HOOT WHAT WHERE

WELCOME TO ANOTHER EDITION OF "HOOT WHAT WHERE," a newsletter developed by Professional Risk Management Services® for the behavioral healthcare network of psychiatrists and mental health professionals. From risk management and claims advice to risk alerts, PRMS announcements, and events, this quarterly newsletter will share relevant news, useful tips, and important updates in the field of psychiatry to help keep you, your patients, and your practice safe.

WHAT YOU'LL FIND INSIDE:

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10 THINGS ABOUT MEDICAL RECORD REQUESTS

1. Access to protected information may be requested by a patient or other individual in a variety of ways for a variety of purposes. It is vitally important that requests for information never be ignored as there are professional, ethical, and legal penalties for failing to respond in a timely manner. Furthermore, failure to respond appropriately to requests in a judicial context may invoke professional liability coverage issues.
2. Your practice should have written policies and procedures for responding to information requests appropriately. It is important to remember, however that responding to a request for information does not always involve disclosing the information, in fact, frequently it does not.
3. Psychiatrists are prohibited from disclosing protected information unless disclosure has been authorized or legally compelled - or unless an emergency exception applies. Once proper authorization has been obtained, only the specific information that has been authorized or compelled should be released.
4. Verbal requests usually come from a patient, a member of the patient's family, or a law-enforcement professional. Verbal requests are almost always insufficient to allow or compel disclosure, and psychiatrists have very little discretion with such requests. The primary exception to this rule is an emergency situation (e.g., a call from the ER or an imminently suicidal patient). If there is no emergency, the appropriate response is to explain that the request must be put in writing. Additionally, if the request is from someone other than the patient, the requester must cite their authority to access the information.
5. Ideally, all requests for information should be in the form of, or include, a written release authorization. Written requests that do not include an authorization are almost always insufficient to allow or compel the release of information. Written release authorizations are documents whereby the individual who has the legal authority to control the protected information gives the psychiatrist permission and direction to disclose specified information. The written release serves to protect the psychiatrist from potential liability for disclosing information. When a written request is received, it should be evaluated as soon as possible, as time is usually of the essence. Some states even specify the time frame within which requests must be processed.
6. From a general risk management perspective, the basic elements that should be present in a valid authorization for release of information include: the specific name or general designation of the person or program being authorized to make the disclosure; the name or title of the individual or the name of the organization to which the disclosure may be made; the name of the patient; the specific type of information to be disclosed (i.e., psychiatric information and substance abuse treatment information); the specific purpose of the disclosure; a statement that the authorization to disclose is subject to revocation at any time except to the extent that the program or person that is to make the disclosure has already acted in reliance on it; the signature of the patient or person legally authorized to give consent with any necessary

supporting documentation (e.g., a copy of the legal papers appointing an individual as representative of a deceased patient's estate); a current date with the signature; and a specific date on which the authorization expires.

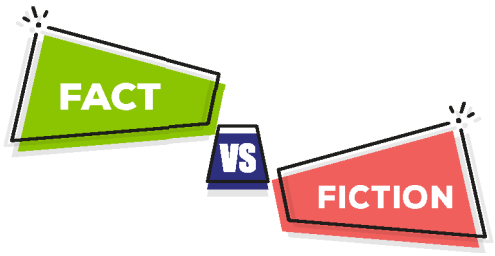
7. In addition to the basic elements of a valid authorization, additional elements may be required depending on the practice state or the type of information being disclosed. For example, federal regulations that protect the confidentiality of substance abuse treatment records require particular elements be included in the written form for disclosure of patient information. (See 42 CFR Part 2, section 2.31). Likewise, psychiatrists who are "covered providers" under the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) must use authorization forms with specific required elements set out by that regulation.
8. A proper authorization almost always compels a psychiatrist to release records, even if they do not wish to do so. Some state statutes as well as the HIPAA Privacy Rule allow a psychiatrist to provide a summary of treatment in lieu of a copy patient's entire chart; however, in many instances, individuals who request a copy of a record will insist on receiving a complete copy. Some states and the Privacy Rule also allow psychiatrists to refuse to release information that would be detrimental to the patient; however, there will typically be an appeal mechanism under which the patient can have the psychiatrist's denial of access reviewed. The standards for exercising this discretion are very high. For example, information could be withheld if disclosure would cause the patient to become imminently suicidal or homicidal, but information could not be withheld if it would simply cause the patient to become angry and file a lawsuit.
9. A subpoena is a legal document used to obtain the testimony (written or oral) of a witness in a legal proceeding. Subpoenas are usually issued by an attorney but while they do have the authority of the court behind them, they do not carry the same weight as actual court orders. Generally, a subpoena alone is not sufficient to compel the release of mental health records. This does not mean, however, that a subpoena may be ignored. Subpoenas require a timely response even if no information is released.
10. A court order is issued by a judge after one or both parties to has made a motion for some kind of action to be taken (e.g., the releasing of psychiatric records). Court orders alone are almost always sufficient to compel the disclosure of information even if the patient does not wish to allow it. However, some court orders may not be sufficient, for example if a proper hearing has not taken place regarding the motion. The hearing is vital, because the involvement of a judge in the decision-making process acts to shield the psychiatrist from potential liability for disclosing information. Indeed, so powerful is the judge's authority, that to refuse to comply with a court order carries the very real possibility of being held in contempt of court.

