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THE RISK MANAGER IS IN!

CHARLES D. CASH, JD, LLM ANSWERS RISK MANAGEMENT QUESTIONS AT THE 2014 RIMHC

MANAGING HANDOFF RISK IN PSYCHIATRY

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ON THE COVER:
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MUSINGS ON PROFESSIONAL LIABILITY IMPLICATIONS OF ACOS

While we are still currently in the early stages of implementing "Obamacare," we do know that the future of medicine will involve integrated healthcare delivery models. This article will provide an overview of the various types of delivery models, as well as thoughts on their potential impact on professional liability exposure. Please note that this article is intended to provide broad, general insight into this new, complex topic to psychiatrists thinking of joining or becoming associated with an integrated healthcare delivery model. Issues related to forming an Affordable Care Organization (ACO) or other integrative care model, and the significant associated risks to the entity (such as the Stark law, anti-kickback statute, and antitrust issues) are beyond the scope of this article.

WHAT IS INTEGRATED HEALTHCARE?

As can be seen from the attached glossary, there is an entire lexicon associated with integrated care but essentially, integrated healthcare refers to care coordinated across providers and settings with quality of care measures. Payers, both private and governmental, are encouraging these models, believing that with increased collaboration and communication, there will be better care delivered and less duplication of services, resulting in reduced healthcare costs. In some models, such as ACOs, providers may share in the financial savings associated with improved patient health and lower cost of care. However, as discussed below in the section on the impact on medical malpractice litigation, there can be significant liability exposure related to this incentivized cost containment.

WHAT ARE THE PROFESSIONAL LIABILITY RISKS FOR PSYCHIATRISTS?

The professional liability risk will vary depending on the model of care.

<u>In Some Collaborative Care Models, the Actual Liability Risks May Not Change</u>

Psychiatrists can be held liable for the acts of other professionals. In a medical malpractice action, the plaintiff's attorney has a professional obligation to pursue every possible defendant. This means that a psychiatrist who has been involved, however remotely, in the plaintiff's treatment can almost always expect to be named as a defendant. Treatment arrangements where liability for the acts of others has typically been a risk include:

- In a split treatment relationship (where the psychiatrist provides psychopharmacology and a therapist provides therapy), the liability risks have been the same since this model was introduced in the managed care era. The psychiatrist has always been responsible for ensuring the patient receives appropriate care. Ultimately, however, the court and the jury will decide about the *actions and/or omissions* of the psychiatrist and non-medical therapist that will be determinative of liability. They may choose to ignore the distinctions on which the professionals functioned.
- When working with nurse practitioners, whether in a supervisory or collaborative role, the psychiatrist always has increased liability exposure based on the nurse practitioner's actions or omissions.

Psychiatrists providing a true consultation (not prescribing, not writing orders) will continue to take on minimal liability. The closer the consultant's specialty and training is to that of the person seeking the consultation, the less risk there is. For example, a child and adolescent psychiatrist providing a consult to another child and adolescent psychiatrist bears far less risk than a psychiatrist providing a consult to a social worker.

Care may be delivered via telemedicine. The risks vary with the remote treatment model used, and may be dependent upon the extent to which the psychiatrists' lost abilities (such as to hear, see, and smell) can be restored. Additionally, psychiatrists must consider whether they can clear attendant legal and clinical hurdles such as licensure (care is rendered where the patient is physically located, so the psychiatrist may need to be licensed in the patient's state) and meeting the standard of care remotely (the standard of care for remote treatment is the same as if the patient was in the psychiatrist's office).

But the overall risk may increase. Having said the actual risks in these models may not change, with increased utilization of these collaborative care arrangements, psychiatrists' overall liability can be expected to increase. In other words, the risk per patient remains as it has historically been, but there may be more patients treated via this care model so the aggregate risk increases.

<u>In Newer Integrated Care Models, There Could Be New Liability Risks</u>

As discussed above, there are many different types of integrated care models. However, the remainder of the article will focus specifically on ACOs, since many other types will follow the ACO requirements.

New roles bring new liability risks. With all of the newly insured patients, and the shortage of psychiatrists, psychiatrists who join an ACO may be asked to take on roles beyond direct patient care that they have not previously undertaken. Examples include supervising a nurse practitioner or consulting with pediatricians and PCPs.

New duties bring new liability risks. The more the practice of medicine is regulated, the greater the liability exposure. For example, ACO providers are required to use patient and caregiver assessments as well as use individualized care plans. Failure to use these new required items could be seen by plaintiffs' attorneys are failure to meet the standard of care, and could be seen by the regulators as violations of the law resulting in penalties. As another example, there is language in the law requiring "patient engagement" particularly in terms of making treatment-related decisions. Specifically, ACOs are required to share clinical information and evidence-based medicine with patients in an understandable way, sharing their medical records, and working with patients in shared decision-making.

EHRs bring new liability risks. Use of electronic health records (EHRs) is a pre-requisite to the mandated sharing of patient information. Examples of liability risks include, but are not limited to:

- Information overload
- Alert fatigue
- Responsibility for knowing all information
- Inappropriate use of templates / lack of individualized content
- Metadata, such as time it took the psychiatrist to override an alert or clinical support tool, will be available to plaintiffs' attorneys

New requirement of sharing of patient information increases breach risks. Fundamental to integrated care is the extensive sharing of information through a variety of treatment environments, which will increase psychiatrists' potential liability exposure for failure to comply with confidentiality and security of patient information requirements. Sharing of information is important not only to ensure all information is considered when making treatment decisions, but also to avoid duplication of expensive diagnostic studies. The more information that is disclosed (particularly electronic patient information), the greater the likelihood of a breach due to inappropriate access or disclosure as a result of inadequate data security policies. In addition to liability for breach of confidentiality, covered entities under HIPAA are subject to significant civil and criminal penalties.

WHAT IS THE IMPACT ON MEDICAL MALPRACTICE LITIGATION?

Cost Containment

If there is a medical malpractice lawsuit brought by a patient treated in an ACO, the plaintiff could allege that a provider's negligent failure to provide a service - or refer for a service - caused the patient harm and was done to contain costs, given the provider's risk sharing. In fact, such a financial incentive to restrict services could lead to alleged punitive damages for intentional wrongdoing, which are not covered by traditional medical malpractice insurance policies. Medical malpractice litigation will likely include reviewing the ACO's policies on resource utilization and physician compensation.

