F002: Preventing Disasters in Your Practice

The Non Medical Side

Amy Y-Y Chen, MD, FAAD
ayyen@alum.mit.edu
July 26th 2019
Central Connecticut Dermatology

Objective

- Optimize care for patients with limited English proficiency
- Describe legal representative for Health Care Decision

Background

- According to 2014 US Census Bureau, 25 million Americans speak English “less than very well” and 60 million speak a language other than English at home
- Estimated US population is 321.4 million

ARS POLL

Which type of medical interpreter service do you use in your practice?

A) No access to trained/certified medical interpreter (ie use family member, friends, bilingual staff)
B) Trained/certified in-person medical interpreter
C) Trained/certified medical interpreter via phone
D) Both B and C
Background

- Patients with limited English proficiency (LEP):
  - LEP defined as those with “limited ability to read, speak, write, or understand English”
  - Least likely: to receive preventive care, have regular access to care or be satisfied with their care
  - More likely: to have adverse events, poor understanding of diagnosis, being misunderstood by their physicians

What does the law say?

- Title IV of the Civil Rights Act of 1963 requires interpreter services for ALL patients with LEP who are receiving federal financial assistance, with the exception of Medicare Part B

What is happening in practice?

- Medicare, Medicaid and most private insurers do NOT pay for trained medical interpreter services
  - Although prolonged service fee may be appropriate given extra length of time needed
  - California requires interpreter coverage from private insurers
- Often our schedules do not allow extra time to accommodate patients with LEP

- Bilingual physicians: using own limited language skills vs using an interpreter
  - Easier to ask questions than understand the response
  - 1/5 untrained bilingual staff are not able to pass exam to assess medical competence in that language
  - Bilingual physicians generally have a good understanding of their own language limitations
  - Kaiser: both linguistic and culture competence in multiple language and culture

- Rely on ad hoc interpreters: family, friends, bilingual staff
  - Increased risk of patient dissatisfaction, medical errors, unnecessary testing, poor adherence and malpractice exposure
What should happen in practice?

Use a trained/certified medical interpreter

<table>
<thead>
<tr>
<th>Table 2. Problems with Using Ad Hoc Nonprofessional Medical Interpreters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children should not be used as interpreters except in</td>
</tr>
<tr>
<td>emergencies because of their limited understanding of</td>
</tr>
<tr>
<td>adult issues.</td>
</tr>
<tr>
<td>Family members may have personal agendas.</td>
</tr>
<tr>
<td>Interpreters may provide unsolicited advice.</td>
</tr>
<tr>
<td>No guarantee of confidentiality.</td>
</tr>
<tr>
<td>Nonprofessional interpreters are associated with a higher</td>
</tr>
<tr>
<td>risk of longer hospital stay and readmission.</td>
</tr>
<tr>
<td>Physician may lose control of the interview because of</td>
</tr>
<tr>
<td>tangential conversations.</td>
</tr>
<tr>
<td>Scope of inquiry may be limited when using a family</td>
</tr>
<tr>
<td>member or friend because of embarrassment about intimate or</td>
</tr>
<tr>
<td>sexual issues.</td>
</tr>
<tr>
<td>Inability of medical terminology may lead to</td>
</tr>
<tr>
<td>misunderstanding and errors in interpretation.</td>
</tr>
</tbody>
</table>

Information from references 4, 8, 12, 15 through 19.

