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PEACE OF MIND | EXPERTISE | CHOICE | THE MEDPRO GROUP DIFFERENCE

Dentistry by the Numbers

Targeted Risk-Reduction Strategies Based on Malpractice Claims Data

Program speaker

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Ted has worked in the field of medical professional liability since 1987. Ted's professional achievements include experience as a medical malpractice defense attorney, risk management consultant, director of risk management, and director of continuing medical education for both doctor-owned and commercial professional liability insurers.

In his career, Ted has provided instruction to thousands of physicians, dentists, and hospital staffs across the United States and internationally, and he has written extensively on various professional liability-related topics.

In addition to his academic credentials, Ted has been trained in healthcare mediation and conflict resolution by the Harvard School of Public Health and in clinician–patient communication by the Institute for Healthcare Communication. His affiliations include Adjunct Professor of Medical Law at the Thomas M. Cooley Law School, advisory panel member for a physician litigation stress website, and former board member of the Tri-County Medical Control Authority.

Designation of continuing education credit

MedPro Group is designated as an Approved PACE Program Provider by the Academy of General Dentistry (AGD). The formal continuing dental education programs of this program provider are accepted by AGD for Fellowship/ Mastership and membership maintenance credit. Approval does not imply acceptance by a state or provincial board of dentistry or AGD endorsement. The current term of approval extends from October 1, 2018 to September 30, 2022. Provider ID# (218784)

MedPro Group designates this continuing dental education activity, as meeting the criteria for up to 1 hour of continuing education credit. Doctors should claim only those hours actually spent in the activity.

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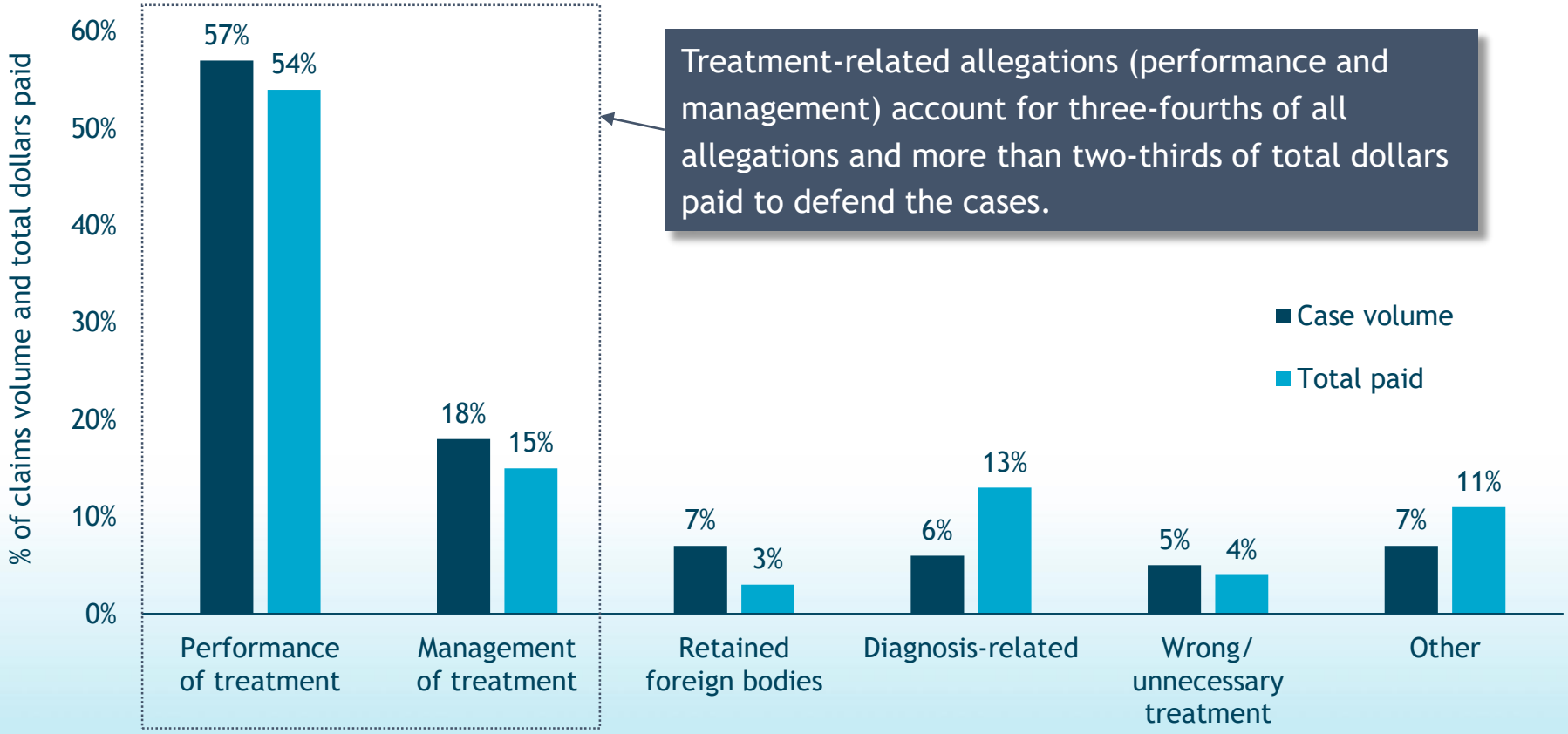
When there are relevant financial relationships, the individual(s) will be listed by name, along with the name of the commercial interest with which the person has a relationship and the nature of the relationship.

Today's faculty, as well as CE planners, content developers, reviewers, editors, and Patient Safety & Risk Solutions staff at MedPro Group have reported that they have no relevant financial relationships with any commercial interests.