Given this very real scenario, the risk management advice is - more than ever in such a treatment setting - for psychiatrists to document not only what was done and why, but also what was considered and rejected and why. Such documentation will be crucial to avoid allegations of putting profit ahead of patient safety.

Another aspect of cost containment involves the choice to settle a medical malpractice lawsuit. For example, a psychiatrist who joins an ACO may not have input into when a case against him is settled. The ACO may decide to settle early to prevent incurring expensive defense costs and perhaps a substantial judgment. So there may be a shift from private practice psychiatrists vigorously defending cases to cases being settled early by the ACO to contain costs.

Standard of Care

ACOs are required by Medicare to promote evidence-based medicine and payment is based on achievement of quality criteria. Some quality criteria could potentially be used to evidence the standard of care in a malpractice case. For

example, a plaintiff's attorney could argue that a psychiatrist's failure to meet the ACO's quality criteria is failure to meet the standard of care, which is negligence.

WHAT ABOUT PROFESSIONAL LIABILITY INSURANCE?

When transitioning from a private practice setting to an ACO, psychiatrists need to confirm coverage and limits of coverage with their employer. Keep in mind that larger health systems are typically self-insured, which can present additional risk exposure. A self-insured insurance plan is only as secure as the company's financial stability. If the employer, such as a hospital system, goes into bankruptcy, there could be adverse insurance implications. Also, self-insured plans generally are not able to participate in a state's guarantee fund, which would otherwise provide insurance coverage in the event of an insurance company's bankruptcy.

FOR MORE INFORMATION:

Massachusetts Medical Society's *Guide to Accountable Care Organizations: What Physicians Need to Know*, September 2013. Available at http://www.massmed.org/acoguide/

Integrated Care Glossary

Accountable Care Organization (ACO) – "Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program." (1)

Affordable Care Act – "The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law." (2)

Capitated Payment – "Capitated payment systems are…based on a payment per person, rather than a payment per service provided. There are several different types of capitation, ranging from relatively modest per member per month (pmpm) case management payments to primary care physicians involved in patient centered medical homes, to pmpm payments covering all professional services, to pmpm payments covering the total risk for all services: professional, facility, pharmaceutical, clinical laboratory, durable medical equipment, etc. Capitated payment is the most common way in which health home providers are reimbursed, discouraging providers from merely focusing on the health services for which they would receive the most payment." (3)

Fee-for-Service (FFS) Payment – Under fee-for-service arrangements, providers are paid directly for services rendered.

Health Home – "A Medicaid integrated care model established to coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person. Only those Medicaid beneficiaries who have 2 or more chronic conditions, have one chronic condition and are at risk for a second, or have one serious and persistent mental health condition are eligible." (4)

Integrated Care – "Integrated care is the systematic coordination of general and behavioral healthcare. Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs." (5)

Medical Home – "An early conceptual approach to providing comprehensive primary care that was principled on physician directed practice, enhanced access, personal and coordinated physician care, a whole person orientation, and quality and safety." (6)

Medicare Shared Savings Program – "A Medicare program established to facilitate coordination and cooperation among providers, improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries, and reduce unnecessary costs. The program rewards ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO)." (7)

Private ACO – Organizational and payment structures are similar to an ACO, but they are done by private insurers rather than Medicare.

Risk Sharing – "Through an ACO, provider organizations enter into contracts/agreements with payers under which they accept responsibility for managing the care and medical costs of a defined patient population and are offered the opportunity to share in the savings associated with improved health and lower cost of care. The financial structure under these agreements can vary by contract and patient population served. Risk sharing can be roughly be divided into two categories: shared savings and shared risk." (8)

> **Shared Savings Model** – "Under this risk sharing model, if the actual total costs of all care received by the patients assigned to a physician practice is lower than budgeted costs, the practice receives a percentage of the difference between the actual and budgeted costs (i.e., a "share of the savings"). However, if actual total costs exceed the budgeted costs, the practice is not on the hook for any portion of the difference." (9)
>
> **Shared Risk Model** – "Under this risk sharing model, if the actual total costs of all care received by the patients assigned to a physician practice is lower than budgeted costs, the practice receives a percentage of the difference between the actual and budgeted costs (i.e., a "share of the savings"). However, if actual total costs exceed budgeted costs, the practice is responsible for a percentage of the difference. When participating in this type of risk sharing, practices usually are entitled to a larger percentage of the savings than in the shared savings model, incentivizing the practice to take on increased risk." (9)

(1) *Affordable Care Act*, Healthcare.gov, https://www.healthcare.gov/glossary/affordable-care-act/ (last visited March 17, 2014).

(2) *Capitation*, American Medical Association, http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/private-payer-reform/state-based-payment-reform/evaluating-payment-options/capitation.page (last visited March 17, 2014).

(3) *Financing and Reimbursement*, Medicaid.gov, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Financing-and-Reimbursement.html (last visited March 17, 2014).

(4) *Health Homes*, Medicaid.gov, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html (last visited March 17, 2014).

(5) *What Is Integrated Care?*, Samhsa.gov, http://www.integration.samhsa.gov/about-us/what-is-integrated-care (last visited March 17, 2014).

(6) *Joint Principles of the Patient Centered Medical Home*, American Medical Student Association, http://www.amsa.org/AMSA/Libraries/Committee_Docs/PCMH_Intro.sflb.ashx (last visited March 17, 2014).

(7) *Medicare Shared Savings Program*, Cms.gov, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/ (last visited March 17, 2014).

(8) Chris Collins and J. Mark Waxman, *MMS Guide to Accountable Care Organizations: What Physicians Need to Know*, Massachusetts Medical Society, http://www.foley.com/files/Publication/59de54ad-4877-4cd6-9bfb-d78177f8452b/Presentation/PublicationAttachment/5b2ba4fa-d727-41ff-b8a5-da3e5bee79b6/ACOGuide%20-%20FINAL.pdf (last visited March 17, 2014).

(9) *Shared Savings*, American Medical Association, http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/private-payer-reform/state-based-payment-reform/evaluating-payment-options/shared-savings.page? (last visited March 17, 2014).

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SUPERVISION OF MEDICAL AND NON-MEDICAL MENTAL HEALTHCARE PROVIDERS

Many psychiatrists and other mental health professionals today work in practice settings where supervision of medical and non-medical mental health care providers is commonplace. One should consider the liability exposure that these arrangements can generate. From a legal perspective, the key issue is "control;" increased control over another provider increases the supervisor's potential liability.

