Meeting the Challenge

Managing Difficult and Noncompliant Patients

Program speaker

The speaker for this program is Christine M. Hoskin, RN, MS, CPHRM, Senior Patient Safety & Risk, MedPro Group (Christine.Hoskin@medpro.com)

Christine has been involved in risk and quality management throughout her career, providing oversight of clinical education, epidemiology, safety, accreditation, risk management, quality improvement, and nursing.

She has experience in a range of care settings — including both inpatient and outpatient facilities, primary care, specialty care, dental care, and rehabilitation — and with various patient populations.

These opportunities have enabled Christine to develop a strong understanding of the challenges and opportunities facing healthcare providers and organizations.

Christine is a registered nurse. She earned her bachelor of science and master of science degrees from Nebraska Methodist College of Nursing and Allied Health. Additionally, Christine is a member of the American Society for Healthcare Risk Management and holds a certificate in healthcare risk management.

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

Objectives

At the conclusion of this program, you should be able to:

- Identify factors that may contribute to problematic or noncompliant patient behaviors
- Identify proactive steps for reducing the escalation of problematic or noncompliant patient behaviors
- Discuss the role of technology in patient engagement
- Discuss strategies for effectively handling new or established patient visits when patients are difficult and/or noncompliant
- Summarize the process for discharging a patient from the practice

What the media say

Angry parent launches Facebook attack on Calif. dentist
By Donna Domino, Features Editor

Angry Patient Threatens to 'Smoke Up' Hospital: Cops

Patient angry at Advocate Christ Medical Center staff, claimed to be in a gang, told police: "I mean my people going to come to fight."

Oak Lawn, IL

By Lorraine Swanson (Patch Staff) - May 7, 2016 6:59 pm ET

Bryan Farrow, 36, confronted his dentist Neil Chapple at his practice with a 3ft scaffolding pole and challenged him to a fight outside

Retired dentist stabbed to death by former patient seeking compensation for his discolored teeth