Objectives

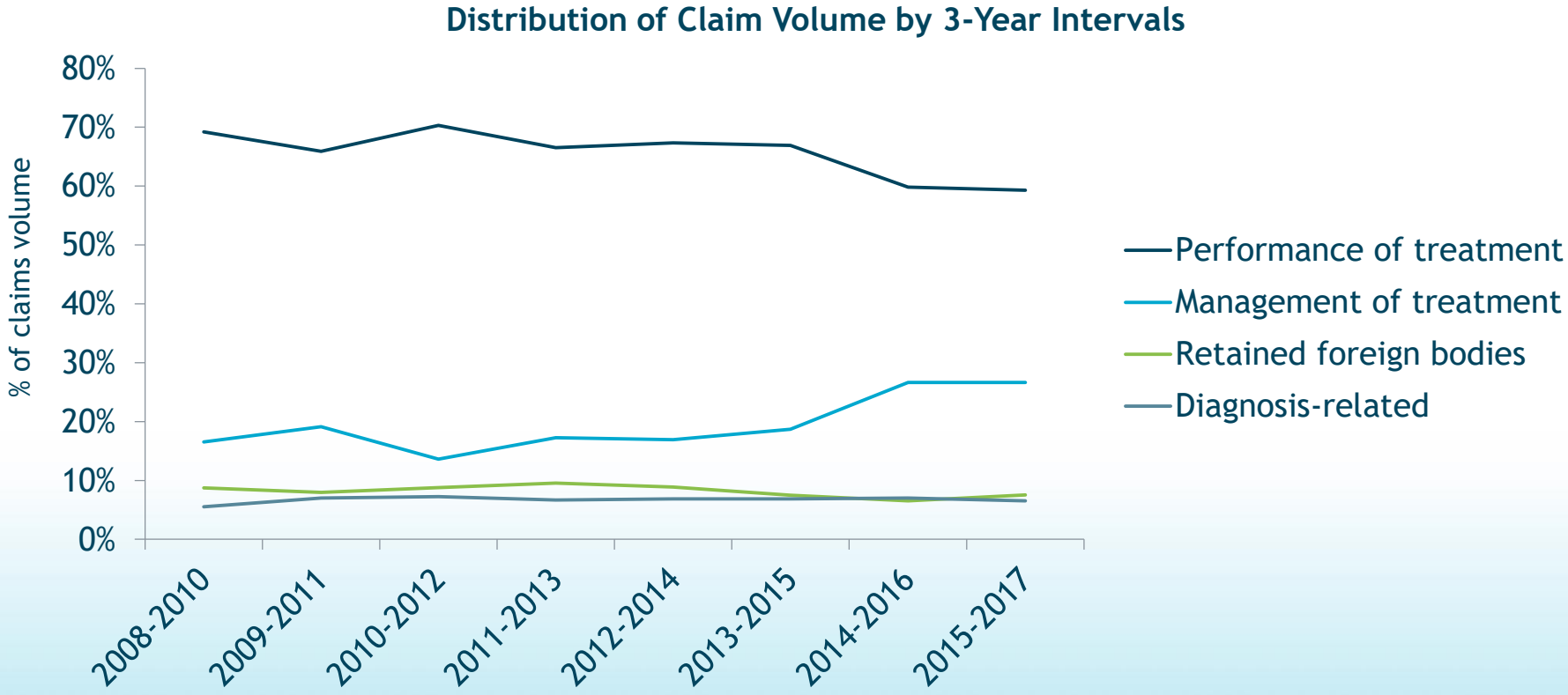
- At the conclusion of this presentation, the participant should be able to:
  - Review dental malpractice claims data to identify the top allegation categories and leading contributing risk factors in these claims
  - Identify the most common reasons dentists call MedPro Group for risk management advice
  - Discuss how the risk factors identified in claims data and telephone consultations can affect evolving claim trends and claims defense
  - Develop strategies to address issues identified in claims data and telephone consultations

Claims by allegation category and financial severity

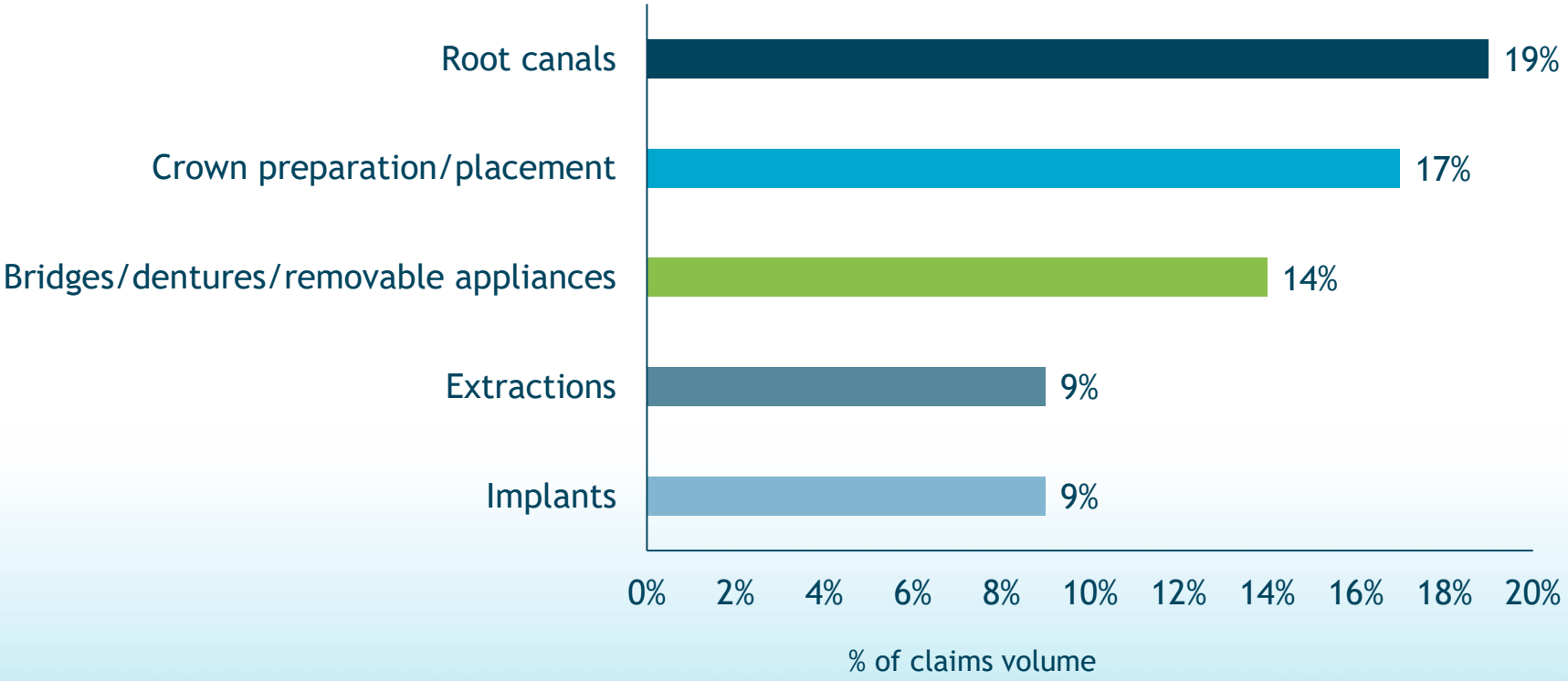


Data source throughout: MedPro Group closed claims, 2008-2017; total paid = indemnity + expense; "Other" includes allegations for which no significant claim volume exists; any totals not equal to 100% are a result of rounding

