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445 East 4500 South #130
Salt Lake City, UT 84107
801-262-0200 Local
800-432-5743 Statewide
801-262-0285 Fax
info@pieutah.org
www.pieutah.org

MORE ON ELECTRONIC RECORDS

We have covered some of the problems we have encountered with electronic or digital records previously but we wanted to share information we obtained about a non-PIE case and problems encountered with the records in that case. In this case the defense lawyers described having to work around the following problems:

1. The records did not provide sufficient detail to provide a complete picture as to what happened during the patient's treatment.
2. The records did not describe any of the difficulties the treating dentist encountered.
3. The printouts with actual dates of treatment were scant and hard to follow chronologically.
4. There were inconsistencies with appointment dates in the progress notes, financial ledger and prescription records.
5. There were omissions or deficiencies in the author of the treatment note.
6. Some appointment dates included no progress notes at all or simply a one-line entry.
7. As treatment evolved there was no new proposed treatment plan noted, even though the original plan was included in the records.
8. Telephone conversations with the patient were not recorded.
9. The dentist kept the system terminals open under one user name each day. As a result, the name of that user appeared on every entry in the records for that day, regardless of who actually made the entry.

The interesting thing we must pass on is that we have encountered every one of these problems ourselves several times, and even all in one case as was described here. We have yet to see any one electronic records system that would satisfy our concerns but we can provide the following suggestions to help you help us:

1. Do not be satisfied with your templates alone to document what happened. Be sure you can add additional information as necessary to ensure adequate detail. Make each entry as if you knew PIE would be reviewing it two years later yet could understand exactly what happened.
2. Be sure to document problems you encounter such as a pinpoint exposure during cavity preparation, a calcified root canal, a small sinus perforation during an extraction, and so forth.
3. Make sure your system allows printouts to appear chronologically and consistently no matter what date they are printed.
4. Make sure that all dates are accurate and that there are no discrepancies when you compare the financial ledger, progress notes, treatment notes, journal entries, prescription records or anything else. The challenge here is to make your entries in a timely fashion on the day the procedure was performed.
5. No matter whose user name is used to open terminals, etc. made sure it is clear which dentist provided the treatment and which assistants were involved and who made the entry, especially in a group practice. Initials are acceptable as long as there is a log kept as to which initials apply to which person.
6. System crashes can be responsible for situations where there are blocks of appointments with no notes, etc. Be sure to back up properly especially right before a systems upgrade. Be sure before you log out for the day that there are no unfinished entries or dates with no notes accompanying the date.
7. Be sure there is some way to preserve the original treatment plan as some systems will delete procedures from the electronic treatment plan once they are performed. As things change, be sure to either re-do the treatment plan or document clearly why a change was necessary.
8. All telephone conversations with patients regarding treatment and especially complications must be documented. If the dentist takes a call at home in the evening, he/she should make written notes and enter them the next day in the electronic system using the next day's date.
9. As mentioned in #5 above, it should be clear from the records who did what.

The biggest problem we have seen in our cases is that we almost never get a complete set of electronic records initially. Things such as Journal Notes, Prescription Records, financial ledgers,

health history forms, etc. are often not included. You can help us by making an effort to provide us with every single piece of electronic data you have on the patient, even if you think that it may be irrelevant.
--RCE

THE CONTROLLED SUBSTANCE DATA BASE: A REVIEW

Utah dentists are fortunate in that they have a means of assessing the drug history of patients who they suspect may be abusing narcotics. Drug issues often play a role in the malpractice cases PIE deals with so we thought it would be worthwhile to provide you with the latest information from DOPL. You can consider this information which was received directly from DOPL to be up-to-date as of January 20, 2016.

CSD Information and Reporting Illegal Activity

1. It is unlawful for any person knowingly and intentionally to possess an altered or forged prescription or written order for a controlled substance. It is unlawful to acquire and possess a controlled substance obtained by fraud and deceit.

2. Call the Division of Occupational & Professional Licensing (DOPL), Bureau of Investigation at 801-530-6630 to:
   A. Request a pharmacy alert to be issued by DOPL regarding the misuse of the practitioner's (dentist) Drug Enforcement Administration (DEA) number.
   B. Report DOPL licensed individuals who may be altering, forging, or prescribing inappropriate amounts of controlled substances.
   C. Report a patient that is suspected of "doctor shopping" or committing prescription fraud to DOPL for a pharmacy alert and local law enforcement for investigation.
   D. Complaints to DOPL may be submitted online at http://dopl.utah.gov/investigations/complaint.html

3. All dentists who possess a current Utah license to administer and prescribe controlled substances are required to register to access the Controlled Substance DataBase Program (CSD). The link (url) to register and use the CSD is www.csd.utah.gov.

