Special Care Patients Create Special Liability Exposures

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Special Care Advocates In Dentistry

2012 Annual Seminar
Hampton Inn & Suites
Raleigh-Durham Airport-Brier Creek
8021 Arco Corporate Drive
Raleigh, North Carolina

Presented By:
David P Sousa, Sr VP & General Counsel
MMIC/ MSIC

Topics for Discussion

©

- Special Needs Demographics
- Special Needs Resources Available
- Basic Risk Management Issues
- Privacy Issues
- New *e*-Communications Rules in Litigation
- Treating the Elderly
- Treating Minors
- Informed Consent Issues

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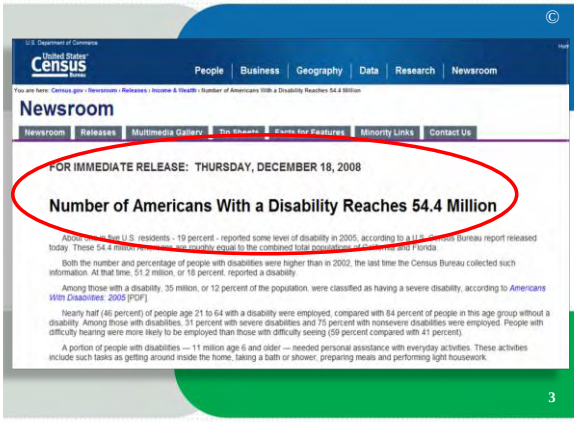

Special Needs Stats…

- Among people 15 and older, 7 8 million (3%) had difficulty hearing a normal conversation, including 1 million being unable to hear at all Although not part of the definition of disability used in the report, 4 3 million people reported using a hearing aid
- Roughly 3 3 million people (1%), age 15 and older used a wheelchair or similar device, with 10 2 million (4%), using a cane, crutches or walker
- Nearly 7 8 million people age 15 and older had difficulty seeing words or letters in ordinary newspaper print, including 1 8 million being completely unable to see

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Special Needs Stats…

- More than 16 million people had difficulty with cognitive, mental or emotional functioning This included 8 4 million with one or more problems that interfere with daily activities, such as frequently being depressed or anxious, trouble getting along with others, trouble concentrating and trouble coping with stress
- The chances of having a disability increase with age: 18 1 million people 65 and older (52%), had a disability Of this number, 12 9 million (37%), had a severe disability For people 80 and older, the disability rate was 71%, with 56% having a severe disability

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Special Needs Stats…

- Among people 16 to 64, 13 3 million (7%), reported difficulty finding a job or remaining employed because of a health-related condition
- Among people 25 to 64 with a severe disability, 27% were in poverty, compared with 12 percent for people with a non-severe disability and 9% for those without a disability
- Median monthly earnings were $1,458 for people with a severe disability, $2,250 for people with a non-severe disability and $2,539 for those with no disability

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Special Needs Stats…

- Parents reported that 228,000 children under age 3 (2%), had a disability Specifically, they either had a developmental delay or difficulty moving their arms or legs In addition, there were 475,000 children 3 to 5 years (4%), with a disability, which meant they had either a developmental delay or difficulty walking, running or playing
- There were 4 7 million children 6 to 14 (13%), with a disability The most prevalent type was difficulty doing regular schoolwork (2 5 million or 7%)

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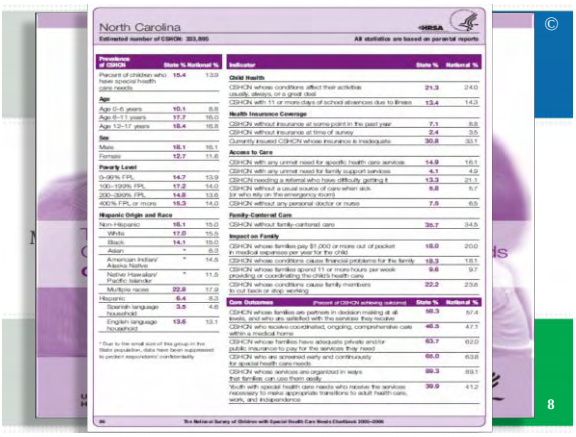
North Carolina

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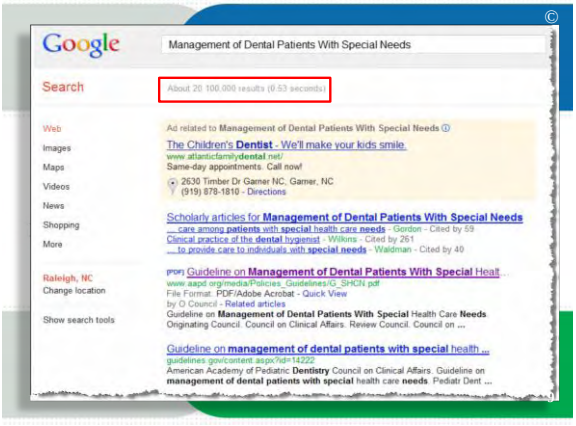
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Management of Dental Patients With Special Needs