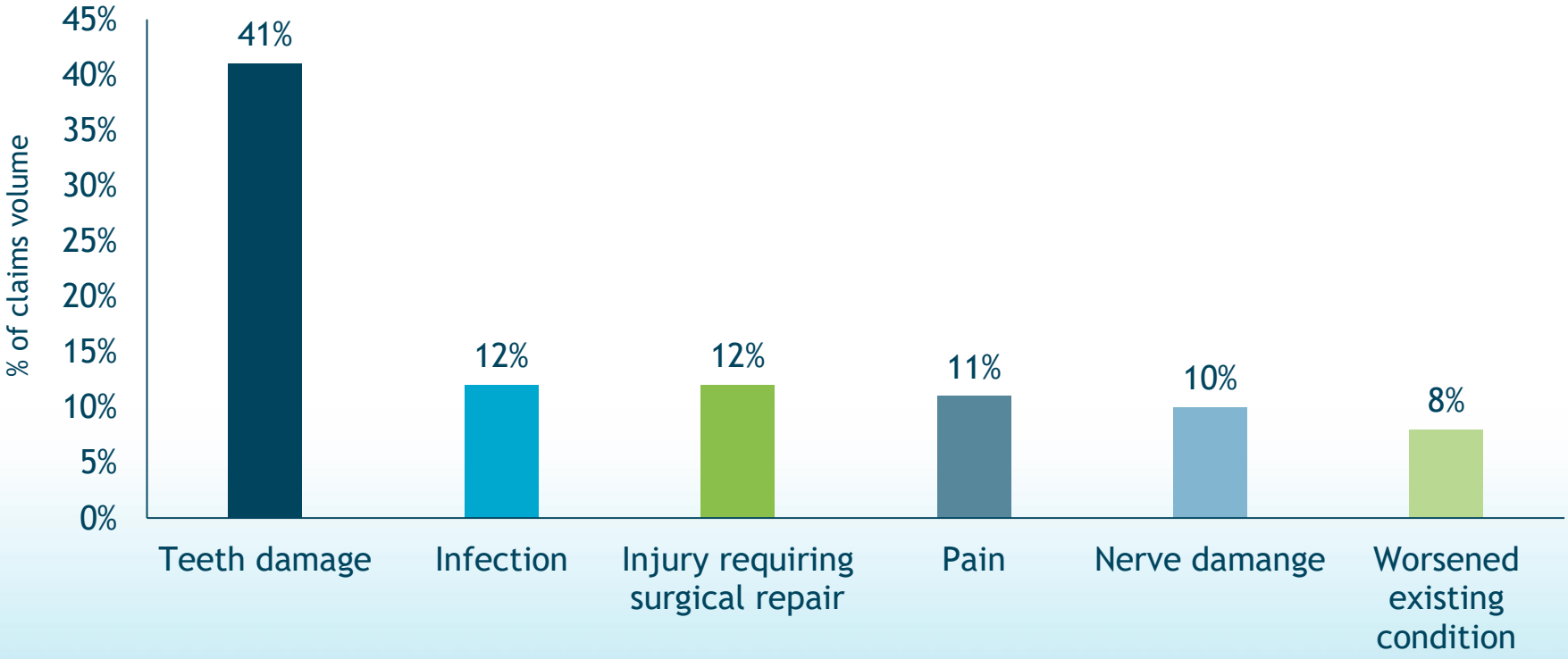
Top allegation trending



Top procedures in treatment-related claims

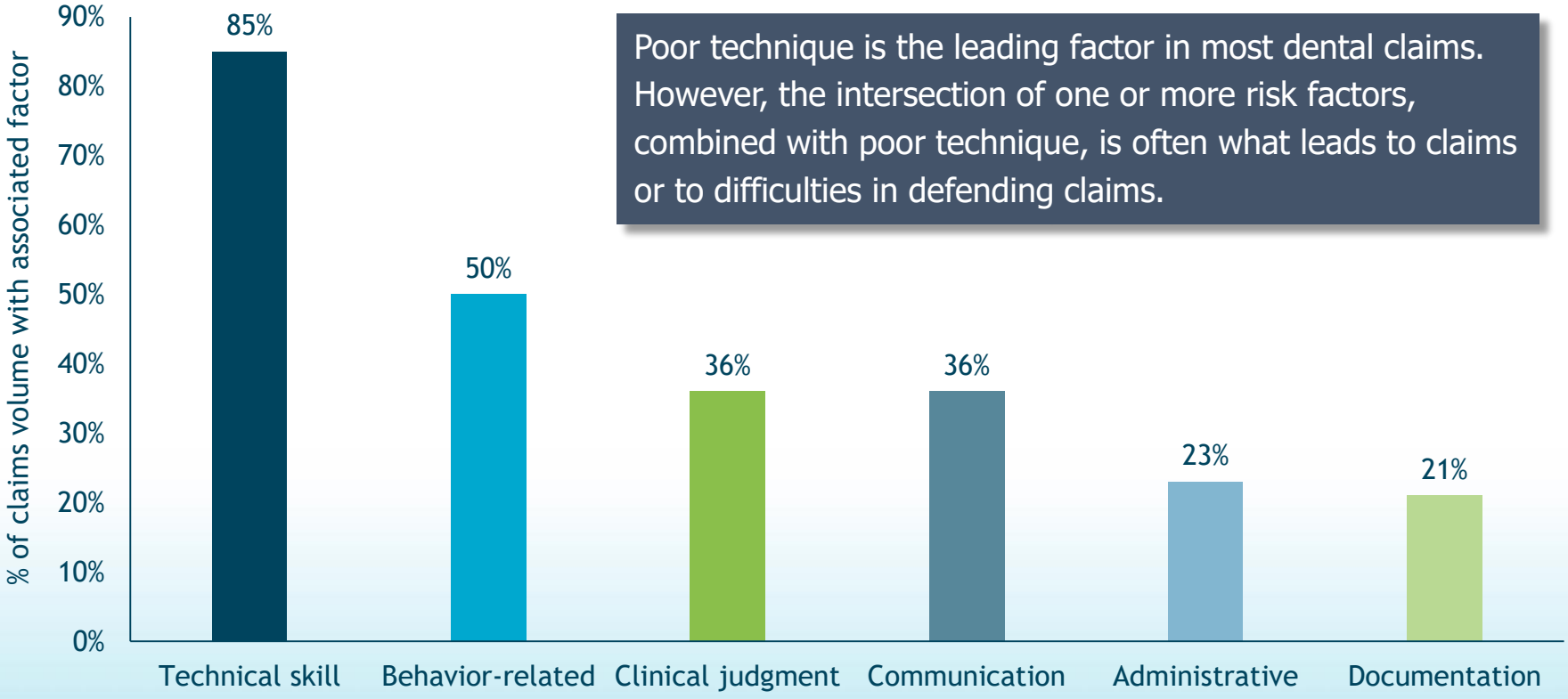


Top patient injuries in treatment-related claims



Note: More than one patient injury type might occur per claim.

