Clinical Issues and Lessons Learned in Implants, Extractions and Failure to Diagnose Cases

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Fortress Insurance Company

- A nationwide malpractice insurance company
  - Owned and operated by dentists
  - EXCLUSIVELY for dentists
  - Offers complementary Risk Management resources
    - Phone consultation with Risk Managers (800-522-6675)
    - Courses: Live and Web-based

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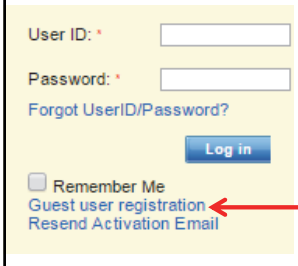
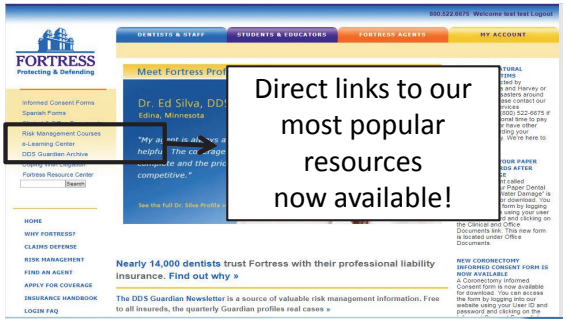


Policyholders
User ID: Policy number (begins with 3)

Staff & Others
Register with "Guest User Registration"

Improved Website Navigation



New Informed Consent Forms

- Standard template
- The forms are…
  - Procedure specific
  - Consolidated for ease
  - Efficient and patient – friendly
    - Initial line at the bottom of each page
  - Ideal for the transition from paper to electronic

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e-Learning Center

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- Online Risk Management
  - 2 Part HIPAA Series
  - Electronic Medical Records
  - Managing Social Media Risks
  - Anatomy of a Malpractice Suit

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The Course Objectives

- Identify common risk factors in implant, extraction, and failure to diagnose cases.
- Understand how to implement key clinical risk management strategies to help mitigate associated risk factors, improve patient safety, and reduce untoward outcomes and malpractice claims.
- Gain knowledge about opioid management, including considerations for prescribing and securing opioids in the dental practice.
- Learn effective policies and procedures to help improve HIPAA/HITECH compliance in the dental practice.

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Common Reasons Patients Sue ***Other*** Than Malpractice

- Not happy with results
- Financial incentive
- Criticism from a professional colleague
- Unreasonable expectations
- Communication issues
- Personality conflicts

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The "Unhappy" Patient

- 78 year old male
- Presented for denture consultation
  - Promised "top of the line" dentures
- A temporary denture was seated
- Small claim and board complaint were filed
  - Allegations: "top of the line" dentures were promised, but temporary ("flimsy") dentures remained in place for "too long"
  - DDS provided a refund and claim was dismissed

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The "Financial Opportunist"

- 60 year old male
- Crown work was performed: 16 teeth
- Patient was not pleased with the "time it took to complete" the crown work
  - Was told 4-6 visits but it took 9 visits
  - No complaints regarding the care and treatment rendered
- Patient requested a refund of $2,500
  - DDS provided a refund; no claim was filed

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The "Bad Mouthing" Colleague

- 29 year old female
- Needs orthodontics, but wants restorations only
- Veneers and crowns placed at #4-13
  - Patient rejected ideal plan, and was unhappy with the limitations of the alternate plan using restorations
- Patient sees another dentist
  - Very critical of the 1st dentist based on patient's story
- Suit filed against the 1st dentist
  - Settled at mediation

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The "Great Expectations" Patient

- 63 year old female
- Seen by a number of different dentists 
  - Recommended root canals and implants to restore poor dentition
  - She would only consent to bridges that came with some limitations
- Her DDS agreed to fabricate bridges
- She didn't like the wax-up
- Suit filed: Defense verdict

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The "You Never Told Me" Patient

- 35 year old male
- Presents with pain and decay of tooth #4
  - Root canal therapy performed
- The RCT failed one month later
- Her DDS referred her to an OMS for extraction
- Patient demands the dentist pay for the extraction, refund the root canal fee and threatens litigation
  - **Complaint**: "I was never told the RCT could fail"

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The "Bad" Attitude

- 15 year old female
- Presented with superficial caries of #30
  - Apprehensive about dental treatment and local anesthesia
  - Treatment attempted without local
  - Patient began crying
  - "Stop acting like a child"
  - Eventually agreed to a Local anesthetic: filling completed
- A board complaint was filed
  - **Allegations**: The dentist became impatient and rude
  - The Board dismissed the claim: PT seemed unreasonable

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"Do you swear to spin the truth,
the whole truth, and nothing but the truth?"

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Risk Management Goals

- Increase patient safety
  - Improve the quality of care; Avoid patient injury
- Reduce claims exposure
  - Mitigate damages
- Create valuable defense tools
  - Make a claim more defensible; Buffer your defense
- Minimize financial loss
  - Reduce the monetary impact; Time out of office

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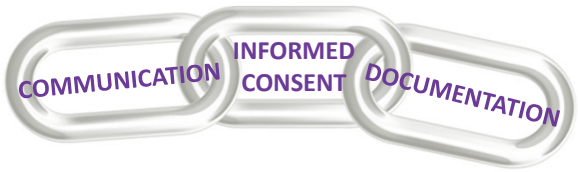
Core Risk Management Principles



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Communication

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Communication: Setting the Stage

- In-office
- Phone
- Website
- Word of Mouth
- Online Reviews
  - Yelp, Facebook, Angie's List, etc.

Staff Training & Staff Monitoring

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Communication Challenges

80% of malpractice claims are attributed to communication issues[1]

- Literacy gap
- Social media
- Online reviews
- Seniors & Minors
- Limited English Proficiency (LEP) & American with Disabilities Act (ADA)
- Miscommunication

1. "Sorry Works"

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The Literacy Gap

- National Assessment of Adult Literacy:
  - 32 million adults in the US cannot read
  - 21% of adults in the US read below a 5th grade level
  - 19% of high school graduates can't read
- Leave out the dental jargon
  - "cavities" versus "caries"

http://www.statisticbrain.com/number-of-american-adults-who-cant-read/

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Social Media

- Marketing & communication tool considerations:
  - HIPAA
    - Patient permission (redacted images)
  - Separate profiles
    - Personal vs. Professional
  - Promises
    - "Teeth in a day" (disclaimer)
  - Patient communication
    - Caution patients from reporting health issues

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Online Reviews

- Did you get a negative review?
  - Evaluate the options (respond, delete, ignore, hide)
- Things to consider before responding:
  - HIPAA violation
  - Reach out to the patient (not while your upset)
    - Phone or direct messaging
  - Post ONE generic response (no back and forth)
- Encourage positive reviews from other patients
- Monitor your online reputation

Contact Fortress Risk Management for guidance

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Case Analysis: Online Review

- 21 year old male
- Presented for extraction of #1
- Tooth extracted without incident
- Patient is upset with the bill he received in the mail 2 weeks later.
- Creates Facebook page: "Dr _ is a Con"

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Case Analysis: Online Review

- Facebook page attracts other patients who experienced similar issues
- Patients begin placing comments on wall

Dr. responds to patient's allegations stating:

"I discussed with you before the appointment what it was going to cost to extract your wisdom tooth. I gave you a discount because you said you couldn't afford it."

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What Can We Learn From This?

- Consider alternatives to responding
  - Delete, Ignore, "Hide"
- Utilize a generic response
  - Avoid posting identifiable patient information online
  - Request the patient contact your office to resolve the matter
- Contact Fortress Risk Management for guidance

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Seniors & Minors

- Seniors
  - Medically compromised/Comorbidities
  - Polypharmacy
  - Consent
    - Power of Attorney
    - Auditory or visual issues
- Minors
  - Compliance
  - Consent
    - Power of Attorney for Minors
    - Divorce/Guardianship Challenges

Check your state dental board for specific regulations

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Case Analysis: Minor of Divorce

- 10 year old male
- Presents with rampant decay
- Treatment plan:
  - Extractions, Endodontics, Restorations and Ortho treatment
- Mother requested and consented to hospital treatment under anesthesia
- The dentist agreed to the mother's request

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Case Analysis : Minor of Divorce

- Dentist was unaware the minor's parents were divorced
  - Per custody agreement: Father was required to pay and consent to treatment
- Father refused to pay
- The case went to court and for several years there was no amicable solution

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What Can We Learn From This?

- Identify the patient's legal guardian before you obtain informed consent
- Determine who is financially responsible
- If necessary, require all parties to agree to consent and financial agreements
- Use forms to document this agreement

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American with Disabilities Act (ADA)

- Most prevalent accessibility issues:
  - Lack of effective communication
    - Complicated and interactive communications require a Sign Language Interpreter or translator
    - Family or friends cannot be forced to interpret
  - Lack of accessible equipment & services
    - Health care service, medical equipment and diagnostic tests are accessible to individuals with disabilities
  - Refusal of care
    - Refusal to treat HIV patients (Bragdon v. Abbott)
-

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Limited English Proficiency (LEP)

- Must ensure effective communication at ***NO*** cost to the patient
- The patient determines if he or she has limited English proficiency
  - Read
  - Write
  - Speak

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LEP Frequently Asked Questions

1. Who decides interpretation is needed?
2. Can an appointment be rescheduled if interpreter is not available?
3. Can the patient be asked to bring in a family member?
4. Do you have to use an interpreter selected by the patient?
5. Who pays for the interpreter?