4. Dentists are encouraged to search the CSD on a patient before a controlled substance is prescribed.

5. Dentists are encouraged to take advantage of the "Notification Program" (NP) within the CSD.
   A. You will be notified by either email, text, or both if a patient obtains another controlled substance prescription from another practitioner within 15-90 days.
   B. You may set up your own parameters by clicking on "Notifications Settings" after clicking on the "Notifications" button on the main search page.
   C. You may choose to opt out by changing the number of days to zero.

6. Dentists may check their controlled substance prescribing activity regarding their DEA number by clicking the "Search by DEA #" button on the main search page.

Please note that you cannot simply use the telephone to request a drug report on a patient. You have to use the online method to register first and then follow the prompts to request the needed information. The telephone number listed should only be used to report problems as described in #2 above.
--RCE

WHAT IS A BROKER OF RECORD? WHAT DOES IT HAVE TO DO WITH PIE?

Most if not all of you know that PIE has a wholly owned agency called Professional Assurance Corporation (PAC) through which we can offer limited insurance products such as Business Owners Policies to cover your equipment + business liability and Workers Compensation Insurance. For many years PAC has enjoyed an excellent working relationship with Berkley Risk Services of Colorado whose agents offer various options for these coverages at very competitive rates. The advantage to PIE insured for obtaining coverage with Berkley Risk is that we can sometimes assist in the claim process and help to expedite resolution of the problem by assisting you and Berkley Risk. PAC also shares the commissions associated with the policies Berkley can sell to PIE members which turns into non-premium income for PIE.

When obtain these policies through Berkley Risk which currently offers options through either Travelers, Hartford or Hanover insurance companies Berkley Risk is considered to be the **Broker of Record**. However, any agent who also works with these companies can approach you and try to entice you to name them as the Broker of Record. If you agree to do this, then you no longer can receive any benefit or help from PIE, and your renewals no longer benefit PIE as no commission can come in. The agent who talks you into the switch is basically getting a free ride as they did nothing to research the various companies to see which one can give you the best deal, which is what Berkley Risk will do for you.

So we encourage you to rebuff any efforts by agents who approach you and try to convince you to name them as the Broker of Record. Instead, please keep things as they are with Berkley Risk as the agent of record and PIE is a position to continue to be able to help you if necessary.
--RCE

WHAT WILL BE YOUR LEGACY?

What kind of dentist do you want to be? How do you want to be remembered when you pass on?

Over the years I have met some wonderful dentists who became really good friends. One of these was Dr. Bruce L. Lambson who practiced near downtown Salt Lake City for thirty-three years.

Dr. Lambson had a successful practice and had a reputation for being really proficient at doing excellent restorative dentistry. He retired at age 67 and was in excellent physical shape because he ran, played racquetball and golf. Indeed, I got to know him through Utah Dental Golf and we had many fun outings through the years. But unfortunately Dr. Lambson had a series of atypical accidents and concomitant health issues which culminated in his death at age 80 in January 2016. As people reminisced about him what came out was his patients appreciated the efforts he made to be an accomplished and respected dentist. Indeed, on the lid of his casket a medallion was attached which read, "May the work I have done speak for me."

So, how do you want to be remembered? As a dentist more interested in the bottom line and indifferently cramming as many patients into a day as possible or someone who was known for taking the time to do an excellent job with flair and kindness thrown in.

When I was in practice, I had a patient who was a high school auto repair instructor who taught his students the mantra "If you aren't going to do it right, don't even start!" I thought that was excellent advice and tried to keep this in mind as I performed dental procedures. Dr. Lambson followed this mantra as well as the one on the medallion and retired with a stellar reputation and with patients who were sad to see him go.

The other lesson Dr. Lambson would teach us is that you can be in the best physical shape possible yet have no guarantees that this condition will continue. So there may be merit in not putting things off until retirement, etc. as travel and other activities that you contemplate during the "golden years." In other words, go for the gusto now because the window of opportunity may close before you know it!

