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DDS GUARDIAN

A Patient Safety and Risk Management Newsletter from Fortress Insurance Company

FORTRESS
PROTECTION FOR DENTISTRY

New Office Opening

On February 11, 2019, the Fortress Board, OMSNIC Board, Fortress Leadership Team, and local officials recognized the opening of our new offices in Schaumburg, IL with a ribbon cutting ceremony.

Periodontal Disease Treatment: Best Practices to Improve Patient Outcomes and Mitigate Risk

Julie Goldberg, DDS - *Education Coordinator*

Periodontal disease is the most common cause of tooth loss among adults.[1] Mismanagement of this disease can lead to patient dissatisfaction, allegations of supervised neglect, and failed implants. This article will cover best practices to improve patient outcomes and mitigate risk related to the assessment and treatment of periodontal disease.

Identify risk factors and indicators

Review existing office health history forms

The health history form may provide the first opportunity to identify patients who are at risk for periodontal disease. Pre-existing health issues and behaviors that may indicate an increased risk of periodontal disease includes: diabetes, xerostomia, smoking, electronic cigarette and smokeless tobacco use, and any barriers to maintaining oral hygiene. Including these conditions and habits on your health history form provides an opportunity to discuss treatment of the condition or cessation of the habit.

Evaluate a patient's health history responses and document any clarifying conversations

Reviewing your patient's health history forms for accuracy, can help provide a thorough understanding of the patient's condition and dental habits. For example, many patients are unaware that they may be prone to xerostomia with certain medications. A discussion with the patient to confirm their self-reported history also allows you an opportunity to educate the patient on their identified periodontal disease risks. Subsequent documentation of these discussions in the patient's chart further supports your efforts.

Document your exam and radiographic findings in the progress notes

Indicators for periodontal disease include bone loss, loss of gingival attachment and bleeding upon probing. Identification and documentation of these indicators in the patient's chart provides evidence to support your periodontal disease assessments. Supportive documentation includes periodontal charts, probing charts, documentation of bleeding on probing, and radiographic imaging. Patients should know that implants require the same level of oral hygiene as "real" teeth. For patients with dental implants it is important to assess and document any identified peri-implantitis. Documentation of your exam findings can help support your indications for treatment and/or any referrals made.

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Implement measures to reduce risk

Document your recommended risk reduction measures and any efforts made by the patient to reduce periodontal or peri-implantitis risks

Once you have identified patient specific risks and indicators, discuss with your patient the recommended treatment plan to reduce their risk and improve their periodontal health. During these discussions, it is important to emphasize the essential role each patient plays in their own periodontal health. Document in the patient chart your treatment plan and the patient's response.

Implement a standard recall policy for patients at higher risk for periodontal conditions

Depending on their overall clinical presentation, patients with periodontal disease, or those who are at risk, may benefit from more frequent dental health monitoring. During these additional dental treatment sessions, you can assess the patient's oral hygiene status and reinforce the benefits of treatment plan compliance. After these additional treatment sessions, include in your documentation any progress with cessation of contributing habits and any updates to the treatment plan based on your findings.

Manage patient expectations and compliance

Inform at risk patients of their expected periodontal prognosis prior to initiating a treatment plan

Restoration and implant patients with periodontal disease may experience additional healing challenges. To improve patient satisfaction, it is important to assess patient expectations and discuss their expected prognosis during the care planning phases. For patients undergoing serial extractions in preparation of full mouth implants, their dental

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health history, current oral hygiene status, and any existing periodontal disease will most likely impact the treatment outcomes. To promote realistic treatment outcomes and patient satisfaction for patients with periodontal disease, patient communication related to proper home care, cessation of risk contributing habits, and treatment plan compliance is warranted.

Monitor and document patient compliance

Missing or incomplete documentation may contribute to allegations of supervised neglect. Therefore, when managing periodontal disease, documentation of your patient's compliance with recommended treatment plans and risk reducing interventions is a priority. For this patient population, supportive documentation includes changes in the patient's periodontal disease presentation, the patient's compliance with risk reducing interventions, and any required modifications to the treatment plan.