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Miscommunication

- The failure to convey relevant dental information to key players in the team
  - Dentist to staff/Staff to dentist
    - Chain of command, Dental emergencies
  - Dentist to referral/Referral to dentist
    - No referral document
  - Patient to dentist/Dentist to patient
    - "The dental shopper(s)", Medical history omission

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Extractions & Implants

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Imaging Considerations

- Imaging should add useful information and aid in assessing **treatment options, risks & referrals**
- Is a traditional radiograph (panorex/periapical) and clinical exam sufficient?
- Cone Beam CT Scans (CBCT) might be indicated and useful in some cases
- Beware of overuse, overcharge, over-radiation
  - William Scarfe "All that Glitters is not Gold"

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Dental Extractions: Steps to Success

- **Examine & Develop** a diagnosis and treatment plan
  - Exercise professional judgment re: extract or refer
- **Manage** patient expectations early
  - Communicate the plan and obtain consent
  - Present options, explain common risks
  - Discussed and documented failure to follow up complications until treatment is completed
- **Use written referrals**
  - Refrain from relying on a layperson's claim of tooth # or verbal instructions from referrals

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Causes of Wrong Tooth Extractions

- Miscommunication among providers
- Counting errors
- Relying on patient to identify tooth
- Rushing
- Failing to take and/or review x-rays
- Failing to review referral form

Slow down Count accurately Review x-ray

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Extraction Documentation: What is commonly left out

- Radiograph(s)
  - Missing, old or only partial tooth structure
- Documenting Which tooth/teeth?
  - Identify the tooth number & tooth
- Discuss concerns of the DDS and patient
  - Options, evidence of higher risks/complications (i.e. impacted tooth), address patient concerns
  - Referral if complex or complications likely
    - Patient's decision, but treat within your comfort zone

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Case Analysis: The Extraction

- 40 year old male
- History of pericoronitis surrounding tooth #32
- Presented to the dental office requesting extraction
  - Deep vertical impaction with part of the crown exposed
  - X-ray did not show the apex of the root

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The Procedure

- Extraction of #32 started
  - Only able to remove crown after half-hour
- Patient referred to an OMS and seen immediately
  - Panorex: Apex of the root **millimeters from the inferior border**, involving the **inferior alveolar canal**, possible **fracture**
  - Pain medication and antibiotics given
  - Further treatment delayed to assess potential nerve damage

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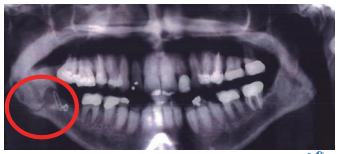
Post Procedure

- The next day, the patient returned to the OMS complaining of numbness
  - The remaining root was removed
  - A severed nerve was repaired
  - A fracture was reduced



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Litigation

- Patient sued
  - He never regained full sensation
- The dentist conceded a referral may have been a better option during deposition
- Settled before trial

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What Can We Learn From This?

- Consider your comfort level and experience
  - Good image helps assess and make decisions
  - Procedures can become more difficult than expected
- Refer to specialist:
  - If too complex, risky after exam and consult
  - When complications develop
- Obtain adequate radiographs before treatment
  - See entire tooth before you begin treatment

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Implants: Steps to Success

- **Assess** difficulty of the ENTIRE procedure
  - Bone graft? Implant position? Restorable? High risk patient?
- **Develop** an appropriate treatment plan
- **Communicate** the treatment plan: PT & team
  - Who will be involved in the process from start to end
  - Ensure the patient accepts his/her role and responsibilities; manage expectations
- **Execute** "the plan" → **Discuss** a "change in plan"
- **Document** the treatment plan, consent, complications, compliance, patient satisfaction

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Common Omissions in Implant Documentation

- Communication with other team members
  - Implant make, type, abutment
  - Respective responsibilities
  - Surgical guide
- Implant size
  - Describe in progress notes
  - Imaging should support the plan
    - Traditional imaging (Pano, PA)
    - Is advanced imaging beneficial? (CBCT)

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Case Analysis: Extraction & Implant

- 45 year old female
- Extensive medical & surgical history
- Presented for extraction of "broken" tooth #31
- Treatment plan:
  - Extract #31, place implant after healing
- Tooth #31 removed without issues
- 18 months later implants placed at #30 and 31
  - Antibiotics were prescribed prophylactically

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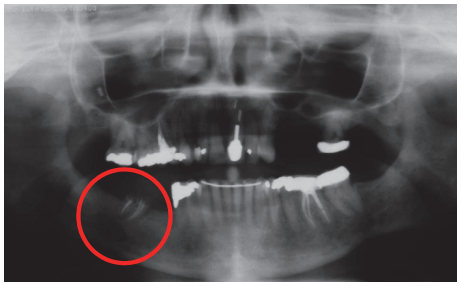
Pre – Procedural Panorex



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1 Week Post – Procedure

- Patient disputed consent for implant at #30
  - "This was never discussed with me"
- Post-op pain and swelling continued
  - Antibiotics are changed
- Referred to an OMS
  - Patient has submandibular swelling
- Admitted to the hospital for IV antibiotics

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2 Weeks Post - Procedure

- **Readmitted** to the hospital for submandibular swelling
  - I&D performed
  - IV antibiotics administered
  - Implants were removed

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2 Months Post - Procedure

- **Third hospital admission** for non-healing implant site
  - I&D performed (again)
  - IV antibiotics administered (again)
- Patient now has a perforation of the lingual plate near the implant site
  - Teeth #28 and 29 were extracted

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Subsequent Treatment

- Mandible resection performed: 5 cm bone removed
  - After 4 unsuccessful I&Ds
  - IV antibiotic treatment continued
- Bone graft from tibia used for mandibular reconstruction
  - Now there are 2 surgical sites

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Litigation

- Suit was filed against the dentist
- Allegations:
  - No Informed consent for #30 implant
    - alleged battery
  - Perforation of the lingual plate led to the prolonged infection and the need for subsequent surgeries

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Expert Review & Resolution

- Defense expert review:
  - Liability problem re: informed consent
  - Causation regarding the infection was questionable
  - Were prior medical complications relevant?
  - Was clearance or a consult needed?
- Case settled before trial

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What Can We Learn From This?

- Document
  - Why implant was needed at #30
  - Patient's consent to add #30 implant
  - Possible increased risks
- Prior medical conditions may raise issues:
  - Establish DDS was aware and considered medical issues
  - Was a medical consult or more information needed?
- A patient should be informed of risks before consenting to treatment
- Consider an OMS referral in complex or difficult cases

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The Informed Consent Process

- How judges define it to jurors
- Elements
- Benefits and minor limitations

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Example of Jury Instruction

"Negligence may consist of… **failure on the part of the dentist to reasonably inform Plaintiff of risks or hazards** which may follow treatment contemplated by the dentist. "Reasonably inform"… means information must have been **given timely** and in compliance with **accepted standards of practice** among members of the profession with similar training and experience…."

"There are **risks inherent in medical treatment** that are **not within a doctor's control**. A doctor is **not liable** merely because of an **adverse result**. **However**, a doctor is **liable if the doctor is negligent** and that negligence is a proximate cause of an adverse result."

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Informed Consent: The *COMPLETE* Process

-Discuss, use a good form, chart discussions & consent

-Use layman's term, simple wording based on patient's education level

- Include:
  - Diagnosis/Prognosis
  - Proposed treatment, reasonable options
  - Benefits and risk of each(incl. no treatment)
  - Signatures: patient, witness (if applicable) and doctor
- Give the patient time to review the form
- The DDS should ensure all questions are answered
- Avoid negating by saying "one in a million" or it has never happened to my patients: use stats accurately

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Informed Consent Goals

- Enhance rapport, trust & reasonable expectations
- Document patient's acceptance of reasonable risks
- I.D. Limitations: When your PT only wants TX likely to cause unacceptable results/risks
  - Risks of letting PT "accept" substandard care?
- A valuable defense tool
  - In lawsuits, peer review, board of dentistry complaints
  - Negates false claims by patients

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Case Analysis: Implant Placement

- 72 year old female
- History of thyroid problems
- Presented for implant consultation
- Treatment plan:
  - CT scan
  - Implant placement at site #13, 14 and 20

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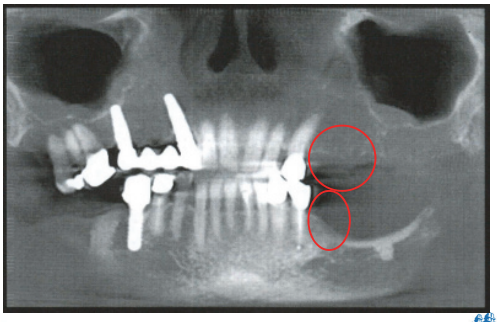
Pre – Procedure CT Scan

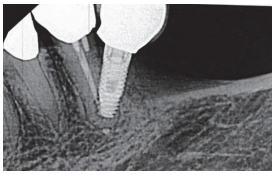


The Procedure

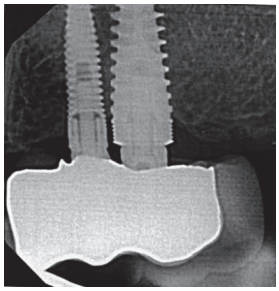
- Implants were placed
- Vicodin was prescribed
- Four months later restorative work was done
  - 3 unit bridge (12-14) was seated, adjusted and cemented
  - A crown was placed on #20

Post – Procedure

- Complaints of food getting stuck under 12-14 and difficulty flossing around 20
  - Bite Wings: Implant #20 intersected the root tip of #21



Post - Procedure



- 1½ months later bridge was redone
  - Patient did not like the way it looked
  - Looked "fake"

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Post – Procedure

- 4 months later, the patient still had complaints:
  - Can't clean the bridge
  - Food gets stuck
  - It's bloody and smelly