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Scholarly articles for Management of Dental Patients With Special Needs
... care among patients with special health care needs - Gordon - Cited by 59
Clinical practice of the dental hygienist - Wilkins - Cited by 261
... to provide care to individuals with special needs - Waldman - Cited by 40

[PDF] Guideline on Management of Dental Patients With Special Healt...
www.aapd.org/media/Policies_Guidelines/G_SHCN.pdf
File Format: PDF/Adobe Acrobat - Quick View
by O Council - Related articles
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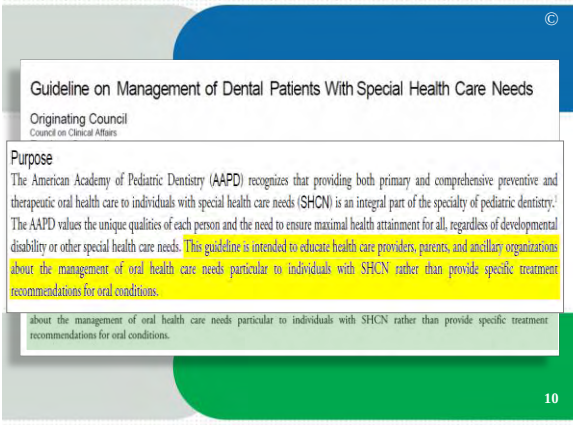
guidelines.gov/content.aspx?id=14222
American Academy of Pediatric Dentistry Council on Clinical Affairs. Guideline on management of dental patients with special health care needs. Pediatr Dent ...


Guideline on Management of Dental Patients With Special Health Care Needs
Originating Council
Council on Clinical Affairs
Purpose
The American Academy of Pediatric Dentistry (AAPD) recognizes that providing both primary and comprehensive preventive and therapeutic oral health care to individuals with special health care needs (SHCN) is an integral part of the specialty of pediatric dentistry.[1] The AAPD values the unique qualities of each person and the need to ensure maximal health attainment for all, regardless of developmental disability or other special health care needs. This guideline is intended to educate health care providers, parents, and ancillary organizations about the management of oral health care needs particular to individuals with SHCN rather than provide specific treatment recommendations for oral conditions.
about the management of oral health care needs particular to individuals with SHCN rather than provide specific treatment recommendations for oral conditions.
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Special Care DENTISTRY ASSOCIATION
Every practice has patients with special needs.
Every practitioner needs Special Care Dentistry Association.
Useful Links & Resources
Useful Links
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PMC
BMJ helping doctors make better decisions
Oral health care for patients with special needs
Roger Davies, Raman Bedi, and Crispian Scully
People with special needs are those whose dental care is complicated by a physical, mental, or social disability. They have tended to receive less oral health care, or of lower quality, than the general population, yet they may have oral problems that can affect systemic health. Improving oral health for people with special needs is possible mainly through community based dental care systems. Education of patients and parents or carers with regard to prevention and treatment of oral disease must be planned from an early stage. This will minimise disease and operative intervention since extractions and surgical procedures in particular often produce major problems. Dental healthcare workers also often need to be educated about this subject.
In this context various conditions can lead to people needing special care, not least patients with dental phobias. Many of these patients can be treated with behavioural modification techniques, though a minority will require sedation or general anaesthesia.
This article concentrates on those who are medically compromised, mentally challenged, mentally ill, or socially excluded.
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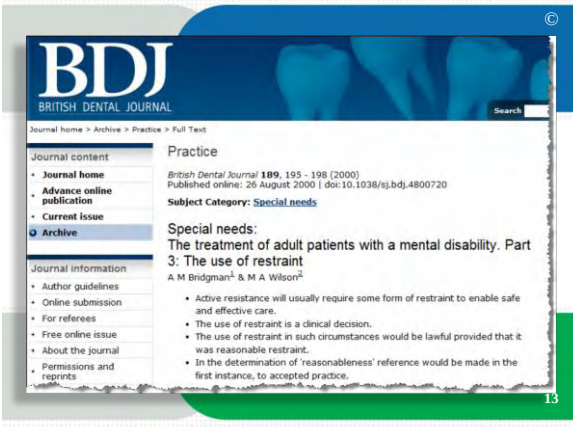
BDJ
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Practice
British Dental Journal 189, 195 - 198 (2000)
Published online: 26 August 2000 | doi:10.1038/sj.bdj.4800720
Subject Category: Special needs
Special needs:
The treatment of adult patients with a mental disability. Part 3: The use of restraint
A M Bridgman[1] & M A Wilson[2]
Active resistance will usually require some form of restraint to enable safe and effective care.
The use of restraint is a clinical decision.
The use of restraint in such circumstances would be lawful provided that it was reasonable restraint.
In the determination of 'reasonableness' reference would be made in the first instance, to accepted practice.
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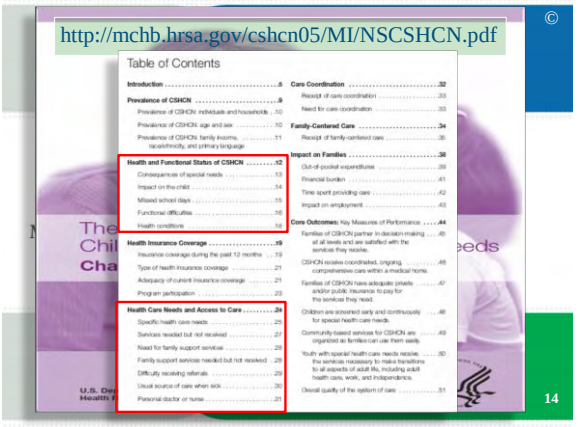
http://mchb.hrsa.gov/cshcn05/MI/NSCSHCN.pdf
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RISK ASSESSMENT
It's Not Worth It
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Basic Risk Issues

