely decline to answer inquiries about patients

- Assure the requesting party that while I wish to be cooperative, I may have conflicting obligations to maintain patient confidentiality

- Ask the requesting party to put the request in writing and cite his/her authority for obtaining the information.

- Assure that the request will be processed as quickly as possible.

- Call to consult with Risk Management if I have any questions about the request for information.

I and my staff understand that confidential patient information must not be discussed in places or at times when others may overhear, whether in or out of the office.

If I have staff, I allow staff only to access medical records on a "need to know" basis and only to the extent necessary for staff to fulfill their designated functions.

Because confidentiality survives the death of a patient:

When faced with inquiries from insurance companies, law enforcement officers, other government officials, other patients, my staff and I politely decline to answer inquiries, and ask the requesting party to put the request in writing and cite his/her authority for obtaining the information.

When faced with inquiries from family members of a deceased patient, I am supportive to the family, but understand that specific confidential treatment information about the patient cannot be disclosed to family members without valid authorization from the person legally authorized to give consent after death. I understand that an appreciation of confidentiality obligations does not preclude me from offering support and expressing care and concern for the patient's family.

I never hesitate to consult with a risk manager for advice on handling requests for deceased patients' confidential information.

When releasing patient information, I never provide the original record – I provide a copy.

I understand the relevant law related to subpoenas for records and understand that a subpoena is not a court order and may not be sufficient to compel release of psychiatric information.

If I have any questions about the validity of a subpoena or court order, I call to consult with Risk Management.

Each member of my staff has received training on confidentiality of patient information.

The training is documented.

The training is updated periodically with new requirements and just to remind staff of their obligations.

Each member of my staff has signed a confidentiality agreement acknowledging their obligation to protect patient confidentiality.

If patient information is released to a third party to perform a service or function on my behalf (such as a billing service or software vendor):

Only the minimum information necessary to provide the service is to be released.

The third party should provide a confidentiality agreement, or if I am a covered entity under HIPAA, a "Business Associate Agreement".

If a patient account is turned over to a collection agency:

Only the minimum information necessary to pursue the account is released – patient demographics, dates of service, and amount owed.

The collection agency should provide a confidentiality agreement, or if I am a covered entity under HIPAA, a "Business Associate Agreement".

TREATING PATIENTS WITH SUICIDAL BEHAVIORS ASSESSMENT

I explore suicide potential at the outset of treatment and at other points during treatment, including, but not limited to:

- Whenever there is an incidence of suicidal or self-destructive ideation or behavior
- When significant clinical changes occur
- When there is any modification in supervision or observation level
- At the time of discharge or transfer from one level of care to another
- At other times, as clinically indicated

I try to obtain past treatment records and I document my attempts.

I communicate with other treaters, especially when the patient is being treated in a split or collaborative treatment arrangement.

I inquire about access to firearms and other weapons.

I involve the patient's family or significant others to gather information and develop safety plans.

I know the criteria and procedures for involuntary hospitalization in the jurisdictions in which I practice.

I do not rely solely on "no-harm" contracts as a guarantee of patient safety. If I use such a tool, I understand it is one part of a comprehensive treatment plan and it is my responsibility to evaluate the patient's overall suicide risk and ability to participate in the overall treatment plan.

I try to document all relevant information about a patient's condition, treatment options considered, and the rationales for choosing or rejecting each option.

I never alter or destroy a patient record after an adverse event.

- If there is relevant information I believe should be added, I do not hesitate to consult with my risk manager to determine how to do so without altering the record.

I use extreme care when terminating treatment with potentially suicidal patients.

I avoid terminating during periods of crisis.

If termination is necessary, I consider terminating (transferring care) while patient is hospitalized under the care of another psychiatrist. (See also Termination on page 9.)

I prescribe medications judiciously and carefully manage prescription refill requests.

I try to alert my covering colleagues to my high-risk patients.

I consider alerting family members / significant others, even without patient consent, to the risk of outpatient suicide when the risk is significant, family members do not seem to be aware of the risk, and the family might contribute to the patient's safety.

I try to stay current with authoritative clinical guidelines to assess the level of suicide risk and facilitate the development of a reasonable intervention and treatment plan based on the assessed risk level.

I am familiar with, and follow, facility policy and procedures regarding the management of patients with suicidal behaviors, including ordering appropriate patient supervision levels.

I understand that listening to concerns of family members and other third parties is not breaching confidentiality; in fact, listening to others may provide invaluable information and insight into the patient's suicide risk.