1st missed opportunity

- Request for a FULL refund
  - A partial refund was offered
  - The patient left to seek a second opinion

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The Second Opinion

- **Second DDS opinions**:
  - The bridge was fabricated incorrectly
  - #20 implant is in the root of #21
- New treatment plan:
  - Extract tooth #21
  - Remove implant at #20
  - Place new implants in the areas of #20 and #21

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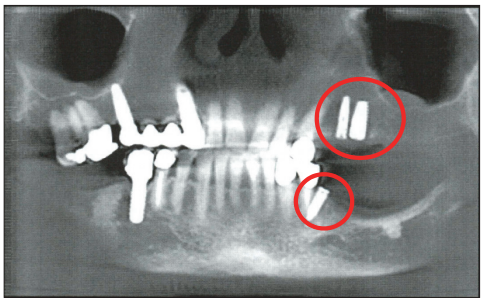
Post – Procedure CT Scan



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The Third Opinion

- **The patient saw a periodontist** **2nd missed opportunity**
  - Agreed with the second opinion
  - DDS denied second request for compensation
- The subsequent treaters wrote reports critical of the original DDS, supporting of the patient
  - Given to the original dentist
  - The dentist followed up with 2 letter to the patient

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The Dentist's Response to the Patient

[redacted]

"I am sorry you feel my bridge is inferior. I feel it is just fine…"

"I want another Dentist – any Dentist you chose to tell me my Bridge is not right and that he can do better. I want a 2nd opinion if indeed my bridge is inferior – have him call me and I will pay for it."

[redacted]

The Second Letter

[redacted]

"Your lawyer broke protocol by calling my office – twice. Therefore I don't feel bad about writing you this letter…"

"…I want you to go to another implant Dentist. If you choose not to – then it's courts, lawyers, motions being filed… I have malpractice. My lawyer is paid for. Please consider going to a Dentist I met a week ago [I already shared your treatment plan with him]."

The Outcome

- The patient's attorney wrote the dentist
  - The DDS provided **substandard care** with upper bridge and lower implant
  - The DDS **violated HIPAA** by discussing private information with a stranger, without permission
  - **Damages** will include: Re-doing dental work, pain and suffering, punitive damages, legal fees, and will pursue HIPAA violation
- The case was settled before litigation

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What Can We Learn From This?

- Listen to patient complaints, review the entire case and try to resolve problems ***before*** your patient seeks other treaters or lawyers
- Patients should not feel their complaints are ignored
- Consider how this case will look to peer review, a dental board or jury
- Avoid continued, escalating arguments with your patient, especially in writing
- Don't have other DDSs review your patient's case without your patient's permission

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HIPAA & HITECH

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In the News

Dental patients' info dumped outside building on Detroit's east side

Eviction notice posted on Dental Clinic

Indiana Dentist Fined by State for HIPAA Violations

Three top-3 lists for using HIPAA compliant email in your dental practice

DrBicuspid.com

Angry Facebook dad says dentist violated HIPAA laws

ADANews

HIPAA security is not a game

Thursday Troubleshooter: Is it a HIPAA violation to email radiographs to other dentists?

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What is HIPAA & HITECH?

- Health Insurance Portability and Accountability Act (HIPAA)
  - Standardizes confidentiality requirements for health care information, reduce fraud and abuse
- Health Information Technology for Economic and Clinical Health Act (HITECH)
  - Advances safe and secure use of electronic medical records (encryption, security measures)

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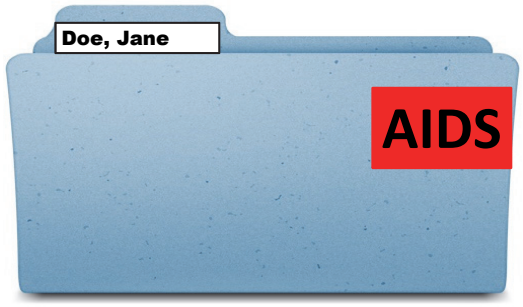
What's a violation?



The Health Record Should…

- Be secured
  - Take reasonable steps and precautions

Indiana Dentist Fined by State for HIPAA Violations

- Failed to protect personal information and properly dispose of records containing personal information
- Violated Indiana Privacy Laws and HIPAA

Examples of Fines (HHS site)

- $1.5 million for **stolen unencrypted laptop**
- $150,000 **stolen unencrypted thumb drive**
- $1.2 million for **returning copiers without wiping clean**
- $1.7 million for allowing **unauthorized access to network** during software upgrades
- $800,000: Hospital employee **left 71 boxes of records on driveway of retired MD** to "assist him"

HIPAA/HITECH "Compliance"

- MANDATORY Security Risk Assessment
  - www.healthIT.gov
- Designate a HIPAA Officer
- Train Staff
- Create office and sanction policies
- Establish: BA Agreements, Encryption, Usernames, Passwords, Screensavers

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HIPAA/HITECH "Compliance"

- Credible document destruction process
- Secure the server
- Secure the wireless network
- Data "backup" restoration
- Have a plan

HIPAA/HITECH series in the e-Learning Center

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Documentation

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Health Record: The Story

- History
- Exam
- Diagnosis
- Treatment
- Consent
- Follow Up & Progress (including the result)

Good records tell a story of the care provided

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Charting Basics: History

- Health history form
  - All pertinent medical/dental conditions (TMJ symptoms)
  - Medications (i.e. Aspirin, Plavix, Bisphosphonate)
  - Dietary Supplements, Herbals, Vitamins, etc.
  - Allergies
  - A comment section
  - Signatures (including doctor)
- Ensure all questions are answered
- Audit for relevancy routinely

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Sample Health History

PATIENT MEDICAL HISTORY

Do you have or have you ever had:

Congenital heart disease, cardiovascular disease (heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker)?	Yes	No	Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing)?	Yes	No
			Glaucoma?	Yes	No
Implants placed anywhere in the body (heart valve, pacemaker, hip, knee)?	Yes	No	Bleeding disorder, anemia, bleeding tendency, blood transfusion? Do you bruise easily?	Yes	No
Kidney disease or kidney failure, requiring dialysis?	Yes	No	Liver disease (jaundice, hepatitis A, B, or C)?	Yes	No
Thyroid disease?	Yes	No	Diabetes?	Yes	No
Stomach ulcers or colitis?	Yes	No	Arthritis?	Yes	No
Clicking, popping, or pain within the jaw joint and/or difficulty opening mouth?	Yes	No	Significant weight loss or gain?	Yes	No
			Seizures, convulsions, epilepsy, fainting or dizziness?	Yes	No
Frequent or recurring mouth sores?	Yes	No	Sinus or nasal problems?	Yes	No
Radiation to the head or neck for cancer treatment?	Yes	No	Osteoporosis or osteopenia?	Yes	No
Any disease, chemotherapy or transplant operation? Cancer?				Yes	No

If so, where? _____, and when was the date of your last treatment? _____

Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Yes No

If yes, please explain: _____

Sample Health History

MEDICATIONS

Are you using any of the following:

Antibiotics?	Yes	No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes	No
Anticoagulants (blood thinners)?	Yes	No	Insulin or oral anti-diabetic drugs?	Yes	No
Heart drugs?	Yes	No	High blood pressure medications?	Yes	No
Steroids (cortisone, prednisone, etc.)? antianxiety agents, sedative-hypnotics and antidepressants	Yes	No	Bisphosphonates, antiangeogenic and/or antiresorptive medications for osteoporosis, multiple myeloma or other cancers? If yes, list drugs used and time of use.	Yes	No
Prescription pain medication?	Yes	No			

Please list any other medications you have taken or are currently taking not listed above including prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins or minerals: _____

ALLERGIES

Are you allergic to or have you had an adverse reaction to:

Latex?	Yes	No	Codeine or other pain killers?	Yes	No
Food products?	Yes	No	Aspirin, Motrin, Aleve, or ibuprofen?	Yes	No
Sedatives, barbiturates?	Yes	No	Penicillin or other antibiotics?	Yes	No

Have you or an immediate family member had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes No If yes, which anesthetic? _____ Relationship? _____

Other drug allergies not listed above: _____

Sample Health History

I understand the importance of a truthful and complete health history to assist my doctor in providing the best care possible. To the best of my knowledge, the above information is complete and correct.

Signature of patient, parent, guardian _____ Date _____

Printed name of patient, parent, guardian _____ Relationship _____

HEALTH HISTORY UPDATE

Date	Comments	Signature
_____	_____	_____
_____	_____	_____

Charting Basics: Exam & Diagnosis

- Exam
  - **S**ubjective: Patient's chief complaint, etc.
  - **O**bjective:
    - Oral exam findings
    - Lab results (if applicable)
    - Imaging (films, scans)
- Diagnosis (**A**ssessment, **P**lan)
  - The differential diagnosis
  - Prognosis considerations & Plan

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Charting Basics: Treatment

- Treatment Note:
  - Informed Consent discussion
    - Include recommended intervention(s), advice & patient response
  - Any changes to treatment plan based on exam
  - NPO status (if applicable)
  - Use of surgical guide, pre-medication, etc.
  - Medication(s) provided during the treatment
  - Complications

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Charting Basics: Follow Up & Progress

- Follow Up & Progress Notes:
  - The suggested return date
  - Referral to specialist(s)
    - Be specific and clear (include "who" and "why")
  - Clinical correspondence
  - Test results & patient notification
  - The patient's progress & status
    - Include the good news ("healing well", "lesion gone")
  - Patient compliance
    - Cancellations, No-shows, etc.