- Collecting correct, responsible party information
- Getting sedation and bisphosphonate informed consent documentation
- Treatment permission via phone, mail, e-mail, through a 3rd party
- How to handle "day of" changes in the agreed upon (and properly consent to) treatment plan

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Basic Risk Issues (*cont'd.)*

- Basic components of a post-extraction sheet: how to adapt when patient returns to a facility
- Informed consent for restraint of patient during treatment
  - Be certain to detail in the patient chart the need and justification for restraint, people present during restraint, type of restraint used, length of time restrained, patient's condition during and at conclusion of restraint

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Privacy Issues

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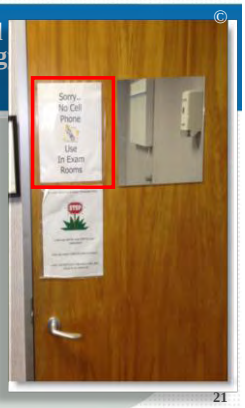
Advanced Camera Technology and Privacy *(Patient and Practice Issues)*

- Ease of snapping photos, uploading, and viewing increases with every new device invented
- We rarely question posing for or posting a photo online
- Health care facilities and providers however must guard against posting any picture of a patient:
  - during treatment (even at home)
  - inside a health care facility

Advanced Camera Technology and Privacy *(cont'd.)*

- Photos of patients during treatment
  - constitute an invasion of privacy
  - could be protected health information under HIPAA
- Imperative that written policies regarding the use of all cameras, especially cell phone and PDA cameras, are adopted and enforced

Advanced Technolog *(cont'd.)*



- Other safeguards against privacy violations:
  - Conspicuously posted signs clearly stating bans or limitations on cell phone or camera usage within facilities so that staff, volunteers and patients are all aware
  - Training regarding privacy and improper usage

Avoid Violations *(Practice Solutions)*

- Providers should avoid violating a patient's PHI when participating in social media by, at a minimum, requiring potential online patient/friends to agree to a written statement indicating that they have read an online disclosure BEFORE an online "friendship" can be started
- Do **not** comment online without a patient's express written authorization to do so

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Avoid Violations *(Practice Solutions)*

Consent to Use of Electronic Mail

(Name of Practice) _____ _____would like to give you the chance to communicate with your doctors, other healthcare providers (such as nurses), and administrative services by electronic mail (email).

Sending private patient information by email, however, has a number of risks that you should think about.

Risks of Email

- Email may be instantly sent worldwide and be received by many intended and unintended recipients.
- Those who get email can pass on messages to anyone without the original sender's permission or knowledge.
- Users can easily misaddress an email.

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e-Communications: New Methods, New Rules

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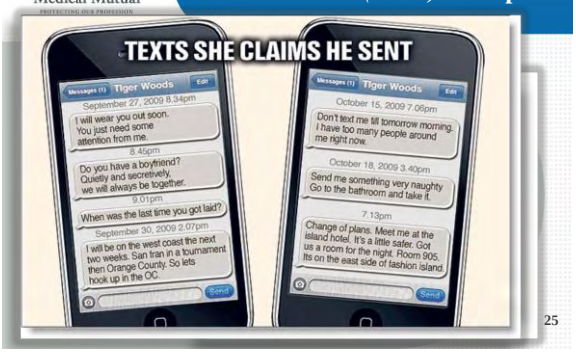
Electronically Stored Information *("ESI")* Examples



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Actual "Status Updates" Posted On facebook

- **"***Bored to death at work. It goes from 4 crashing patients at one time last night to silence tonight***."**
- "*I'm trying to gear up for the move to the night shift! Have my first go around on Monday night. Fingers crossed. I am fearful, but hopeful that I will survive the return to my vampire schedule from my early 20's.*"

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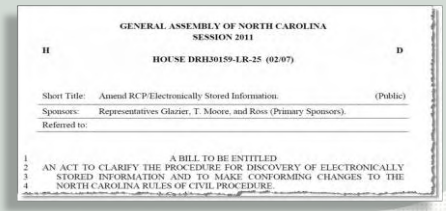
NC *e*-Discovery Rules

- On 10/1/11 e-discovery rules (patterned after federal legislation, and applied to all cases pending on or after that date) took effect in NC:



GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2011

H D

HOUSE DRH30159-LR-25 (02/07)

Short Title: Amend RCP/Electronically Stored Information. (Public)

Sponsors: Representatives Glazier, T. Moore, and Ross (Primary Sponsors).

