Meeting at the Quality Crossroad
Where Quality, Governance, FTCA, Risk Management and Liability Intersect

Our mission is to improve the oral health of all.
Meeting at the Crossroads
What Will Success Look Like?
Cut Right to the Chase

None

Full of It

The Baloney Meter
Governance

- Compliance with Federal, State and Local Regulations and with the State Practice Act
- Compliance Officer
- Policy and Procedure Manual
- Credentialing Policy
- Privileging Policy/Competencies
- Annual Safety/Infection Control/Hazardous Waste Training
- Preparation for a HRSA Operational Site Visit (OSV)
- Preparation for an FTCA Compliance Audit
- Quality Management System= QA/CQI
Accessible Hours of Operation/Locations:
Health center provides *services at times and locations that assure accessibility* and meet the needs of the population to be served. (Section 330(k)(3)(A) of the PHS Act)

**After-Hours Coverage:** Health center provides professional *coverage during hours when the center is closed*. (Section 330(k)(3)(A) of the PHS Act)
Operational Site Visit Dental Compliance Issues

**Budget:** Health center has developed a *budget* that *reflects the costs of operations, expenses, and revenues (including the Federal grant) necessary to accomplish the service delivery plan,* including the number of patients to be served. (Section 330(k)(3)(D), Section 330(k)(3)(I)(i), and 45 CFR Part 74.25)

**Scope of Project:** Health center *maintains its funded scope of project (sites, services, service area, target population, and providers),* including any increases based on recent grant awards. (45 CFR Part 74.25)
Operational Site Visit Dental Compliance Issues

**Sliding Fee Discounts:** Health center has a *system in place to determine eligibility for patient discounts adjusted on the basis of the patient’s ability to pay.*

- This system must provide a **full discount to individuals and families with annual incomes at or below 100% of the Federal poverty guidelines (only nominal fees may be charged)** and for those with **incomes between 100% and 200% of poverty, fees must be charged in accordance with a sliding discount policy based on family size and income.***

- **No discounts** may be provided to patients with incomes over **200% of the Federal poverty guidelines.***

- **No patient will be denied health care services by the health center due to an individual’s inability to pay for such services, assuring that any fees or payments required by the center for such services will be reduced or waived.** (Section 330(k)(3)(G) of the PHS Act, 42 CFR Part 51c.303(f)), and 42 CFR Part 51c.303(u))
Section II, Guideline 8: Quality Improvement/Assurance Plan

Requirement:

*Health center has an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management, and that maintains the confidentiality of patient records.*
Quality Improvement/Assurance Plan

The QI/QA program must include:

• A clinical director whose focus of responsibility is to support the quality improvement/assurance program and the provision of high quality patient care

• Periodic assessment of the appropriateness of the utilization of services and the quality of services provided or proposed to be provided to individuals served by the health center
What Does QA/QI Mean for Dental?

• If you still have paper charts in dental, are they secured when staff is not present?
• Is the dental director responsible for QI/QA or is it delegated?
• Do you have a process for periodic chart reviews? If so, who does them and how often? How are the results shared and used?
• Is there a formal process to follow up on deficiencies noted during these reviews? Are formal action plans developed and documented? Is regular re-evaluation part of your overall QI/QA process?
What Does QA/CQI Mean for Dental? (cont.)

- Do your records have standardized content and organization?
- Is patient information handled in a way that is HIPAA compliant?
- Is there a process within your health center (including dental) to report/track incidents/adverse outcomes?
- What happens with these reports? How is follow-up documented?
- Is the dental program tracking clinical outcome measures? Where are they reported? How are the results used? Be ready with data!
Quality: Chart Audits and Peer Review

• The Section 330 core program requirements dictate that the QI/QA program should involve periodic assessment of data from patient records, conducted or supervised by a physician (dentist), to identify areas for improvement.

• In addition, health centers are required to implement changes to the way they provide services to address the areas targeted for improvement.
Quality: Chart Review – Retrospective Review

- All dentists should review each other's charts
- Can be limited by the # of charts possible to review
- Is a risk management tool
- Difficult to pick up radiograph diagnosis issues
- Can identify basic charting issues: i.e. BPs, periodontal charting
- Raises overall awareness to QA issues
- Chart Review Guidelines: Essential!!!!
- Discuss results at monthly staff meetings
APPENDIX B: QUARTERLY DENTAL CHART AUDIT TOOL

Dentist: ____________________ Patient Chart #: _______________ Date of Patent visit: ___________

Note: This review applies to the most recent treatment episode provided by the Clinician being evaluated. You may however need to review chart notes from the last exam forward to answer the questions below correctly. Explain any comments or suggestions in space below and return confidentially to the Dental Director.