If I have staff, the threshold for getting patient concerns to me is low.

I appeal, if appropriate, adverse benefits decisions by insurance companies.

I do not hesitate to consult with or refer to colleagues when appropriate.

If a patient attempts or completes suicide:

I call my liability insurance carrier to report an event as soon as possible.

I refrain from discussing the case with anyone other than my Claims Examiner and my attorney.

I call my risk manager with all requests for patient information after the event.

I understand that confidentiality survives the patient death. (See Confidentiality on page 16 for specific advice.)

Suicide Assessment Five-step Evaluation and Triage **SAFE-T**

1	2	3	4	5
IDENTIFY RISK FACTORS Note those that can be modified to reduce risk	IDENTIFY PROTECTIVE FACTORS Note those that can be enhanced	CONDUCT SUICIDE INQUIRY Suicidal thoughts, plans, behavior and intent	DETERMINE RISK LEVEL/INTERVENTION Determine risk. Choose appropriate intervention to address and reduce risk	DOCUMENT Assessment of risk, rationale, intervention, and follow-up

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge

1. RISK FACTORS

- ✓ **Current/past psychiatric diagnoses:** especially mood disorders, psychotic disorders, alcohol/substance abuse, Cluster B personality disorders. *Co-morbidity and recent onset of illness increase risk*
- ✓ **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- ✓ **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
- ✓ **Family history:** of suicide, attempts or Axis I psychiatric diagnoses requiring hospitalization
- ✓ **Precipitants/stressors:** triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). History of abuse or neglect. Intoxication
- ✓ **Access to firearms**

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- ✓ **Internal:** ability to cope with stress, religious beliefs, frustration tolerance, absence of psychosis
- ✓ **External:** responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- ✓ **Ideation:** frequency, intensity, duration--in last 48 hours, past month and worst ever
- ✓ **Plan:** timing, location, lethality, availability, preparatory acts
- ✓ **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun), versus non-suicidal, self-injurious actions
- ✓ **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; explore *ambivalence*: reasons to die vs. reasons to live

* **Homicide Inquiry:** *when indicated, esp. postpartum, and in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above*

4. RISK LEVEL/INTERVENTION

- ✓ **Assessment of risk level is based on clinical judgment,** after completing steps 1-3
- ✓ **Reassessment** as patient or environmental circumstances change

RISK LEVEL	RISK / PROTECTIVE FACTORS	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric diagnoses with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan Give local/national emergency info*
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction Give local/national emergency info*

(This chart is intended to represent a range of risk levels and interventions, not actual determinations)

National Suicide Prevention Lifeline
***1.800.273.TALK**

5. DOCUMENT

- ✓ **Document:** Rationale for risk level, the treatment plan to address/reduce the current risk (i.e., medication, setting, E.C.T., contact with significant others, consultation) and firearm instructions, if relevant

RESOURCES

- Download this card and additional resources at www.sprc.org or at www.stopasuicide.org
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide <http://www.stopasuicide.org/professional.aspx>
- SAFE-T drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors http://www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx

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DEVELOPED BY DOUGLAS JACOBS, MD



PRESCRIBING ASSESSMENT

PRESCRIBING

I stay current with professional literature and research regarding the medications I prescribe (for both approved and off-label uses).

I prescribe medications only in the context of a physician-patient relationship.

I do not prescribe medications for individuals for whom I am purely a consultant.

I do not prescribe medications that are not FDA approved (NOTE: This is different than off-label prescribing of medications.)

I document all prescriptions and refills (preferably in a medication log for each patient).

I try to document the clinical assessment and clinical judgment which is the basis for treatment recommendations and prescribing decisions.

Periodically, and as new information is released, I reevaluate the medications I prescribe and the clinical basis for prescribing. I update treatment plans and recommendations accordingly.

I obtain the patient's informed consent and document the consent when prescribing medication. Including:

- The nature of the proposed treatment
- The risks, benefits, and potential side-effects of the proposed treatment
- Any alternatives to the proposed treatment
- The risks and benefits of the alternatives
- The risks and benefits of doing nothing

I place a copy of any informational materials given to the patient about the medication in the patient's record.

If applicable, I clarify with the patient that the proposed treatment is an off-label use of the medication.

I maintain a file containing any scientific literature, professional information, and contacts with the FDA and others which supports the off-label use of medications.

I am aware of and use caution when "stacking" medications/using polypharmacy.

I communicate with other health care providers about the medications that are being prescribed by all physicians involved in the patient's treatment and about signs, symptoms, and responses to the medications.