Because of the high degree of control involved in a supervisory relationship, it carries with it responsibilities and risks which are not present in collaborative, consultative, or independent contractor relationships. A supervisor may be named in a lawsuit alleging malpractice against a supervisee. The plaintiff may either try to impute malpractice directly to the supervisor or hold the supervisor liable independently on a theory of negligent supervision. In the end, adequate supervision is necessary to protect the supervisor from liability for the supervisee's actions. Adequate supervision is measured by the continually evolving standard of care for supervision within the health care community generally. The practical pointers below are aimed at helping you identify and reduce the liability exposure which supervisory relationships can generate.

Before entering into a supervisory relationship, review and discuss applicable statutes and regulations with the supervisee.
Comment: *Some states have specific requirements for supervision. For example, statutes may address the supervision requirements for someone seeking professional certification or licensure, the responsibilities of a physician who supervises an advanced practice nurse with prescribing authority, or the details of an imposed supervision for an impaired professional. Contact the relevant licensing/regulating/professional bodies for information and guidance.*

Be aware that there is no universal agreement on what "supervision" means. Know what you are agreeing to.
Comment: *Know what is expected of you before you sign a contract or agreement to be a supervisor and before signing-off on a form as a supervisor. Check with the various organizations that may be involved, such as the client's insurance company or MCO, facilities where you and the supervisee practice, and Medicare/Medicaid, to understand their definition of supervision and supervisor. Required supervision levels should be viewed as the minimum necessary. Depending upon the situation and your level of familiarity with the supervisee, additional supervision may be warranted.*

Consider developing a written agreement, either by contract or some other formal arrangement, prior to supervision.
Comment: *A formal agreement should promote communication by setting parameters, clarifying responsibilities and expectations, establishing procedures, and limiting ambiguity. Some states require a written agreement for certain supervisory relationships and even require a review of the agreement by the respective licensing boards. Any agreement should be strictly*

followed. In a professional malpractice lawsuit, failure to meet the standards that you and the supervisee have agreed to will increase the risk that you will be found to have breached appropriate supervision standards.

Know that a legal document cannot totally eliminate your liability risks that arise from a supervisory relationship.
Comment: *Should the supervisory relationship ever be questioned, the substance of the relationship will be considered as well as any formal agreement.*

Educate the patient about the supervisory relationship. This should include obtaining consent from the patient for the supervisee to discuss confidential information with you.
Comment: *At a minimum, the patient should know your name, credentials, and role.*

Do not supervise relatives, close friends, or employers.
Comment: *Dual relationships can impair your objectivity and professional judgment and should be avoided.*

Do not provide supervision to someone practicing outside of your scope of practice.
Comment: *You will be held to the standard of care for that practice area.*

Verify the supervisee's education, training, licensing, credentialing, and professional liability insurance coverage. Also, contact the relevant licensing body to inquire about administrative complaints or actions. Make certain that you document these efforts including with whom you spoke and when.
Comment: *The supervisee should have the same insurance limits that you have. The supervisee should notify you immediately of any investigations or disciplinary actions, loss or limitation to licensure, or insurance coverage changes.*

Tailor your involvement to the supervisee's education, training, and skills, as well as the clinical needs of the patient.
Comment: *Do not make assumptions about the supervisee's knowledge; assess his skills carefully. Document internal training and continuing medical education, as well as other educational efforts provided to the supervisee.*

Ensure on-going communication between yourself and the supervisee.
Comment: *This is especially critical with regard to emergent situations. If at anytime there are material changes in the patient's status, including, but not limited to, suicidality and/or homicidality, the supervisee should notify you ASAP.*

Ensure that the supervisee is aware of the appropriate professional code of ethics.

Ensure that a supervisee who will be prescribing medications on his own has complied with statutory, regulatory, and payor requirements and has obtained his own DEA number and prescription pads.

Remember that you are responsible for ensuring that the supervisee performs responsibly, competently, and ethically. Evaluate the supervisee on the basis of actual performance and reasonable standards. If at any time and for any reason, you determine

that the supervisee is not providing services commensurate with the standard of care, develop and implement a written plan for remediation.

Comment: *Ensure that the patient is being provided with appropriate care by you or another competent health care professional until the supervisee is able to assume the responsibility for care.*

Document your supervision.

Comment: *Your documentation should meet the requirements specific to your supervisory role and may include the dates of each supervisory meeting, the duration of in-person supervisions, and an ongoing record of the total number of hours of supervision to date.*

Check your professional liability insurance policy and/or contact your underwriter for policy provisions specific to supervisory roles.

Consult with personal legal counsel for state specific legal advice and for information about financial and billing matters related to your supervisory role.

The APA's "Guidelines for Psychiatrist in Consultative, Supervisory or Collaborative Relationships with Non-medical Clinicians" provides some additional guidance on this topic.

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THE "CURBSIDE" CONSULT AND WHAT IT MEANS FOR YOU

Who in psychiatric practice has not been faced with a challenging or troublesome situation and wished that they could run the situation by a colleague or mentor? Who has not secretly yearned for guidance from their residency director?

Medicine is a collegial profession, both in theory and in practice, and physicians consult with one another regularly. Indeed there is an expectation of consultation, particularly when faced with a situation beyond one's usual area of expertise.

Consultation with a colleague can be formal or informal.

Formal Consultation: For a formal consultation, the treating physician refers the patient to another physician, often a specialist, in order to obtain formal guidance on some aspect of the patient's care and treatment.

The consultant performs the evaluation –in-person or by reviewing treatment records, studies, test results, or other pertinent information– and documents the evaluation either in the patient's record or by providing a written opinion or report. The consultant does not write orders, write prescriptions, or take any other kind of action regarding treatment.

The consultant typically is paid for this work.

Informal Consultation: Informal consultations are sometimes referred to as "curbside", "hallway," "elevator," or "sidewalk" consults. Curbside consults are a desirable, well-accepted part of medical practice.

For a curbside consultation, the treating physician seeks informal information or advice about patient care or the answer to an academic question from a colleague. Often the colleague has a particular expertise or talent that can be brought to bear.

Curbside consults typically are based on the treater's presentation of the case or by posing direct questions. The colleague-consultant does not see the patient or review the chart.

The colleague is not paid for the consultation.

Professional liability is minimal.

Physicians occasionally voice concern about the professional liability risks associated with providing curbside consults. While it is true that liability risk exists in any professional undertaking, including providing curbside consults, it is important to maintain a realistic perspective.