<table>
<thead>
<tr>
<th>NA</th>
<th>Outstanding</th>
<th>Satisfactory</th>
<th>Needs Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orders appropriate/dx radiographs</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Radiographic dx appropriate</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Sequenced treatment plan present and appropriate</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Periodontal charting present</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Diagnosis present for all emergency exams and supported by documentation</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Appropriate clinical judgment used</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Blood pressure protocols followed</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Follows charting protocols</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Patient post-op instructions documented</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Follows medical hx protocols</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Appropriate use of referral</td>
<td>□</td>
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<tr>
<td>Follows protocols for patient vital signs</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Appropriate use of medications?</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Sedation protocols followed</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Appropriate emergency follow-up done</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Correct billing procedures followed</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Handwriting legible (if paper charts)</td>
<td>□</td>
<td>□</td>
<td>□</td>
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</table>
Federal Tort Claims Act (FTCA)

• To receive FTCA coverage, a health center has to be deemed. To become deemed, a health center has to apply and go through the deeming process.

• Until a health center is deemed to have FTCA coverage, they must have private malpractice insurance. (Gap Malpractice)

• Deemed health center program grantees are immune from medical malpractice lawsuits resulting from the performance of medical, surgical, dental or related functions within the approved scope of project. Key words – approved scope of project.

• FTCA applies to employees and qualified contractors of eligible health centers. Key words – employees and eligible.

• As of October 1, 2017*, volunteer health professionals are also eligible for FTCA coverage, provided the sponsoring health center is deemed.

*https://bphc.hrsa.gov/ftca/about/health_center_volunteers_pal.pdf
Federal Tort Claims Act (FTCA)

• All licensed or certified health center providers who work or volunteer in a health center must undergo a credentialing and privileging process in accordance with PIN 2002-22.

• Deemed health centers must have and submit a QI/QA plan.

• The health center’s QI/QA plan must be reviewed by the Board every 3 years.
FTCA: Employees

• HRSA/BPHC uses the IRS definition to establish who is an employee (thus they must receive a salary from a covered entity on a regular basis with taxes and benefits deducted along with coverage for unemployment compensation).

• Employees receive a W-2 form.

• Employees are covered – full time or part time.
FTCA: Qualified Contractors

• Typically a covered entity health center will issue a Form 1099 to an individual who is a contractor

• Contract! To ensure FTCA coverage for contractors, providers should have a contracted professional relationship

• Corporations are not covered

• Individuals only
FTCA: Credentialing and Privileging

- **HRSA Pin 2002-22** Requires Credentialing and Privileging of providers including dentists.
- **Credentialing** is the process of establishing and insuring that a provider is qualified to practice in a health center.
- Health center dental programs should own and control the credentialing process.
- **Privileging** is establishing the right of a provider to perform specific procedures.
- The Dental Director in a health center should own and control the privileging process.
- Defines for the incoming dentist what procedures are allowed at the clinic and for that dentist.
- Required for FTCA insurance and many other malpractice insurers.
FTCA: ATTACHMENTS for Annual Redeeming Application

Attachment A – Policies for Tracking System
Attachment B1 – Copy of Health Center’s Quality Improvement/Assurance Plan* * The health center must submit the policy along with evidence that the policy has been approved, dated and signed by the Board (Please see PAL for details)
Attachment B2 – Signed and Dated Minutes Demonstrating Board Approval of Quality Improvement/Assurance Plan
Attachment C – Six sets of minutes from QI/QA committee meetings that clearly document QI/QA activities (See PAL for specific dates)
Attachment D – Six sets of minutes from Board meetings that are related to QI/QA activities (See PAL for specific dates)
Attachment E – Any health center committee reports in addition to the minutes noted above, that further evidence QI/QA activities
Attachment F – List of Licensed or Certified Health Care Practitioners
Attachment G1 – Credentialing and Privileging Policy*
Attachment G2 – Signed and Dated Minutes Demonstrating Board Approval of Credentialing and Privileging Policy
Attachment H – Review of Professional Liability History (as applicable)
Attachment I – Other Supporting Documentation

https://bphc.hrsa.gov/programrequirements/policies/pinspals.html
Core privileges in Dentistry include diagnosis, evaluation, management and treatment of dental patients who present with general dental problems, including emergency dental care and preventative care.

Please indicate by using the checkboxes √ in the requested column to apply for those privileges that are commensurate with your clinical ability, training and experience for which you are applying. For reappointments: Those boxes already checked are your current privileges. Please complete the other columns, sign and return to the Medical Director’s Office.