I consider accessing my state's Prescription Monitoring Program (PMP) database prior to prescribing controlled substances, even if I'm not technically required to do so.

I consider professional consultation or a referral to another physician with appropriate training and expertise, when appropriate.

I remain aware of and assess for the potential for misuse or abuse of medications by the patient or those who may have access to the medication.

I discuss with the patient the importance/benefits of:

- Seeing only one psychiatrist
- Having prescriptions filled at only one pharmacy
- Keeping track of medications
- Getting prescriptions only during office hours
- Destroying all old or unused medications

I document that the following were completed when medications are prescribed:

- Appropriate baseline laboratory testing
- A comprehensive patient history
- Any necessary physical examinations

MONITORING

I have in place a system for regularly monitoring medications prescribed as well as documenting the results of monitoring. For elements of a monitoring system, see page 25.

I am aware of the relevant authoritative guidelines related to monitoring and either comply or if not appropriate to follow, have alternative methods to ensure the standard of care is met. If I do not follow the guidelines, I document the basis for the monitoring that is being done and the reasoning for deviation from authoritative guidelines.

PRESCRIPTION PADS

I ensure that all writing on prescriptions and drug orders is legible.

I use tamper-resistant prescription pads with security devices to thwart attempts to alter or copy the prescription.

I do not use my prescription pads as note pads.

I am aware of and understand prescription record keeping and prescribing regulations.

I ask patients about their use of non-traditional/complementary/alternative therapies.

ELECTRONIC PRESCRIBING

I know the laws regarding electronic prescribing for the state(s) in which I practice.

I consider having reviewed by a health care attorney all contracts and agreements for electronic prescribing.

I clarify with commercial/third party vendors of electronic prescribing systems how physician and patient information will be collected and used.

I take all necessary security precautions to protect patient confidentiality when transmitting prescription electronically.

I do not rely solely on the medication interaction checks built into the software.

TOOL: ELEMENTS OF A MONITORING SYSTEM

A monitoring system might include, but is not limited to, the following:

- List of medications that routinely require blood levels monitored, a schedule for frequency of testing, testing to be done, etc.
- List of medications and patient conditions that require baseline and ongoing laboratory tests.
- Procedure for the timely review and response to results of lab testing.
- Documentation of instructions to patients to obtain lab testing and documentation that testing was done. If patients refuse or are unable to obtain lab testing, documentation of response and plan to manage this situation.
- Information and instructions to patients (and families when appropriate) about why monitoring is needed. Documentation of instruction.
- Periodic review, and documentation, of the efficacy of medications and adjustments made as a result of information obtained (change in dosage, change in route, change in time of administration of medication, etc.).
- Side-effects and adjustments made as a result of information obtained and documentation of same.
- Regular communication with other involved healthcare professionals about monitoring of side-effects, complementary lab results, etc., and documentation of communication and results.

LIABILITY FOR OTHERS

ASSESSMENT

SUPERVISION

I do not supervise relatives, close friends, or employers.

I clarify the definition of "supervision" and what is expected of me before I sign a contract or agreement to be a supervisor and before signing-off on a form as a supervisor. Various entities/organizations I may need/want to contact include:

- State statutes and regulations
- Insurance company requirements
- Facility requirements
- Medicare/Medicaid requirements
- Professional organizations

I review the practice of medicine statutes and regulations in my state because some states include in their definitions of "unprofessional conduct" or "professional misconduct" information about specific supervision or supervision related activities.

Before entering into a supervisory relationship, I review and discuss applicable statutes, regulations, and requirements with the supervisee.

I have a written agreement in place, either by contract or some other formal arrangement, prior to beginning supervision.

I consult with personal legal counsel for state specific legal advice and for information about financial and billing matters related to my supervisory role.

I verify the supervisee's education, training, licensing, credentialing, and professional liability insurance coverage.

I periodically re-verify the licensing and professional liability insurance coverage of my supervisee.

I contact the relevant licensing body to inquire about administrative complaints or actions against the supervisee.

I review my professional liability insurance policy and contact my underwriter to notify him/her of the supervisory relationship.

I and/or the supervisee educate the patient about the supervisory relationship. At a minimum, the patient is educated about:

My name

My credentials

My role

I tailor my involvement to the supervisee's education, training, and skills, as well as the clinical needs of the patient.

I ensure ongoing communication between myself and the supervisee.

I evaluate the supervisee on the basis of actual performance and reasonable standards.

I ensure that the supervisee is aware of the appropriate professional code of ethics.

