## Feature Article

### The Importance of Pathological Follow Up
Read tips for documenting pathological follow up for your patients.
By: Julie Goldberg, DDS

### Practice Considerations

#### Communication Best Practices
This article suggests best practices related to various communication opportunities between doctors, staff and patients. Effective communication between all individuals involved in the treatment plan is critical to effective and safe care.

### Closed Claim Summary

#### A Case Involving Nerve Injury
Read about a nerve injury claim that included both strengths and challenges for the defense. By: Kimberly Gensler, JD

### Patient Management

#### Do You Know if Your Patients Have a Substance Abuse History?
Have protocols in place to help ensure you are aware of your patient’s substance abuse history. By: Suzanne Moy, CPHRM

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**Also in this issue:**
- Live Seminar Calendar

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**Patient Safety and Risk Management**
In this issue, we explore trending topics regarding pathological follow up with patients, communication best practices and the importance of obtaining a substance abuse history from patients.
The Importance of Pathological Follow Up

Julie Goldberg, DDS - Education Coordinator

The American Cancer Society estimates that in 2017 approximately 49,670 new cases of oral and oropharyngeal cancer were diagnosed, resulting in more than 9,700 deaths. Approximately 80% of these malignancies were classified as squamous cell carcinoma. The incidence of oral squamous cell carcinoma for lip, gingivae, and floor of the mouth have decreased over the last few decades, mirroring decreases during the same time frame in alcohol and tobacco use. Many times, a dentist will be the first person to discover any abnormal pathology in a patient's mouth. In addition to the biopsy and accurate histopathologic diagnosis, strong communication with your patients and other members of the healthcare team will support further management of any suspicious pathology that is diagnosed.

Diagnosis Considerations
Regardless of the method(s) applied to diagnose malignancies, early detection may save a patient's life. Traditionally, major risk factors include tobacco use, alcohol consumption, and age. However, studies have linked the Human Papillomavirus (HPV) to oral squamous cell carcinoma, and patients under the age of 40 are being diagnosed more frequently. Given this information, regular and thorough screenings are important.

Document Your Observations, Communications and Efforts
Once you observe a suspicious lesion, your subsequent observations and efforts should be documented contemporaneously in the chart. If you perform the biopsy, subsequent documentation should include tracking the specimen, delivery of the results to the patient, and appropriate follow up to referrals as needed. If referring the patient to a specialist, the record should reflect your referral and the reason for referral. Establish appropriate checks and balances to make sure the process is followed through to completion, no steps are missed and all appropriate documentation and communication is made. If you observe improvement or resolution of the lesion over time, document this change as well.

Tips for Documenting Biopsies
- Legible documentation including PHI (e.g. patient's name, DOB, MRN)
- Specific test requested
- Date ordered
- Date of your expected follow-up appointment with the patient (consider setting this before the patient leaves your office)
- Date report received
- Doctor's signature indicating report review
- Specific actions and recommended treatment
- Notification of diagnosis/results to the patient
- Document details of the conversation in the chart
- Future appointment dates
- Referrals to specialists
The Importance of Pathological Follow Up

continued from previous page

Additionally, all conversations with the patient regarding their treatment and next steps should be documented in the patient’s chart with the date and time. Effective communication starts with educating the patient about their unique disease process, emphasizing that early diagnosis and treatment is critical to optimize their overall care and reduce any potential untoward results.

Follow-up care is a critical phase of treatment, and documentation of the follow-up with any cancelled or missed appointments is recommended. All members of the dental office can play a significant role in maintaining an efficient system to reduce the likelihood of patients being lost to follow-up.

Managing Patient Non-Compliance

A patient may refuse a biopsy, or a referral to another doctor, for fear of receiving bad news. Approach these situations with the patient’s best interest in mind. Patients who openly and persistently refuse an indicated biopsy may require additional education. Directly communicate with the patient, whether in person or over the phone, and follow up with a letter summarizing your efforts to educate the patient. If the patient does not follow through, document this in the chart. The focus of all of these efforts should be to emphasize to the patient that they have an active role in their care, and their follow through is paramount to obtaining the best clinical outcome. The patient’s continued failure to assume responsibility in their care will negatively impact their overall health.

Documentation of your efforts to inform the patient of their role and the seriousness of these situations is critical in cases that may have the potential to lead to allegations of failure to diagnose. Attentive care and effective communication may reduce the incidence of such allegations.