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Electronic Health Records

- Beneficial
- Risks
  - Templates
  - Copy & Paste
  - Cyber Issues
- Considerations
  - "Lock" system
  - Backup system daily
  - Conduct audits of the system
- There are a number of different EHR Systems
- General Principles:
  - All staff documenting should have a log-in and "signature"
  - "Time Stamp"
    - Meta-Data
  - Do NOT delete/alter notes
    - Amendments/Addendums should maintain the original note

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REMEMBER:
Your best defense in a claim is your chart notes

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Failure To Diagnose

FORTRESS

Oral Cancer: Incidence & Survival

- In 2014: over 43,000 Americans diagnosed with oral cancer
- Rates increased for 8 consecutive years
- Every year:
  - 30,000 new cases diagnosed
  - 8,000 deaths
  - 5 year survival rate= 76% if local CA, but only 19% if metastasized

Early detection saves lives

National Oral Cancer Foundation

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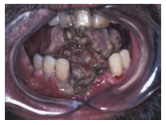
Oral Cancer: Contributing Factors

Traditional risks: smokers, alcohol, age, compromised immune systems

- Significant rise in SCC of the tongue, base of tongue, and tonsils in white patients between 20-44 years of age



"New" Carcinogens:

- Marijuana (debatable)
- **Human Papillomavirus (HPV)**

Shiboski CH, Schmidt BL, Jordan RCK: Tongue and tonsil carcinoma. Increasing trends in the US population ages 20-44 years. Cancer 103: 1843-1849, 2005.

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Oral Cancer: "New" Carcinogens


NYDailyNews.com
DAILY NEWS Health

Oral sex, HPV puts non-smoking men at highest risk for oral cancer: What are the facts?

BY LINDSAY GOLDWERT
DAILY NEWS STAFF WRITER

Originally Published Monday, April 18th 2011, 1:02 PM
Updated: Monday, April 18th 2011, 3:34 PM

Wade/Getty

The tumors forming on the back of their tongues and tonsils have nothing to do with nicotine — they are directly linked to engaging in oral sex with multiple female partners.

80% of women are HPV+ by the age of 50
50% of American males are HPV+

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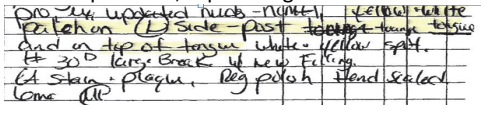
Case Analysis: Oral Cancer

- 67 year old female
- History:
  - Diabetes, COPD, and Hypertension
  - Smoker & Alcohol use
- Referred by the DDS to an OMS for "small yellow lesion on posterior, top of tongue"



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The OMS Visit

- Exam findings:
  - 4 mm triangular white striae on left tongue, ulceration pseudo-membrane, present for 1 year, improving, no nodes
- Diagnosis: Erosive lichen planus posterior tongue
- Plan:
  - No biopsy, benign
  - Kenalog orabase
  - Refer back to DDS to follow up during 6 month prophys

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The Follow Up Visits

Over the next 14 months:

- The patient had 8 visits with the DDS
  - No chart notes about the tongue lesion, exam, etc.
- Patient returns to OMS on her own (no referral)
  - **Complaint**: Lesion increasingly painful for months
  - **Exam findings**: **10 mm** ulcer at left tongue base (was 4 mm)
    Tender enlarged submandibular node
  - **Plan**: Refer to ENT for suspected SCC

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The ENT Visits

- Patient sees an ENT 1 week after OMS referral:
  - A biopsy was performed
    - Diagnosis: Infiltrating keratinizing SCC
    - Classification: Stage 3 SCC: T2, N1, MO
  - Treatment Plan: Glossectomy & Radiation
    - Patient had one malignant node
  - Prognosis: 85% chance it will grow back

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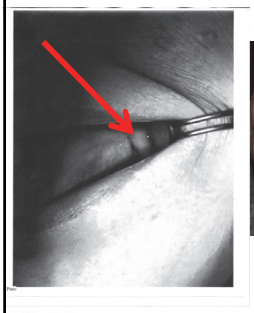
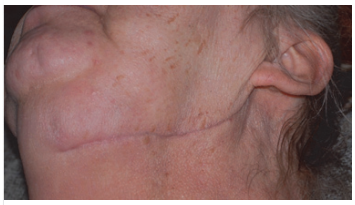
"Benign" lesion → Post-op scar

Went from **benign 4 mm lesion** to **10 mm, SCC stage 3**





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The Outcome

- The patient filed suit against the DDS & OMS
- The DDS claimed:
  - Didn't follow up because of benign diagnosis by OMS
- The OMS claimed:
  - Thought the DDS would monitor and refer back if no improvement
  - Relied on the patient to keep regular appointments with DDS (she did) and DDS to monitor and refer back

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What Can We Learn From This?

- **The GP**: Even if a diagnosis is benign…
  - Examine, monitor progress, chart findings
  - Refer back if it does not improve in a few weeks/months
- **The OMS**: If you rely on someone else to evaluate, or the patient to follow up:
  - Advise all involved in writing: avoid communication breakdown
  - Follow up in an appropriate & timely manner

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What Can We Learn From This?

- Develop a differential diagnosis; can you rule things out?
  - Detailed history: how long was it present, possible causes, etc.?
  - Appropriate exams or referrals until you can rule things out and timely diagnose
  - If patient no-shows for follow up, document efforts to get PT back & consequences
  - When in doubt… REFER OUT

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Cancer: Details to Document

- Details about the onset or other causes:
  - History of onset? Trauma, burns? Treatment & result?
- Note specific symptoms and complaints
- Chart specific exam findings & changes:
  - Location, size, characteristics (Pictures)
- Differential Diagnosis (if appropriate)
- Document Instructions to patient:
  - What to do? When to return? What to look for?
- When a suspicious lesion is gone: ***CHART IT***

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Oral Cancer: Suspected?

Regular cancer exams are important

- If you note suspicious lesions, assume it could be cancer **unless** and **until** you rule it out
- Refer to specialist for consultation, biopsy or monitoring
- If suspicious lesions don't resolve in a few weeks, refer to specialist for biopsy and definitive diagnosis
- **DOCUMENT! DOCUMENT! DOCUMENT!**

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Oral Cancer: Conclusions

- Keep up with the literature and assess high risk patients:
  - Traditional: Smokers, drinkers, older people with compromised immune systems (classic risk factors)
  - Newer: HPV associated oral cancers largely occur among nonsmokers and nondrinkers
- Assume it's cancer until proven otherwise
  - Get a diagnosis: communicate with PT and treaters
  - ***If patients fail to follow up****: contact PT to avoid delays*
- Documentation is critical:
  - Credibility will help counter sympathy in jury trials

Gillison ML, D'Souza G, Westra W et al: Distinct risk factor profiles for human papillomavirus type 16-positive and human papillomavirus type 16-negative head and neck cancers. J Natl Cancer Inst 100: 407-420, 2008.

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REMEMBER:
Screen Early
Screen Thoroughly
Screen Routinely
Did we mention DOCUMENT??

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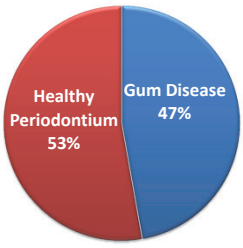
Prevalence of Gum Disease in the US

Adults over 30



Other Risk Groups

65 or older have perio disease: **70%**

More men than women: **56% to 38%**

Below federal poverty level: **65%**

Non-high school graduates: **67%**

Smokers: **64%**

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Periodontal Disease: Steps to Success

- **Assess** patient risk factors
- **Document Baseline**, note changes
- Develop office **protocol for screening** for periodontal disease; **use it religiously**
- Regularly update **imaging**
- Document patient **non-compliance**, warnings
- **Modify** diagnosis, treatment plan, referrals
- **Refer** to specialists when necessary

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Case Analysis: Periodontal Disease

- 33 year old male
- Dental history includes extraction of 4 wisdom teeth, 4 bicuspids (orthodontic treatment plan) and tooth #18
- Patient presented for routine exams and cleanings
  - Moderate to **severe recession** observed on the **lingual side of the maxillary arch**
    - No periodontal charting done

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The Visits

- **Two years** after initial presentation
  - Patient was referred to a periodontist for "implant consult"
    - The patient did not go
- **Over the next 3 years** the patient kept regular prophy visits (exams & cleanings)
  - "great OH"; "flosses daily and wears NG faithfully"
  - **No chart references to earlier recession or perio**

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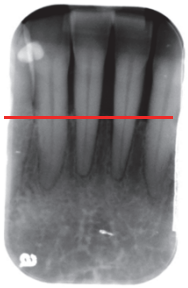
The "Problem"

- Patient presented for a limited evaluation of a loose mandibular anterior tooth after biting a carrot
  - An x-ray showed bone loss on teeth #22-26
  - The second referral to a periodontist was made



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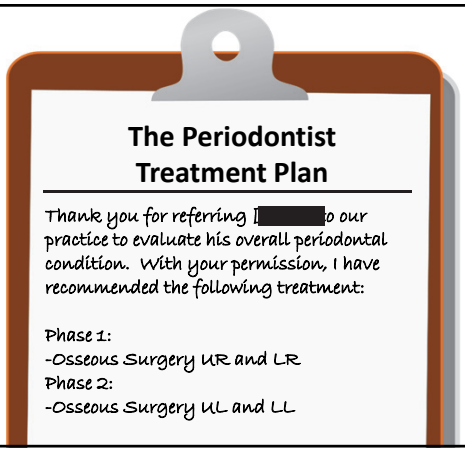

The Next Visit

- The patient returned to the dentist for a prophy and perio charting
  - This **first perio charting** was performed ***after*** the periodontist's diagnosis, 5 years after recession
  - Probe depths: 2-6mm
  - This was the last visit to this dentist
- The patient sought a second periodontist opinion
  - He discontinued treatment with the 1st periodontist

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The Second Periodontist

- The findings: Periodontal disease
  - Some pockets over 7mm, some exceeded 9mm at the lower anterior
  - Recession at #3 (2mm), 4 (3mm), 14 (3mm), 15 (3mm), 20 (3mm), 28 (3mm), 30 (2mm) & 31 (2mm)
  - Bone loss in all four quadrants
- Recommended osseous surgery in all 4 quads

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Litigation

- The allegations:
  - Despite routine dental care over a number of years…
    - He had progressive periodontal disease for 5 years, but was never informed about it
    - No periodontal screening was performed and no baseline documented before referral to a periodontist
    - Surgery on all four quadrants was required to treat the disease; was preventable

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The Outcome

- The patient had surgery
  - #22-27 were splinted
- The patient improved after several periodontal treatments over 2 years
- The case was settled before trial

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What Can We Learn From This?

