

Guidelines for Psychiatrists in Consultative, Supervisory or Collaborative Relationships with Nonphysician Clinicians

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The practice of psychiatry and of other mental health disciplines frequently occurs in the framework of organized health delivery systems. Psychiatrists are working with other professionals and nonprofessionals in hospital settings, community mental health centers, health maintenance organizations, as well as in group practices, and in consultative work with schools, family agencies, court clinics, etc. Interprofessional relationships are an essential aspect of good patient care and should be encouraged. They serve as a valuable educational experience and contribute to the continuing development of all who are concerned with patient care. The addition of other professionals and extenders to the health team enlarges the capacity to provide service. In turn, this requires a review of the role and responsibilities of psychiatrists in the entire range of consultative, supervisory, and collaborative relationships.

OBJECTIVES OF THE PROFESSION OF PSYCHIATRY

The American Psychiatric Association, in its *Bylaws*, states the following to be its objectives:

- (a) to promote the common professional interests of its members;
- (b) to improve the treatment, rehabilitation, and care of persons with mental disorders (including mental retardation and substance-related disorders);
- (c) to advance the standards of all psychiatric services and facilities;
- (d) to promote research, professional education in psychiatry and allied fields, and the prevention of psychiatric disabilities;
- (e) to foster the cooperation of all who are concerned with the medical, psychological, social, and legal aspects of mental health and illness;
- (f) to make psychiatric knowledge available to practitioners of medicine, to scientists, and to the public;
- (g) to promote the best interests of patients and those actually or potentially making use of mental health services; and
- (h) to advocate for its members

The psychiatrist is a physician whose work constantly involves the differential diagnosis of disease and disorder and whose practice is concerned with elucidating and addressing the complex intertwined relationships of the physical and emotional aspects of diseases and disorders. In this work with patients the psychiatrist continually monitors, reassesses, and refines diagnoses and pursues therapeutic aims, using a wide range of treatment modalities, including psychotherapies, medications, and other somatic treatments and, at times, hospital care.

Psychiatry's Responsibilities to Other Professions

Definition and delineation of interprofessional relationships. To recognize that every professional group has a right to establish and maintain its identity and independence within its scope of practice by setting up its own educational

and training programs, and establishing its own standards of service. As a responsibility to the public, society may recognize the profession and set up such controls as it may deem necessary.

Education and Training. The responsibilities of psychiatry include the following:

- To inform members of other professions regarding training, experience, areas of special competence, and appropriate spheres of activity of the psychiatrist.
- To assist when invited in the education and training of other professionals in any areas in which psychiatry has a contribution to make, and on subjects within the scope of those other professions as they may be legally defined.
- To encourage and foster ongoing mutual education programs through joint meetings, seminars, and workshops with other professional organizations.

Standards of service. To work in close cooperation with other professionals when requested to do so in order to utilize the expertise of all available professions in the provision of high standards of service to the public.

Ethics. To recognize that the establishment and maintenance of codes of ethics are an internal responsibility of each profession and that complaints against other professionals should be directed to the responsible authorities of the profession concerned.

Manpower, research, and prevention. To collaborate with other professions in these important areas.

Liaison responsibilities. To recognize such responsibilities, the American Psychiatric Association offers the following guidelines in reference to the settings and situations in which problems in interprofessional relations often arise:

- **In medical settings:** The American Psychiatric Association, in concurrence with the American Hospital Association, endorses the principle of appointing members of other professions such as nurses, dentists, social workers, sociologists, ministers, and psychologists to the staff of hospital and other facilities to bring to the treatment of patients their specialized knowledge, skill, and experience. In such a setting the physician-psychiatrist retains the primary medical responsibility, established by law and custom, for the admission, diagnosis, treatment, rehabilitation, and discharge of patients.
- **In nonmedical settings:** Psychiatrists function increasingly in many settings such as mental retardation centers, regular and special education schools, correctional institutions, social service agencies, and others that do not have a primarily medical orientation. A psychiatrist working as a consultant, supervisor, therapist, or administrative staff member in such a setting has essentially the same relationship to the organization as other professionals have in a medical setting. However, he must retain ultimate responsibility for the psychiatric care of the patients or clients whom he serves.
- **In office practice:** The psychiatrist recognizes the special skills and competencies of other professionals and sends or refers people to them for appropriate services, based on the other professionals' education, training, experience, competence, and reputation.
- **Third-party payments:** Psychiatry recognizes that reimbursement occurs under medical insurance plans such as Medicaid or Medicare to nonphysician health professionals who are duly credentialed to provide such services. A person/potential patient should feel free to select the practitioner of his/her choice from among qualified professionals. If there is a public demand for health-related services that are not normally regarded as medical or offered as part of a total medical treatment program, insurance companies may offer insurance for such health-related services as they currently do for medical treatment.
- **Legal responsibility:** When psychiatrists extend their services to other health professionals in meaningful collaboration (which includes supervision of cases or participation in interdisciplinary teamwork), they are obliged to

know about and to be willing to assume the established legal responsibilities involved.

Psychiatrists have raised questions about the nature of their working relationships with members of the nonphysician mental health professions and extenders. In terms of inpatients, in 1976 the Board of Trustees adopted this statement: "The Board of Trustees, in recognition of the need of psychiatric patients to have the total care that is provided only through a physician trained in psychiatry, strongly reaffirms its conviction that the treatment of psychiatric patients within a hospital setting must be under the supervision of a physician."

The appropriate use of consultative, supervisory, and collaborative relationships is basic to good patient care. These guidelines are not in any way an attempt to define the roles and conditions of practice that exist in other disciplines and should not be interpreted or used for that purpose.

1. *Consultative relationship between a psychiatrist and a nonphysician clinician.* In this type of relationship the psychiatrist does not assume responsibility for the patient's care. The psychiatrist evaluates the information provided by the nonphysician clinician and offers a medical opinion which the clinician may or may not accept. In this instance the nonphysician clinician must have met professional and institutional standards for independent functioning (e.g., certification). Consultation is not a one-way process and psychiatrists do and should seek appropriate consultation from members of other disciplines in order to provide more comprehensive services to patients (see sections 4 & 5).

2. *Supervisory relationships between a psychiatrist and a nonphysician clinician.* In a supervisory relationship the psychiatrist retains direct responsibility for patient care and gives professional direction and active guidance to the nonphysician clinician. In this relationship the nonphysician clinician may be an employee of an organized health-care setting or of the psychiatrist. The psychiatrist is clinically responsible for the initial workup, diagnosis, and prescription of a treatment plan, as well as for assuring that adequate and timely attention is paid to the patient's physical status and that such information is integrated into the overall evaluation, diagnosis, and planning. The psychiatrist remains ethically and medically responsible for the patient's care as long as the treatment continues under his or her supervision. The patient should be fully informed of the existence and nature of, and any changes in, the supervisory relationship.

3. *Collaborative relationship between a psychiatrist and a nonphysician clinician.* Implicit in this relationship is mutually shared responsibility for the patient's care in accordance with the qualifications and limitations of each nonphysician clinician's discipline and abilities. The patient must be informed of the respective responsibilities of each nonphysician clinician. In support of patient-centered services, a patient has the right and responsibility to seek his/her own healthcare. If a patient autonomously and independently seeks nonphysician services, the psychiatrist does not have supervisory responsibility over the nonphysician clinician. The psychiatrist has the option to pursue a collaborative relationship. Psychiatrists engaged in administrative supervisory, consultative or collaborative relationships should be guided by the AMA Collaborative Practice document (under development as of May 2009).

4. *Appropriateness of care.* Psychiatrists working in administrative supervisory, consultative, or collaborative relationships should at all times work towards maintaining and/or improving the quality of care and undertake relationships with a nonphysician clinician only if they are able to keep themselves appropriately informed of the nature of treatment and the progress of those patients for whom they are acting as supervisor, consultant, or collaborator, and can assure themselves that the treatment is being carried out competently and adequately.