How to Access Related Resources

1. Log on to [www.omsnic.com](http://www.omsnic.com)
2. Click on “Clinical and Office Documents” on the left side of the page.
3. Under the heading “Pathology and Biopsy Documents” you will find the following resources:
   • Biopsy Informed Consent
   • Biopsy Refusal Noncompliance Letter
   • Biopsy Lab Test Log
   • Informed Refusal of Biopsy Form
   • Patient Education Following a Pathological Diagnosis
   • Treatment of Cysts or Tumors Informed Consent
# Communication Best Practices

The key principles of patient safety and risk management are communication, documentation and informed consent. Evaluation of claims data has historically revealed that a lack of appropriate doctor-patient communication may lead to an increase in malpractice allegations. Consider the following preventative measures related to communication that may increase patient safety and mitigate malpractice claims.

## In-Office Communication

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<tr>
<th>Step</th>
<th>Description</th>
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<tr>
<td>1.</td>
<td>Evaluate medical history forms for completeness and ask follow up questions related to positive responses. Use the medical history form as a springboard to gather more information about your patient and their medical status.</td>
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<td>2.</td>
<td>Empower staff to speak up prior to or during a procedure to ensure patient safety. Use “Time Outs” to verify daily procedures, patient information and avoid adverse events.</td>
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<td>3.</td>
<td>Review all prescriptions before providing to patient or escort. Ensure any allergies are addressed and patient education related to potential medication abuse is discussed.</td>
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<td>4.</td>
<td>Prepare for in office emergencies. Consider contacting your local emergency medical service personnel and setting up a drill. Assign roles to each staff member during the emergency drill. Evaluate equipment, office space, medication and personnel availability during these drills. Once the drills are complete, evaluate areas for improvement. For more information, please see the 2017 Q4 OMS Guardian article, “A Perspective from an OMS Office: Preparing for In-Office Emergencies.”</td>
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<td>5.</td>
<td>Develop policies for how calls of a clinical nature will be handled in your office. If a patient has post-operative concerns and/or complications, who should these calls be directed to? Additionally, create policies for how clinical staff will communicate patient concerns to front office staff. For example, if a patient is unhappy with treatment due to esthetics or an adverse event, front office staff should be notified of the situation so that conversations regarding future appointments and/or billing can be tailored for the patient and the situation.</td>
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Out-of-Office Communication

- Develop a plan for how out-of-office communication with patients, whether via phone, text or email, will be documented. Document all relevant patient communication in a timely manner.

- Ensure all communication with patients outside of the office is secure. Cell phones and email should be encrypted.

- Assess your office website regularly. Update office, doctor and staff photos as necessary. Additionally, evaluate statements made on your website that may negate consent or set unrealistic expectations, such as “painless dentistry” or “guaranteed results”.

- Avoid communication with patients through social media. This form of communication may lead to HIPAA violations and state board actions. Encourage patients to contact you via phone with any questions or concerns.

- Evaluate your options related to online reviews. Online review responses have the potential to lead to claims of HIPAA violations. If you feel you must respond to an online review, consider the following statement: “We appreciate your feedback. Our office strives to provide an excellent experience, and we work hard to constantly improve our practice. In order to protect the privacy of our patients or potential patients, we do not address specific comments made online. Please contact our office to discuss any concerns that you may have.”

- Develop a plan for after-hours access for patients of record and ensure that they know how to reach you in the event of an emergency.
Communication Best Practices

Communication With Referrals

- Ensure all patient referrals are accurate and legible. Contact the referral and communicate details of patient care over the phone or in person. Avoid reliance on a patient to relay referral recommendations to other providers.

- Update referrals on relevant information related to patient care. Changes to a patient’s medical history, allergic status, decision making abilities, current prescriptions or treatment plan are valuable details for all team members to be apprised of. Ask the same of your referrals in return.

- Discuss any concerns related to patient care with referrals or other treatment providers in order to ensure evaluation of past, current and future treatment/diagnoses can be made objectively.

To summarize, allegations of malpractice often arise from a breakdown in communication. A review of current practices and evaluation of office policies may reveal areas for improvement. This improvement in communication within, outside, and between offices has the potential to increase patient safety and reduce liability.

References

A Case Involving Nerve Injury
Kimberly Gensler, JD - Claims Manager

Our insured, a general dentist, performed the extraction of all four third molars on a male patient in his mid-30s. The patient signed a consent form, documenting that he was informed of the risks of the procedure, including the potential for nerve injury. The day following the extractions, the patient complained of pain and numbness on his tongue, and limited opening of his jaw. He was advised to perform jaw exercises, and continue to take pain medication. He was also advised that the symptoms were considered a part of the normal healing process.

By the time the patient returned to the insured, approximately one week later, he had already visited the emergency room due to complaints of pain and numbness. He was still complaining of pain and numbness at the time of this appointment. He was instructed to continue to take pain medication, an antibiotic, and to perform salt water rinses.

