Medical Mutual℠

PROTECTING OUR PROFESSION

NC IOM Task Force
April 5, 2019

Agenda

- Introduction of Medical Mutual
  - Helping physician in medicine, business and life

- Compliance and Risk
  - Improve Patient Safety
  - Educational content, resource documents, consent forms, webinars, staff education, on-call access, etc.

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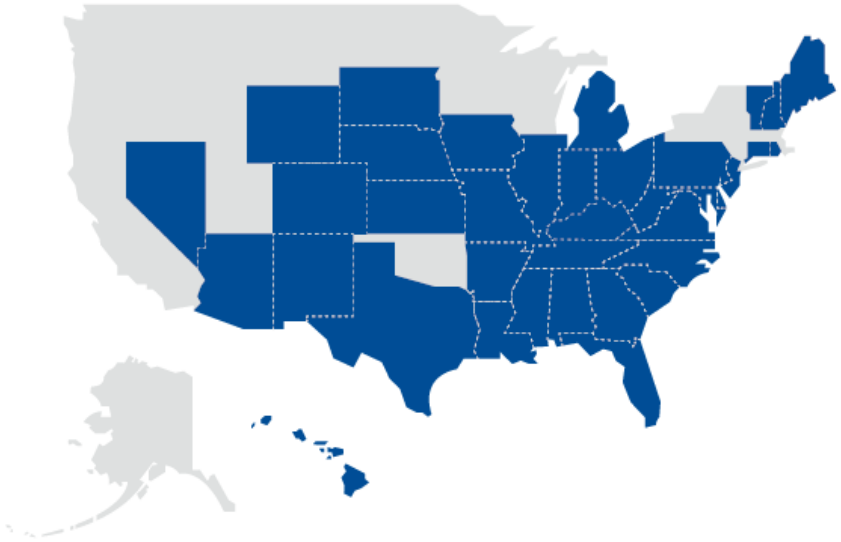
We're able to serve physicians in nearly three-quarters of the United States.

Medical Mutual is now authorized to do business in **37 states and the District of Columbia**—expanding our reach to Connecticut, Maine, Michigan, New Hampshire, and Rhode Island in 2017.



Alabama	Indiana	Nebraska	South Dakota
Arizona	Iowa	Nevada	Tennessee
Arkansas	Kansas	**New Hampshire**	Texas
Colorado	Kentucky	New Jersey	Vermont
Connecticut	Louisiana	New Mexico	Virginia
Delaware	**Maine**	North Carolina	West Virginia
Florida	Maryland	Ohio	Washington DC
Georgia	**Michigan**	Pennsylvania	Wyoming
Hawaii	Mississippi	**Rhode Island**	
Illinois	Missouri	South Carolina	

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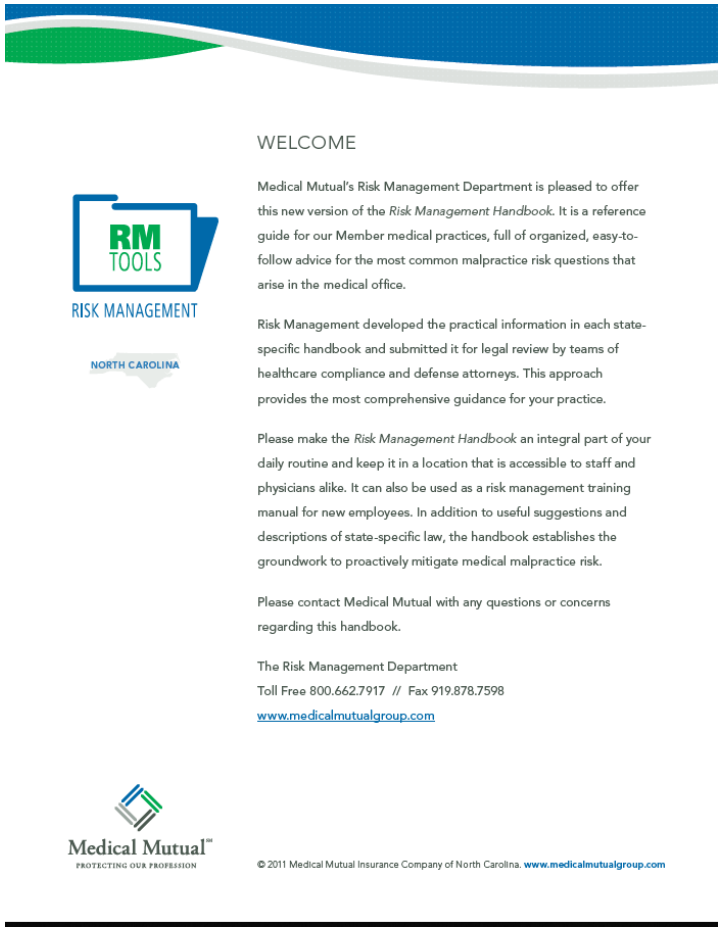
North Carolina Risk Management Handbook



RM TOOLS
RISK MANAGEMENT
NORTH CAROLINA

WELCOME

Medical Mutual's Risk Management Department is pleased to offer this new version of the *Risk Management Handbook*. It is a reference guide for our Member medical practices, full of organized, easy-to-follow advice for the most common malpractice risk questions that arise in the medical office.