Referred to:

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE PROCEDURE FOR DISCOVERY OF ELECTRONICALLY STORED INFORMATION AND TO MAKE CONFORMING CHANGES TO THE NORTH CAROLINA RULES OF CIVIL PROCEDURE.

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e-Discovery Rules *(cont'd.)*

- There will be several requirements under the rules which can/will impact dental practices:
  - Parties to a lawsuit will have to meet and prepare a written plan, approved by the court, for discovery of **all** electronically stored information ("ESI")
  - ESI shall include all "metadata" – evidence of (1) date sent, (2) date received, (3) author, and (4) recipients of **all** ESI The parties must agree, or the court may order, production of additional metadata
  - Parties must construct "privilege logs" describing any materials withheld from discovery

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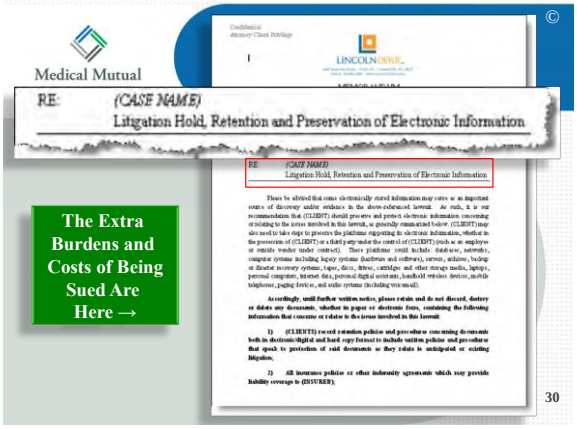
The Extra Burdens and Costs of Being Sued Are Here →



RE: *(CASE NAME)*
Litigation Hold, Retention and Preservation of Electronic Information

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Treating the Elderly

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Communication As The Key Risk Avoidance Component

- Communication with an Alzheimer's patient, or any elderly patient with cognitive issues, presents unique challenges that must be met if you are to adequately serve this patient segment
- Strategies to use from the Cleveland Clinic Neuroscience Center:
  1. **Gain attention** – of the patient before talking
  2. **Maintain eye contact**
  3. **Be attentive**
  4. **Hands away** – from your face when talking

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Alzheimer's Communication Strategies *(cont'd.)*

5. **Speak naturally** – distinctly, relaxed voice, normal rate, short, simple and familiar words
6. **Keep it simple** – and use their name often
7. **Be positive** – "Let's try this" v "Don't do that"
8. **Rephrase rather than repeat**
9. **Adapt to your patient** – try to understand how they are trying to communicate; don't "talk down"
10. **Reduce background noise**
11. **Be patient with your patient**

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Cognitively Impaired Patient Risk Factors

- You need to assure that the care the patient needs is communicated to the person who can follow-up with the care
- *Ex.*, telling an impaired patient to increase his/her meds, or to see a specialist for f/u care, is not acceptable
- If you are aware of the impairment, then you have an obligation to have a patient rep. involved with the outcome of any OV, and to receive f/u instructions

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Cognitively/ Physically Impaired Patient Risk Factors

- Do not assume that ingress/egress from your office can be done safely – you may need someone to walk the person to their ride, and assure that the ride is there
- Frequency of reassessment depends on the acuity of the needs of the patient and caregiver – more frequent when complex or potentially harmful symptoms emerge
- With f/u, assess caregiver status, and needed intervention

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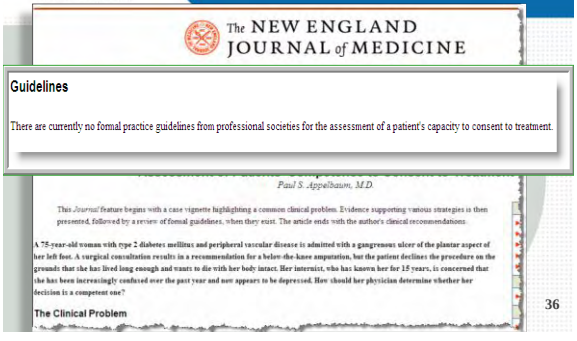
Elderly -- Informed Consent Issues


The NEW ENGLAND JOURNAL of MEDICINE

Guidelines

There are currently no formal practice guidelines from professional societies for the assessment of a patient's capacity to consent to treatment.

Paul S. Appelbaum, M.D.

This *Journal* feature begins with a case vignette highlighting a common clinical problem. Evidence supporting various strategies is then presented, followed by a review of formal guidelines, when they exist. The article ends with the author's clinical recommendations.

A 75-year-old woman with type 2 diabetes mellitus and peripheral vascular disease is admitted with a gangrenous ulcer of the plantar aspect of her left foot. A surgical consultation results in a recommendation for a below-the-knee amputation, but the patient declines the procedure on the grounds that she has lived long enough and wants to die with her body intact. Her internist, who has known her for 15 years, is concerned that she has been increasingly confused over the past year and now appears to be depressed. How should her physician determine whether her decision is a competent one?