<table>
<thead>
<tr>
<th>Table 4. Benefits of Proper Use of Trained Medical Interpreters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fewer errors in communication.</td>
</tr>
<tr>
<td>Improved patient satisfaction.</td>
</tr>
<tr>
<td>Interpreter may act as a cultural liaison to ensure</td>
</tr>
<tr>
<td>clarification for the physician.</td>
</tr>
<tr>
<td>Interpreter may clarify patient meaning beyond language.</td>
</tr>
<tr>
<td>Interpreter may function as a link between patients and the</td>
</tr>
<tr>
<td>health system.</td>
</tr>
<tr>
<td>Lower malpractice risk.</td>
</tr>
<tr>
<td>Use of a trained interpreter is associated with significantly</td>
</tr>
<tr>
<td>shorter hospital stays and reduced 30-day rehospitalization.</td>
</tr>
<tr>
<td>Use of a trained interpreter meets legal requirements of</td>
</tr>
<tr>
<td>Title VI of the Civil Rights Act.</td>
</tr>
</tbody>
</table>

Information from references 4, 6, 8, 15 through 19, 23, and 24.

Competency for interpreter

- In the US, Dept of Health and Human Services (HHS) establishes competency required of a qualified interpreter
  - Specialized terminology
  - Interpreter ethics
  - Skills to interpret accurately, effectively and impartially

Competency for interpreter

- HHS also requires hospitals conduct assessment of individuals claiming to have competencies prior to designating them as qualified interpreters.
- HHS requires hospitals to include multilingual nondiscrimination notices on significant patient documents and to include information on their websites indicating how patients can access language assistance services.

Other HHS guidelines

- HHS guideline allows for ad hoc interpreters in situations involving imminent threat to safety or welfare of a patient when no qualified interpreter.
National certification of medical interpreters

- Certification Commission for Healthcare Interpreters
- National Board of Certification for Medical Interpreter
- Registry of Interpreters for the Deaf

Getting connected with interpreter service

- Most feasible with a telephone interpreter service
  - LanguageLine Solutions (3.95 per minute; http://www.languageline.com)
  - Cyracom Language Solutions (http://interpret.cyracom.com)
  - Subscription or pay per call (~ 2-3 dollars per min without contract)
- Health Care Interpreter Network
- Multilingual staff should be encouraged to receive additional training so they can be certified

Getting connected with interpreter service

- For deaf patients:
  - Video relays (onscreen sign language interpreters)
  - Closed captioning
  - Texting or writing
  - Lip reading

Tips for using a medical interpreter in a busy clinic

- Document the name or “interpreter ID” in the progress note
- Seat the interpreter next to or slightly behind the patient
- Speak directly to the patient (not the interpreter)
- Use first person statements; avoid saying “tell her” or “he said”

Tips for using a medical interpreter in a busy clinic

- Ask one question at a time
- Open ended vs yes/no questions
- Speak in short sentences
- Speak slowly
- Insist on sentence-by-sentence interpretation to avoid tangential conversation

What if ?

- What if the patient refuses an interpreter?
- What if the patient insists on having family member interpret?
- What if the patient gets offended?
Tips for using a medical interpreter in a busy clinic

• Allow interpreter time to finish
• Prioritize and limit to 3 key points
• Use “teach back” or “show me” technique
• No jargon, humor, idioms, acronyms
• Do not make comments you do not want patients to understand

Train your staff

• To pick up patients with LEP who may need interpreter in advance
  – Takes a few minutes to get connected
• Waivers

Objective

• Optimize care for patients with limited English proficiency
• Describe legal representative for Health Care Decision
  – Minor
  – Adult who lacks mental capacity

Background

• Many of us take care of minor patients or patients who lack the mental capacity to make their own health care decisions
• Need to know your state law and institution policy

ARS POLL

An 11-year-old girl is brought in by her aunt for the first visit for acne. Aunt has child’s insurance card and past medical hx sheet that was filled out by one of the parents. Per aunt, parents are working. What would you do:

A) See the patient and prescribe what’s needed
B) See the patient but explain to aunt that parents need to be present to review medication side effects and treatment expectations for you to prescribe the medication
C) Ask the patient to be re-scheduled on a day that one of her parents can bring her in
D) Call the parents to obtain a verbal “permission to treat”

Legal Age of Majority

• “Age of Majority” = the age that child becomes adult by law
• Most, but not all, states in the United States = 18
  – Alabama, Nebraska - 19
  – Mississippi - 21 (as is Puerto Rico)
Policy of Legal Representative for Health Care Decisions