And RIP and sincere thanks to Dr. Lambson and all of the other excellent dentists who have passed on but whose excellent dental work will continue to speak for them for many years to come.
--RCE

TWO COMMON QUESTIONS WE GET:

1. **If a patient personally requests copies of their dental records must I have them sign a request form?**

The answer is NO! However, if you get a third party request from another dentist or a person other than the patient, you should have the patient sign a simple authorization such as: *I authorize Dr. X to provide a copy of my dental records to Dr. Y."* Now, if the patient's spouse requests the copies you should still refrain from furnishing copies without the authorization in case the patient is in the middle of a divorce that you may be unaware is going on..

2. **I had a deaf patient request an appointment who then told me I am required to provide a sign language interpreter at my expense. Is this true?**

Yes, this is correct! Through a law passed a couple of years ago a dentist must obtain an interpreter for any appointment and you must pay for them! Alternatively you can refer the patient to Dr. Ben Young who learned sign language as a child and has informed PIE that he is happy to see these patients. His office is in Sandy and he can be reached at 801-352-8288.

CBCT IMAGES: AN EXPERT OPINION

In the April and July issues of the PIE Newsletter we published articles that had to do with the relatively new CBCT or Cone Beam technology that has become more prevalent in the Utah dental community. Earlier this summer we were fortunate to have, for the first time, an ***oral and maxillofacial radiologist****, Dr. Anthony R. Mecham, come to the intermountain area to practice. I asked Dr. Mecham to share his views on the topic of CBCT image quality and also state his opinions on the use of the images generated which can be very detailed and very comprehensive. Dr. Mecham has gone the extra mile in providing a detailed and frank account of his opinions that are well worth your consideration. The first part of his report will cover the earlier articles and the second part will cover his and my opinions on how CBCT images should be reviewed once they are taken.*

"Dr. Engar asked me to express my opinion on the matter of CBCT image quality that was mentioned in two articles published in the April and July PIE Newsletter. In the April newsletter, Dr. Engar began the article with the question, 'Are cone beam units a great and expensive leap backwards?' There is no doubt that the wording was a little harsh, but after seeing the images he referred to, I understand his frustration.

In the July newsletter, Dr. James L. Guinn shared his thoughts on the subject. I appreciated Dr. Guinn's article and thought it was a well-written and well-stated response. Dr. Guinn covered many of the issues I also would have raised in response to the initial article. Many of my points will agree with what Dr. Guinn said, but I'll try to focus on additional points of emphasis and clarification.

Point 1: Panoramic images printed from cone beam data are far inferior to images generated by panoramic x-ray units, either digital or film based.
This is a blanket statement that I think gives the wrong impression of the overall quality of cone beam images. Cone beam images offer roughly similar resolution to panoramic x-rays and when acquired and handled correctly can offer a superior image to images to traditional panoramic images due to several factors, including the lack of ghost images, blurring, magnification, sensitivity to patient orientation, and overlap of structures.

I think the major issue here is comparing printed images to film images or images viewed digitally. There are two reasons that printed images are inferior to viewing digital or film images: loss of spatial resolution or loss of contrast resolution. It is possible to maintain the spatial resolution of a printed image, but you would have to use a high resolution printer (which is typically very expensive), magnify the image, or a combination of both. It is not

possible, even with a nice, photo-quality printer, to maintain the contrast resolution of an image. Images will have a contrast resolution of at least 8 bits (256 shades of gray) up to 16 bits (65,536 shades of gray). Since a printer doesn't have hundreds of shades of gray ink, gray is made by printing a varying number of black dots and a maximum of 65 gray values can be reconstructed. Another limiting factor is the ratio of the amount of light reflected by white paper to that absorbed by black ink, which limits the contrast ratio to 25:1 (White & Pharoah, 2014). To summarize: you always lose image quality by printing it. High quality, high resolution printers on photo paper can do a decent job at maintaining enough image quality to render a diagnostic quality image, but will never be as good as the original image. Based on the images that Dr. Engar had sent to him, it looked like this was a major factor in their quality.

Point 2: Some of the uses of cone beam images.
There is no consensus on when a cone beam CT should be used. There have been several different attempts at compiling guidelines, which vary greatly and always ends up stating that each patient should be evaluated individually and the decision is left up to the practitioner's judgement. I would argue from a medicolegal standpoint, that CBCT should always be considered in the case of implants. It is becoming accepted as the standard of care for implant planning. For other uses of CBCT, as a general rule, it should not be used as a screening tool but if you need more information than can be gained from a 2D image, CBCT is recommended. That can include impacted teeth, endodontic evaluation, anatomical structure localization (inferior alveolar canal, mental foramen, maxillary sinuses), trauma evaluation, evaluation of pathology, TMJ evaluation, and airway analysis.