10 THINGS ABOUT SPLIT TREATMENT

1. 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.
2. While theoretically each professional should only bear the risk of liability for their own actions, in practice when one of the professionals is a non-physician, the psychiatrist may be seen as bearing a greater burden of care due to their education and training. This is true even though the psychiatrist has no supervisory responsibility over the other clinician.
3. In the best case scenario, split-treatment can enhance care and patient safety as it allows for closer patient monitoring using the separate expertise of two skilled clinicians. Unfortunately, there are also those situations where the psychiatrist and the therapist don't work well together, putting both patient and clinicians at risk.
4. Psychiatrists who have been in practice for a number of years may already have a cadre of therapists with whom they are comfortable sharing treatment. Should a patient choose a therapist with whom the psychiatrist does not have a professional relationship, before agreeing to work with a therapist, the psychiatrist should make efforts to determine whether they are comfortable doing so.
5. If the patient is high-risk, it is particularly important to ensure that the therapist is up to the task of dealing with a complex patient. It is not inappropriate to inquire as to their experience level and prior training as well as licensure and malpractice coverage.
6. There should be an agreement between the psychiatrist and the therapist as to how they will communicate, how often they will communicate, and what information will be shared. They should also determine whether there will be certain events/situations that will trigger contact for example, missed appointments, medication changes, or reports of suicidal ideation.
7. The psychiatrist and therapist should agree upon their respective roles. While each will take the lead in their agreed upon role, they must avoid operating within rigid parameters. For example, if the therapist notes a negative change in the patient's behavior following a medication change they should be prepared to bring this to the psychiatrist's attention.
8. It may be helpful to memorialize your understanding of the treatment arrangement in a formal written agreement. It may also be beneficial to have the patient be a party to this agreement so that they understand each clinician's role, whom to reach out to in various situations and how, and to otherwise manage expectations.
9. It is not uncommon for manipulative patients to try to pit clinicians against one and other by presenting vastly different information to each thus causing the clinicians to recommend courses of treatment that may be conflicting. Some of

this may be mitigated by frequent and open communication.

10. If a psychiatrist finds themself in a situation where their recommendations are being ignored by the patient and are not supported by the therapist, they should consider the feasibility of remaining in the treatment relationship. While it may be the psychiatrist's clinical judgment that the patient would benefit from medication, they must consider whether another psychiatrist might have greater success in convincing the patient of this and whether their continued involvement in the treatment relationship does anything further than increase their liability exposure.



WHAT DO YOU THINK - FACT OR FICTION?

FACT OR FICTION?

You've been treating a 10-year-old patient for a number of months. He has always been brought in by his father, who has told you he is divorced from the mother, and that she is no longer involved in the patient's life. Out of the blue, you get a call from the patient's mother who just found out that you are treating her son and is upset about the medication you are prescribing. She demands a copy of the child's record. When you explain to her that the father had given consent for the medications, she tells you she and the father have joint decision-making authority for all medical care. She further tells you she wants to be involved in her son's care, but the father is preventing this. She offers to send you a copy of the custody order. You contact the father who assures you that he is the one with sole physical custody, and only he can consent to release of the record; he also tells you that nothing in the custody order changes that and there's no need for you to review the order. You may rely on the father's assurances since he always brings in your patient.

What do you think - fact or fiction?

Fiction!

You need to see the custody order as it will likely spell out which parent(s) must consent to treatment, and who can access the patient's record. If parents are in disagreement over consent to treatment and/or release of treatment information, and these issues are not addressed in the order, the parents should seek resolution from their attorneys.

Psychiatrists treating minors may want to consider the following:

- When a new appointment is made for a new patient who is a minor, ask if the parents are divorced. If so, advise that a copy of the custody order will need to be brought to the first appointment. Without the order, the psychiatrist may not be able to see the patient because there is no proof that the parent bringing the minor has the legal authority to consent to treatment.
- Manage the expectations of all parties. Explain your process for keeping parents informed about their child's treatment.

WHERE'S PRMS HEADED THIS FALL?

North Carolina Psychiatric Association Annual Meeting & Scientific Session | September 18-21

Psych Congress | September 18-20

Pennsylvania Psychiatric Society Philadelphia Chapter Career Fair | September 20

Orange County Psychiatric Society Summer Social | September 21

Indiana Psychiatric Society Regional Integrated Mental Health Conference | September 26-28

Northern California Psychiatric Society Membership Meeting | October 1

Psychiatric Society of Virginia Fall Meeting | October 3-4

Association of Medicine and Psychiatry Annual Meeting | October 9-11

Florida Psychiatric Society Fall Meeting | October 10-12

Pennsylvania Psychiatric Society Pittsburgh Chapter Resident Poster Contest | October 14

American Academy of Clinical Psychiatrists Psychopharmacology Update | October 17-18

American Academy of Child and Adolescent Psychiatry Annual Meeting | October 20-24

Indo-American Psychiatric Association Fall Meeting | October 25

American Academy of Psychiatry and the Law Annual Meeting | October 30- November 2

American Academy of Addiction Psychiatry Annual Meeting and Scientific Symposium | November 6-9

Texas Society of Psychiatric Physicians Association Annual Convention | November 6-9

Illinois Council on Child and Adolescent Psychiatry Fall Networking Dinner | November 12

New Jersey Psychiatric Association Annual Conference | November 16

Academy of Consultation-Liaison Psychiatry Annual Meeting | November 19-22

... and more!

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