POLICE BLOTTER: Angry patient smacks doctor's employee in face with door

COMMENT Tweet

By staff reports

Posted May 9, 2016 at 4:00 AM
Updated May 9, 2016 at 6:53 AM

Lansing Doctor's Office Damaged After Upset Patient Drove Car Into Building

Posted: Nov 18, 2015 4:33 PM CST
Updated: Nov 25, 2015 4:33 PM CST

By Jamie Valentine, Producer CONNECT

What the researchers say

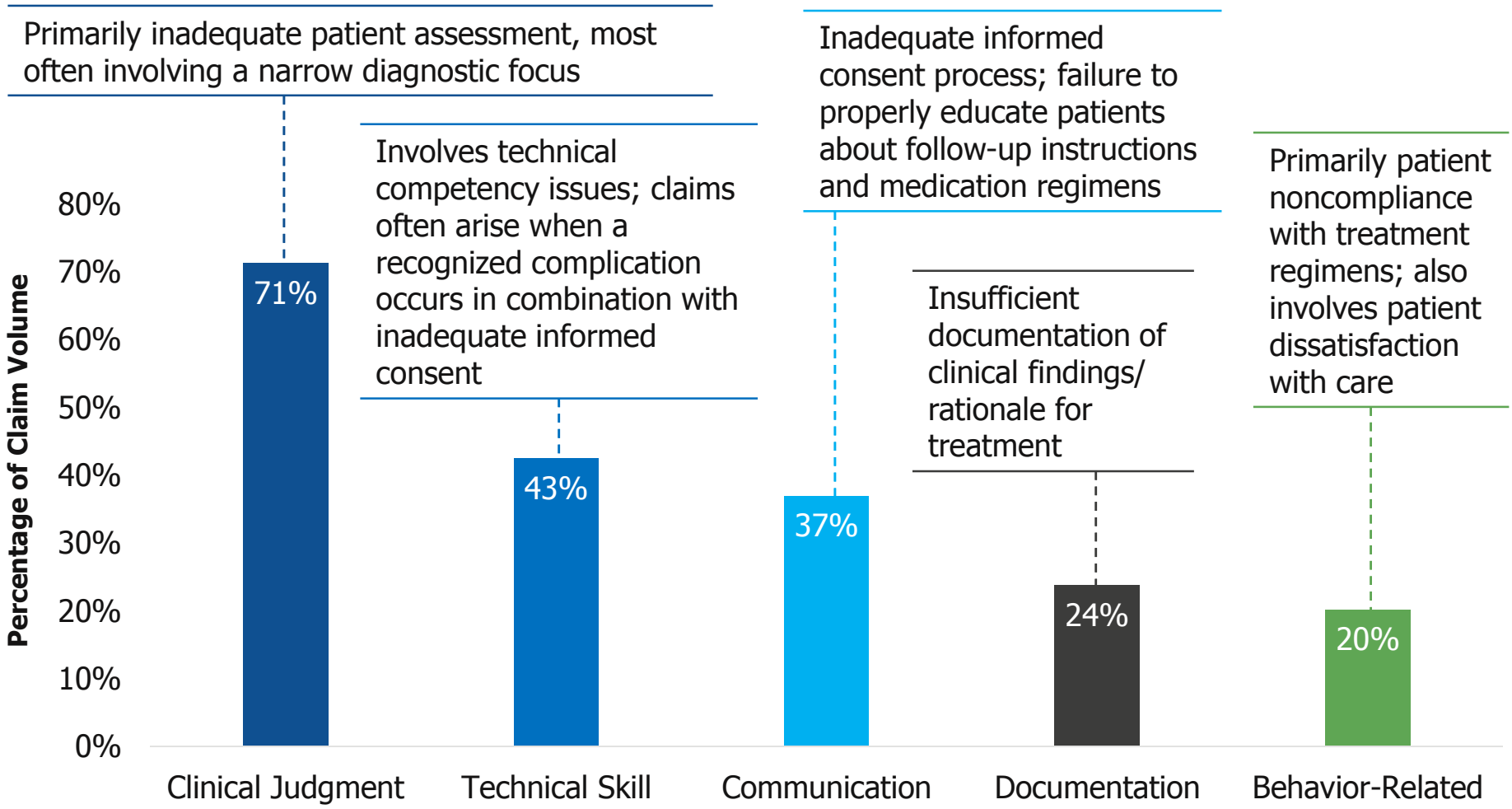
When dealing with difficult patients:

- Clinicians are 42% more likely to wrongly diagnose a complex medical issue
- Clinicians are 6% more likely to wrongly diagnose a simple medical issue

Source: Schmidt, H. G., et al. (2016, March). Do patients' disruptive behaviours influence the accuracy of a doctor's diagnosis? A randomised experiment. *BMJ Quality & Safety.* Retrieved from http://qualitysafety.bmj.com/content/early/2016/02/09/bmjqs-2015-004109