When patient noncompliance is identified during treatment, the treating doctor can reinforce the importance of the recommended treatment plan and document all patient responses. The communication and documentation of these patient education efforts should include any missed appointments. Some patients may require additional communication regarding the impact of their non-compliant behavior on the success of their treatment and the continuation of their doctor-patient relationship.

Missing or incomplete documentation may contribute to allegations of supervised neglect. Therefore, when managing periodontal disease, documentation of your patient's compliance with recommended treatment plans and risk reducing interventions is a priority.

Patients who are identified as at risk for periodontal disease (and those with indicators) can benefit from implementation of measures designed to reduce risk. In addition, management of patient expectations and compliance related to periodontal conditions can help improve patient outcomes.

1. https://www.nidcr.nih.gov/research/data-statistics/periodontal-disease

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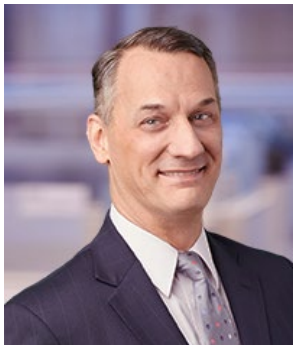
Minor Patients: A Systematic Approach to Selecting Appropriate Health Care Decision Makers

Stephen Pavkovic, RN, MPH, JD, CPHRM - *Senior Risk Manager*



Planning is required to consistently identify the appropriate decision maker for your minor patients. Absent a medical emergency or any state law requirements, providers must identify an appropriate medical decision maker before treating a minor patient.

In most clinical scenarios, this process is not a challenge - the parent or legal guardian will accompany the minor patient for treatment and is present to consent on behalf of the minor. However, identifying an appropriate medical decision maker can be a challenge when a minor's parent or their legal guardian is unavailable.

Know the applicable state law

The first step is to understand the applicable state laws regarding minor patients and consents. Your state licensing boards and your personal legal counsel are both sources for definitive information on these laws. A few framing questions to begin this discussion are:

What is the age of majority for medical decisions in my state?

The age of majority is the age when a minor is legally considered an adult. For most states, minor status ends on the 18th birthday. However, a few states recognize "adulthood" at older ages.

Does my state recognize any social status or conditions that decrease the age of majority?

Each state defines the scenarios that change the age of majority. Some examples of changes in social status that may decrease the age of majority include a minor's pregnancy, parenthood, or military enlistment. Additionally, some states permit a minor to make their own health care decisions for access to specific medical treatment like birth control, HIV testing, STI testing and treatment, and mental health counseling.

Is my patient the subject of any legal actions that have decreased the age of majority or replaced the parent or legal guardian as the minor's medical decision maker?

An emancipation order can decrease the age of majority. The emancipation order is the result of a hearing or other proceeding where a minor's unique social situation is considered. Then based on the presented facts, the court determines that the minor has demonstrated an "adult" capacity for some decisions including health care. Factors considered in emancipation proceedings include the minor's financial independence, living arrangements, school enrollment, and the level of support from their parent or legal guardian.

A court order may remove a parent or legal guardian's right to consent. Some examples of these scenarios include when minors are identified as wards of the state due to child abuse investigations or with the minor's incarceration. In these situations, a court order would likely also identify a surrogate decision maker. Surrogate healthcare decision orders need review for court-imposed limits, like requiring that all care be delivered within the jurisdiction of the issuing court or before an expiration date.

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When a court order is the basis for determining a minor's healthcare decision maker, the actual court order needs to be requested and a copy placed in the patient's record. If there are any questions about the scope or content of the court order, your practice should review the order with your legal counsel or the issuing court before initiating treatment.

Establish and enact your practice standards regarding minor patient treatment

Once the applicable state laws are identified, your practice can establish standards to reliably identify the appropriate medical decision maker for your minor patients. Considerations for establishing your practice standards regarding minor patients include:

- Whether or not your practice will require that all minors be accompanied by a parent or legal guardian for their initial visits;
- Determining the required steps for a parent or guardian to authorize another individual to accompany a minor patient for treatment or to have access to the minor's protected health information; and
- Identifying the scenarios when your practice will require the actual court documents or other authorization forms when the parent or legal guardians are not present during treatment.