Point 3: Dentists charging exorbitant rates for copies of cone beam data.
I agree that this is ridiculous! A duplication fee should either be included in the cost of cone beam acquisition or a nominal charge, just to cover the cost of the disc and the minimal time of an employee to copy the data to a disc, should be considered as the proper fee to charge.

Point 4. Not all patients need to undergo a cone beam scan.
I would hope this is self-explanatory and we are all diligent about limiting the amount of radiation our patients are exposed to. With that said, the effective dose given to a patient for one of the newer generation cone beam scanners for medium or even large fields of view is usually comparable to the dose a patient would receive from a full mouth series of x-rays. Some of the low dose protocols are comparable to the dose from a panoramic radiograph. Each practitioner should be aware of the effective dose their machine is exposing the patient to for specific imaging protocols, and I would not trust numbers reported by the companies selling them. A good reference for doses for the most common machines can be found in 'Effective dose of dental CBCT—a meta analysis of published data and additional data for nine CBCT units.' Dentomaxillofac Radiol 2015; 44. You are welcome to contact me if you would like the dose numbers for your specific machine.

Point 5: Cone beams are not infallible.
No tool or technology that we have is infallible. For imaging modality it always comes down to having the correct acquisition technique, and software manipulation and interpretation skills. I agree that being able to recognize different types of artifacts is crucial to CBCT interpretation, Arguably, discerning artifacts is **the most important skill** –right up there with anatomical knowledge. In the case of needle localization, I'm surprised a cone beam couldn't localize a needle in a case described. It seems like a decent quality cone beam image would be able to show the location. Many ENTs are starting to use cone beam CTs because of their high resolution, low cost, low dose compared to medical CT, and accessibility.

Summary
Like Dr. Guinn, I'll also quote Gordon Christensen who swears by the usefulness of CBCT in dentistry and says that not every dentist necessarily needs his or her own unit, but should have access to a CBCT when the need arises. I can understand the trepidation of referring patients to another general dentist who owns a CBCT for fear of losing patients, but there are likely specialists who would be happy to image other provider's patients. Imaging Centers are another option, like Oral-Maxillofacial Imaging Center in Murray, or Ultradent in South Jordan. As a service to Utah dentists, I have started to put together a list of clinics that are willing to take patients for CBCT imaging. I am constantly updating a page on my website that shows these clinics on a map, along with their contact information. Please contact me if you would like to be added to the list or if you need help finding it. A reference I used to provide information for this article is: White, S.C. & Pharoh, M.J. Oral and Maxillofacial Radiology, St Louis: Elsevier Health Sciences, 2014."

We appreciate Dr. Mecham for providing the above opinion and commentary for you all to consider. Now I asked him to take the next step and provide his commentary on the best way for CBCT technology to be used to benefit patients. Utah is not used to having a Maxillofacial Radiologist available to help read and interpret the CBCT generated images so Dr. Mecham's comments may appear blunt and thought-provoking but my hope is that they encourage our PIE insured to consider using the expertise that Dr. Mecham can provide to help you and your patients.

CBCT Interpretation
I would like to take some time to mention cone beam CT interpretation. When I was deciding on oral radiology as a specialty, I was in the Air Force in Anchorage, Alaska. We had our own cone beam machine that we would use periodically for implants or third molar extractions. I quickly recognized that outside the dentition itself, I really didn't know what I was looking at…..and I wasn't alone! There was a rule in the Air Force that each and every scan be read by a radiologist, but this wasn't being followed due to a shortage of radiologists. This wasn't a problem that was unique to the military. Cone beam CT machines were proliferating like crazy and the education to interpret the images they were generating was virtually non-existent. I recognized this huge gap between image generation and interpretation, and knew I wanted to help fill that gap.

After finishing my radiology program and entering the world outside the military environment, it is apparent that this gap still exists and is wider than ever. It has become clear that dentists practicing in 2015 and 2016 do not like to be told that they should refer scans to a radiologist and I have given in to the pressure to

not recommend it as strongly as I should have. After being involved as an expert witness in a litigation case in Utah, it has become abundantly clear that I'm not doing anyone any favors by telling you that you don't have to refer to a radiologist.