Top contributing risk factor categories



Poor technique is the leading factor in most dental claims. However, the intersection of one or more risk factors, combined with poor technique, is often what leads to claims or to difficulties in defending claims.

Note: Totals do not equal 100% because more than one factor often occurs in each case.

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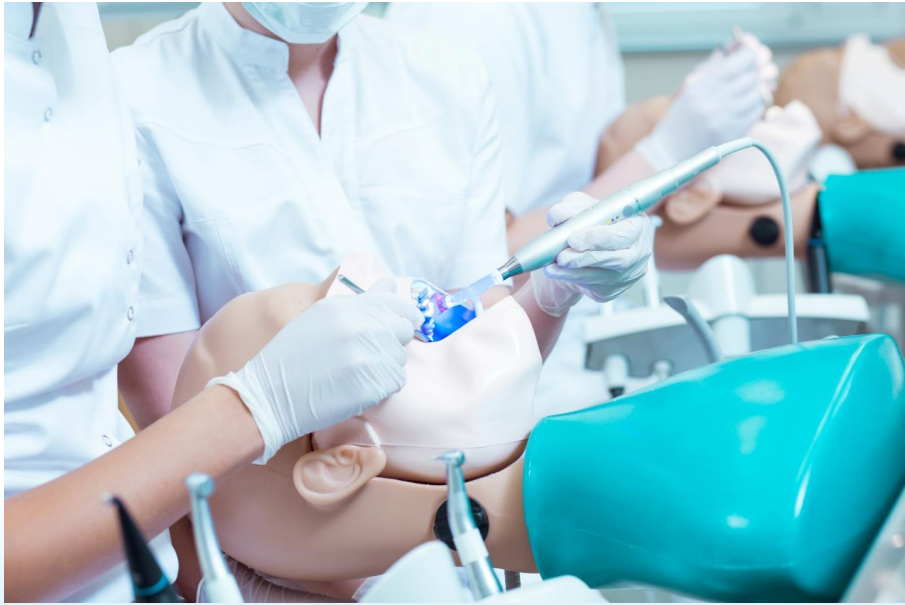
Technical Skill

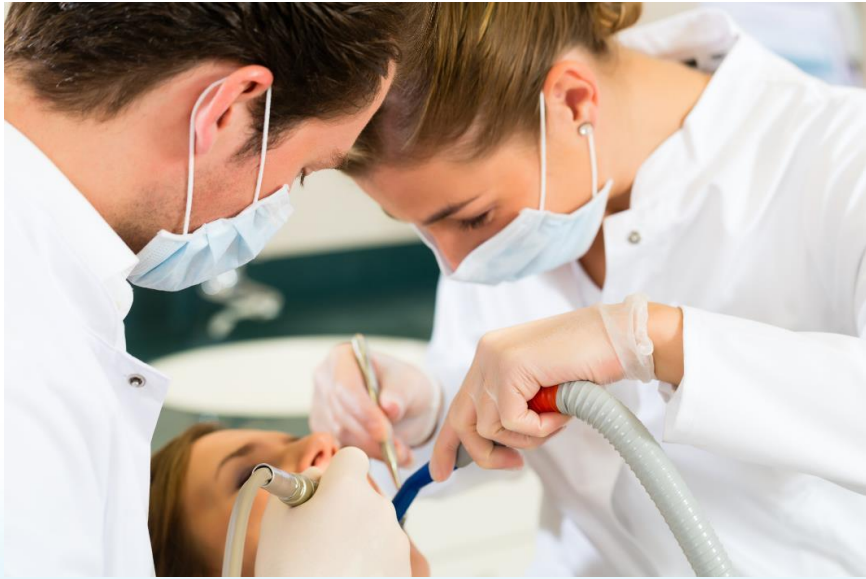
Technical skill: competence of dentists

- Past experience
- Weekend/short courses
- Mentoring/proctoring



Technical skill: competence of staff

- Scope of practice
- Job description
- Supervision
- Ongoing competency review
- Policies and procedures



Risk strategies: technical skill

Provide appropriate supervision and oversight for clinical staff.

Enhance technical skills through continuing education programs. Consider the format of educational programs and whether the content is rigorous.

Ensure that staff and provider training is consistent with roles and responsibilities.

Implement appropriate training for new or upgraded systems and technologies.

Define an organizational process for ongoing assessment of competency and quality review.

- **Behavior-related**

Contributing factors to patient behavioral issues

- Complex medical/dental history
- Psychiatric disorders
- Drug and/or alcohol abuse
- Social/personal issues
- Cultural factors
- Language barriers
- Health literacy

Proactive steps: screening process

Have you carefully reviewed the patient's medical and dental history? (Obtain records in advance, if possible.)

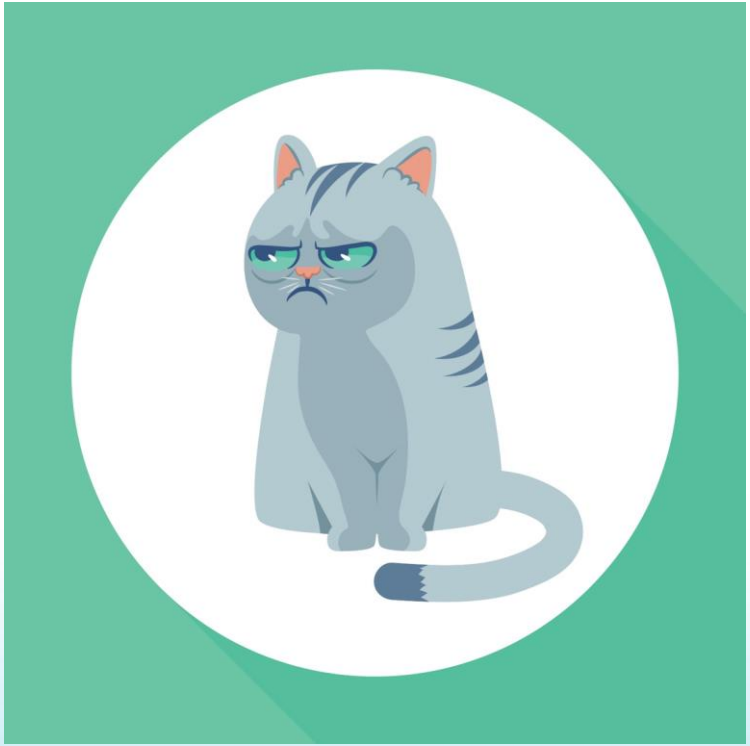
Do gaps exist in the patient's history/information?

