Department of Health

# Dental contract reform:

## Managing Patient Compliance and Motivation

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### Introduction

The purpose of this note is to:

- provide advice on patient non-compliance eg what to do if you are unable to complete an examination or a patient refuses to answer a social history or medical history question question)
- Provide advice on dealing with particular scenarios eg where patient compliance remains unsatisfactory and provision of advanced care may not be appropriate
- Signpost prototypes to the further guidance on patient motivation, communication and changing patient behaviour that is available

### Risk assessment

The matrices are set to function on the basis of clinical findings and patient information provided. The system enables you to indicate if a patient is non-compliant in one or more of the four clinical domains (caries, perio, tooth surface loss and soft tissues). For example, if a BPE cannot be completed for a dentate adult patient then you may tick the "non-compliant" box for the periodontal domain. This response will then be transmitted for the domain and you will not have to enter a BPE score.

### Medical & social histories

The system specifies only the questions that are required to enable the matrices to function. Answering these questions is not mandatory from a risk assessment point of view, so if a patient refuses to answer a particular question(s), the software system will allow you to move on to the next question on section. The matrices will then generate a risk rating (RAG) for any given clinical domain based on the clinical and patient information entered.

There is a template which sets out the minimum information needed to drive the matrices. Practices may add to this as they wish. The templates can be found at: http://www.pcc-cic.org.uk/article/making-it-work-clinically

The software systems contain a medical and social history template which providers can use or adapt for their practice so long as the questions that drive the matrices to generate the RAG score for the patient are incorporated

Where patients are unwilling to answer certain questions then you should of course explain to them why this information is helpful in assessing and managing their risk of current and future oral disease. Retaining the scanned signed copies of the medical and social histories as part of the clinical record is important. It would also be advisable to make a note of any discussion with the patient regarding this as part of the clinical record, including any limitations placed on the care and advice you are then able to offer the patient as a result.

Whilst the preventive pathway may have limitations should a patient decline to provide a complete social and medical history, it would **not** normally be appropriate to refuse to offer NHS care and treatment to such patients.

However, practitioners have a professional responsibility to consider patient safety when treating all patients. You may feel that a patient's refusal to answer certain questions (especially medical history ones, whether these are related to the risk matrices or not), impacts on their safe treatment – in which case, it may be reasonable to limit the care and treatment you provide accordingly. Again, any discussions of this nature with the patient, including the potential clinical impact, should be clearly recorded in the clinical record.

**Completion of an oral health assessment (OHA)**

There are some patients - for example, those with learning disabilities or challenging behavior - for whom it may be difficult or impossible to complete a full OHA. When this happens, it is important to make a record in the patient's record of the reason(s) as well as ticking the "patient non-compliant" box for the relevant domain(s).

Whilst the number of non-compliant patients will vary dependent on the patient groups treated, unless a service is providing special care dentistry it would not normally be expected that significant numbers of patients would be non-compliant for one or more domains. Information on non-compliance will be transmitted and where significant numbers of patients are recorded as being non-compliant, you should be able to justify this on an individual case basis if required.

Where a patient is non-compliant, you may still enter a RAG rating for a domain if you want to. For example, you might choose to record a patient with very poor oral hygiene and complex medical and social needs as red for the periodontal domain. The patient's record should reflect this and your reasons for doing so.

Where, for whatever reason, a complete medical and social history cannot be recorded, you may consider the preventive pathway is significantly compromised. Aside from the Community Dental Services (CDS), this would be expected to be a very infrequent occurrence, so you would need to make a clinical judgement as to the value of continuing the pathway or providing more limited treatment, bearing in mind the need to:

- avoid discrimination against any particular group(s)s of individuals
- reduce healthcare inequalities

For some patients you might need to consider referral to a special care dentistry provider.

**Preventative care and advice to patients - Interim Care (IC)**

Where the pathway suggests additional preventative care and advice in the form of interim care is appropriate for a patient questions have been raised as to how long practices should continue to provide this despite their best efforts, there is little or no change in the patient's behaviour and consequently no improvement in oral health.

This is a matter for individual clinical judgement and will depend on the particular circumstances of each case. Should a practitioner consider that the patient response to preventive advice continues to be poor then the reasons for deviating from the pathway should be clearly explained to the patient and recorded in the clinical record. The patient should still be encouraged to attend for a recall as appropriate in accordance with their recorded OHA.

A common related question is "At what point does a pathway cease to have any value?" Treatment is limited by what the patient is willing to accept and the advice s/he is willing to adhere to. Some patients are not interested in prevention, preferring simply to attend the dentist when in pain. They may agree one or more IC appointments and then simply not turn up. Again, it is a matter for individual clinical judgement to decide whether, and at what point, to discontinue the pathway.