Risk Management developed the practical information in each state-specific handbook and submitted it for legal review by teams of healthcare compliance and defense attorneys. This approach provides the most comprehensive guidance for your practice.

Please make the *Risk Management Handbook* an integral part of your daily routine and keep it in a location that is accessible to staff and physicians alike. It can also be used as a risk management training manual for new employees. In addition to useful suggestions and descriptions of state-specific law, the handbook establishes the groundwork to proactively mitigate medical malpractice risk.

Please contact Medical Mutual with any questions or concerns regarding this handbook.

The Risk Management Department
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Relevant Chapters in the Handbook

- Do we have to accept appointment request from patients who do not speak English?
- Do we have to provide translation services to the patient at no charge?
- Can we bill the patient?
- Can we use family members to translate?
- Who is competent to provide interpreter services?
- What is the government's goal related to patients who need interpreters?

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DO WE HAVE TO PROVIDE A SIGN LANGUAGE INTERPRETER FOR HEARING IMPAIRED PATIENTS?

In order to be compliant with the Americans with Disabilities Act (ADA) and the earlier Rehabilitation Act of 1973, Section 504, your office cannot refuse to accept a patient based solely on the fact that the person is hearing impaired. However, the ADA does recognize that providing accommodations may put an undue financial burden on some entities.

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Practice size might matter

- Office of Civil Rights (OCR) indicates “one size does not fit all” when it comes to providing interpreters.
  - Practice size
  - Number of potential patients who need interpreters
  - Program scope and intent
  - Setting
  - Resources available and costs
- Disabled Access Tax Credit – for 50% of all amounts spent on service for the Deaf, after the first $250.00 is spent, this amount is in addition to the 50% deduction fro the business expense.

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Who decides what type of auxiliary aid should be provided? According to the ADA, you should:

> ...consult with individuals with disabilities wherever possible to determine what type of auxiliary aid is needed to ensure effective communication. In many cases, more than one type of auxiliary aid or service may make effective communication possible. While consultation is strongly encouraged, the ultimate decision as to what measures to take to ensure effective communication rests in the hands of the physician, provided that the method chosen results in effective communication.

In some instances, using written materials or communicating by writing **could** be sufficient. For simple office visits this **may** be appropriate (physicians will have to make this determination after consultation with the patient).

When communicating with a patient using written notes, ask yourself if you are providing less information in writing than you would if you were speaking. If the answer is yes, this is an indication that written notes are inappropriate.

Before using written communication, confirm that the patient has adequate reading skills. Many deaf persons consider sign language to be their first language and have difficulty reading and understanding written English.

If the patient has a complicated diagnosis or treatment plan, or if you are having an important informed consent discussion, from a risk management perspective we would recommend that you hire a sign language interpreter. Note that you may **not** impose a surcharge on the patient for the use of an interpreter.

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IF A SIGN LANGUAGE INTERPRETER IS REQUIRED FOR EFFECTIVI COMMUNICATION, MUST ONLY A CERTIFIED INTERPRETER BE PROVIDED?

No. According to the ADA:

> **The key question in determining whether effective communication will result is whether the interpreter is "qualified," not whether he or she has been actually certified by an official licensing body.**
>
> A qualified interpreter is one who is able to interpret effectively, accurately and impartially, both receptively and expressively, using any necessary specialized vocabulary. An individual does not have to be certified in order to meet this standard. A certified interpreter may not meet this standard in all situations, e.g., where the interpreter is not familiar with the specialized vocabulary involved in the communication at issue.

Reference

www.ada.gov

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HOW DO WE CHOOSE A SIGN LANGUAGE INTERPRETER? CAN WE USE A STAFF MEMBER WHO KNOWS HOW TO SIGN?

Title III of the ADA provides guidance on choosing the right type of interpreter for your patient. According to the ADA:

> There are a number of sign language systems in use by persons who use sign language. (The most common systems of sign language are American Sign Language and signed English.) Individuals who use a particular system may not communicate effectively through an interpreter who uses another system. When an interpreter is required, the public accommodation should provide a qualified interpreter, that is, an interpreter who is able to sign to the individual who is deaf what is being said by the hearing person and who can voice to the hearing person what is being signed by the individual who is deaf. This communication must be conveyed effectively, accurately, and impartially, through the use of any necessary specialized vocabulary.
>
> Signing and interpreting are not the same thing. Being able to sign does not mean that a person can process spoken communication into the proper signs, nor does it mean that he or she possesses the proper skills to observe someone signing and change their signed or finger-spelled communication into spoken words. The interpreter must be able to interpret both receptively and expressively.

You may only use a staff member if that person can interpret effectively, accurately, and impartially, using the appropriate medical terminology. The use of the patient's family or friends is **not** recommended. Often, such persons are too emotionally involved to interpret impartially.

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The Importance of Effective Communication

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Recommendations

- Have a procedure for identifying the language and communication needs of patients.
- Have ready access to proficient interpreters in a timely manner during hours of operation.
- Develop written policies and procedures regarding interpreter services.
- Disseminate interpreter policies and procedures to staff and ensure staff awareness of their Title VI and ADA obligations.

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Resources

- www.ada.gov
- www.nad.org

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