Does the patient have realistic expectations?

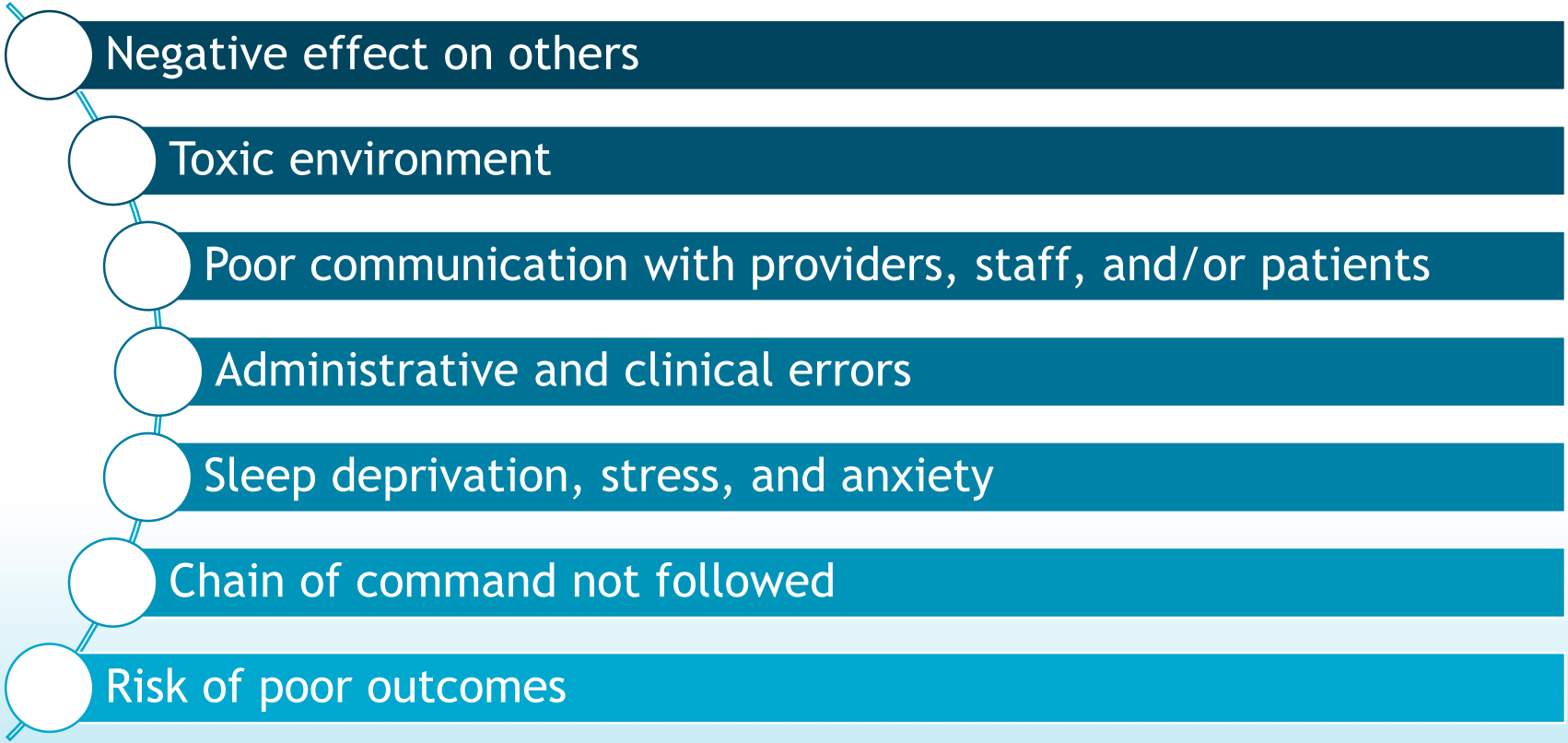
Why did the patient choose your practice?

Factoring in provider/staff behavior

- Fatigued
- Frustrated
- Angry or defensive
- Dogmatic
- Inexperienced
- Distracted
- Condescending
- Unprofessional
- Impatient
- Apathetic



Consequences of provider/staff behaviors



Risk strategies: behavior-related

Patient behavior

- Policies and procedures (e.g., patient responsibilities)
- Written patient agreements/contracts
- Termination from the practice

Dentist/staff behavior

- Policies and procedures (e.g., code of ethics)
- Supervision and evaluation
- Training and education

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Clinical judgment

Clinical judgment: critical thinking and reasoning

Critical thinking and reasoning help facilitate:	
Accurate problem identification	Optimal problem resolution

Clinical reasoning occurs within clinicians' minds . . . and involves judgment under uncertainty, with a consideration of possible diagnoses that might explain symptoms and signs, the harms and benefits of diagnostic testing and treatment for each of those diagnoses, and patient preferences and values."

— *Improving Diagnosis in Healthcare* (2015), National Academies of Sciences, Engineering, and Medicine

Source: Facione, N., & Facione, P. (2008). *Critical thinking and clinical reasoning in the health sciences: A teaching anthology.* Insight Assessment/The California Academic Press.

Diagnostic biases affect decision-making

Anchoring
- Locking onto initial presentation

Availability
- Relying on recent experience

Confirmation bias
- Looking for confirming evidence

Diagnosis momentum
- Accepting a previous diagnosis without question

Gender bias
- Making gender a determining factor when no basis exists

Need for closure
- Feeling pressure due to time or feelings of doubt

Framing effect
- Perceiving the story in the way it is framed or presented

Sunk costs
- Maintaining a diagnosis due to time/ effort invested

Zebra retreat
- Feeling less confident in a remote or unusual diagnosis

Case study: clinical judgment

Patient	56-year-old male
Case overview	The individual was a patient of record at a dental practice for more than 20 years. In February 2009, he presented with pain and a whitish sore at tooth number 14. Penicillin V potassium was ordered, and the patient's teeth were cleaned. Following the February visit, the patient had five more visits and two short courses of penicillin V potassium before he was referred to an oral surgeon in August 2009. A biopsy ordered by the oral surgeon showed squamous cell carcinoma with lymph node metastasis. Radical surgery was required, and the patient ultimately died.
Outcome	The patient's estate sued the dentist. The plaintiff's expert testified that if the patient had been diagnosed in February/March of 2009, his rate of survival/cure would have been 91%. However, because the dentist treated for infection and delayed referral to the oral surgeon, the patient died.