The Clinical Problem

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Table 1. Legally Relevant Criteria for Decision-Making Capacity and Approaches to Assessment of the Patient. ©

Criterion	Patient's Task	Physician's Assessment Approach	Questions for Clinical Assessment*	Comments
Communicate a choice	Clearly indicate preferred treatment option	Ask patient to indicate a treatment choice	Have you decided whether to follow your doctor's [or my] recommendation for treatment? Can you tell me what that decision is? [If no decision] What is making it hard for you to decide?	Frequent reversals of choice because of psychiatric or neurologic conditions may indicate lack of capacity
Understand the relevant information	Grasp the fundamental meaning of information communicated by physician	Encourage patient to paraphrase disclosed information regarding medical condition and treatment	Please tell me in your own words what your doctor [or I] told you about: The problem with your health now The recommended treatment The possible benefits and risks (or discomforts) of the treatment Any alternative treatments and their risks and benefits The risks and benefits of no treatment	Information to be understood includes nature of patient's condition, nature and purpose of proposed treatment, possible benefits and risks of that treatment, and alternative approaches (including no treatment) and their benefits and risks
Appreciate the situation and its consequences	Acknowledge medical condition and likely consequences of treatment options	Ask patient to describe views of medical condition, proposed treatment, and likely outcomes	What do you believe is wrong with your health now? Do you believe that you need some kind of treatment? What is treatment likely to do for you? What makes you believe it will have that effect? What do you believe will happen if you are not treated? Why do you think your doctor has [or I have] recommended this treatment?	Courts have recognized that patients who do not acknowledge their illnesses (often referred to as "lack of insight") cannot make valid decisions about treatment Delusions or pathologic levels of distortion or denial are the most common causes of impairment
Reason about treatment options	Engage in a rational process of manipulating the relevant information	Ask patient to compare treatment options and consequences and to offer reasons for selection of option	How did you decide to accept or reject the recommended treatment? What makes [chosen option] better than [alternative option]?	This criterion focuses on the process by which a decision is reached, not the outcome of the patient's choice, since patients have the right to make "unreasonable" choices

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* Questions are adapted from Grisso and Appelbaum.[9] Patients' responses to these questions need not be verbal.

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Elderly -- Informed Consent Issues *(cont'd.)* ©

- *We see many elderly patients who have a person (often a relative) designated as their health care power of attorney. Is that person responsible for signing the consent form?*
  - A person designated as "Health Care Power of Attorney" does not gain the power to make decisions until the patient becomes incompetent Once the patient is not able to make decisions for himself due to mental or physical disability, the Health Care Power of Attorney may take over and give consent If the patient is still competent, he can make decisions for himself

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Dealing With Health Care Powers of Attorney In Treating the Elderly ©

- So, an elderly patient with obvious or known issues of competency issues is brought to you for treatment, and you need to be able to communicate regarding the treatment, and/or obtain consent for certain aspects of treatment
- What do you do:
  - ☐ *Nothing, just treat as you would any adult patient*
  - ☑ *If the patient is accompanied by a caregiver, speak with them and get from them any needed consent*
  - ☑ *Inquire whether the patient has a Health Care Power of Attorney and abide by it*

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Very Distinct forms drafted in accordance w/ NC laws

NORTH CAROLINA
WAKE COUNTY

HEALTH CARE POWER OF ATTORNEY

NOTE: YOU SHOULD USE THIS DOCUMENT TO NAME A PERSON AS YOUR HEALTH CARE AGENT IF YOU ARE COMFORTABLE GIVING THAT PERSON BROAD AND SWEEPING POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A HEALTH CARE POWER OF ATTORNEY.

EXPLANATION: You have the right to name someone to make health care decisions for you when you cannot make or communicate those decisions. This form may be used to create a health care power of attorney, and meets the requirements of North Carolina law. However, you are not required to use this form, and North Carolina law allows the use of other forms that meet certain requirements. If you prepare your own health care power of attorney, you should be very careful to make sure it is consistent with North Carolina law.

This document gives the person you designate as your health care agent broad powers to make health care decisions for you when you cannot make the decision yourself or cannot communicate your decision to other people. You should discuss your wishes concerning life prolonging measures, mental health treatment, and other health care decisions with your health care agent. Except to the extent that you express specific limitations or restrictions in this form, your health care agent may make any health care decision you could make yourself.

This form does not impose a duty on your health care agent to exercise granted powers, but when a power is exercised, your health care agent will be obligated to use due care to act in your best interests and in accordance with this document.

This Health Care Power of Attorney form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.

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Health Care Powers of Attorney *(cont'd.)*

4. **General Statement of Authority Granted.**

Subject to any restrictions set forth in Section 6 below, I grant to my health care agent full power and authority to make and carry out all health care decisions for me. These decisions include, but are not limited to:

A. Requesting, reviewing, and receiving any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information.

B. Employing or discharging my health care providers.

C. Consenting to and authorizing my admission to and discharge from a hospital, nursing or convalescent home, hospice, long term care facility, or other health care facility.