- Perform routine periodontal evaluations, document
- If you identify a potential problem (focal or systemic) chart it, advise the patient and follow progress timely
- Treat within your training & comfort level
- Refer early when appropriate
- Make specific referrals and ensure patient goes
- Note non-compliance along with warnings of harm
- Document all findings, progress and conversations with your patient!
- "If it wasn't documented… It was never done"

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Was There Supervised Neglect?

Classic case: "it happened on his watch":

- The **chart included evidence of a perio problem** but **no evidence the DDS diagnosed it** or **offered a treatment plan** early
- The problem progressed despite regular appointments, without a diagnosis or referral.
- Another DDS diagnosed periodontal disease
- Unnecessary surgery, tooth loss, etc. was caused by supervised neglect
- Easy cases for lawyers:
  - Neglect and delay caused avoidable damage

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Supervised Neglect

- Proper follow up & charting or a referral should be considered after evidence of a problem
  - serves the patient's best interests
- When non-compliant patients **no-show or refuse needed periodontal referrals** putting their health at risk, consider:
  - Informed Refusal
  - Patient Termination

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Informed Refusal: Patient and Dentist's Rights & Duties

- **Patient autonomy:** Patients have the right to refuse treatment, elect alternative treatment, or change their mind
- **Dentists have the right not provide sub-standard care likely to cause unreasonable results or risks**
- **Patients can be asked to accept *reasonable* risks and limitations** associated with refused care or selection of an alternative: get it in writing!

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Informed Refusal Process

- Document
  - your **recommendation**, **care or refused referral**
  - the **patient's treatment choice** & **limitations and risks**
- Patients should **accept reasonable risks and complications** associated with their choice; chart discussion of those risks
- **Assess the risks/limitations: Are they reasonable**, in the DDS's professional opinion?
- Offer referral or second opinion if appropriate
- Use **Informed Refusal Forms** signed by the patient and DDS

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What is "reasonable"?

- Patients who **refuse X-rays**
  - Healthy 20 year old v. 65 year old smoker, ETOH?
- Patients who **refuse referrals**
  - Periodontal care? (minor problem v. facing tooth loss)
  - Biopsy of suspicious lesion?
- How the legal system/jurors analyze:
  - Legal Test: would a "reasonable DDS" allow a patient to accept these risks?
  - Jurors hear opinions from "Experts" and lawyers

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Last Resort: Withdrawal

- When your patient will only consent to **substandard care** you are **unwilling to provide**
- Send a **certified letter & regular mail** documenting:
  - Prior conversions about options and risks, reasons for withdrawal, treatment needed, where to seek it (i.e. a dental clinic, dental school or other opinions)
  - Give reasonable time to find new DDS
  - Don't delay transfer: Don't hold records hostage
- Call Fortress Risk Management before proceeding

Additional Information - DDS 401: Treating Challenging Patients

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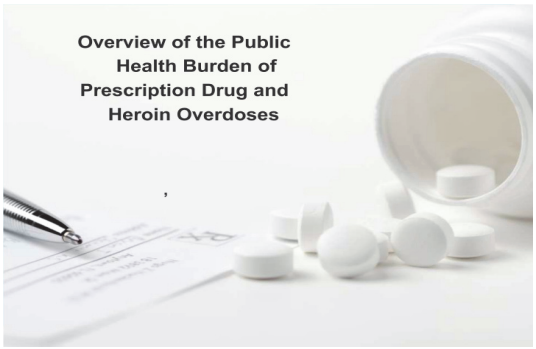
Opioid Management

FORTRESS



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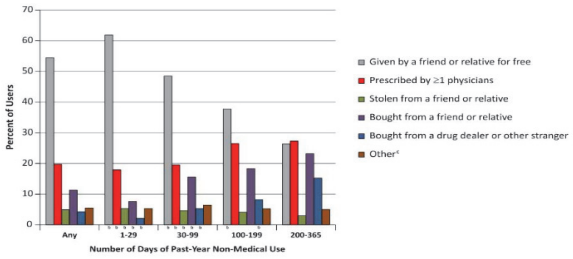
Sources of Prescription Opioids Among Past-Year Non-Medical Users[a]



[a] Obtained from the US National Survey on Drug Use and Health, 2008 through 2011.[7]
[b] Estimate is statistically significantly different from that for highest-frequency users (200-365 days) ($P < .05$).
[c] Includes written fake prescriptions and those opioids stolen from a physician's office, clinic, hospital, or pharmacy; purchases on the Internet; and obtained some other way.

SOURCE: Jones C, Paulozzi L, Mack K. Sources of prescription opioid pain relievers by frequency of past-year nonmedical use: United States, 2008–2011. JAMA Int Med 2014; 174(5):802-803.

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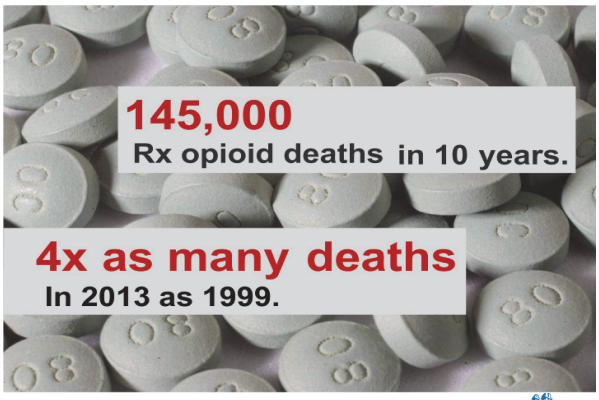

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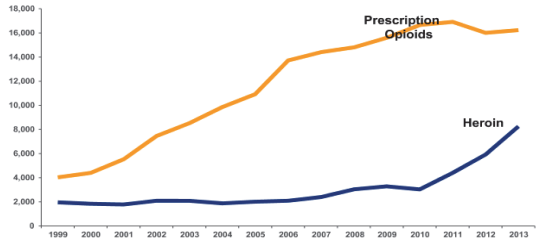
Rise in Rx overdose deaths since 1999 and recent increase in heroin deaths



CDC, National Center for Health Statistics, National Vital Statistics System

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For every Rx opioid overdose death in 2011, there were...

- **12** treatment admissions for opioids
- **25** emergency department visits for opioids
- **105** people who abused or were dependent on opioids
- **659** nonmedical opioid users

0 100 200 300 400 500 600 700

SAMHSA NSDUH, DAWN, TEDS data sets.

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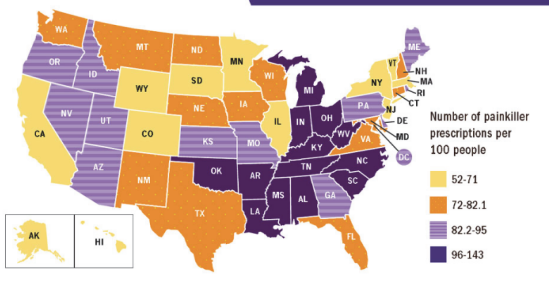
Some states have more painkiller prescriptions per person than others.



Number of painkiller prescriptions per 100 people

- 52-71
- 72-82.1
- 82.2-95
- 96-143

SOURCE: IMS, National Prescription Audit (NPA™), 2012.

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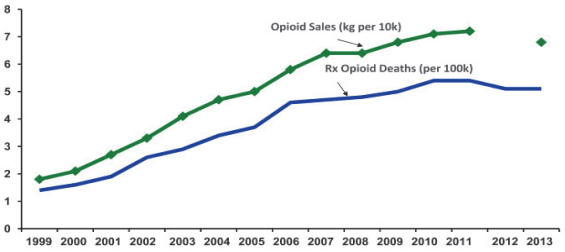
Sharp increases in opioid prescribing coincides with sharp increases in Rx opioid deaths



National Vital Statistics System, DEA's Automation of Reports and Consolidated Orders System.

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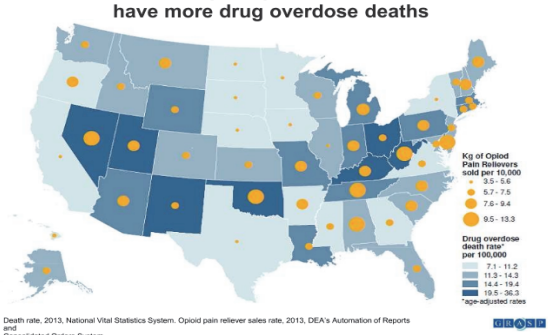
States with more opioid pain reliever sales tend to have more drug overdose deaths



Death rate, 2013, National Vital Statistics System. Opioid pain reliever sales rate, 2013, DEA's Automation of Reports and Consolidated Orders System

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The Role of Opioid Prescribing

Upper Midwest

Appalachia

Death rate, 2013, National Vital Statistics System. Opioid pain reliever sales rate, 2013, DEA's Automation of Reports and Consolidated Orders System

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A small fraction of prescribers fueling the problem

Swedlow et al. Prescribing patterns of schedule II opioids in California Workers' Compensation, CWCI Institute, 2011

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3 Percent Prescribe. . .