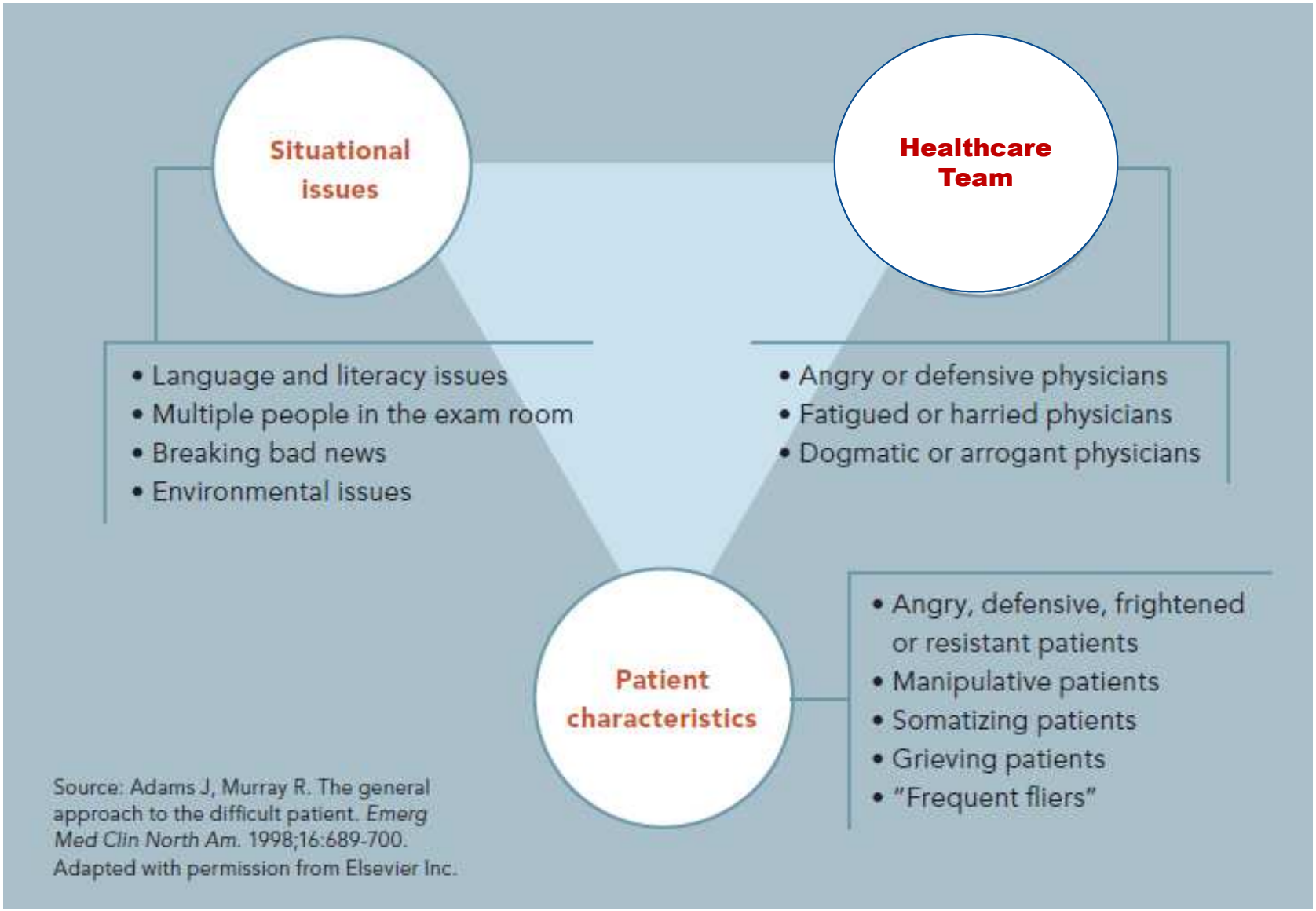
What the claims data say about risk factors

Risk factors are broad areas of concern that may have contributed to allegations, injuries, or initiation of claims.



Source: MedPro Group closed claims data, 2005–2014 (all specialties); totals do not equal 100% because more than one factor may be coded per claim.

Components of a difficult clinical encounter



Source: Hull, S. K., & Broquet, K. (2007, June). How to manage difficult patient encounters. *Family Practice Management.* Retrieved from http://www.aafp.org/fpm/2007/0600/p30.html