Oral radiology has been a recognized dental specialty for 15 years now and as for any dental specialty, a dentist interpreting their own images will be held to the same standard as a trained radiologist. This is why physicians have every radiograph read by a radiologist. I think it is clear that this is something that is beneficial to the patients. Whenever we expose the patient to any imaging, we have the responsibility to interpret the entire image, not only what we think applies to our specific area of interest. I have seen evidence to the fact that interpretation of the entire dataset is more often than not being completely ignored. Some dentists ONLY LOOK AT A PANO RECONSTRUCTION of a large field of view cone beam! A panoramic reconstruction is made from a volume about 1-2cm wide around the dentition of the patient. This is about 10% of the entire dataset! Does this then show only a level of 10% concern for the overall well-being of the patient?

What can and should be done to improve the level of patient treatment? Maybe the cost of CBCT acquisition has to increase to cover the cost of interpretation. I think if the reason for interpretation by a radiologist is explained, then the patient will understand. I have made a pamphlet explaining to the patient why it is important that they have an oral radiologist look at their cone beams. You can see this pamphlet on my website; please let me know if you would like some copies for your patients.

Many people have asked me if there are any public cases of dentists being sued for missing things on cone beams. There are cases out there, probably more than anyone is aware of since many are typically handled internally and settlements are confidential. From the line of questioning I've seen by lawyers, I fully expect to see more and more in the very near future. I want to be very unambiguous here; I believe it is in the best interest of the patient as well as the provider to refer cone beam scans to be read by a radiologist. I have been doing everything I can to get the word out there and to make the referral process as seamless as possible.

I appreciate Dr. Mecham's candid and direct commentary. Please do not consider his opinions to be self-serving as I asked him specifically to be blunt and direct since we are talking new ground here and he is able to provide a service that most if not all of you have not yet been able to utilize. He is currently practicing in Idaho. If there is enough interest, he will consider helping dentists with implant planning which would include a radiology report and fabrication of surgical guides using a 3D printer for a set fee. If you can use his services he can be contacted as follows:
Web site: www.oralradiologists.com
e-mail addresses: tony.mecham@gmail.com or oralradiologist@gmail.com
Telephone Number: 617-347-5670
--RCE

AN INTERESTING IMPLANT CASE

We recently received information about an implant case involving a non-PIE insured dentist. As some aspects of the case are quite interesting we thought it would be worthwhile to list the allegations as they appeared in the complaint and then discuss the ramifications and what mistakes the dentist made in the case. The four main allegations were listed in the Complaint as follows:

1. Failure to properly assess, document and treat "infected bone."
2. Failure to properly assess, document and treat an implant that "had become dislodged in September 2014.
3. Poor dentistry leading to inability to eat food by mouth, dramatic weight loss and failure to thrive.
4. Wanton disregard for the patient's well-being justifying a claim for punitive damages.

Now, could any of these allegations be significant? If this were a PIE case, would we be worried? Let us evaluate the allegations:

1. This allegation is valid if the patient should have received additional dosages of antibiotics or if improper instructions regarding the initial prescription were given. Interestingly, in a recent article I received through the ADA the author, a periodontist, advocated the advantages of azithromycin over amoxicillin used prophylactically before implant placement. The authors of the article noted that the most remarkable finding of their research was that a single dose of azithromycin also helped reduce inflammation and had a possibly favorable influence on healing

2. One month after an implant was placed in the patient's lower right mandible, according to the complaint it later "came out due to infected bone." The subject dentist allegedly "removed the implant, sterilized it, and placed it 2mm further back (distally?) into healthy bone." Have you ever heard of taking an implant out, sterilizing it, and replacing it? That was news to me. The question arose, is this is something that falls within the standard of care? Or, does it simply represent a cheap dentist? I spoke with several general dentists and specialists, including an oral surgeon and periodontist, and none of them had ever sterilized and then tried to replace the same implant in the same patient or even another patient. The standard of care is to generally return the failed implant to the manufacturer as there may be a rebate or refund available depending on the manufacturer. Otherwise, the failed implant is used as a sample once it is cleaned up, etc. to show inquisitive patients what an implant looks like. There are apparently no studies to show the efficacy of sterilizing an implant for replacement or whether this procedure does anything to the surface of the implant that would interfere with osseointegration.

3. If these allegations are true, then the restorative work done would have been below the standard of care but these claims are often subjective in nature and can be

dealt with by analyzing medical records and even social media as often patients will blab or blog about their great vacations, etc. while their deposition testimony attempts to paint an entirely different picture of their lack of enjoyment of life.