55% of opioid Rx

62% of morphine equivalents

65% of associated payments

Swedlow et al. Prescribing patterns of schedule II opioids in California Workers' Compensation, CWCI Institute, 2011

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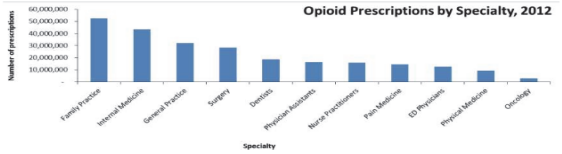
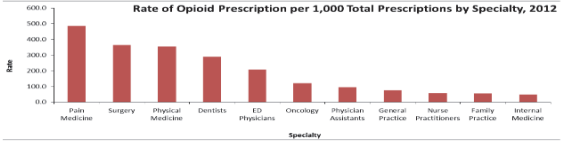
Primary care providers prescribe the most opioids



Pain specialists prescribe opioids most frequently



Health, National Prescription Audit, United States, 2012

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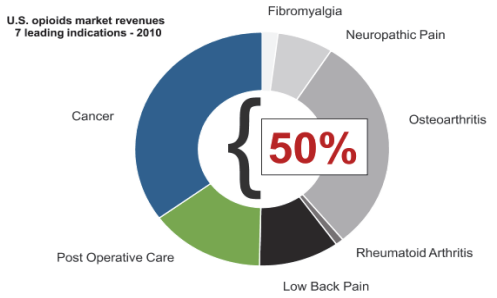
Half of US Opioids Market is Treatment for Chronic, Non-Cancer Pain



Source: GBI Research. Opioids Market to 2017. June

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Opioid Side Effects

- Tolerance—meaning you might need to take more of the medication for the same pain relief
- Physical dependence—meaning you have symptoms of withdrawal when the medication is stopped
- Increased sensitivity to pain
- Constipation
- Nausea, vomiting, and dry mouth
- Sleepiness and dizziness
- Confusion
- Depression
- Low levels of testosterone that can result in lower sex drive, energy, and strength
- Itching and sweating

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Who is at risk for an overdose?

Risk Factors

- ☐ Patients receiving opioids from multiple prescribers and/or pharmacies
- ☐ Patients taking high daily doses of opioids

Demographics

- ☐ Men
- ☐ 35-54 year olds
- ☐ Whites
- ☐ American Indians/Alaska Natives

Socioeconomics & geography

- ☐ Medicaid
- ☐ Rural

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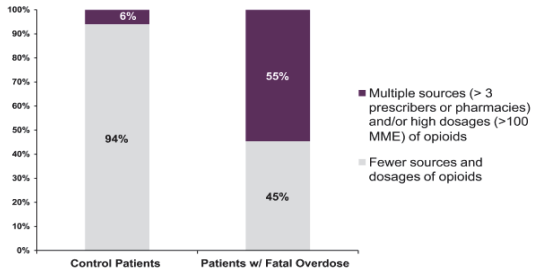
Majority of opioid overdose deaths associated with multiple sources and/or high dosages



Baumblatt JAG et al. High Risk Use by Patients Prescribed Opioids for Pain and its Role in Overdose Deaths. *JAMA Intern Med* 2014; 174: 796 -801.

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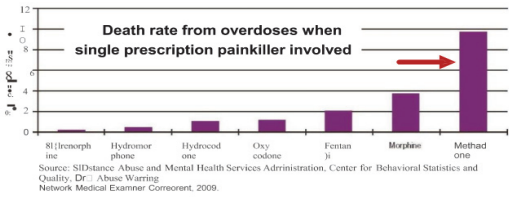
Methadone contributes to largest fraction of opioid-related deaths



Source: SIDstance Abuse and Mental Health Services Adrrinistration, Center for Behavioral Statistics and Quality, Dr□ Abuse Warring Network Medical Examner Correorent, 2009.

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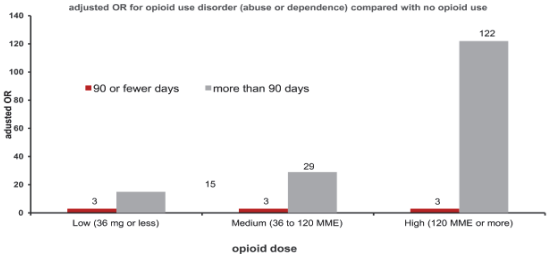
Longer durations and higher doses of opioid treatment are associated with opioid use disorder



Edlund, MJ et al.The role of opioid prescription in incident opioid abuse & dependence among individuals with chronic noncancer pain. *Clin J Pain* 2014; 30: 557-564.

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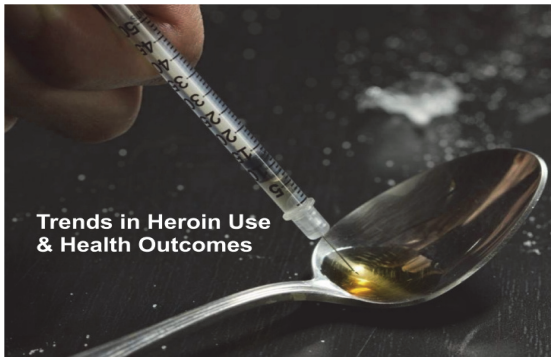

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HIV and HEP C Outbreak 2015

- 135 new HIV infections diagnosed in town of 4,200 people – Austin, Indiana.
- Co-infection with hepatitis C virus in 84% of patients
- Spread by Injection Drug Users using OPANA. Daily injections ranged from 4 to 15.
- Average of nine syringe-sharing partners, sex partners, or other social contacts
- Reported number of injection partners ranged from 1 to 6 per injection event

SOURCE: Conrad, C. et al. (2015). Community outbreak of HIV infection linked to injection drug use of oxymorphone—Indiana, 2015. MMWR Morb Mortal Wkly Rep, 64(16), 443-444..

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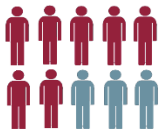
Prescription opioid misuse is a major risk factor for heroin use

3 out of 4 people who used heroin in the past year misused opioids first



7 out of 10 people who used heroin in the past year also misused opioids in the past year

Jones, C.M., Heroin use and heroin use risk behaviors among nonmedical users of prescription opioid pain relievers – United States, 2002–2004 and 2008–2010. Drug Alcohol Depend. (2013).

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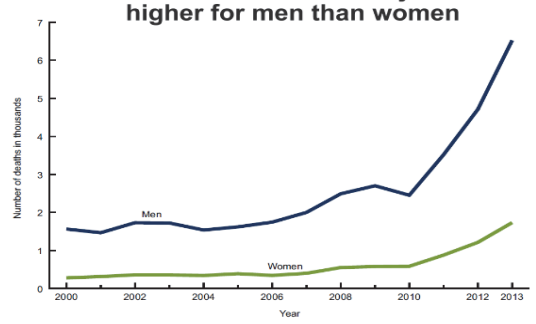
Heroin overdose deaths nearly four times higher for men than women



CDC/NCHS, National Vital Statistics System, Mortality.

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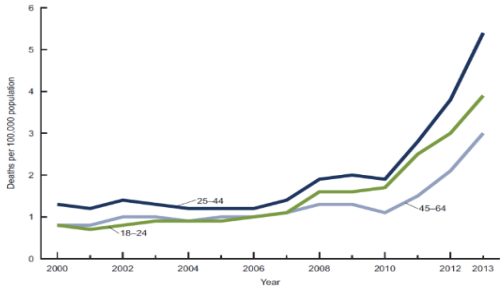
Adults age 25-44 have the highest rate of heroin overdose



CDC/NCHS, National Vital Statistics System, Mortality.

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Three Pillars of CDC's Prescription Drug Overdose Prevention Work

- **Improve data** quality and track trends
- **Strengthen state efforts** by scaling up effective public health interventions
- **Supply healthcare providers with resources** to improve patient safety

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Statement on the Use of Opioids in the Treatment of Dental Pain

- *ADA House of DelegatesAdopted:October,2016*
- Prepared by: Division of Government and Public Affairs
- Last Updated: February 24, 2017

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ADA House of Delegates

- When considering prescribing opioids, dentists should conduct a medical and dental history to determine current medications, potential drug interactions and history of substance abuse.
- Dentists should follow and continually review Centers for Disease Control and State Licensing Boards recommendations for safe opioid prescribing.

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ADA House of Delegates

- Dentists should consider treatment options that utilize best practices to prevent exacerbation of or relapse of opioid misuse.
- Dentists should consider non-steroidal anti-inflammatory analgesics as the first-line therapy for acute pain management.

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ADA House of Delegates

- Dentists should recognize multimodal pain strategies for management for acute postoperative pain as a means for sparing the need for opioid analgesics.
- Dentists should consider coordination with other treating doctors, including pain specialists when prescribing opioids for management of chronic orofacial pain.

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ADA House of Delegates

- Dentists should register with and utilize prescription drug monitoring program (PDMP) to promote the appropriate use of controlled substances for legitimate medical purposes, while deterring the misuse, abuse and diversion of these substances.
- Dentists should have a discussion with patients regarding their responsibilities for preventing misuse, abuse, storage and disposal of prescription opioids.