I ensure that a supervisee who will be prescribing medications on his/her own complies with statutory, regulatory, and payor requirements and has obtained his/her own DEA number and prescription pads.

If at any time and for any reason, I determine that the supervisee is not providing services commensurate with the standard of care, I develop and implement a written plan for remediation.

I document supervision.

SUPERVISION OF NURSE PRACTITIONER (SEE SUPERVISION ABOVE)

I review and understand my state's statutory and regulatory requirements specifically regarding the regulation of nurse practitioners. The topics of state regulation of nurse practitioners may include, but are not limited to, the following:

Limiting the number of nurse practitioners a physician can work with at the same time.

Requiring a physician to be interviewed by and register with the Medical Board.

Specifying the time intervals for on-site visits by the physician

Stipulating the content of written practice agreements and written protocols.

I understand that I can have more stringent supervision requirements than required by the state, such as requiring chart review more frequently than the state requires.

COLLABORATION

I clarify the definition of “collaboration” and clarify the expectations and responsibilities of all parties, including the patient, at the outset of treatment.

I use a written collaborative agreement to help clarify and manage expectations.

I verify my colleague’s education, training, licensing, credentialing, and professional liability insurance coverage.

I contact the relevant licensing body to inquire about administrative complaints or actions against my colleague.

I ensure on-going communication between myself and my colleague.

If at any time and for any reason, I determine that my colleague is not providing services commensurate with the standard of care, I address my concerns with my colleague and/or the patient.

I document communication with my colleague.

CONSULTATION

I provide an opinion and recommendation only. The treatment provider requesting the consult is entirely free to accept or reject—in whole or in part - my opinion and recommendation.

I do not prescribe medications or write/change orders.

I educate the patient about the limited nature of my involvement in his/her care.

OFFICE SHARING

I consult with my personal attorney when developing office sharing arrangements in order to ensure compliance with all relevant statutes and regulations (e.g., no fee-splitting).

I consult with my personal attorney to assess whether my shared office arrangement may be perceived as a legal entity (e.g., a limited or general partnership) in spite of my intent.

I inform office staff and my office mate(s) about the liability risks involved when professionals share staff, phones, receptionists, and billing personnel.

I avoid the appearance of any control of or supervision of my office mates.

I refrain from engaging in any contract(s) with my office mates that could be construed as an employment contract.

I keep my patient and business records separate from those of my office mate(s).

I eliminate as many objective indicators of association with my office mate(s) as possible. This might include shared outdoor signs, letterhead, office telephone numbers, billing personnel, etc.

I post and provide to every patient a fact sheet or disclosure statement stating, at a minimum:

That all of the professionals are independent practitioners.

That I am not in partnership with them.

That I have no responsibility for their billing.

That I neither control nor supervise the services that they provide.

I periodically check to confirm that my written protocols and procedures are being followed. For example, I call my office and answering service to ensure that the receptionist and operators are answering the phone with words that identify me and my office appropriately and not with a phrase such as "The offices of _____ and _____."

I understand that there may be ethical and legal issues related to fee-splitting if I accept or pay a percentage of fees collected for office space, secretarial services, and other administrative support. To avoid the appearance of fee-splitting, psychiatrists should negotiate a mutually agreed upon specific, set, reasonable fee for the use of the space and other expenses. I consult with my personal attorney as needed.

I contact the relevant licensing body to inquire about administrative complaints or actions against my office mate(s).

I verify my office mate's professional liability insurance coverage.

EMPLOYER

I understand that I am responsible for the acts of my employees; therefore, I have written policies and procedures to guide and assist employees in the performance of their duties.

My office staff are trained how to triage patients contacts appropriately. Guidelines include information about:

- The symptoms or conditions that require immediate referral to the psychiatrist or another clinician.

- Procedures for handling routine, non-emergency patient calls.

- How to manage calls about lab results and calls from hospitals and other facilities where patients are admitted.

Only staff with the appropriate training and professional credentials provide clinical information or recommendations to patients.

The threshold for obtaining my involvement/response is relatively low – any uncertainty on the part of the staff means it is discussed with me.

SIGNATURES

I clarify the purpose of my signature prior to signing charts/documents/etc.

I ensure that my signature accurately reflects my activities/level of involvement. If necessary, I annotate my signature.