The patient eventually sought follow up care with an OMS. At that time, he was complaining of continued numbness and radiating pain on the side of his right tongue. He was immediately referred to a nerve repair specialist by the OMS. The patient underwent a nerve repair surgery with excision of neuroma. The surgery resulted in some improvement, but the patient claimed a permanent numbness on the right side of his tongue and a permanent loss of taste. The patient brought suit, alleging that the insured performed unnecessary extractions, failed to properly perform the procedure, and failed to timely refer him to a specialist.

This claim presented both strengths and challenges to the defense. Overall, the notes were detailed and complete, and the signed consent form specifically advised of the risk of nerve injury, therefore given the indication for removal of the teeth was not documented clearly by our insured, there was an argument made that the patient should have been referred to a specialist for evaluation sooner. For these reasons, our insured consented to settlement of this claim and we were able to achieve a reasonable settlement in advance of trial.

Risk Management Tips

• Always document the indications for the recommended procedure.
• When a patient experiences a complication, a post-op visit should be scheduled and the patient should be followed closely.
• In the event of a nerve injury, referral to a specialist in a timely manner can increase the likelihood for a good outcome.
Do You Know if Your Patients Have a Substance Abuse History?
Suzanne Moy, CPHRM - Patient Safety and Risk Manager

Each day, more than 100 people in the United States die after overdosing on opioids. The opioid crisis is discussed in the news regularly as new legislation is being enacted, and states are in the process of adopting requirements for patient education related to opioids. While the focus is currently on opioids, it is important to remember that some patients may be using or abusing other drugs, alcohol, and/or a combination of drugs and alcohol that may interact with prescribed medications.

Substance Abuse Statistics
According to SAMHSA's National Survey on Drug Use and Health, among teenagers who report using pain-relievers and other drugs, more than 50% say that the drugs are provided by their friends and family members.

In addition, 66% of people aged twelve years or older reported drinking alcohol in the last twelve months, and approximately 5,000 individuals, under age twenty-one, die as a result of drinking each year. According to the National Institute on Drug Abuse, since the year 2014, prescription drug misuse and abuse is increasing among people in their fifties. Additionally, it was reported that men reported higher rates of illicit drug use than women.

Obtain a Health and Substance Abuse History
While you cannot control a patient’s behavior outside of your office, taking steps to obtain a thorough health history that includes questions about substance abuse, prior to treatment may help identify relevant clinical considerations for patients who report use or abuse of certain drugs or medications. A patient may be concerned with confidentiality of their substance abuse information. Have a conversation with your patients to explain that their privacy and confidentiality is taken seriously to encourage the patient to be more forthcoming with information. Additionally, some patients worry that if they are honest about the types of medications they are taking, such as antidepressants or antipsychotic medication, they will be treated differently. For minor patients, ensure information is obtained from both the parent and the minor. Do not accept “blanks” on the form and ask for clarification if the patient does not answer a question, responds affirmatively, or otherwise discloses pertinent information.

Protocols
In addition to obtaining a complete health history on each patient, consider these other important protocols:

- Strongly advise patients to avoid using drugs, such as marijuana (medical or recreational), prior to undergoing a procedure involving anesthesia. Inform them of the potential harmful and even life threatening effects that certain drugs can have when anesthesia is administered.
- Do a thorough assessment of the patient. If a patient presents for care and is showing signs of drug or alcohol influence, it is recommended to reschedule the treatment for another day.
- Be familiar with and follow your state specific regulations regarding the monitoring and reporting of substance abuse.
Do You Know if Your Patients Have a Substance Abuse History?

continued from previous page

- Check and verify any substance use/abuse reported through your state Prescription Drug Monitoring Program (PDMP).
- Track narcotic prescribing and/or dispensing daily in your office. Keep controlled substances under lock and key.
- If in a group practice, be aware of, and strive for, consistency in the prescribing practices of all providers.
- If you suspect a patient may be using illicit drugs, refer the patient to a physician or drug counseling service.
- Understand that refusal of dental treatment of substance abuse patients can violate the Americans with Disabilities Act.3

References

2. Substance Abuse and Mental Health Services Administration (SAMSHA) 2018 https://www.samhsa.gov

How to Access Related Resources

The Health History Form available on the Fortress website contains questions about social and substance abuse history, including how long they have been using the substance, and if they have ever been hospitalized for substance abuse. This form can help guide the discussion with your patient.

- Login to www.dds4dds.com and click on the Clinical and Office Documents Folder.
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The live Fortress three-hour seminar, Improving Patient Safety: An Analysis of Dental Risks and Liability, discusses several risk management scenarios 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 or email rm@fortressins.com.

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