D. Consenting to and authorizing my admission to and retention in a facility for the care or treatment of mental illness.

E. Consenting to and authorizing the administration of medications for mental health treatment and electroconvulsive treatment (ECT) commonly referred to as "shock treatment."

F. Giving consent for, withdrawing consent for, or withholding consent for, X ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, podiatrist, or other health care provider. This authorization specifically includes the power to consent to measures for relief of pain.

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Ethical Obligations -- Elder Abuse

- Chapter 108A of NCGS – "Abused, Neglected, or Exploited Disabled Adults":

§ 108A-102. Duty to report; content of report; immunity.

(a) Any person having reasonable cause to believe that a disabled adult is in need of protective services shall report such information to the director.

(b) The report may be made orally or in writing. The report shall include the name and address of the disabled adult, the name and address of the disabled adult's caretaker, the age of the disabled adult, the nature and extent of the disabled adult's injury or condition resulting from abuse or neglect, and other pertinent information.

(c) Anyone who makes a report pursuant to this statute, who testifies in any judicial proceeding arising from the report, or who participates in a required evaluation shall be immune from any civil or criminal liability on account of such report or testimony or participation, unless such person acted in bad faith or with a malicious purpose.

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Treating Minors

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The Legal Basics

- Who is a minor? *By law in NC, anyone under the age of 18*
  - "General Rule" for treatment of minors: *Must obtain prior consent for treatment from parent or legal guardian*
- Who is an emancipated minor?
  - Any juvenile who is 16 years old, and emancipated by judicial action, or;
  - A married juvenile

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The Legal Basics *(cont'd.)*

- By law (*NCGS § 90-21.5*) an emancipated minor may consent to any dental treatment
  - They must consent in writing to the release of any of their dental record (just like an adult)
  - They are entitled, upon execution of such a release, to their dental record
  - Their record can not be released to their parents w/o their consent

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The Legal Basics *(cont'd.)*

- Exceptions to "General Rule" *(must have parental consent to treat a minor)* – 4 areas which, by law, do not require parental consent -- for prevention, diagnosis and treatment of:
  - Sexually transmitted diseases
  - Pregnancy (but not abortions)
  - Substance abuse
  - Emotional disturbance (but not admissions to in-patient facility)

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The Legal Basics *(cont'd.)*

- Exception to the exception:

  If, in your opinion, sharing of health info of a minor is "essential to the life and health of that minor" you may, but do not have to, inform the parent – your call

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The Legal Basics *(cont'd.)*

- A minor does not become emancipated by:
  - Moving out of their parents' home, or;
  - By having a baby
- Marriage or a court order is required

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Practical Situations

- Parents of a minor may give advance authorization to another adult to consent to treatment – e.g., a sitter, grandparent, neighbor or friend
- NCGS §32A-34 contains a non-exclusive form to use: *(see next slide)*

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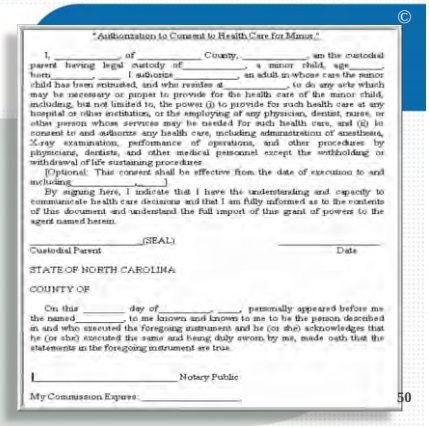
Authorization Form for Consent To Heath Care Of Minor



"Authorization to Consent to Health Care for Minor."

I, _____, of _____ County, _____ am the custodial parent having legal custody of _____, a minor child, age _____, born _____. I authorize _____, an adult in whose care the minor child has been entrusted, and who resides at _____, to do any acts which may be necessary or proper to provide for the health care of the minor child, including, but not limited to, the power (i) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (ii) to consent to and authorize any health care, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining procedures.

[Optional: This consent shall be effective from the date of execution to and including _____.]

By signing here, I indicate that I have the understanding and capacity to communicate health care decisions and that I am fully informed as to the contents of this document and understand the full import of this grant of powers to the agent named herein.

_____ (SEAL) _____
Custodial Parent Date

STATE OF NORTH CAROLINA

COUNTY OF

On this _____ day of _____, ____, personally appeared before me the named _____, to me known and known to me to be the person described in and who executed the foregoing instrument and he (or she) acknowledges that he (or she) executed the same and being duly sworn by me, made oath that the statements in the foregoing instrument are true.

I _____ Notary Public

My Commission Expires: _____

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Practical Situations *(cont'd.)*

- If parental rights have been terminated, the agency or person currently having legal custody must produce written proof of guardian rights
- Where a minor comes to your office alone for treatment, it's a good idea to have a consent to treatment form signed by the parent in the minor's record
- In an emergency, do not withhold treatment at the health risk of the minor because you do not have consent to treat

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Practical Situations *(cont'd.)*

- Disputes between divorced parents over treatment of their minor child:
  - Unless revoked by court order, both parents have equal rights to request and consent to treatment
  - Written directives from one of 2 parents must be honored unless they try to eliminate the rights of the other parent (e.g., *I do not consent to any treatment of my child when brought in by her stepmom*."