In some institutional settings nonpsychiatric professionals or mental health workers may be supervised by a senior nonpsychiatric mental health worker of the same discipline. The psychiatrist must function in this system as if the relationship were a collaborative or supervisory one. In no circumstances can the relationship be defined as collaborative if the other treating professional has not met professional and institutional standards for independent functioning.

5. *Frequency of supervision, consultation, and collaboration.* Because of the wide range of competence and training that currently exists among nonphysician clinicians, it is difficult to specify precisely what an optimum number and frequency of supervision, consultation, or collaboration contacts between a psychiatrist and a nonphysician clinician should be. Clearly, adequate communication between the psychiatrist and the agency and/or nonphysician clinician(s) is a sine qua non. Moreover, it is incumbent upon the psychiatrists to satisfy themselves as to the competence, level of training, and, where required, licensure of the other clinicians. They must then provide an amount of supervision, consultation, or collaboration sufficient to assure that their ethical, medical, and legal responsibilities toward the patient are met and are consistent with any local or state guidelines outlining these responsibilities.

6. *Billing practices for psychiatrists working with nonphysician clinicians.* A psychiatrist's bill should reflect the services actually rendered. Psychiatrists should not bill a patient, insurance company, or other third-party payer for a service that they do not personally provide directly to the patient, except in circumstances noted in sections (a) and (b) below. (This does not apply to direct consultations provided to agencies and institutions.)

- (a) When a psychiatrist employs a nonphysician clinician on a salary or fee-for-service basis, the patient or third-party payer may be billed on a psychiatrist's billhead. However, the bill should note the name of the clinician actually providing the service, his or her training (Ph.D., M.S.W., R.N., Mental Health Counselor), number of visits, the rate per visit, and the total charges.
- (b) In some circumstances psychiatrists may bill for their own time spent in behalf of the treatment of the patient, but not actually with the patient. Such circumstances include extensive time spent in discussing past treatment with other physicians or nonphysician clinicians and occasional necessary meetings with nonphysician clinicians of important individuals in a patient's life. Such charges should usually be made after first informing the patient. Psychiatrists should keep careful, detailed records of all billed contacts in accordance with the APA and AMA guidelines.
- (c) Except as noted in section (a) above, psychiatrists should not bill patients, third-party carriers, or others in their own names for services that they do not provide, nor should psychiatrists allow their names to be used to imply that they have provided therapy that they have not actually provided. Rather, nonphysician clinicians should bill the patient, insurance company, or other third-party payer in their own names for their own services at whatever rate they have agreed on with the patient, using their own billhead.
- (d) When psychiatrists personally interview patients, as part of their supervisory, consultative, or collaborative responsibilities, they may bill the patient, insurance company, or other third-party payer for such services on their own billhead, but only at the rate which corresponds to the time or service they actually provided to the patient.
- (e) Except as cited in sections (a) and (b) above, psychiatrists may bill only for the time they actually spend with the patient. Financial reimbursement of psychiatrists for consultative and/or supervisory time provided directly to the nonphysician clinician, and which did not involve seeing the patient, is up to individual arrangement between the psychiatrist and the nonphysician clinician. This reimbursement should be based on the actual amount of time spent on supervision or consultation, plus appropriate administrative costs such as rental office space and sharing of secretarial services. An arrangement in which the psychiatrist is reimbursed by the nonphysician clinician with a percentage of the latter's fees or gross income is not acceptable; this could constitute fee-splitting. Under no circumstance should a psychiatrist be compensated directly or indirectly for the referral of a patient to a nonphysician clinician. The mutually agreed upon set fee or salary should be open to renegotiation when a change in the time demand occurs. It is recommended that these arrangements be made in writing, specifying the obligations of both parties. Third parties may be notified of such a supervisory relationship when documentation is required for the nonphysician clinician to receive payment.