

Guidelines for Communications and Information Sharing Between GPs and Community Partners



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Background and Purpose

With the implementation of the “A GP for Me” initiative for the Delta Division of Family Practice, one of the primary goals was to improve communications processes to enable GPs to identify and rapidly refer to targeted Mental Health and Substance Use (MHSU) and allied health care resources, and to receive timely feedback, which would enable a smoother journey for the MHSU adult patient.

In addition to developing searchable on-line resources, the Division assembled community partners to explore the value of establishing a provider network that could enable more effective working relationships and communications. Improvements were identified through collaborative planning with our GPs, medical office assistants, allied health care professionals, community service organizations, Fraser Health MHSU, and the Corporation of Delta.

The care of mental health and substance use patients typically involves sensitive personal information, and these guidelines are intended to offer clarity about information sharing between GPs and community partners for **MHSU adult patients (non-urgent care)**.

These guidelines have been prepared to exist within the context of current legislation, including two privacy laws:

- *The BC Personal Information Protection Act (PIPA)*, which is the ‘private sector’ privacy law that covers the Delta Division of Family Practice, Doctors of BC, A GP for Me, health clinics, psychologists, GPs, counselors, and not-for-profit organizations, etc., and
- *The BC Freedom of Information and Protection of Privacy Act (FIPPA)*, the ‘public sector’ law, which applies to the Ministry of Health and Health Authorities.

Definitions

- **Community Partners:** Allied health care professionals and community service organizations (e.g., Alongside You, Alzheimer’s Society, Canadian Mental Health Association, D.A.W.N., Deltassist, Little House) that provide mental health and substance use services to patients/clients in our community.
- **MHSU Provider Network:** The network of GPs, medical office assistants, Fraser Health MHSU, community partners, the Corporation of Delta, and emergency services (police, fire, and ambulance) working collaboratively to provide care for MHSU patients/clients in the community
- **Personal Information:** Information about an identifiable individual.

Guiding Principles

Principles underlying the MHSU Provider Network communications and information processes:

- a. Relevant personal information should be shared on a 'need to know' basis among authorized participants in the 'circle of care' for the patient or client.
- b. Always state that you are collecting, using, and disclosing personal information under controlled conditions, and in compliance with the applicable law(s).
- c. The delivery of healthcare in BC functions on the basis of an implied consent model. Implied consent is given, for example, when the patient goes to the GP or the community partner for care.
 - o When the patient or client provides sensitive information that is not relevant to a referral, such information should not be disclosed to another care provider. (Note: Practically speaking, the provider must use clinical judgment and the standard of reasonableness when deciding how much of "a record" to send, for example if the information is not easily partitioned or severed.)
 - o While consent is implied, some individuals may prefer a stronger standard, for example, when there is sensitive personal information, the community partner may choose to explicitly request permission to disclose. (Note that perceptions of sensitivity of personal information may vary from one person to another.)
 - o It is understood that health care providers have to assess their various legal obligations and potential liability with the collection, use and disclosure of personal information, and may want to engage in risk mitigation by obtaining more express forms of consent.

Communications and Information Sharing Processes for Adult MHSU Patients

Processes for communications and information sharing between GPs and community partners are presented with use of scenarios and supplementary questions.

Scenario A: Patient visits a GP who then refers to a community partner

When the GP refers or recommends to a community partner, the GP may provide a note for the patient to bring to the provider, or the GP may want to send information directly to the community partner.

The GP arranges to have the information faxed to the community partner. Obviously, if the patient expressly refuses to further disclosure, then the information is not shared unless there is a duty to report (due to serious risk of harm to self or harm to others).

Question: When consent is implied, is there a need to communicate anything further to the patient about information transfer?

- Answer: Informing is not necessary, but if there was something extremely sensitive the GP may want to inform the patient about what is being sent.

Question: Why would the GP provide a note to the patient instead of faxing information to community partner directly?

- Answer: When the GP is assessing whether the patient will take more responsibility for his or her own health, the GP may direct the patient to take information to a counselor.

Scenario B: Client/Patient visits a community partner*, and the community partner becomes aware of information that should be shared with the patient's GP.

* In this scenario, either the patient was referred by the GP, or the patient has self-referred.