A common related question is “If a patient won’t comply at what point does following the recommendations the pathway suggests for a patient cease to have any value?” Treatment is limited by what the patient is willing to accept and the advice s/he is willing to adhere to. Some patients are not interested in prevention, preferring simply to attend the dentist when in pain. They may accept preventative treatment at the OHA agree one or more IC appointments and then simply not turn up. Again, it is a matter for individual clinical judgement to decide whether, and at what point, to discontinue offering the additional prevention recommended by the pathway. The reasons for the deviation should be recorded, explained to the patient and he or she should still be encouraged to attend for a recall as appropriate in accordance with their recorded OHA.

An FP17 should be opened at the start of an IC course of treatment and closed at the end. The patients charge is a band 1A unless the CoT is advice only in which case there is no charge.

**When advanced should care be provided?**

Advanced care includes treatments such as indirect restorations, metal based partial dentures, and advanced endodontic treatments. A requirement to provide advanced care does not necessarily indicate a need to refer a patient – this will normally be determined by the complexity of the advanced care required.

It is considered good clinical practice to provide these treatments when the optimal benefit in terms of outcome can be achieved for the patient. Evidence suggests that if these treatments are provided when active disease is present (i.e. periodontal disease and/or dental caries) the outcome is generally much poorer. Whilst the preventive pathway provides a structure to support decisions on when advanced care should be delivered, this should not be seen as restricting a practitioner’s clinical judgement. Neither does it change the “NHS offer”: all dental treatments currently available on the NHS are available under the pathway. Should a practitioner consider that for sound clinical reasons a particular advanced care treatment should not be offered to a patient being treated on an NHS care pathway, then s/he should also be consider whether offering such a treatment under any other treatment arrangement might also be considered inappropriate clinically

Clinical and patient factors should be considered carefully before advanced care is provided. For example, “red” patients should have active disease stabilised first. Treatment will therefore focus initially on stabilising active caries and periodontal disease - and not on doing complex restorations on teeth in an oral environment where further disease is likely to occur. This approach is both for the long term benefit of the patient and to ensure effective use of dental resources. There will of course be circumstances where active disease has not been completely stabilised and a practitioner considers that delaying an advanced care treatment might jeopardise the long term outcome for the patient. Such cases would not be expected to be frequent and you should make a clinical judgement based on the circumstances of each individual case.

**What is the difference between advanced care and complex care?**

Advanced care relates to the type of care provided – so treatment such as a crown on a single tooth would be considered advanced care.

In the context of the dental contract reform programme the term “complex care” is often used to refer to the element of contract value assigned to non-routine care (essentially Band 3 treatments). (It can also be used more generally to refer to either the level of complexity of a particular procedure, or the complexity of managing a particular patient.)

Specialty commissioning guides that deal with that aspect of developing a new and more modern and more clear system about the relationship between primary care and specialist delivery are in development. Three have published to date:

- Oral Surgery
- Special care dentistry
- Orthodontics

**Patient motivation and communication**

The pathway approach aims to encourage patients / carers to be more informed about, and more involved in, managing their own oral health. This is based on research[1] which shows that shifting from ‘compliance' (where patients obey a set of instructions) to 'concordance' (where patient and practitioner achieve a set of shared goals) achieves better results.

The use of RAG and the self-care plan are important here – patient feedback (ICM Survey 2012 link to evidence and learning reports) has indicated that both are important in terms of communication and motivation.

**Changing patient behaviour**

Oral hygiene, alcohol and tobacco consumption, diet, use of fluorides and dental attendance all impact on oral health. The prevention of oral diseases is largely dependent upon patients changing their behaviour in these areas in line with professional advice. Partovi[2] makes the point that dental professionals are educators as well as providers of dental care, and that patient education is an integral part of dental treatment. His five principles of effective instruction are:

- Present small amounts of information at one time
- Let patients set their own pace
- Supervise the patient when teaching a new skill to ensure the correct technique is learnt
- Provide immediate feedback - the longer the delay, the less the patient will remember
- Use positive reinforcement – do not wait until the patient perfects the technique, praise them whenever they do something correctly. Don't focus solely on mistakes – this can lead to a negative attitude towards oral hygiene.

Some patients may not be interested in prevention and choose to ignore the advice given to them. They may say that they do want to attend an interim care appointment or agree one or more appointments then simply do not turn up.

**Further guidance available**

The third edition of “Delivering better Oral Health; an evidence based toolkit for prevention” (published June 2014) contains a chapter on helping patients to change their behaviour.

Further information can be found using the following links;

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/367563/DBOHv32014OCTMainDocument_3.pdf
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/357838/DBOHv3SEP2014SummaryTables.pdf

**References**

1 Marinker M. From compliance to concordance: achieving shared goals in medicine taking. London: Royal Pharmaceutical Society 1998
2 M Partovi 2006. Compliance and your patients. Academy of Dental Therapeutics and Stomatology. http://www.rdhmag.com/articles/print/volume-30/issue-11/features/compliance-and-your-patients.html

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