To begin with, providing a consultation –whether formally or informally– is an extremely low risk undertaking. Both the Program's experience with managing malpractice claims and reports in the literature demonstrate that curbside consultants are very rarely included in a lawsuit. This limited risk is related to the concept of control in the therapeutic relationship.

Generally speaking, the degree of professional liability risk exposure inherent in a professional relationship is directly related to the degree of control, either real or perceived, that the psychiatrist exercises over patient care decisions. In other words, the greater the degree of control, the greater is the liability risk exposure. This makes sense as liability derives from the physician-patient relationship and the subsequent duty of care owed to the patient.

A true consultative relationship involves providing an opinion and nothing more. The treating physician requesting the consult is entirely free to accept or reject –in whole or in part– the opinion and recommendation of the consultant. Therefore, it is the treating physician who retains most of the liability risk. The curbside consultant often is viewed as providing a service to the physician seeking consultation rather than to the patient. In fact, a patient may not even know if or when her or his physician obtained a curbside consult.

Even if a professional relationship were to be found by a court to exist between a patient and a curbside consultant, in order to prevail in a lawsuit, the plaintiff would have to prove that the consultation was negligently done *and* was a direct/proximate cause of her or his injury. This is a fairly challenging undertaking considering that the physician seeking the curbside consult remains free to exercise her or his own professional judgment in accepting, rejecting, or otherwise relying on the consultant's advice.

Lest anyone decide that the risk of obtaining a curbside consult is still too great, bear in mind that seeking consultation from a colleague is one of the best risk management strategies available. Seeking curbside consults with colleagues when appropriate shows thoughtfulness by the treating physician, and without doubt, patient care benefits when physicians are able to obtain informal consultation.

One concern regarding curbside consults is that an informal consultation might be sought when a formal consultation would be more appropriate. Whether a formal consultation would be more appropriate is a matter

of judgment for both the treating and consulting physicians. Some factors to consider, among others, when deciding whether or not to obtain a formal or information consultation are listed below.

Low risk for an informal consultation	Consider a formal consultation
Academic questions for the general education of the person seeking the consult	When you need to examine the patient to give good advice
Does not involve making or confirming a diagnosis	The situation presents complex issues or multiple variables to sort out
No detailed discussions or complex advice are required	When the patient requested the consult or knows of your consultation
No need to review patient records or history	If it becomes clear to you that your colleague will suspend his or her own professional judgment to substantially rely on your advice
No need to examine the patient	When you are consulted because of your specialization or expertise in an area
Questions about whether to order laboratory tests, studies, etc.	You are billing for your advice
Amenable to short, simple answers; in general terms; little complexity/few variables to the case; non-specific advice	
To ascertain whether a formal consultation is needed	

Documentation remains the exercise of professional judgment.

There is no consensus about how to approach documentation of informal consults. While this lack of clear guidance can be anxiety provoking, the up-side is that it gives physicians significant leeway about whether and how to document such encounters. In other words, you have significant discretion to exercise your professional judgment.

From a risk management perspective, documentation of informal consults can be an important risk management action. When deciding your overall approach to documentation, try to be consistent. For

example, try to be consistent about what kind of information is documented and how that documentation is maintained.

Informal consultation as a volunteer with a professional organization

Some professional organizations, such as some APA District Branches, have developed programs in which members provide informal consultations to primary care physicians.

These programs have been initiated to help address the shortage of psychiatrists and the lack of access to psychiatric care for patients in many areas of the country. If you participate in one of these programs, you should understand the essential requirements and the policies and procedures of the program and abide by them. Furthermore, you should understand the limits of your role as a consultant and continually evaluate whether or not a formal consult is required.

As previously stated, documentation of the consultation can be an important risk management action. Note that some programs have standards regarding documentation.

When seeking a curbside consult . . .

When seeking a curbside consult, consider whether the advice or input that you seek might be more appropriate for a formal consultation.

Avoid documenting the name of the colleague from whom you obtained an informal consult unless you have obtained the colleague's permission to do so.

When giving a curbside consult . . .

When asked for a curbside consult, first, make sure you understand exactly what is being asked of you. Have a low threshold for suggesting a formal consultation.

Remember that the treating physician controls patient care. If you direct care (for example, order laboratory tests, write prescriptions, adjust medications, etc.) you will almost certainly be establishing a professional relationship with all the attendant obligations and liability risks. Couch your response in terms of giving advice and make clear that you are relying on the facts as presented by the physician requesting the curbside consult.

If the advice you give is academic and solely for the education of the provider seeking the consult, then typically it should not be necessary to document the encounter. If the advice that you give is more patient-specific, consider creating a note of the encounter that details the advice that you gave. In the highly unlikely event that you are named in a lawsuit, such contemporaneous documentation would serve to bolster your defense. If documentation of a curbside consult becomes lengthy, it is probably best to suggest a formal consultation.

Finally, offering a specific diagnosis via curbside consult is risky. The foundation of successful treatment is an accurate, well-founded diagnosis. It is at the point of diagnosis that the decision tree branches into multiple, potentially erroneous courses of action. Diagnostic formulation probably should not be entrusted to a curbside consult. Because of the potential stakes, the same likely holds true for most admission or discharge decisions. Diagnosis and admission or discharge decisions in most cases should be the subject of formal consultations rather than curbside consults.

Resources

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“Malpractice Liability for Informal Consultations.” Robert S. Olick, JD, PhD and George R. Bergus, MD, MAEd. *Family Medicine*. Vol. 35, No. 7, 2003.

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MANAGING HANDOFF RISK IN PSYCHIATRY

Managing Handoff Risk in Psychiatry

Patient handoffs in hospitals have been referred to as “the Bermuda Triangle of health care” – a time during which “dangerous errors and oversights can occur in the gap when a patient is moved to another unit or turned over to a new nurse or doctor during a shift change.”[1]

While much of the focus has been on handoffs occurring in healthcare facilities, handoffs in the outpatient setting, or as the patient is being transferred between inpatient and outpatient care, are equally risk prone and thus merit consideration. It is important to recognize that any time more than one clinician is providing care, there will be some type of handoff that potentially sets the stage for communication errors.

Breakdowns in communication are a factor in most malpractice claims made against physicians. They result in such things as errors or delays in diagnosis and claims of patient abandonment. By focusing attention on areas where such a breakdown is most likely to occur and developing internal systems to facilitate communication, physicians can do a great deal to mitigate risk. The following is a discussion of frequent points of transition in patient care and recommendations to help reduce risk during handoffs.