Sometimes the community partner may know more than the GP about the patient, particularly if he/she spends more time with a patient. The community partner may become aware of information that the GP might need.

When information is sensitive, professional judgment and discretion should be used. The community partner can choose to ask the client/patient, "Have you told your GP?", and "Do I have your permission to contact your GP / share this information with your GP?", or let the client/ patient know that information will be shared with the GP on a 'need-to-know' basis. If the patient expressly refuses, then the information is not shared unless there is a duty to report (due to risk of serious harm to self or harm to others).

The community partner arranges to have the following information faxed to the GP:

- **The patient was seen on (date), by whom (name of community partner), and community partner's credentials**
 - This information is required because patients don't always remember whom they have seen.
- **Brief summary** (not detailed unless necessary)
 - E.g., "Mr. Jones was scheduled to be seen 6 times for anxiety, and showed up twice."
- **Any relevant context** - Exercise clinical judgment to determine what to send.
 - E.g., "abuse happening"
 - E.g., behaviours that the GP should know about

Question: What if the GP requested feedback from the community partner on something specific, and the patient tells the community partner that they don't want that information shared?

- Answer: The patient's rights must be respected. The community provider can relay that the "patient would not consent". In a serious matter, a community partner could make the clinical judgment that the GP has a "need to know".

Scenario C: Client/Patient visits the community partner, and the community partner has a question for the GP.

The community partner follows the same procedure as outlined above in Scenario B.

Question: Wouldn't the community partner need a Release of Information form, signed by the client/patient?

- Answer: A Release of Information form can be used if preferred, but it is not necessary in these circumstances.

Scenario D: The community partner becomes aware that the patient was admitted to the hospital because he/she was suicidal.

Question: Does the community partner need to communicate that information to the GP, and /or to Delta Mental Health?

Answer: Yes – please communicate to both. The MHSU Liaison team may not see all urgent patients before they are discharged from the ER, so the GP may not receive details. If you have become aware, please:

- Notify the GP (by fax or phone), and
- Contact the Delta Mental Health GP Liaison at 604.592.3700, or the South Delta Mental Health switchboard at 604.948.7010.

Scenario E: Client visits the community partner (self-referral), but has no GP. The community partner becomes aware of information that should be shared with a GP and recommends that the client see a GP.

The community partner recommends that the client go to a walk-in clinic and may provide the client with information to take with him/her.

The community partner also recommends that the client register for a GP on the Delta FETCH website, and provides the client with the URL. If the patient does not have access to a computer or does not have supports to assist, then the community partner can offer to register on the client's behalf.

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The community partner, using the Patient Registry function on FETCH, enters:

- The client's name, address, and phone number
- Community partner's name and organization should the GP need to contact him or her.
- Whether consent was received, so that you can print for a record if needed (but you are under no obligation to keep this on file).

Scenario F: A person approaches the MOA at a clinic looking for a GP.

If there is no GP that can take the person on as a patient, the MOA can provide the client with the FETCH URL, or if the patient does not have access to a computer or does not have supports to assist, then the community partner can offer to register on the client's behalf. Consent is not required, as the person has already requested a GP. The MOA, using the Patient Registry function on FETCH, enters:

- The client's name, address, and phone number
- "Community partner name": enter "MOA" (your name is not necessary)
- "Community Partner Organization": enter the name of your clinic
- It is not necessary to fill the Consent field

Additional Questions:

1. Question: When would a GP communicate the patient's physical/medical issues to Delta Mental Health?

Answer: When A GP is aware that the patient has received care from Delta Mental Health (i.e. there is a Delta Mental Health report on the patient's chart), then it is necessary to communicate any significant medical issue that could affect the patient's mental health. Examples include poly-pharmacy, terminal disease diagnosis, chronic pain, and endocrine.

2. When would there be a need for AHCP, community partner to call the GP, and not just fax information?

Answer: The GP expects, and wants, a call when the client/patient is a danger to self or to others.

3. What about a situation where the client is with a community partner and is experiencing an incident / crisis (non-urgent)?

Answer: The community partner should exercise professional judgment regarding when to call the GP or send relevant information.