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Practical Situations *(cont'd.)*

- Divorce, *cont'd*.:
  - If/ when a dispute arises between divorced parents, advise them in writing that you will not see the minor again until they work through their dispute and advise you in writing as to who can consent, and when
  - If there is an emergency with the minor, treat first, so long as one parent consents

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Practical Situations *(cont'd.)*

- When you find the unexpected while treating a minor, and do not otherwise have to get/have parental consent *(e.g., you know the parents of a married 17 y.o. whom you are treating, and discover she has oral cancer)*
  - ***TELL?***
  - ***DON'T TELL?***
- If, in your prof. opinion, parental notification is essential to life and health of the minor, do so

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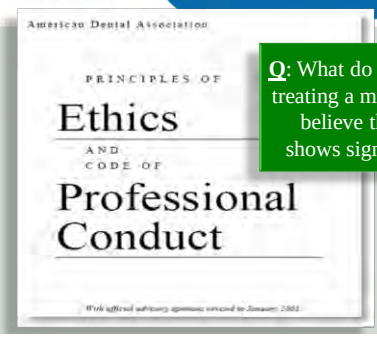
Ethical Considerations



Q: What do you do when treating a minor and you believe that minor shows signs of abuse?

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3.E. Abuse and Neglect. Dentists shall be obliged to become familiar with the signs of abuse and neglect and to report suspected cases to the proper authorities, consistent with state laws.

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Advisory Opinion

3.E.1. Reporting Abuse and Neglect. The public and the profession are best served by dentists who are familiar with identifying the signs of abuse and neglect and knowledgeable about the appropriate intervention resources for all populations.

A dentist's ethical obligation to identify and report the signs of abuse and neglect is, at a minimum, to be consistent with a dentist's legal obligation in the jurisdiction where the dentist practices. Dentists, therefore, are ethically obliged to identify and report suspected cases of abuse and neglect to the same extent as they are legally obliged to do so in the jurisdiction where they practice. Dentists have a concurrent ethical obligation to respect an adult patient's right to self-determination and confidentiality and to promote the welfare of all patients. Care should be exercised to respect the wishes of an adult patient who asks that a suspected case of abuse and/or neglect not be reported, where such a report is not mandated by law. With the patient's permission, other possible solutions may be sought.

Dentists should be aware that jurisdictional laws vary in their definitions of abuse and neglect, in their reporting requirements and the extent to which immunity is granted to good faith reporters. The variances may raise potential legal and other risks that should be considered, while keeping in mind the duty to put the welfare of the patient first. Therefore a dentist's ethical obligation to identify and report suspected cases of abuse and neglect can vary from one jurisdiction to another

Dentists are ethically obligated to keep current their knowledge of both identifying abuse and neglect and reporting it in the jurisdiction(s) where they practice

See also: Report of the ADA Council on Ethics, Bylaws and Judicial Affairs on Advisory Opinion 3.E.1 Reporting Abuse and Neglect

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Reporting Abuse in NC

§ 7B-301. Duty to report abuse, neglect, dependency, or death due to maltreatment.

Any person or institution who has cause to suspect that any juvenile is abused, neglected, or dependent, as defined by G.S. 7B-101, or has died as the result of maltreatment, shall report the case of that juvenile to the director of the department of social services in the county where the juvenile resides or is found. The report may be made orally, by telephone, or in writing. The report shall include information as is known to the person making it including the name and address of the juvenile; the name and address of the juvenile's parent, guardian, or caretaker; the age of the juvenile; the names and ages of other juveniles in the home; the present whereabouts of the juvenile if not at the home address; the nature and extent of any injury or condition resulting from abuse, neglect, or dependency; and any other information which the person making the report believes might be helpful in establishing the need for protective services or court intervention. If the report is made orally or by telephone, the person making the report shall give the person's name, address, and telephone number. Refusal of the person making the report to give a name shall not preclude the department's assessment of the alleged abuse, neglect, dependency, or death as a result of maltreatment.

Upon receipt of any report of sexual abuse of the juvenile in a child care facility, the director shall notify the State Bureau of Investigation within 24 hours or on the next workday. If sexual abuse in a child care facility is not alleged in the initial report, but during the course of the assessment there is reason to suspect that sexual abuse has occurred, the director shall immediately notify the State Bureau of Investigation. Upon notification that sexual abuse may have occurred in a child care facility, the State Bureau of Investigation may form a task force to investigate the report. (1979, c. 815, s. 1; 1991 (Reg. Sess., 1992), c. 923, s. 2; 1993, c. 516, s. 4; 1997-506, s. 32; 1998-202, s. 6; 1999-456, s. 60; 2005-55, s. 3.)