Handoff between inpatient and outpatient care

Patients in hospitals are typically seen by a number of physicians, one of whom may or may not be their own treating psychiatrist. Because of the number of providers involved, there is a high risk of failures in continuity of care between the inpatient and outpatient settings. “Patients seldom escape the hospital without changes to their drug regimen and often go home with more medication than prior to admission.”[2] These medication changes may be confusing to patients and/or their caregivers and may result in adverse outcomes. One study showed that of the 19% of patients who had an adverse event following discharge from the hospital, “the majority related to medication management.”[3]
In addition to problems relating to medication, a study published in the September 2009 issue of the Journal of Internal General Medicine found significant numbers of patients being discharged with pending test results, the fact of which was not noted in the discharge summary. Even more problematic is the fact that when such results are obtained, “there are no accepted standards for who should receive those results and who is responsible for following up on them.”[4]

- In spite of these obstacles, physicians should take steps to obtain discharge information – either directly from the hospital or from the patient– and chart these efforts.
- Establish a checklist of the information you believe to be essential in every case and take the necessary steps to obtain that information. This may include such things as:
    - Dates of hospitalization and treatment provided;

- Patient's condition or functional status at discharge;
- Information given to the patient and family;
- Reconciled discharge medication regimen, with rationale for changes and reasons for new prescriptions;
- Specific follow-up needs – appointments or procedures to be scheduled;
- Tests pending at discharge.[5]

- Try to see patients as soon as possible after discharge, and ask them to bring along any instructions and/or medication lists they received upon discharge.

Handoff between multiple physicians

"The major concern when multiple physicians are involved in the care of a patient with a specialty condition is whether the appropriate physician is responsible for the patient and whether patient care is coordinated."[6] This may be further complicated in psychiatry as primary care physicians (PCPs) manage many psychiatric conditions, thus leading to disagreement as to whether a patient is appropriately managed by the psychiatrist or the PCP. To avoid potential conflicts or confusion on the part of either physicians or the patient, consider the following:

- Upon receipt of a referral from another physician, make certain that you are told the purpose of the consultation and the expectations of the referring physician.
- If a patient does not keep the scheduled appointment, advise the referring physician.
- When preparing the report for the referring physician, reiterate your understanding of who is to assume the patient's ongoing care.
- If in your evaluation of the patient you determine that the patient's condition merits immediate attention, contact the referring physician so the situation may be discussed and a decision reached regarding who is to provide care and a treatment plan.
- Advise the patient with whom to follow up and in what time frame. Provide this information in writing to avoid any confusion on the part of the patient.

Handoff between treating psychiatrist and covering psychiatrist

Physicians who are asked to cover for another physician in his or her absence are often at a disadvantage, as they do not know the patient's history or plans for ongoing care. Patients themselves may not be the best historians, particularly if theirs is a complex illness, which may further complicate the situation.

On those rare occasions when you actually manage to get away from your practice for a few days, take steps to minimize potential problems.

- Discuss with covering physician(s) those patients about whom you have particular concerns or who might be expected to require treatment in your absence.

- Make certain that all dictation and/or EHR entry is up-to-date to give covering physicians a clear picture of the patient's current status.
- If any of your patients are hospitalized, advise the hospital of your intended absence and plans for coverage.

Handoff between covering psychiatrist and treating psychiatrist

In the event that you have been called upon to provide care to another psychiatrist's patient during his or her absence or while you were on call, provide the other physician with a written report of your activities to include the following:

- Contact you have had with the patient and/or treatment rendered;
- Contact with other healthcare providers regarding the patient;
- Prescriptions given and/or refilled;
- Any recommendations for follow-up.

Handoff between physician and patient/family

Medicine is becoming more and more complex; and at the same time, patients are being left to assume more responsibility for their own follow-up care due to such things as earlier discharge from hospitals and the refusal of insurance companies to pay for certain care. One way in which to avoid having patients slip through the cracks is to involve them in the handoff process. "The patient and family are the only constant and are thus in a position to play a critical role in ensuring continuity of care."[7] Despite all that has been written about patient rights, many are still reluctant to "overstep their bounds" and question their physicians. As such, it is important to take steps to actively engage patients. Some steps to consider toward this end are:

- Provide written instructions for follow-up care specifically stating with whom and in what time frame. (Provide copies of this information to patient's PCP to further memorialize your expectations regarding the patient's ongoing care.) Standardized forms may be helpful to save time for you and your staff and to minimize confusion on the part of the patient.
- Provide basic information regarding the patient's disease and types of treatment utilized. This will help prepare patients for the next steps. It will also help to involve the patient and the patient's family in the process, so they can be active participants and help to ensure that necessary treatment is obtained in a timely manner. The American Psychiatric Association's website, www.psych.org, has a section for the public that is an excellent source of information on psychiatric disorders and provides links for further reading.

In all treatment settings, there are obstacles or barriers in achieving successful handoffs of which physicians should be cognizant. These include the physical setting, language barriers, methods of communication and timing/convenience of the handoff itself. The overall key is to standardize handoff communication procedures by finding system solutions to lessen the burden of trying to remember everything. Just as in the hospital setting, mnemonic tools, checklists and technology solutions may be helpful.

For each type of handoff, establish the critical information to be obtained or conveyed and determine the most effective way to accomplish this task. Tools used in the hospital setting such as the Situation, Background, Assessment and Recommendation

(SBAR) process[8] can be adapted to the outpatient setting. Whatever system is used, it should be something that can be readily incorporated into your individual practice and easily utilized by all members.

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[2] Bayley, K. B., Savitz, L. A., Rodriguez, G., Gillanders, W. & Stoner, S. Barriers associated with medication information handoffs. Advances in Patient Safety: From Research to Implementation. Volumes 1-4, AHRQ Publication Nos. 050021 (1-4). February 2005. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/qual/advances. Accessed November 7, 2012.
[3] Id.
[4] Were, M. C., Li, X., Kesterson, J., Cadwallader, J., Asirwa, C., Khan, B., et al. (2009). Adequacy of hospital discharge summaries in documenting tests with pending results and outpatient follow-up providers. Journal of General Internal Medicine, 24, 1002–1006.
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DOES SPLIT TREATMENT CHANGE THE RISK IN PSYCHIATRY?