Risk strategies: clinical judgment

- Perform a complete assessment.
- Update and review patient's medical and dental history on a regular basis (6-12 months).
- Review allergies, medications, and new medical issues.
- Carefully consider repeated patient complaints or concerns when making clinical decisions about patient care, additional testing, and referrals.
- Consult with medical providers as often as necessary.

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Communication

Communication methods and pathways

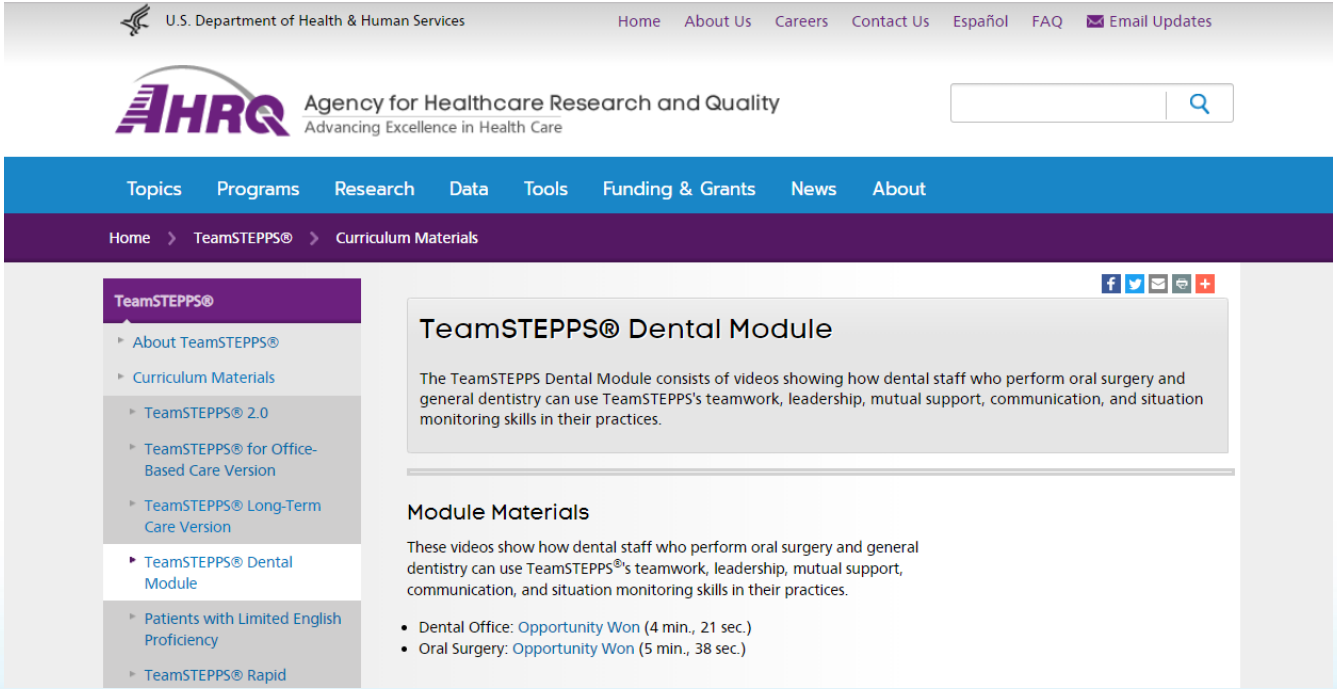
Methods

- Verbal
- Written

Pathways

- Dentist ↔ Patient
- Staff ↔ Patient
- Dentist ↔ Staff
- Dentist ↔ Other providers

Resource: TeamSTEPPS® Dental Module



www.ahrq.gov/teamstepps/dental/index.html

Improving communication: teach-back

The teach-back technique, a research-based health literacy intervention that improves patient/provider communication and patient health outcomes, is a helpful method for gauging patient comprehension.

"I want to be sure that I did a good job explaining your problem. Can you tell me:

- What your condition is?
- What you need to do?
- Why you need to do it?"

Resource

Always Use Teach-Back! Training Toolkit (www.teachbacktraining.org/)

Improving communication: health literacy

Clear communication can improve a patient's comprehension.

- Speak slowly and clearly.
- Focus on and repeat "need to know" concepts and information.
- Avoid clinical jargon.
- Use illustrations to explain important concepts.
- Use plain language educational materials.
- Encourage interactive dialogue.
- Use the "teach-back" technique to gauge comprehension.
- Provide treatment and follow-up care instructions verbally and in writing.

Source: Institute for Healthcare Improvement. (n.d.). Health literacy. Retrieved from www.npsf.org/page/healthliteracy

Improving communication: plain language

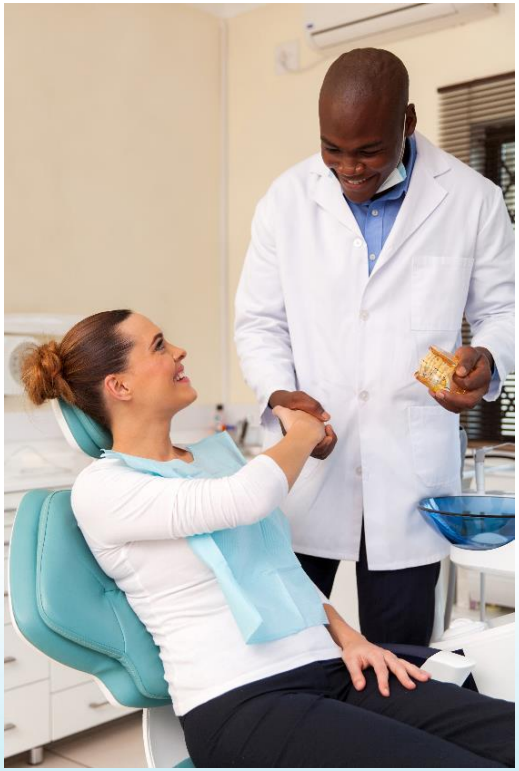
When selecting or developing written educational materials and instructions, remember:

- Use a font size of 12–14 points.
- Use concrete nouns and active voice.
- Avoid excessive use of *italic font*, ALL CAPS, and underlining — all of which are hard to read.
- Limit information to no more than three to four key messages.
- Put the most important information at the beginning and repeat it at the end.
- Avoid lengthy lists.
- Use simple one- or two-syllable words when possible (e.g., “dry mouth” instead of “xerostomia.”)
- Eliminate clinical jargon.
- Use visuals to reinforce concepts and help clarify information.