4. How is our ability to share information limited by privacy requirements when there isn't a specific diagnosis?

Answer:

- A diagnosis is not necessary to provide service to the client / patient, or to share information
- Questions to reflect on:
 - Would a diagnosis change anything for the patient?
 - What about the patient/client's right to live at risk?

5. If a referral is made and information is shared (either with a GP or with a community partner) and the patient doesn't show up, what do we need to consider from a privacy perspective?

Answer:

- The GP and community partner have done due diligence and acted reasonably. The information won't be used unless the patient shows up for the appointment.
- Sometimes providers don't have an understanding of cultural issues such as a patient's reluctance to see a health care provider for certain matters and can be quick to dismiss the patient / client as "not interested".
- There are also culturally sensitive ways to make referrals. In some cases, it may be best not to make appointments for the patient, but provide them with the needed information to make the appointment himself. In this way the provider is giving the "care issue" back to the patient. Sometimes the patient needs time to process it, and the patient can be asked to come back for a follow up appointment.

6. What if the client provides consent to a GP or community partner, but in retrospect doesn't feel comfortable or confident to refuse? (i.e. there was no duress, but the client was not personally comfortable.)

Answer:

- The GP or community partner has done due diligence.
- The patient can inform the caregiver that he or she is withdrawing his or her consent.
- Refer to the comment in question #4 above re: cultural awareness.

7. What if the client is not capable of providing consent and there is no family/ guardian present? (E.g., a community service worker may be present to assist the client.)

Answer:

- The legal representative of the client is responsible in such circumstances. The "Health Care Providers' Guide to Consent to Health Care" provides an ordered list of those that qualify (see Appendix 1 – "Temporary Substitute Decision Maker") and states, "If there are no near relations or close friends available for the health care provider to choose, the health care provider must ask the Public Guardian and Trustee to authorize a person to be appointed as a TSDM." A Community Service Worker does not qualify as a "close friend".

8. As a community partner, I have sent recommendations to the GP, and the GP changes a course of action / doesn't agree with my recommendations. Why would this happen?

Answer:

- The GP may determine that it would be inappropriate to proceed with the community partner's recommendations, for example, medical complications might alter recommendations.
- Even if the community partner was expecting to hear back from the GP on a specific concern, the GP may not be able to communicate this related information due to other complications.
- If the community partner has remaining questions/concerns regarding recommendations, he/she should follow up with the GP before dismissing concerns.

9. What consent is required when police/fire need to contact the GP when a non-urgent incident arises?

Answer:

- Police have a duty to disclose that overrides privacy requirements; they would never need consent to disclose personal information to a GP, e.g. for law enforcement purposes.
- The GP would exercise clinical judgment regarding disclosing information. A formal Release of Information request may be required.

Appendix 1: Temporary Substitute Decision Maker

This information was excerpted from *Health Care Providers' Guide to Consent to Health Care*, Ministry of Health, July 2011.

“To obtain substitute consent to provide major or minor health care to an adult, a health care provider must choose the first, in listed order, of the following who is available and qualifies:

1. The adult’s spouse;
2. The adult’s child;
3. The adult’s parent;
4. The adult’s brother or sister;
5. The adult’s grandparent;
6. The adult’s grandchild;
7. Anyone else related by birth or adoption to the adult;
8. A close friend of the adult;
9. A person immediately related to the adult by marriage.

To qualify a person must:

1. Be at least 19 years of age;
2. Have been in contact with the adult during the preceding 12 months;
3. Have no dispute with the adult;
4. Be capable of giving, refusing or revoking substitute consent; and
5. Be willing to comply with the duties of a TSDM. (See, HCCCFAA¹, s.16)”

[Section: “Adults with no Personal Guardian or Representative or Advance Directive”, page 20.]

A “close friend” cannot be “Temporary Substitute Decision Maker” if he/she “receives compensation for providing personal care or health care to the adult”

“If there are no near relations or close friends available for the health care provider to choose, the health care provider must ask the Public Guardian and Trustee to authorize a person to be appointed as Temporary Substitute Decision Maker.”

[Section: “Appendix 1: Glossary of Terms”, page 20.]

¹ HCCCFAA: Health Care (Consent) and Care Facility (Admission) Act