Once your office standards are determined, the parents and legal guardians of your patients need notice of your office practice regarding minor patients. This notice should begin with scheduling of the first appointment and continue with appointment reminders. Telephone scripting for your scheduling staff and updating your office forms can help to reliably enact these standards.

Sample scheduling staff telephone scripting:

Our Practice requires the consent of a parent or legal guardian to provide most types of routine care for patients under the age of 18. Minor patients who present without an accompanying parent or legal guardian will have their appointment rescheduled.

- Who will be accompanying this patient on the day of their initial appointment?
- Will this person have the authority to consent to medical treatment for the minor?

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Minors and the informed consent process

As a reminder, the informed consent process is the same for minor and adult patients. Based on a patient's presenting conditions, their diagnosis, and the goals of treatment, the provider develops and communicates a patient-specific treatment plan. Through the provider's communication, the patient may evaluate and select from several treatment options, each with distinct risks, benefits, and alternatives.

The general rule is that a minor patient is not legally recognized to possess the capacity to evaluate the treatment plan's risks, benefits, and alternatives. A minor patient's medical decision maker should participate in the entire informed consent process so that the identified decision maker has the information required to execute treatment decisions in the best interest of the minor.

If at any time during the informed consent process the provider questions whether the minor's decision maker is acting within the best interest of the minor or the minor patient refuses treatment, treatment should be delayed until these questions are decided. Likewise, if a provider cannot identify an appropriate medical decision maker or if two otherwise appropriate medical decision makers cannot agree on the treatment plan for a minor, the treatment should be delayed until these issues are determined. In rare scenarios, enacting the resources of your state's child welfare services may be required to resolve these issues.

Practice considerations

With knowledge of your state laws and defining your practice standards for treating minor patients, your practice can promote the informed consent process, patient autonomy, and beneficence. Providing notice of your practice's standards at the time of scheduling may prevent care delays and ensure the identification of an appropriate medical decision maker for all minor patients.

Access related resources on www.dds4dds.com

- Information Guide for Treatment of Minors
- Authorization for Disclosure of Health Information
- General Dentistry Minor Informed Consent Template

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Closed Claim Summary: Coming in Loud and Clear

Justina DeGrado, JD - *Senior Claims Analyst*

Managing patient dissatisfaction is a challenge. This Closed Case Summary highlights the supportive role that empathetic communication and complete clinical documentation can play in claim resolution.

A female patient in her mid-twenties presented to our insured orthodontist for occlusal evaluation with TMJ complaints. After performing a thorough evaluation, the patient and the doctor agreed on a comprehensive orthodontic treatment plan. The patient signed a consent form before commencing the treatment.

After completing the orthodontic treatment, the brackets were removed and the patient complained of some rough areas and enamel discoloration. To address these concerns, the insured discussed with the patient the use of a finishing bur to smooth the enamel. When the bur smoothing was completed, the patient asserted that the insured changed the shape of her teeth without her consent. The orthodontist's post-treatment images demonstrated the absence of any enamel damage and an objectively overall aesthetically pleasing outcome.

The patient requested a follow up appointment with the orthodontist to discuss her treatment outcome and concerns. During the follow up appointment the patient repeatedly attempted to obtain a verbal admission from the orthodontist that he changed the shape of her teeth with the finishing bur. He did not make such an admission, but did generally apologize because she was not satisfied with the treatment. Unknown to the insured and without his consent, the patient surreptitiously recorded audio during this follow up visit. The patient hired an attorney to pursue her alleged damages and produced the audio recording as support of her claim that the insured admitted negligent treatment.

The audio recording however, did not include an admission of negligence. Rather, it supported that the orthodontist shared his sincere and empathetic responses to the patient's dissatisfaction. The claim was denied and suit was never filed against the orthodontist.

Patient Safety and Risk Management Tips

Know your state's laws regarding consent and recordings

Jurisdictions differ on whether all parties must have knowledge and consent before recording a conversation. In practice, this means that in some jurisdictions, a person can "consent" to their own recording of a conversation without putting anyone else on notice.

Consider that you are being recorded

Given the near constant access to high quality recording devices and smartphones, it is prudent to consider that your patients may be recording their clinical interactions. This possibility of your unconsented recording is likely elevated during contacts with dissatisfied patients.