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ADA House of Delegates

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- Dentists who are practicing in good faith and who use professional judgment regarding the prescription of opioids for the treatment of pain should not be held responsible for the willful and deceptive behavior of patients who successfully obtain opioids for non-dental purposes.
- Dental students, residents and practicing dentists are encouraged to seek continuing education in addictive disease and pain management as related to opioid prescribing.

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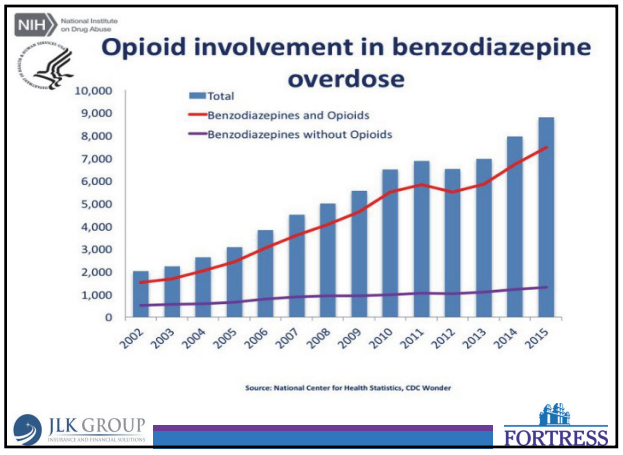

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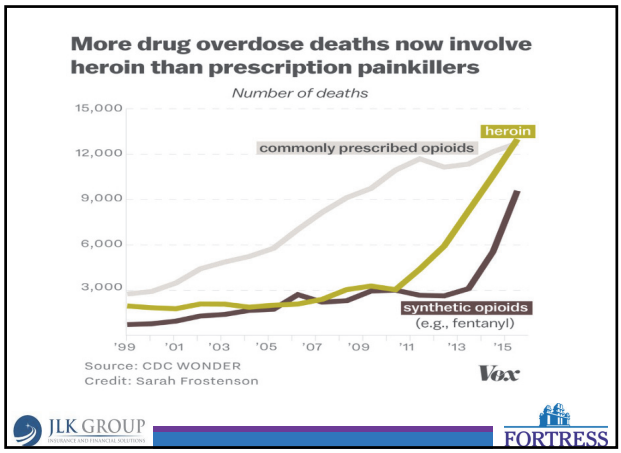
More drug overdose deaths now involve heroin than prescription painkillers
Number of deaths
15,000
12,000
9,000
6,000
3,000
heroin
commonly prescribed opioids
synthetic opioids
(e.g., fentanyl)
'99
'01
'03
'05
'07
'09
'11
'13
'15
Source: CDC WONDER
Credit: Sarah Frostenson
Vox
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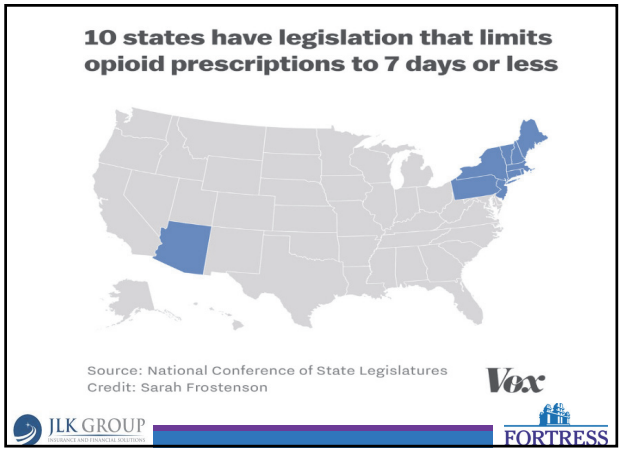
10 states have legislation that limits opioid prescriptions to 7 days or less
Source: National Conference of State Legislatures
Credit: Sarah Frostenson
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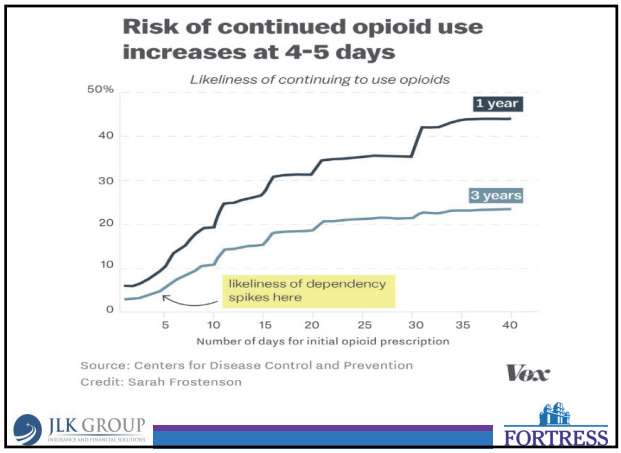
Risk of continued opioid use increases at 4-5 days
Likeliness of continuing to use opioids
50%
40
30
20
10
0
1 year
3 years
likeliness of dependency spikes here
5
10
15
20
25
30
35
40
Number of days for initial opioid prescription
Source: Centers for Disease Control and Prevention
Credit: Sarah Frostenson
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To understand just how bad the opioid epidemic has gotten, consider these statistics:

- Drug overdoses in 2015 were linked to more deaths than car crashes or guns, and in fact killed more people than car crashes and gun homicides *combined*.
- Drug overdoses in 2015 also killed more people in the US than HIV/AIDS did during its peak in 1995

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Drug, painkiller, heroin, and other opioid overdose deaths are still on the rise

- Between 1999 and 2015, more than 560,000 people in the US died to drug overdoses — a death toll larger than the entire population of Atlanta.
- First, opioid painkiller overdoses began to rise, as doctors began to fill out a record number of prescriptions for the drugs in an attempt to treat patients' pain conditions.
- Second, people hooked on painkillers began to move over to heroin as they or their sources of drugs lost their prescriptions.
- Recently, more people have begun moving to fentanyl, an opioid that's even more potent and cheaper than heroin. The result is a deadly epidemic that so far shows no signs of slowing down.

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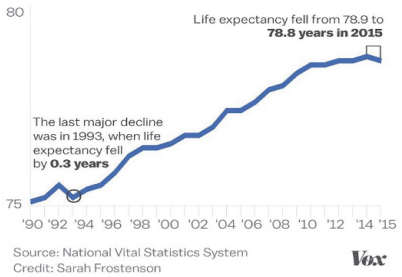
Life expectancy has improved in the US, but a 2015 dip shows that might be changing



Source: National Vital Statistics System
Credit: Sarah Frostenson

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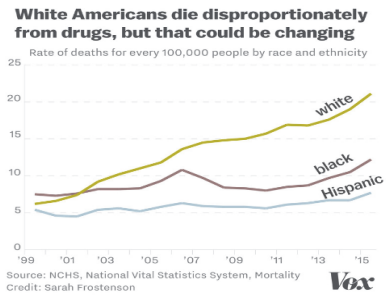
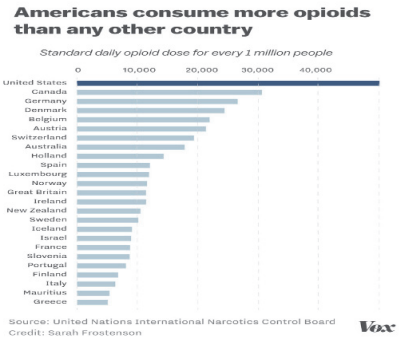
By and large, the drug overdose epidemic has hit white Americans the hardest



- This is a shift from before the 2000s, when past drug crises tended to hit black, urban communities much harder
- One reason for the disparity may, ironically, be racism against nonwhite Americans
- Studies show that doctors are more reluctant to prescribe painkillers to minorities, because doctors mistakenly believe that minority patients feel less pain or are more likely to misuse and sell the drugs
- In a perverse way, this shielded minority patients from the tsunami of opioid painkiller prescriptions that got white Americans hooked on opioids and led to a wave of deadly overdoses.



So why do Americans consume so many opioids?

- Starting in the 1980s and '90s, doctors were under pressure to take pain more seriously.
- About 100 million US adults suffer from chronic pain, according to **a 2011 report** from the Institute of Medicine.

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So why do Americans consume so many opioids?

- HCPs — under pressure from drug companies, medical organizations, government agencies, and pain patient advocates — resorted to opioids.
- The result: In 2012, US physicians wrote **259 million prescriptions** for opioid painkillers — enough to give a bottle of pills to **every adult in the country**.
- And these pills didn't just end up in patients' hands; they also proliferated to black markets, were shared among friends and family, landed in the hands of teens who rummaged through parents' medicine cabinets, etc.

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Big Pharma

- Seeing the demand for doctors to take pain more seriously, drug companies pitched newer products like OxyContin as the big medical solution.
- Marketing was extremely misleading, often presenting these drugs as safer and more effective than other painkillers and opioids on the market — when these drugs were in fact extremely addictive and dangerous.
- Purdue Pharma, producer of OxyContin, in 2007 **paid** hundreds of millions of dollars in fines for its false claims. Purdue and other opioid producers **remain in legal battles** over the drugs to this day.