Source: Centers for Disease Control and Prevention. (2009, April). *Simply put: A guide for creating easy-to-understand materials.* Retrieved from www.cdc.gov/healthliteracy/pdf/Simply_Put.pdf

Risk strategies: communication

- Start with the diagnosis and educate the patient.
- Explain the recommended procedure.
- Offer an explanation and rationale for why this is an appropriate treatment plan.
- Go over the treatment plan step by step.
- Ask the patient to repeat in his/her own words the proposed treatment plan and/or informed consent discussion.
- Provide written documentation for the patient to take home, and document the informed consent discussion and educational efforts in the patient's health record.
- Reinforce patient teaching techniques with staff members.



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Documentation

Documentation issues

Documentation issues in dental malpractice claims often are associated with content, appropriateness, and/or mechanics.

Content
- Complete, timely, factual, consistent

Appropriateness
- Nothing other than what's pertinent to the care of the patient

Mechanics
- Legibility, correct method for making addendums or corrections, alterations

Electronic documentation issues

- Documentation gaps/errors in transition from paper records to electronic records
- New error pathways, particularly when trying to force old habits on a new system
- Inconsistencies in use and following policies
- Flow of information not intuitive
- Copy/paste errors
- Failure to use system capabilities (e.g., alerts and reports)
- Hybrid systems — paper and electronic
- First year of use — experience and training

Risk strategies: documentation

- Develop thorough documentation policies, including requirements related to content, format, use of forms/checklists, and review procedures.
- Document:
  - Each patient encounter, including any changes in medical/dental history, medications, allergies, diagnosis, clinical decision-making and rationale, treatment decisions, etc.
  - Informed consent discussions and patient education efforts.
  - Instances of patient nonadherence, including missed or cancelled appointments, deviations from treatment plans, and failures or delays in following through with referrals.
  - Receipt of tests results and patient follow-up.
  - Unexpected outcomes, including any disclosure discussions.
  - Electronic and verbal communication with patients, including after-hours calls/emails.
  - All consults and receipt of consultative reports.
- Use objective, factual comments rather than subjective statements.
- Train staff on documentation policies and procedures (e.g., how to correctly amend a health record).
- Routinely audit documentation policies and procedures for compliance.

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Risk management dental consultations

Top dental consultations

- Refunds and waivers
- Complaints/ communication
- Record release/retention
- Terminating the provider–patient relationship
- Demands or claims from patients
- Adverse events

Case study: Refunds and waivers

Patient	57-year-old female patient who was quite anxious and called the dental office four times for reassurance prior to her first appointment.
Case overview	The patient accepted the dentist's recommendation for several veneers on her upper front teeth. She selected the color and tried the veneers. With the patient's permission, the dentist seated them. A week later, the patient returned crying and very unhappy. She said the veneer color was wrong and "awful." The dentist replaced the veneers two more times for the same reason. The patient then began calling the office at least twice a day demanding a refund and complaining about the dentist.
Outcome	The dentist spoke with his MedPro Group Senior Patient Safety and Risk Consultant. Together, they discussed the options of giving the patient no refund, giving the patient a partial refund, or giving the patient a total refund. The dentist just wanted to be done with this patient, so he offered her a total refund.

Refunds and waivers

Business decision vs. true liability

Options

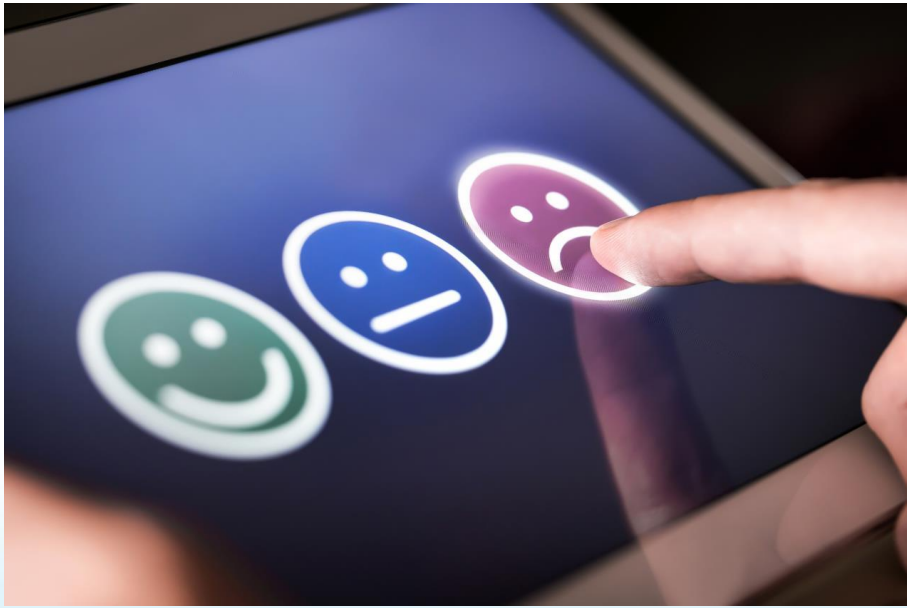
- Deny a request
- Offer a partial refund or waiver
- Offer a full refund or waiver

Release from liability

Complaints/communication

Sources of complaints

- In person
- Phone
- Email or letter
- Social media
- State attorney general's office
- State licensing boards
- Office of Civil Rights
- Federal Trade Commission



Complaints/communication

Complaints are opportunities to evaluate:

- Quality of care
- Policies and procedures
- Communication issues

Complaints/communication

- Develop a plan for managing complaints to proactively address issues that arise.
- Determine who will handle and respond to complaints.
- Seek staff input and agreement on the plan, and educate staff about the specifics of the plan.
- Identify code words to use during an emergency.
- Train staff to execute the plan, including drills, role-playing, etc.
- Identify inappropriate and unacceptable behavior, such as offensive language and threats of any type.
- Trend complaint data for use in quality improvement initiatives.

Record release/retention

Key considerations

- Authorized consent (patients; patient-authorized representatives; legal, judicial, and military entities)
- Record release authorization form
- Release of sensitive information
- Release of minors' dental records
- Charging for dental records
- Denial of records release

Record release/retention: frequently asked questions

Q: Can I provide copies of records to other providers without a patient's authorization?