Psychiatrists can be held liable for the acts of other professionals and nonprofessionals involved with the care of patients. This is not news to anyone practicing in the field of mental health. Liability for the acts of others in practice relationships has always been a risk. In the event of a malpractice lawsuit, the plaintiff's attorney will seek to name all the clinicians who were connected to, or may have been connected to, the treatment of a patient during the time(s) the patient (plaintiff) alleges that he or she was injured. This means that a physician who has been involved, however remotely, in the plaintiff's treatment can almost always expect to be named as a defendant.

The New Norm

Whereas once it was the psychiatrist who alone provided both therapy and medication management, today split treatment arrangements, where a psychiatrist provides pharmacotherapy and a non-medical therapist provides psychotherapy, have become much more common. In such arrangements, psychiatrists frequently find that they have substantially less control over their patients' overall treatment than they did in more traditional arrangements. As a result, psychiatrists have become increasingly aware of, and increasingly concerned about, the potential for malpractice exposure related to such relationships. Psychiatrists want to know if they will be responsible only for the part of the treatment they provide in a shared treatment relationship or whether they will be responsible for the overall treatment of the patient - even when they have limited control over the rest of the treatment.

Traditionally, malpractice law has regarded physicians as having broad authority and responsibility for patient care, no matter what the physician's actual role in the treatment provided, and no matter what the levels of involvement of other professionals. The physician is considered the professional *most* responsible for overall patient care and thus bears more of the professional liability burden. Legislatures and licensing bodies have long recognized the independence of other healthcare professionals with regard to their responsibilities for patient care. The legal system has not caught up.

Defining Collaborative Relationships

The American Psychiatric Association's "Guidelines for Psychiatrists in Consultative, Supervisory, or Collaborative Relationships with Non-medical Therapists," (www.apa.org), defines traditional relationships between psychiatrists and non-medical therapists. In "Guidelines for Prescribing Psychiatrists in Consultative, Collaborative, and Supervisory Relationships," Sederer et al. also defined these relationships and developed corresponding guidelines, specifically for prescribing psychiatrists. Shared treatment relationships, due to their potential complexities and varied natures, may not

always fit into only one of these specifically defined categories, but the definitions are important tools for both psychiatrists and non-medical therapists to use in understanding and communicating with each other and the patient about the nature and scope of the shared treatment relationship. The definitions provide guidance for the professionals and their patients in understanding the parameters of responsibility for each person in the patient- multiple provider relationship. Clarifying the relative responsibilities and expectations, as well as ongoing communication among the parties, is critical for successful split treatment that meets the standard of care and reduces liability risks.

In a malpractice lawsuit, these definitions may be used to assist in understanding the relative duties and responsibilities in a shared treatment relationship. Ultimately, however, the court and the jury will decide about the *actions and/or omissions* of the psychiatrist and non-medical therapist that will be determinative of liability. They may choose to ignore the distinctions on which the professionals functioned.

Liability Analysis Remains the Same

Although the nature and configuration of practice relationships may change, the liability analysis does not. Therefore, a psychiatrist's actions or omissions would be subject to the same liability analysis regardless of the practice relationship.

In a medical professional malpractice lawsuit, four elements must be proven in order to find the psychiatrist liable:

1. a duty was owed to the patient (i.e., the plaintiff) by the physician (i.e., the defendant);
2. the physician breached (i.e., violated) that duty;
3. the breach was the proximate cause (i.e., direct cause) of the claimed injuries/damages; and
4. there were actual injuries/damages sustained by the patient

The accepted *standard of care* is the criterion used to determine the duty that was owed to the patient and if that duty was breached. Generally, the standard of care is the degree of care and skill expected of a reasonably competent physician in the same specialty acting under similar circumstances. In a medical malpractice lawsuit, medical expert witnesses must testify as to the applicable standard of care and whether or not there was a deviation from that standard.

Liability Implications

What impact does the existence of a split treatment relationship have on the psychiatrist's duty to the patient? None. The psychiatrist *always* remains responsible for ensuring that the patient receives the appropriate care. A physician's duty to provide the standard of care emanates from the common law and from professional, ethical, and statutory/licensing responsibilities.

Psychiatrists may face conflicting responsibilities because of their unique role in determining what care a patient needs and, at the same time, complying with the cost containment requirements of the patient's insurance company. Utilization

decisions by the insurance company do not relieve the psychiatrist's responsibility of providing the appropriate standard of care to the patient. Pleading difficult practice conditions or economic constraints will not be an adequate defense in a malpractice lawsuit. Psychiatric expert witnesses *do not* testify that cost containment considerations may preempt patient care.

The difficult question is, "What does the psychiatrist need to do in order to ensure that the standard of care is being met?"

Examples of Increasing Risk

The following scenarios illustrate some ways in which shared treatment relationships can give rise to professional liability problems. The examples are a compilation of facts taken from actual claims, litigation and risk management consultations at the APA-endorsed Psychiatrists' Professional Liability Insurance Program. Identifying information has been modified.

Scenario 1. A patient reported to her prescribing psychiatrist that she felt uneasy about her relationship with her therapist, a "drama therapist." After discussing the patient's concerns, the psychiatrist determined that the therapist might have breached sexual boundaries. In the process of investigating his duty to report the therapist's misconduct, the psychiatrist discovered that the therapist was not licensed and, in fact, that drama therapy was not recognized or regulated in the state. The psychiatrist realized he knew nothing about the therapist's qualifications, competence, or the therapy that was being provided. *Comment. If a lawsuit arises in this situation, the psychiatrist may bear most of the liability risk. Especially since unlicensed therapists may not be held to the same clinical and legal standards and probably do not carry malpractice insurance, the court may be looking for a way to compensate an injured plaintiff. The psychiatrist may be found to have some accountability for knowing the qualifications of the therapist, supervising the therapist and/or informing the patient. In this situation the psychiatrist was unable to evaluate the quality of care being provided to the patient.*

Scenario 2. A patient refused to allow his psychotherapist to discuss his ongoing substance abuse with the prescribing psychiatrist. The psychotherapist informed the patient that sharing this information with the psychiatrist was critical to his treatment and safety. The psychotherapist ultimately terminated treatment with the patient and informed the psychiatrist that the patient refused to consent to disclosing important clinical information. When the psychiatrist confronted the patient, the patient refused to discuss the situation. Subsequently, the psychiatrist referred the patient and terminated his treatment. *Comment. Get the patient's written consent to disclose confidential information in the shared treatment relationship* before *beginning treatment. If the patient will not consent to such communication, the psychiatrist and psychotherapist must decide whether they can work therapeutically with the patient. Lack of important information adversely affects quality of care and increases liability risks.*