- State and institution dependent
- Example: patients < 18 yo “should be informed and participate in their health care to the extent possible, but lack legal capacity for health care decisions unless certain exception apply”

“Exceptions”

- Inpatient mental health when > 16 yo. Age 14-15 may give voluntary consent for admission but requires parent/guardian notification within 5 days
- Making a health decision for minor’s own child
- Screening and treatment of STD (should document why parent/guardian is not involved)

“Exceptions”

- Reproductive health decision (contraception and pregnancy)
- Abortion for > 16 yo are treated as adults. If < 16, may consent without parent/guardian if appropriate counseling is provided or in an emergency
- Emancipated minors: judge vs. common law
  - Common law emancipation= evidence that the minor is living independently. Parents have no financial responsibility

Emancipation

- Legal process that gives a teenager who is 16* or older, legal independence from his/her parents or legal guardians. Can only ordered by a judge.
- Must also meet one of the criteria:
  - Must be married, or
  - Must be in the US armed forces, or
  - Must be living apart from parents or guardian and be managing his/her own finance
  - Court must decide that emancipation is in the best interests of the minor or minor’s parents or minor’s child

* 16 in CT, no specific age in MA. Cut off age is different depending on the state

So who makes the decision for < 18 yo

- The natural or adoptive parent
  - Co-guardians: a parent or a court-appointed guardian may share responsibility w/ a grandparent or other relative who has been granted the co-guardianship by the Probate Court
  - Standby guardian: may be assigned when a parent is ill, unable to care for the child or incarcerated. Parent has a written agreement w/ the standby guardian, can last up to 1 yr. No need for court order. Parent can terminate at any time

So who makes the decision for < 18 yo

- Non-custodial parents, unless restricted by court
  - Custodial: parent the child resides w/ or spends majority of time w/ or parent who has been given sole physical custody
  - vs non-custodial parents
- Step-parents, foster parents and other informal guardians (family care givers, etc) are NOT health care decision makers
Tips on caring for minors

- Always write down who is with the minor in the room
- Write down who provides history
- On intake form -> who lives at home
- Do not perform “procedures” unless parent/guardian present (liquid nitrogen, cantharidin, intralesional injections, biopsies, excisions, etc.)

Train your staff

- Minor patients
  - Front desk: verify person ID of the person who is bringing patient in
  - “Permission to treat”
  - MA: again verify relationship

Our Scenario

An 11-year-old girl is brought in by her aunt for the first visit for acne. Aunt has child’s insurance card and past medical hx sheet that was filled out by one of the parents. Per aunt, parents are working. What would you do:

A) See the patient and prescribe what’s needed
B) See the patient but explain to aunt that parents need to be present to review medication side effects and treatment expectations for you to prescribe the medication
C) Ask the patient to be re-scheduled on a day that one of her parents can bring her in
D) Call the parents to obtain written or verbal “permission to treat”

Adults patient who lacks mental capacity to make decision

- Health Care Representative named in Advanced Directive
- Court appointed conservator
- Durable Power of Attorney for Health Care
- Health Care Agent

Adults patient who lacks mental capacity to make decision

- Next of kin: spouse (same or opposite sex), adult child, parent, adult sibling, grandparent
  - Proof of next of kin relationship is not required unless more than 1 person claims to be the patient representative or there is reasonable suspicion that a person is falsely asserting to be next of kin

Tips on adults patient who lacks mental capacity to make decision

- Document who was present
- Document who you spoke to, relationship with the patient
- No procedures unless legal representative for health care decision is present
Train your staff

- Find out who is making decision for them, ideally should be done when making the appointment
- Nursing home patients

Summary

- It is our legal and ethical responsibility to communicate with LEP patients through qualified interpreters
- State and/or institutional policy regarding legal representative for Health Care Decision

Thank you very much!