<table>
<thead>
<tr>
<th>PRIVILEGE LIST:</th>
<th>√</th>
<th>Performed in the past 24 months? (Yes or No)</th>
<th>Relevant CDE</th>
<th>Had Training &amp; Experience</th>
<th>Corporate Dental Director Notes</th>
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<tbody>
<tr>
<td>Basic Dental Core Privilege Package (includes all procedures listed below)</td>
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<tr>
<td>Oral Diagnosis, Prevention and Adjunct Services</td>
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<tr>
<td>Restorative Dentistry</td>
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<tr>
<td>Endodontics</td>
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<td>Prosthodontics (removable)</td>
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<td>Implant Restorative Services</td>
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<td>Prosthodontics (fixed)</td>
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<tr>
<td>Oral and Maxillofacial Surgery and Periodontics Level 1</td>
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<tr>
<td>Sedation: minimal sedation- nitrous oxide/ oxygen only</td>
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<td>Additional Procedures (requested separately)</td>
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<tr>
<td>Oral and Maxillofacial Surgery Level 2</td>
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<tr>
<td>Oral and Maxillofacial Surgery Level 3</td>
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<tr>
<td>Periodontics Level 2</td>
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<td>Implant placement</td>
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<tr>
<td>Sedation: minimal sedation N2O with one oral medication</td>
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<tr>
<td>Sedation: moderate</td>
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<tr>
<td>Active Orthodontic appliances</td>
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<td>PNAM</td>
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<td>Other (Specify CDT code)</td>
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FTCA Coverage

- **Occurrence Policy**
- **Occurrence:** *Actions and omissions* during the time that the policy is in effect
- **In the case of non-covered individuals:** The CHC remains covered but the individual is not, thus they need Gap/individual malpractice insurance.
- **FTCA is restricted to acts within the scope of employment of a covered individual, which should be documented in a contract.**
- **Activities should be within the approved scope of the project, including sites, services, activities and locations as defined in PIN 2008-01.**
FTCA Coverage

• FTCA coverage for new services and sites is dependent on HRSA/BPHC approval of a change in the scope of project, thus a request for change and scope should be submitted. (Gap Ins.)

• ALL professionals covered by FTCA need contracts and job descriptions that delineate duties within project scope.

• Moonlighting is NOT covered by FTCA.
FTCA: Teaching Activities

• The covered CHC and the CHC employee teaching provider are covered by FTCA when services being provided are within the scope of project.
• The student or resident is not covered by FTCA.
• Service provided under the teacher/student relationship in non-health center facilities also are not covered.
• Once again: Service provided outside of the scope of project are not covered by FTCA.
• FQHC should have a contract with the school.
FTCA: Dual Coverage

- Dual malpractice coverage for the same services is not allowed. In other words, for those services covered by FTCA (In Scope of Project Services) it is not allowed to also have private malpractice insurance. Conversely.....

- The combined use of FTCA and gap coverage (private insurance for activities not subject to FTCA coverage) is allowable. This is accomplished by the purchasing of a policy for discreet activities or as a wraparound (gap policy) that clearly delineates that the coverage is only for activities not subject to FTCA coverage.
"There's absolutely nothing to worry about!..."
Risk Management and Patient Safety

One of the basic principles of prevention in risk management is: “Performing the appropriate procedures in the appropriate manner”

“Standard of Care”
The “Standard of Care”

The “medical standard of care” is typically defined as the level and type of care that a reasonably competent and skilled health care professional, with a similar background and in the same medical community, would have provided under the circumstances that led to the alleged malpractice.
The “Standard of Care”

- The care provided by most experienced competent dentists in the same case
- The care that is taught in dental school as evidence based
- The best care that can be expected
- The same level of care a specialist would provide
Level 1: most experienced competent practitioners would have handled care similarly in all significant aspects.
Level 2: most experienced competent practitioners might have handled care differently in one or more aspects.
Level 3: most experienced competent practitioners would have handled care differently in one or more aspects.
Top Potential Risk Areas

1. Lack of a Proper Consent (General and Informed)
2. Insufficient Documentation (Chart Notes missing or illegible)
3. Fee Disputes (Money $$$$)
4. Failure to Diagnose (Everything/esp. Perio Disease)
5. Lack of a Thorough Exam
6. Failure to Follow-Up on Emergencies
7. Treatment of the Wrong Tooth (Time Out Policy)
8. Surgical Complications (Inferior Alveolar nerve/Fractures/Sinus)
9. Unsatisfactory Dentures
10. Lack of/Inadequate Treatment Plan
11. Inappropriate Procedures
12. Incomplete Treatment
13. Spoliation (intentional or negligent withholding, hiding, altering, or destroying of evidence relevant to a legal proceeding)
Risk Management: Illegible Information

New Massachusetts regulations require:

“Patient records shall be legible and clear in meaning to a subsequent examining or treating dentist, the patient, dental auxiliaries or other authorized persons.”
Risk Management: Where Do Problems Arise?