Scenario 3. A nurse practitioner contacted a psychiatric group practice requesting that a patient in psychotherapy be evaluated for possible medication management. The group's policy was to perform a complete psychiatric evaluation

before recommending any medication. The nurse practitioner objected to the need for a psychiatric evaluation. He stated that he was qualified and authorized to perform the clinical evaluation under the state advanced nurse practice laws and was only referring the patient for a limited medication evaluation. The psychiatric group stood by the policy, and the nurse referred the patient elsewhere. *Comment. To meet the standard of care, a prescribing psychiatrist must perform an evaluation in order to have adequate information on which to base clinical recommendations and treatment. Do not let others set the standard of care for you.*

Scenario 4. A psychiatrist is asked by a nurse practitioner to be a supervisor. The state nurse practice act permits nurse practitioners to prescribe medications under the supervision of a physician. The psychiatrist wants to know if she is at higher risk for malpractice lawsuits if she agrees to be the nurse's supervisor. What information should the psychiatrist have before deciding whether to enter into a supervisory relationship? *Comment. In supervisory relationships, the supervisor is directly responsible for the patient's care and must provide the level of supervision required to make sure the standard of care is met. The psychiatrist should know and follow the requirements set out by the applicable licensing boards for this type of practice relationship. For example, some state's laws require that prescribing nurse practitioners complete pharmacology courses; obtain their own Drug Enforcement Administration number; be re-certified every every few years; and establish a written practice agreement with the collaborating psychiatrist that includes provisions for emergency coverage, physician review of patient records every three months, etc. Additionally, the psychiatrist should require that the therapist has equivalent professional liability limits.*

Scenario 5. The prescribing psychiatrist was confident of a therapist's qualifications and competence and relied on her input for prescribing and monitoring the medications of several patients they treated collaboratively. When the psychiatrist's schedule became very hectic due to the volume of patients he was seeing for medication management, he gave the therapist a supply of signed prescription pads. The psychiatrist decreased the face-to-face visits with the patient and, instead, conferred with the therapist by telephone during the patient's psychotherapy visits and directed the therapist how to fill out the pre-signed prescription form. Subsequently, the psychiatrist and the therapist were named in a lawsuit that alleged the patient was injured due to inadequate time spent to perform a psychiatric evaluation, medication inappropriate for condition, incorrect dosage, failure to monitor drug side effects, and failure to coordinate treatment with the psychotherapist. *Comment. Not only did the psychiatrist and the therapist breach the standard of care, they violated their respective licensing board regulations and may have violated federal and/or state drug enforcement law about prescribing medications. Allegations in a malpractice lawsuit made in relation to unlawful and/or criminal acts are usually excluded from coverage under a professional liability insurance policy.*

Scenario 6. The prescribing psychiatrist and the therapist did not establish a plan for communication. The psychiatrist thought it was the therapist's responsibility to contact him. The therapist did not call. During a medication visit, the psychiatrist found that the patient's clinical status had deteriorated, that she needed intensive clinical intervention and possible hospitalization; however, he was unsuccessful in reaching the therapist to develop a plan of care. By this time he thought the patient was at risk for suicide and should not wait to be seen at her regular psychotherapy appointment. The

psychiatrist was very concerned about the potential liability risk if the patient did not receive intensive intervention and decided to terminate his relationship with the patient in order to decrease the risk.

Comment. Regardless of the difficult practice situation, patient care needs must be met. The psychiatrist cannot minimize liability by terminating with a patient who is in crisis. In fact, allegations of patient abandonment could be made against the psychiatrist. Termination of the patient-psychiatrist relationship can only be accomplished through a proper termination process that includes adequate notice, treatment options, and relevant information.

Does Shared Treatment Increase the Malpractice Risk?

The elements for increased liability risk are present in these relationships, but each individual situation must be evaluated to understand its particular risk profile. The risk analysis must evaluate the risks inherent in the treatment of the particular patient (What are this patient's clinical needs?), coupled with an evaluation of the risks presented by the shared relationship (How does the split treatment complicate/increase problems in meeting the standard of care for this patient? Are there ways to manage those risks so that you are satisfied that patient care needs are being met?)

Risk management seeks to improve the quality of care provided to patients and to reduce legal liability. The best risk management strategy is to pursue quality care that is in the patient's interest. Coordination and communication with non-medical therapists are essential to providing good treatment.

SUPERVISION OF NURSE PRACTITIONERS

More and more psychiatrists are considering supervising nurse practitioners, both in the context of hiring a nurse practitioner for their private practices or being asked to work with a nurse practitioner in a clinic or other facility setting. This trend is expected to continue, as utilization of allied healthcare professionals can be an effective solution to the problem of limited psychiatric resources. As with all practice arrangements, psychiatrists need to be aware of the potential malpractice risks when entering into a supervisory arrangement with a nurse practitioner, as well as how to minimize and manage those risks.

What Are the Liability Risks Associated With Supervision of Nurse Practitioners?

While the specific activities that constitute supervision by a psychiatrist vary from state to state, a psychiatrist's potential liability for the actions of the nurse practitioner does not; a psychiatrist will almost certainly be named as a defendant in any lawsuit alleging malpractice against a nurse practitioner whom the psychiatrist is supervising. Depending upon individual state law, the plaintiff/patient may try to impute negligence upon the psychiatrist on two grounds:

- *Vicarious Liability/Respondeat Superior*. Vicarious liability is based upon the legal doctrine of respondeat superior, which literally means "let the master respond." Provided that the nurse practitioner was found to have committed the act of negligence within the scope of his or her employment (i.e., engaging in an act to further the business of the psychiatrist) the psychiatrist may also be found liable. This can occur even though the psychiatrist's own care of the patient or supervision of the nurse practitioner was above reproach.

- *Negligent Supervision.* Each state's laws have provisions regarding the supervision of nurse practitioners by physician(s). Should an error occur on the part of the nurse practitioner the plaintiff will undoubtedly look at whether there were any lapses in oversight to support an allegation of negligent supervision.

The bottom line is that adequate supervision is necessary to protect the psychiatrist from liability for the nurse practitioner's actions or inactions.

What Can Psychiatrists Do To Manage the Liability Risks?

In general, the best way to minimize liability is to establish and follow appropriate guidelines for the nurse practitioner's practice, supervision, and review.