STATE	PSYCHIATRIC SOCIETY	MEDICAL SOCIETY	BOARD OF MEDICINE
AL	334-954-2500 www.alabamapsych.org	800-239-6272 334-954-2500 www.masalink.org	334-242-4116 www.albme.org
AK	907-566-7800 www.psychiatryalaska.org	907-562-0304 www.aksma.org	907-269-8163 www.dced.state.ak.us/occ/pmed.htm
AZ	602-288-5100	602-246-8901 800-482-3480 www.azmedassn.org	MD: 480-551-2700 www.azmdboard.org DO: 480-657-7703 www.azdo.gov
AR	501-663-6182 www.arkansaspsychiatricsociety.org	501-224-8967 800-542-1058 www.arkmed.org	501-296-1802 www.armedicalboard.org
CA	CPA: 916-442-5196 www.calpsych.org Central: 888-234-1613 www.cencalpsych.org Northern: 415-334-2418 www.ncps.org Orange County 714-978-3016 www.ocps.org Southern: 310-815-3650 www.socalpsych.org	800-786-4262 www.cmanet.org	MD: 800-633-2322 www.medbd.ca.gov DO: 916-928-8390 www.ombc.ca.gov
CO	303-692-8783 www.coloradopsychiatric.org	720-859-1001 800-654-5653 www.cms.org	303-894-7690 www.dora.state.co.us/medical
CT	860-243-3977 www.ctpsych.org	203-865-0587 www.csms.org	860-509-7648 www.state.ct.us/dph/
DE	302-224-5181 www.medicalsocietyofdelaware.org/SpecialtySocieties/PSD.aspx	302-366-1400 www.medicalsocietyofdelaware.org	302-744-4500 http://dpr.delaware.gov/boards/medical-practice/index.shtml
DC	202-595-9498 www.dcpsych.org	202-466-1800 www.msdc.org	877-672-2174 www.hpla.doh.dc.gov/bomed
FL	800-521-7465 www.floridapsych.org	800-762-0233 www.fmaonline.org	MD: 850-245-4131 www.doh.state.fl.us/mqa/index.html DO: 850-245-4161 www.doh.state.fl.us
GA	404-298-7100 www.gapsychiatry.org	678-303-9290 800-282-0224 www.mag.org	404-656-3913 www.medicalboard.georgia.gov

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HI	808-263-3070 www.hawaiiipsychiatric.org	808-536-7702 www.hmaonline.net	808-586-3000 www.hawaii.gov/dcca/areas/pvl/boards/medical/
ID	208-344-7888	208-344-7888 http://www.idmed.org	208-327-7000 www.bom.state.id.us
IL	312-224-2600 www.illinoispsychiatricsociety.org	312-782-1654 www.isms.org	217-785-0800 www.idpr.com/WHO/med.asp
IN	888-477-9119 www.indianapsychiatricsociety.org	317-261-2060 800-257-4762 www.ismanet.org	317-232-2960 www.in.gov/pla/medical.htm
IA	515-633-0341 www.iowapsych.org	515-223-1401 www.iowamedical.org	515-281-5171 www.medicalboard.iowa.gov
KS	785-233-7154 http://kansas.psych.org	785-235-2383 800-332-0156 www.kmsonline.org	785-296-7150 www.ksbha.org
KY	502-695-4843 www.kypsych.org	502-426-6200 www.kyama.org	502-429-8046 kbml.ky.gov
LA	225-761-3718 www.lpma.net	225-763-8500 800-375-9508 www.lsms.org	504-568-6820 www.lsbme.org
ME	207-622-7743 www.mainepsych.org	207-622-3374 http://www.mainemed.com	MD: 207-287-3601 www.docboard.org/me/me_home.htm DO: 207-287-2480 www.maine.gov/osteo
MD	410-625-0232 www.mdpsych.org	410-539-0872 800-492-1056 www.medchi.org	410-764-4777 www.mbp.state.md.us
MA	781-237-8100 ext 211 www.psychiatry-mps.org	781-893-4610/3800 www.massmed.org	781-876-8200 www.mass.gov/massmedboard
MI	517-333-0838 www.mpsonline.org	517-337-1351 www.msms.org	MD: 517-335-0918 www.michigan.gov/mdch/0,1607,7-132-27417---,00.html DO: 517-335-0918 www.michigan.gov/healthlicense DO: 517-335-0918 www.michigan.gov/healthlicense
MN	651-407-1873 www.mnpsychsoc.org	612-378-1875 800-342-5662 www.mnmed.org	612-617-2130 www.bmp.state.mn.us
MS	601-957-9800	601-853-6733 800-898-0251 www.msmaonline.com	601-987-3079 www.msbl.state.ms.us