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Informed Consent
(All Patients)

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Protecting Yourself Through The Informed Consent Process

§ 90-21.13. Informed consent to health care treatment or procedure.

(a) No recovery shall be allowed against any health care provider upon the grounds that the health care treatment was rendered without the informed consent of the patient or the patient's spouse, parent, guardian, nearest relative or other person authorized to give consent for the patient where:

(1) The action of the health care provider in obtaining the consent of the patient or other person authorized to give consent for the patient was in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities; and

(2) A reasonable person, from the information provided by the health care provider under the circumstances, would have a general understanding of the procedures or treatments and of the usual and most frequent risks and hazards inherent in the proposed procedures or treatments which are recognized and followed by other health care providers engaged in the same field of practice in the same or similar communities; or

(3) A reasonable person, under all the surrounding circumstances, would have undergone such treatment or procedure had he been advised by the health care provider in accordance with the provisions of subdivisions (1) and (2) of this subsection.

(b) A consent which is evidenced in writing and which meets the foregoing standards, and which is signed by the patient or other authorized person, shall be presumed to be a valid consent. This presumption, however, may be subject to rebuttal only upon proof that such consent was obtained by fraud, deception or misrepresentation of a material fact.

(c) A valid consent is one which is given by a person who under all the surrounding circumstances is mentally and physically competent to give consent.

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Informed Consent Process
(cont'd.)

- MSIC recommends using procedure specific consent forms in dental practices.
- Do not rely upon any "standard" hospital consent form.
- List the specific risks, benefits, alternatives and complications that the patient may encounter as a result of that procedure.

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Informed Consent Process *(cont'd.)*

- It is particularly important that informed consent be obtained when the care is rendered either to a minor, or to an elderly patient – otherwise there's too much room for argument that consent was not given w/ a bad outcome *(disgruntled parents and guilty children of the elderly can be vocal protesters when things do not go as planned – and bills pile up)*

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Informed Consent Process *(cont'd.)*

- All consent forms used should be:
  - Procedure/use specific
  - Written to a 6th grade health literacy level
  - Consistently used with all patients
  - Fully executed, dated and retained in the patient's chart

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Medicaid Health Literacy Reading Level Guidelines By Grade

Grade Level	# Of States^	States
No Guidelines	4 (8%)	Indiana Mississippi North Dakota South Dakota
6th – 8th	1 (2%)	North Carolina
5th – 7th	1 (2%)	Utah
7th	2 (4%)	Connecticut Minnesota
6th	28 (56%)	Alaska Arizona Colorado Delaware Georgia Hawaii Iowa Illinois Kentucky Louisiana Maine Maryland Massachusetts Michigan Missouri Montana Nevada New Hampshire New Mexico Oklahoma Oregon

al Survey of Medicaid
nes for Health Literacy

& Introduction

ns cannot read or understand their health
n. In 2003, the National Assessment of Adult
) reported in the National Assessment of
y (NALS) that nearly 93 million of U.S. adults
at basic and below basic literacy levels or
do the most basic reading tasks needed to
ety. This information was confirmed by a
f Medicine (IOM) report, "Health Literacy: A
end Confusion" which states that of these
illion people, about 40 million read below the

alarming news, most of the health care
oduces health information at 10th grade
r higher". This gap – between what the health
roduces and what many Americans
eaves many Americans unable to follow or
th care information. And when consumers
land health care information – medication
kage inserts, brochures or websites –
on and people can get hurt.

ue, known as health literacy, is defined as the
h individuals can obtain, process, and

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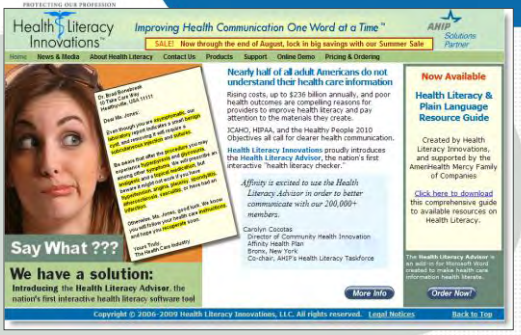
Health Literacy *(cont'd.)*



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Informed Consent Process *(cont'd.)*

Narcotic Medication Treatment Educational Material, Consent Form, and Agreement

The following information will help you understand more about the treatment your doctor has recommended. Please read it carefully. You will be asked to sign the last page of this form.

Your Condition

You have a pain control problem. Your doctor has recommended treatment with narcotic pain medication.

The Purpose of Narcotic Pain Medication

This medication is intended to reduce or relieve your pain. However, there are some important things you must understand about narcotic pain medication before you agree to treatment.

- Narcotics have significant side effects and risks. If you get only partial pain relief, it may not be worth taking them.
- Using long-term narcotics is a serious commitment that may require documented lifestyle change.
- Narcotic use is under the control of several regulatory agencies. Doctors must follow local, state, and federal laws when prescribing these drugs.

Risks and Common Complications

Addiction: Narcotic medications can be addictive. You could become both physically and mentally addicted to them. If you stop taking the medication suddenly, you may

Sample

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Your Questions/ Concerns and Feedback

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