- Understand Your State's Statutory and Regulatory Requirements

The first step in establishing such guidelines is having a very clear understanding of what is required by the state's nursing board as well as your licensing board. The scope of the nurse practitioner's practice, including prescribing authority, is defined by each state, either by the legislature and/or nursing board regulations. States vary in the extent to which a nurse practitioner's practice is regulated and in the degree of supervision required. A few states treat the nurse practitioner as a truly independent practitioner, requiring no supervision or collaboration; some states regulate the relationship extensively; and other states are somewhere between the two extremes. The majority of states require some supervision or at least formal collaboration subject to specific regulatory requirements.

The topics of state regulation of nurse practitioners include, but are not limited to, the following:

- Limiting the number of nurse practitioners a physician may work with at the same time
- Requiring a physician to be registered as a supervising/ collaborating physician
- Specifying the frequency for on-site visits by the physician
- Stipulating the content of written practice agreements and written protocols between nurse practitioners and supervising/collaborating physicians

Psychiatrists should contact their state's Board of Nursing or visit their websites to determine the specific requirements in their states.

Psychiatrists should make a similar inquiry of their state licensing board. Many states' definitions of "unprofessional conduct" or "professional misconduct" specifically include supervision or supervision-related activities which could subject the physician to discipline. For example:

- Failing to properly supervise (New York)
- Failing to delegate properly (New York)
- Entering into or continuing in a collaborative agreement that fails to meet generally acceptable standards of medical practice (Colorado)

Specific Risk Management Strategies

Consider the following *before* agreeing to work with a nurse practitioner:

- Review and discuss all applicable statutes and regulations with the nurse practitioner.
- Verify the nurse practitioner's education, training, licensing, credentialing, and employment history.

- Contact the Nursing Board to inquire about any administrative complaints or lawsuits that may have been filed against the nurse practitioner.

- Verify the nurse practitioner's professional liability coverage. The nurse practitioner should have the same professional liability insurance coverage limits as you do.

- Check your professional liability insurance policy and contact your Underwriter to notify him of the supervision arrangement.

- Be aware that there is no universal agreement on what constitutes "supervision." Know what you are agreeing to. Know what is expected of you before you sign a contract or agreement to be a supervisor and before signing-off on a form as a supervisor. Check with the various organizations that may be involved, such as the patient's insurance company, facilities where you and the nurse practitioner practice, and Medicare/Medicaid, to understand their definitions of supervision and supervisor.

- Be trained and experienced in the same area of practice as the individual you are supervising. You will be held to the standard of care for that practice area.

- Do not supervise relatives, close friends, employers, or patients. Dual relationships can impair your objectivity and professional judgment and should be avoided. Supervision of patients would almost certainly be considered unethical.

- Understand the requirements for and implications of your signature on orders and other documents, especially for a patient that you have not seen. As the signing physician, you must ensure that the level of your involvement is accurately reflected on the document. One way to ensure this is to annotate the signature. For example, you might add "Reviewed by," "Chart reviewed/patient not seen by," or "Under the supervision of" before your signature.

- Ensure that the nurse practitioner who will be prescribing on his own has complied with statutory, regulatory, and payer requirements and has obtained his own DEA number and prescription pads.

- Ensure that the nurse practitioner is aware of his professional code of ethics.

Develop a written agreement prior to supervision, even if not required to do so under state law. A formal agreement should help to promote communication, set parameters, clarify responsibilities and expectations, establish procedures, and limit ambiguity. Some states require a written agreement for supervisory relationships and even require a review of the agreement by the respective licensing boards involved. Any agreement should be strictly followed so that the standards of the agreement are not violated. Specific elements to consider having in a written agreement include, but are not limited to, the following:

- frequency and type of supervision and record review,

- notification by the nurse practitioner of any changes in his professional status, such as an investigation or disciplinary action by professional licensing board and or professional certifying organizations, complaints by patients, etc.,
- loss or limitation of license,
- change in insurance coverage,
- your requirements for notification of material changes in the status of patients (emergencies, crises, side effects, etc.), and
- information to be given to patient about the respective roles of the physician, nurse practitioner, and the patient other, as indicated by the state's statutes and rules.
- Consult with personal legal counsel for state specific requirements, for assistance with the agreement, and for information about financial and billing matters.
- Know that no legal document can totally eliminate your risk for liability from a supervisory relationship. Should the supervisory relationship ever be questioned, the substance of the relationship will be considered as well as any formal agreement.

Tailor your involvement to the nurse practitioner's education, training, and skills, as well as the clinical needs of the patient. Simply meeting your state's requirements for supervision may not be sufficient.

- Do not make assumptions about the nurse practitioner's knowledge; assess his skills carefully. Document internal training and continuing education. Make sure that the nurse practitioner knows his limits and knows when to ask for help (i.e., it is important that the nurse practitioners not wait too long to contact you with important clinical information about a patient or other critical issue.)
- Ensure on-going communication between yourself and the Nurse Practitioner.

This is especially critical with regard to crisis and emergency situations. If at anytime there are materials changes in a patient's status (including, but not limited to, suicidality or homicidality), the nurse practitioner should notify you immediately. There have been cases where the nurse practitioner made significant decisions without informing the physician, who didn't know of the problem until he was named as a defendant in a lawsuit.

Educate the patient about the supervisory relationship. Ensure that the patient understands that the nurse practitioner is not a psychiatrist.

- Document your supervision including the dates of each supervision meeting, the duration of in-person supervision, and an ongoing record of the total number of hours of supervision to date.

- Ensure that in the event of your non-availability, another psychiatrist is available to cover your supervisory responsibilities with the nurse practitioner.

- Evaluate the nurse practitioner on the basis of actual performance and reasonable standards.

Remember that you are responsible for ensuring that the nurse practitioner performs responsibly, competently, and ethically. If at any time and for any reason, you determine that the nurse practitioner is not providing services commensurate with the standard of care, develop and implement a plan for remediation. You may want to consider putting the remediation plan in writing. Such a step could help with communication and compliance and could also be used to provide a defense of your actions should they ever be questioned. If the nurse practitioner is unable to provide appropriate care, patients may need to be seen by you or another competent health care professional until the nurse practitioner is able to resume appropriate care.

Additional Resources:

AMA Guidelines for Integrated Practice of Physician and Nurse Practitioner (Policy H-160.950), available at www.ama-assn.org.

APA Guidelines for Psychotherapists in Consultative, Supervisory, or Collaborative Relationships With Nonmedical Therapists

APA Guidelines for Physician Signatures

APA Ethics Opinion 5-J regarding supervisors' signatures when the supervisor has not examined the patient

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