A: Yes, if the request is for treatment purposes.

Q: If a patient requests records, do I need to provide copies of other providers' records?

A: Yes, any record that a provider uses for treatment decisions, regardless of whether generated by him/her, is part of the designated record set. If a provider references outside notes or labs from another provider, then they become part of the designated record set.

Q: The patient asked for his/her original record. Can I provide the original?

A: You should never release the original record because it's the property of the dental practice. HIPAA stipulates that patients may receive a copy. However, you can offer to allow the patient to inspect the original record onsite with a staff member present.

Q: The patient has requested that we do not provide information to his/her insurance company. Must we honor that request?

A: Yes, you are required to comply with the request as long as the patient pays for the services out of pocket.

Terminating the provider-patient relationship

The process for terminating the provider-patient relationship should comply with practice policies stated in the office brochure.

Termination requires sufficient and objective documentation that supports the decision.

Time termination to avoid allegations of abandonment (e.g., in relation to patients who are in staged phases of treatment).

For nonpayment of bills, be cautious of timing.

Terminating the provider-patient relationship

Notification letter:	Focus on long-term benefits for all, and use a professional tone.
	Providing a reason for discharge is not required.
	Offer emergency care for stated period (e.g., 30 days) specifying when offer expires.
	Offer to send copy of dental record to new dentist; include record release form.
	Indicate need for follow-up and necessary timing; list potential risks if patient does not follow through.

Terminating the provider-patient relationship

- Make sure the process is well thought out and the right choice for each situation.
- Once the decision is made, stick to it.
- Second chances often lead to the patient believing his/her negative behaviors can continue without consequence.

Demands or claims from patients

- Definition of a claim
- Contacting your malpractice carrier
- Release of liability

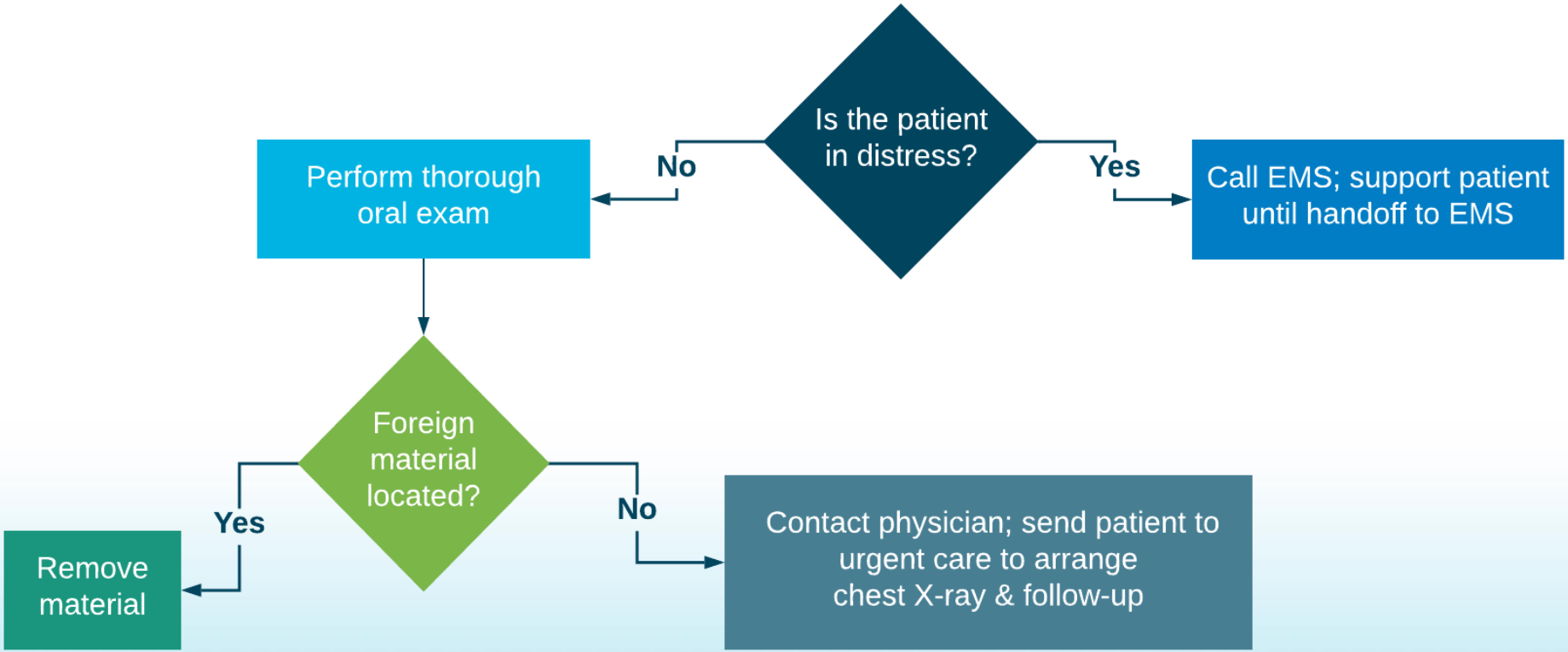
Adverse events

- In emergent situations, patient safety comes first.
- Stabilize the patient and provide assistance as needed.
- Contact malpractice carrier.

Case study: adverse event

Patient	48-year-old female.
Overview	The patient was in the dental office to have a crown seated. After dry-fitting, the crown was being removed. It hit the patient's tongue and went into her throat. The patient coughed once or twice and sat up, but the crown was clearly gone. The patient stated she was fine and was more concerned with the "loss" of the crown and having to pay for the crown again. She did not want follow-up care.
Outcome	The dentist insisted on follow-up care. He called the patient's husband, who came to the office and took the patient to the hospital. A chest X-ray revealed that the crown was in the bronchus. The patient had bronchoscopy with removal of the crown. She was discharged to home that evening.

Assessment matrix for swallowed/aspirated foreign object



Summary

Treatment-related allegations (performance and management) account for the majority of dental malpractice allegations and total dollars paid to defend the cases.

The top procedures in treatment-related allegations are root canals, crown preparation/placement, and bridges/dentures/removable appliances.

Technical skill, which includes poor technique, is the leading risk factor in dental claims.

Other key risk issues identified in claims include behavioral issues, clinical judgment, communication, administrative issues, and documentation.

MedPro's top risk management consultations for dentists involve refunds/waivers, complaints/communication, record release/retention, terminating the provider-patient relationship, demands or claims from patients, and adverse events.

Implementing risk-reduction strategies can help you decrease the potential for claims and complaints as well as save you time and frustration.

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