4. A claim for punitive damages can be bad news as no malpractice policy covers such a claim, including PIE's. What this means is that the plaintiff's lawyer hopes that a jury would feel that the dentist exhibited such wanton disregard for the patient or their well-being that the dentist should be punished financially. If punitive damages are awarded payment would have to come straight out of the dentist's pocket. We have never had a case where punitive damages were awarded against any PIE insured but we will routinely make it clear to the dentist involved if such a claim is part of the suit. Normally we will recommend that the dentist obtain their own counsel to deal with this allegation and normally if the case is that bad efforts would be made to settle to ensure that the case never gets to the point that such a penalty could be assessed against the dentist involved.

What is the moral to this story? If a patient does indeed have infection develop around an implant care must be taken to ensure that proper treatment or referral are rendered. Aggressive steps must be taken including immediate referral to a dental specialist or physician should any early signs of infection become manifested. These patients will require more vigilance and follow-up care to ensure a positive outcome. And no attempt should ever be made to recycle an implant yourself!
--RCE

GUEST COMMENTARY

- **By Gary B. Wiest, DMD**
- **Member, PIE Board of Directors**

Recently, I was reading the obituary page in the daily newspaper. There was an obituary of a young man who had died from an overdose of heroin. This was unsettling as a young life had ended too soon and could have been prevented. Researching his story, I found out that he had gone to his dentist to have his third molars extracted. He was prescribed Oxycodone. He developed a dependency to the narcotic. This led him down the spiral path to addiction to more powerful drugs, and ultimately to his death. Everyone reacts differently to narcotics and other medications. Extreme care needs to be taken in prescribing these to our patients.

Doctors, are we spending the necessary and appropriate time in our schedule evaluating our patients' medical histories? Do we inappropriately prescribe medication like antibiotics or especially pain medication? Do we spend time in the schedule doing a screening of patients before we prescribe any pain medications? Here is a recent scary advertisement from an attorney's firm that made me wonder if I could do better:

"Doctors who negligently prescribe opioid painkillers to their patients may be at fault in the event of an overdose or death. If you or a loved one suffered an overdose as a result of prescribed use of opioid painkiller or other narcotics, you may be eligible to file a lawsuit.

Patients who were treated with a prescription opioid painkiller and experiences complications from the drug-inducing overdose or addiction may be eligible to file a class action lawsuit against the manufacturers of these drugs *or the doctors who prescribed them.*

Despite warnings about the risk of improperly prescribing opioid painkillers to patients, many doctors fail to exercise caution when prescribing these drugs to patients. Doctors improperly prescribe painkillers to their patients increasing their rick of addiction, overdose, or other complications.

Patients who are given too high of a dose, who are not proper candidates for opioid use or who are prescribed painkillers with too many other sedating medications may be at risk. *When doctors fail to educate their patient about the proper use of these drugs, the danger is further increased.*

The attorneys at this firm are the nationwide leaders at trying cases involving side effects from opioid medication. Our lawyers have interviewed hundreds of expert witnesses and reviewed millions of legal and scientific documents for our painkiller lawsuits. Our attorneys have extensive knowledge and experience in litigating cases involving overdoses from negligent painkiller prescribing. For a free consultation, contact our law firm by calling our toll-free number."

"More Americans now die every year from drug overdoses than they do in motor vehicle crashes and the majority of those overdoses misuse prescription medication." This according to a White House release, moved the President to launch a presidential memorandum directing all health care professionals employed by the federal government to be trained in responsible opioid prescribing. With this, the ADA pledged the association's support in raising awareness about the problems and solutions concerning opioid abuse, misuse, and diversion.

One of these solutions in the dental office is **S**creening, **B**rief **I**ntervention and **R**eferred to **T**reatment (SBIRT). Right now efforts are being put in place to educate and train dentists in Utah on the SBIRT model through the online tutorial we have had to complete to get our State Controlled Substance License. SBIRT is a comprehensive and integrated approach to the delivery of early intervention and treatment services through universal screening for persons with substance use disorders and those at risk.

The screening is the kickoff point and that is where our patient's medical history can be such an important tool in our practices. More time needs to be spent to have patients fill out the questions without feeling rushed. More time needs to be planned evaluating the medical history and discussing your findings.

Attached to this newsletter is an updated medical history with questions pertaining to the screening process. Added questions to get the ball rolling are:

1 Any family history of substance abuse/misuse?
2. Any personal history of substance abuse/misuse?
3. Do you take any sedative medication including herbal supplements?

I know of sad stories in Utah where people's lives have dramatically been altered or even ended because of indiscriminant prescribing of opioid medications from a dental office visit. Hopefully, we all can be part of the intervention and treatment services by helping patients who suffer from substance use disorders by using SBIRT in our practices.

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