- Patients, Treatment Plans, Money, Expectations
- Lawyers
- Employees
- Dentists
- Collections Actions
- Delayed Record Production
- Insurers
- Site Inspections
- Bathrooms
Risk Management: Informed Consent – Top Risk Area #1

There are two types of Informed Consent:

• General**
• Specific

**Warning! Not all Informed Consent is Equal and Enduring**
Informed Consent (cont.)

**GENERAL INFORMED CONSENT:**

- Routine examination, diagnosis and treatment
- Basic Restorative Procedures
  - Routine fillings
  - Routine sealants
- Basic Preventive Procedures
  - Routine Cleaning
  - Fluoride Therapy
- Consent to Bill Insurer

The general informed consent may remain in effect until treatment is terminated either by the licensee and/or the patient and the patient is no longer regarded as a patient of record.
Specific Informed Consent:

- Administration of anesthesia other than local anesthesia
- Periodontal Procedures
  - Scaling and Root Planing
  - Flap Surgery
  - Bone and Tissue Grafts
  - Frenulectomy
- Endodontic Procedures
  - Root Canal Therapy
- Orthodontic Procedures
  - Dental Braces
  - Retainers
  - Suresmile
- Prosthetic Procedures
  - Insertion of osseointegrated dental implants
  - Dentures
  - Temporary and Permanent Bridges
  - Crowns
- Oral Procedures
  - Extractions
  - Maxillofacial Procedures
    - Dentoalveolar surgery
    - Ablative and reconstructive surgery, microsurgery
    - Craniofacial surgery
    - Treatment of chronic facial pain disorders
    - Treatment of TMJ disorders
    - Orthognathic surgery
    - Maxillomandibular advancement
    - Treatment of jaw fractures
  - Specialized Treatment for Pediatric Patients (including Behavior Management Techniques)
    - Sedation
    - Protective Stabilization

A specific informed consent should be obtained for each procedure and each visit.
Risk Management: Lack of Informed Consent

• Failure to obtain informed consent is a departure from the standard of care for dental practice. To proceed with the treatment of patients without their approval is considered negligent.

• A signature by the patient/guardian for the intended dental procedure is required to document the risk, possible complications, and treatment alternatives.

• This indicates an understanding of the procedure and both expected outcomes and risk.
Liability and Compliance
Liability: A Policy for Everything!
Liability: Site Inspection Surprises

Most Frequent Non-Compliance Deficiencies:

• Infection Control – none, sporadic or undocumented spore testing (Policy and Procedure manual)
• Substandard Treatment – stringent standards
• Record-Keeping – is it documented and is it legible?
• Administering Anesthesia and Sedation Without Proper Permits – get your own
• Lack of Informed Consent – does it require general or specific consent?
More Frequent Non-Compliance Deficiencies:

- Improper Delegation – just because they can do it, doesn’t mean they may (Privileging and Competencies)
- Impaired Practice – even if it’s prescription
- Lack of Compliance with CEU Requirements – the less you take now, the more you’ll have to take when they find out
- Unlicensed Practice – having a degree is not the same as a license (Credentialing)
- Unwise Case Selection (Perform only what you are trained and experienced enough to perform at a quality level)

What to include:

• **Mission Statement** – partnerships and planning
• **HR** – job descriptions, time sheets, immunization list, workplace manifest, accident and incidence report forms
• **Patient Record Management** – informed consent, health history, privacy notice, treatment record, patient report form, referral form, patient bill of right and dental record release form
• **Patient Services** – scope of services, fee schedule, hours of operation and contact procedures for after hours
• **Portable Dental Equipment** – set-up and breakdown of equipment, daily, weekly, monthly and annual schedule of maintenance
• **Dental Radiographs** – radiation officer contact information, guidelines for prescribing radiographs, dental radiology procedures, safety procedures, infection control guidelines for radiographs and equipment maintenance
• **Infection Control** – initial and annual infection control training for universal and standard precautions, OSAP infection control site assessment checklist, management and follow-up of occupational exposures management of regulated and non-regulated medical waste and management of dental unit water quality
• **Quality Assurance** – chart audit form, peer review site visit protocol and site satisfaction form
Liability: Top Ten Record Keeping Mistakes
Liability: Top Ten Record Keeping Mistakes

#10. Failure to perform an oral cancer exam
#9. Lack of written treatment plans
#8. Failure to perform a periodontal charting and DX
#7. Failure to document conversations
#6. Illegible chart writing
#5. Lack of specific informed consent
#4. Failure to document and record referrals
#3. Failure to document informed refusals
#2. Lack of a general consent
#1. IIIINRIDNH
Spoliation

NEVER ALTER A RECORD
The Spoliation Inference

When a party destroys evidence, it may be reasonable to infer that the party had “consciousness of guilt” or other motivation to avoid the evidence and the jury can review all evidence in as strong a light as possible against the spoliator and in favor of the opposing party.
The Safety Net Solutions Team and Expert Advisors
Partnering to Strengthen and Preserve the Oral Health Safety Net

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A PROGRAM OF THE