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Patients with Service Animals

Suzanne Moy, CPHRM - *Patient Safety and Risk Manager*

Under the Americans with Disability Act (ADA), a service animal is defined as a dog that has been trained to do work or perform tasks for an individual with a disability. The tasks performed by the dog must be directly related to the person's disability. Some examples include a dog trained to assist with an ambulation disability or a dog trained to alert a deaf person when someone approaches.

The ADA requires state and local government agencies, businesses, and organizations that provide goods or services to the public to make "reasonable modifications" in their policies, practices, or procedures to accommodate people with disabilities. Accordingly, entities that have an absolute "no pets" policy generally must allow service animals into the public areas of their facilities.

People with disabilities have the right to train the dog themselves and are not required to use a professional service dog training program.

The ADA does not require service animals to wear a vest, ID tag, or specific harness.

Service Animal Q & A's

Below are a few common questions and answers published by the Department of Justice regarding service animals and the ADA.

Does the ADA require service animals to be professionally trained?

No. People with disabilities have the right to train the dog themselves and are not required to use a professional service dog training program.

What questions can a covered entity's employees ask to determine if a dog is a service animal?

In situations where it is not obvious that the dog is a service animal, staff may ask only two specific questions: (1) is the dog a service animal required because of a disability?; and (2) what work or task has the dog been trained to perform? Staff are not allowed to request any documentation for the dog, require that the dog demonstrate its task, or inquire about the nature of the person's disability.

Do service animals have to wear a vest or patch or special harness identifying them as service animals?

No. The ADA does not require service animals to wear a vest, ID tag, or specific harness.

Are emotional support, therapy, comfort, or companion animals considered service animals under the ADA?

No. These terms are used to describe animals that provide comfort just by being with

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Patients with Service Animals

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a person. Because they have not been trained to perform a specific job or task, they do not qualify as service animals under the ADA. However, some state or local governments have laws that allow people to take emotional support animals into public places. You may check with your state and local government agencies to find out about these laws.

Who is responsible for the care and supervision of a service animal?

The handler is responsible for caring for and supervising the service animal, which includes toileting, feeding, and grooming and veterinary care. Covered entities are not obligated to supervise or otherwise care for a service animal.

Does a hospital have to allow an in-patient with a disability to keep a service animal in his or her room?

Generally, yes. Service animals must be allowed in patient rooms and anywhere else in the hospital[1] the public and patients are allowed to go. They cannot be excluded on the grounds that staff can provide the same services.

Practice considerations

Service animals are an important part of the lives of many disabled persons and you may encounter patients or their family members presenting with a service dog. Under the ADA, their service dogs are permitted in the public areas of your dental office. For additional information about service animals visit https://www.ada.gov/.

[1] While this FAQs mentions an inpatient hospital setting, the ADA applies to other healthcare settings including dental offices.

Additional References:

Frequently Asked Questions about Service Animals and the ADA. Retrieved March 18, 2019 from https://www.ada.gov/regs2010/service_animal_qa.pdf

Americans with Disabilities Act Title II Regulations. Retrieved March 18, 2019 from https://www.ada.gov/regs2010/titleII_2010/titleII_2010_regulations.pdf

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Earn a 10% Premium Credit

Live Patient Safety and Risk Management Seminars

The live Fortress three-hour seminar, *Improving Patient Safety: An Analysis of Dental Risks and Liability*, discusses several clinical scenarios from a risk management perspective including extractions, implants, failure to diagnose oral cancer and periodontal disease, and informed consent. For more information about the live seminars, visit our online calendar for an upcoming seminar in your area.

Can't Attend a Live Seminar?

Improving Patient Safety: An Analysis of Dental Risks and Liability is also available via the e-Learning Center on demand. Complete the course recording to earn 3 CEs and qualify for the renewable 10% risk management credit off your base rate which is applicable for three policy periods.

Visit the e-Learning Center for Complimentary Online CE Courses

Fortress offers over 10 hours of complimentary, online continuing education credit courses in the e-Learning Center at dds4dds.com. On demand courses are designed for dentists and staff, and are available to be completed at your convenience. Curriculum covers topics on risk management and patient safety as well as emerging issues in dentistry.

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