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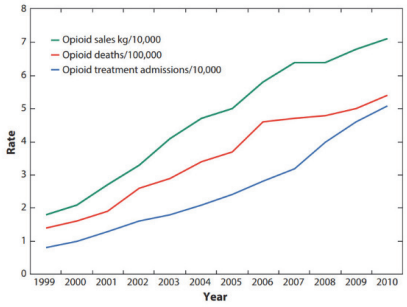
Drug companies have made a lot of money from opioids



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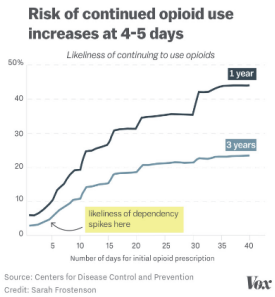
Painkillers are often prescribed for long periods of time, even though there's no evidence they effectively treat chronic pain



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Opioid users moved from painkillers to heroin, because heroin is so cheap

- Heroin is extremely cheap in the black market.
- over the past few decades, the price of heroin in the US has dramatically dropped — to the point that it's not only cheaper than opioid painkillers sold in the black market, but frequently even **candy bars**.
- But heroin is also more potent and, therefore, deadlier than opioid painkillers.
- So even though not every painkiller user went to heroin, just enough did to cause the big spike in heroin overdose deaths that America has seen over the past few years.
- So now more people die of overdoses linked to heroin than die of overdoses linked to commonly prescribed painkillers.

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July 2014

The Changing Face of Heroin Use in the United States

A Retrospective Analysis of the Past 50 Years

- Theodore J. Cicero, PhD[1]; Matthew S. Ellis, MPE[1]; Hilary L. Surratt, PhD[2]; et al.Steven P. Kurtz, PhD
- *JAMA Psychiatry.* 2014;71(7):821-826. doi:10.1001/jamapsychiatry.2014.366

- **Importance** Over the past several years, there have been a number of mainstream media reports that the abuse of heroin has migrated from low-income urban areas with large minority populations to more affluent suburban and rural areas with primarily white populations.

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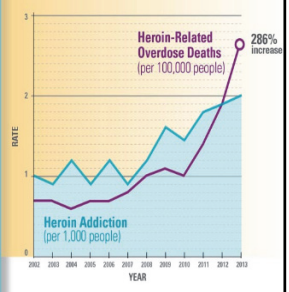
Heroin Use Has INCREASED Among Most Demographic Groups

	2002-2004*	2011-2013*	% CHANGE
SEX			
Male	2.4	3.6	50%
Female	0.8	1.6	100%
AGE, YEARS			
12-17	1.8	1.6	--
18-25	3.5	7.3	109%
26 or older	1.2	1.9	58%
RACE/ETHNICITY			
Non-Hispanic white	1.4	3	114%
Other	2	1.7	--
ANNUAL HOUSEHOLD INCOME			
Less than $20,000	3.4	5.5	62%
$20,000–$49,999	1.3	2.3	77%
$50,000 or more	1	1.6	60%
HEALTH INSURANCE COVERAGE			
None	4.2	6.7	60%
Medicaid	4.3	4.7	--
Private or other	0.8	1.3	63%

Heroin Addiction and Overdose Deaths are Climbing



SOURCES: National Survey on Drug Use and Health (NSDUH), 2002-2013. National Vital Statistics System, 2002-2013.

Heroin use is part of a larger substance abuse

Nearly all people who used heroin also used at least 1 other drug.

Most used at least **3** other drugs.

Heroin is a highly addictive opioid drug with a high risk of overdose and **death** for users.

People who are addicted to...

ALCOHOL	MARIJUANA	COCAINE	R
are	are	are	
2x	3x	15x	

...more likely to be addicted t

SOURCE: National Survey on Dr

Responding to the Heroin Epidemic

PREVENT People From Starting Heroin

Reduce prescription opioid painkiller abuse.
Improve opioid painkiller prescribing practices and identify high-risk individuals early.

REDUCE Heroin Addiction

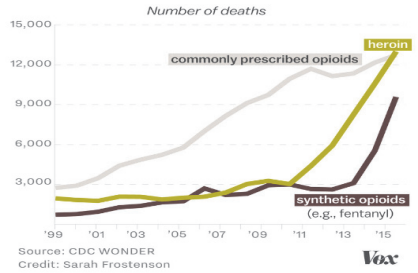
Ensure access to Medication-Assisted Treatment (MAT).
Treat people addicted to heroin or prescription opioid painkillers with MAT which combines the use of medications (methadone, buprenorphine, or naltrexone) with counseling and behavioral therapies.

REVERSE Heroin Overdose

Expand the use of naloxone.
Use naloxone, a life-saving drug that can reverse the effects of an opioid overdose when administered in time.

Fentanyl has become a growing problem as well

More drug overdose deaths now involve heroin than prescription painkillers



Source: CDC WONDER
Credit: Sarah Frostenson

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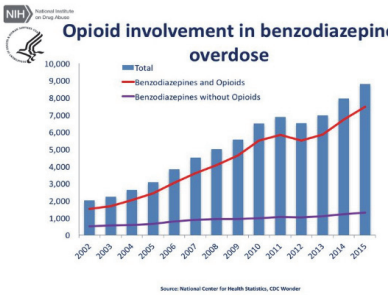
Anti-anxiety drugs are involved in more overdoses as well



Source: National Center for Health Statistics, CDC Wonder

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Benzodiazepines, such as Xanax and Valium, are also increasingly involved in overdose deaths.

- Very often, people use multiple drugs, from painkillers to cocaine to alcohol. This is especially bad because different drugs can heighten other drugs' risk of overdose.
- Alcohol and benzodiazepines, for instance, are known to compound the overdose risk of opioids.
- Most benzodiazepine overdoses have involved opioids in the past few years, as the chart above shows.
- Centers for Disease Control and Prevention previously **found** that 31 percent of opioid painkiller overdose deaths in 2011 were also linked to benzodiazepines.

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Most people who meet the definition for a drug use disorder don't get treatment

- 89 percent of people who met the definition for having a drug use disorder didn't get treatment.
- People **might not have insurance** to pay for drug treatment.
- If they do have insurance, their plans may not fully cover drug treatment.
- And even if their plans do cover drug treatment, there might not be enough space in treatment facilities to take them, leading to **weeks- or months-long waiting periods for care**.

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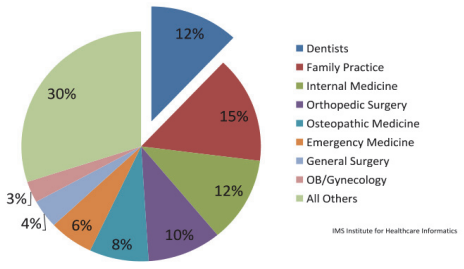
Prescribers of Immediate Release Opioids



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Screening for Potential Drug Abuse

- Incorporate screening process into routine practice
- Develop a referral network
- Watch for signs and symptoms of substance use disorders
- Use Prescription Drug Monitoring Programs
- Involve responsible family members and PCPs

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Opioid Considerations

- Follow responsible and tailored prescribing practices
- Secure all prescription pads when not in use
- Consider alternative medications and treatment modalities
- Discuss the patient's substance use history when referring the patient for specialized dental surgery

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Case Study: The Recovering Addict

- 22 year old male
- Recovering heroin addict but said he was "clean"
- Extraction of #24 and #25
- Prescribed 15 tablets of Vicodin 5/500mg with 1 refill
- Outcome: Patient died 16 days later from a heroin overdose. Claim is filed. Family alleges the reintroduction of opioid medications caused relapse

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What Can We Learn From This?

- Prescribe with caution
- Educate patients on safe disposal of unused medication
- Involve responsible family members and PCP's when appropriate
- Consider available resources when patient abuse is suspected
  - Treatment Referral Hotline: 1-800-662-HELP

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Case Study: The Codependent Dentist

- Dentist routinely prescribes "family friend" Vicodin unnecessarily
- Patient is recovering addict; dentist struggles too
  - Prescriptions split between patient and dentist
- Outcome: Dentist arrested and a claim was filed by the patient's family alleging he was responsible for the patient's relapse

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What Can We Learn From This?

- Monitor supplies and employee access
- Seek help for you and others
- Prescriptions you write are monitored
- Writing prescriptions outside the scope of treatment is illegal, even if your intentions are good

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Recognizing Drug-Impaired Co Workers

- Excessive amounts of time spent near a drug supply
- Heavy "wastage" of drugs
- Sloppy recordkeeping, suspect ledger entries and drug shortages
- Inappropriate prescriptions for large narcotic doses

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EVIDENCE ABOUT OPIOID THERAPY

- Benefits of long-term opioid therapy for chronic pain not well supported by evidence.
- Short-term benefits small to moderate for pain; inconsistent for function.
- Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.

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NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

• Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).

• Physical treatments (eg, exercise therapy, weight loss).

• Behavioral treatment (eg, CBT). • Procedures (eg, intra-articular corticosteroids).

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EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

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Urine drug testing:

- Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.
- Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

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WHY GUIDELINES FOR PRIMARY CARE PROVIDERS?

- Primary care providers account for approximately 50% of prescription opioids dispensed
- Nearly 2 million Americans, aged 12 or older, either abused or were dependent on prescription opioids in 2014
- An estimated 11% of adults experience daily pain
- Millions of Americans are treated with prescription opioids for chronic pain

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Myth vs. Truth

Myth: Opioids are effective and long-term opioids control chronic pain

Truth: While evidence supports short-term effectiveness of opioids, there is insufficient evidence that Opioids are effective long-term opioids control chronic pain effectively over the long term, and there is evidence that other treatments for chronic pain treatments can be effective with less harm.

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Myth vs. Truth

Myth: There is no unsafe dose of opioids as long as opioids are titrated slowly

Truth: Daily opioid dosages close to or greater than 90 MME/day are associated with significant risks, and lower dosages are safer(<50MME/day)

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Myth vs. Truth

Myth: The risk of addiction is minimal

Truth: Up to one quarter of patients receiving prescription opioids long term in a primary care setting exhibit opioid dependence

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Government and Regulatory

- Some states, for example, have limited how long opioid painkillers can be prescribed.
- After years of opioids be prescribed with little concern and adversely impacting tens of thousands of people, HCPs need to be told to take a much more conservative approach to dangerous drugs.

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Thank You

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