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MO	Central: 573-696-0699 Eastern: 636-343-8555 www.emopsych.org Western: 816-531-8432	573-636-5151 www.msma.org	573-751-0098 http://pr.mo.gov/healingarts.asp
MT	406-563-4222	406-443-4000 877-443-4000 www.mmaoffice.org	406-841-2360 www.discoveringmontana.com/dli/bsd/license/bsd_boards/med_board/board_page.asp
NE	402-393-1415	402-474-4472 www.nebmed.org	402-471-2118 www.hhs.state.ne.us/crl/medical/medsur/physur/physur.htm
NV	877-493-0007 www.nvpsychiatry.org	775-825-6788 702-798-6711 www.nsmadocs.org	MD: 702-688-2559 www.medboard.nv.gov DO: 702-732-2147 www.osteostate.nv.us
NH	603-224-7083 www.nhpsych.org	603-224-1909 800-564-1909 www.nhms.org	603-271-1203 www.state.nh.us/medicine
NJ	908-719-2222 www.psychnj.org	609-896-1766 www.msnj.org	609-826-7100 www.state.nj.us/lps/ca/bme/bme.htm
NM	505-828-0237	505-828-0237 www.nmms.org	MD: 505-476-7220 www.nmmb.state.nm.us DO: 505-476-469 www.rld.state.nm.us/osteopathy
NY	516-542-0077 www.nyspsych.org	516-488-6100 www.mssny.org	518-474-3817 www.nysed.gov/prof
NC	919-859-3370 www.ncpsychiatry.org	919-833-3836 800-722-1350 www.ncmedsoc.org	919-326-1100 www.ncmedboard.org
ND	701-223-9475	701-223-9475 http://ndmed.org	701-328-6500 www.ndbomex.com
OH	614-481-7555 www.ohiopsych.org	614-527-6762 800-766-6762 www.osma.org	614-466-3934 www.med.ohio.gov
OK	405-360-5066	405-601-9571 800-522-9452 www.okmed.org	MD: 405-962-1400 www.okmedicalboard.org DO: 405-528-8625 www.ok.gov/osboe
OR	800-533-7031 www.orpsych.org	503-619-8000 www.theoma.org	971-673-2700 www.oregon.gov/BME

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PA	717-558-7750 www.papsych.org	717-558-7750 800-228-7823 www.pamedsoc.org	MD: 717-787-2381 www.dos.state.pa.us/bpoa/cwp/view.asp?a=1104&q=432799 DO: 717-783-4858 www.dos.state.pa.us
PR	787-349-8887 www.puertoricopsychiatricsociety.org		787-782-8989 ext 6582
RI	401-331-1450 http://www.psychri.org	401-331-3207 www.rimed.org	401-222-3855 www.health.ri.gov/hsr/bmlid/
SC	803-798-6207 ext 242 www.scpsych.org	803-798-6207 800-327-1021 www.scmanet.org	803-896-4500 www.llr.state.sc.us/pol/medical
SD	605-322-5719	605-336-1965 www.sdsma.org	605-367-7781 http://doh.sd.gov/boards
TN	615-460-1650	615-385-2100 800-659-1862 www.tnmed.org	MD: 615-532-3202 http://health.state.tn.us/Boards/ME/index.htm DO: 615-532-3202 www.state.tn.us/health
TX	512-478-0605 www.txpsych.org	512-370-1300 800-880-1300 www.texmed.org	512-305-7010 http://www.tmb.state.tx.us
UT	801-747-3500	801-747-3500 www.utahmed.org	MD: 801-530-6628 www.dopl.utah.gov/licensing/physician.html DO: 801-530-6628 www.dopl.utah.gov
VT	802-223-8902	802-223-7898 www.vtmd.org	MD: 802-657-4220 www.healthvermont.gov/hc/med_board/bmp.aspx DO: 802-828-2373 http://vtprofessionals.org/opr1/osteopaths
VA	804-754-1200 www.psva.org	804-353-2721 800-746-6768 www.msv.org	804-367-4220 www.dhp.virginia.gov/medicine
WA	206-367-8704 www.wapsychiatry.org		360-236-2750 www.doh.wa.gov/hsqa/MQAC/Default.htm
WV	304-293-5294	304-925-0342 www.wvsma.com	304-558-2921 www.wvbom.wv.gov
WI	608-516-3960 www.thewpa.org	866-442-3800 www.wisconsinmedical-society.org	608-266-2112 www.drl.state.wi.us
WY	307-268-7136	307-635-2424 www.wyomed.org	307-778-7053 http://wyomedboard.state.wy.us



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