Difficult patients — warning signs

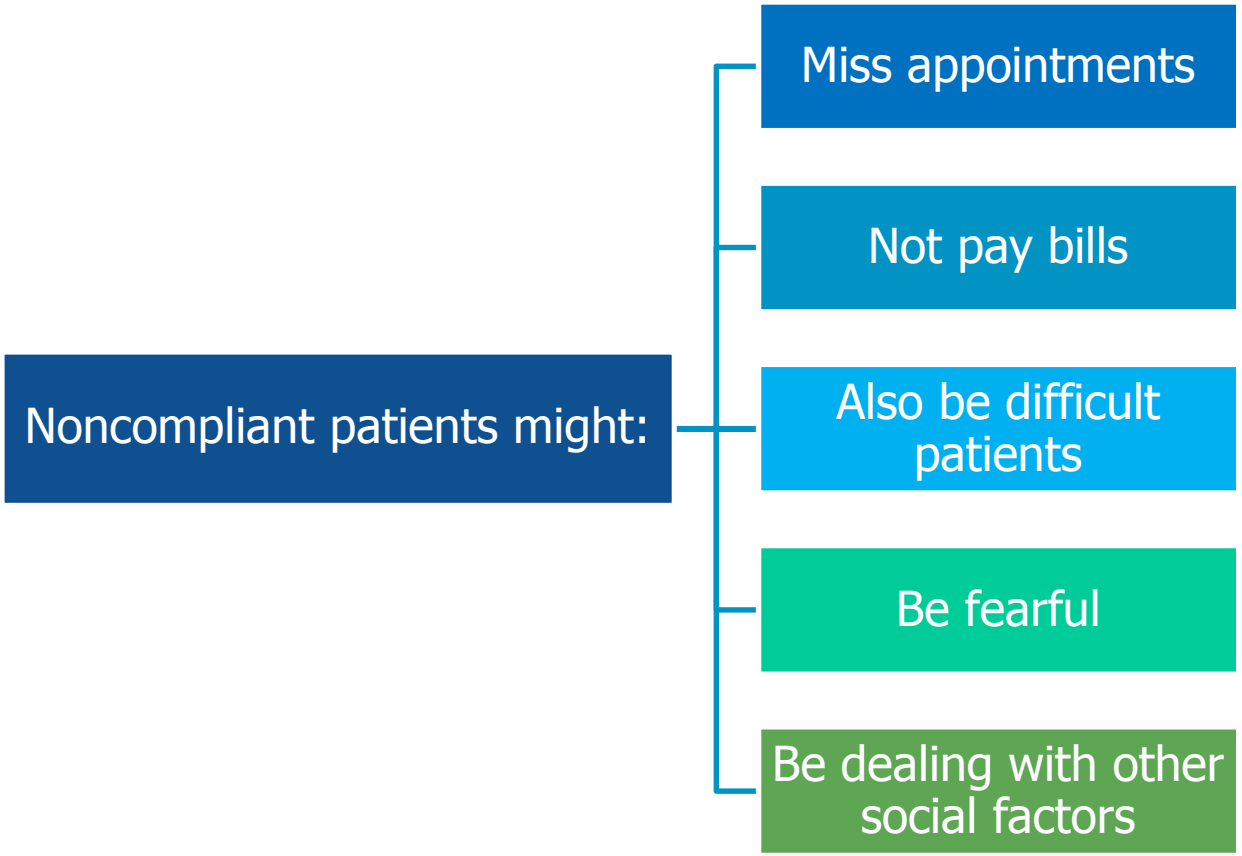
- Unrealistic demands
- Escalating behavior
- "Frequent flyer" behavior
- Frequent requests for refunds/waivers
- Angry/aggressive
- Repetitive complaints without clear clinical significance
- Noncompliant behavior

Case study — the difficult patient

Patient	60-year-old male who had diabetes.
Case overview	The patient had a history of noncompliance and had been discharged from a previous family medicine practice. At the current practice, he was seen multiple times over a year with elevated blood sugar levels. After one lab result showed significantly elevated levels, the family medicine physician talked to the patient about appropriate diet, exercise, and smoking cessation; the doctor also stressed the need for fasting bloodwork. Subsequently, the patient was seen several times but did not follow through on the recommendations. Further, the physician did not document the repeated conversations. The patient did not return phone calls or schedule office visits despite continuing to go for nonfasting bloodwork and dropping by the office for medication samples. When critical values for both glucose and A1C were noted, the practice's clinical assistant called and left messages for the patient, but did not document these communication attempts.
Outcome	Ultimately, the patient was found unresponsive at home, having suffered a stroke (blood sugar >700). He subsequently died due to a multitude of issues, including sepsis, septic shock, pneumococcal pneumonia, stroke, pancreatitis, and hepatitis.

Noncompliant patients

Noncompliance might be due to:	
Lack of understanding	Choice



Case study — the noncompliant patient

Patient	29-year-old male with limited English proficiency who needed a tooth extraction.
Case overview	The patient developed throat pain and was prescribed amoxicillin and clavulanic acid by a physician. One day later, the patient went to the emergency department with continued pain. He was discharged with a script for both pain medication and penicillin. The patient's family told the patient to stop taking the amoxicillin and clavulanic acid, and to take the penicillin only. Four days later, the patient went to a dentist who diagnosed him with severe gingival inflammation, heavy plaque, and calculus on two teeth. Extractions were done. The patient's medication history was blank in the chart. Post-op instructions were given and included only naproxen for pain. No documentation showed whether an interpreter was used. At the post-op visit, the dentist recommended an immediate consult with an oral surgeon due to complications. Because the patient stated he had no money, the dentist referred him to a community health center and prescribed penicillin and pain medication. Later that day, the dentist's staff called the patient, who reported that he felt better and had not seen another provider.
Outcome	The patient died later that same day. Sepsis related to oral infection was determined as the cause of death.

Guidelines and Policies

Recommended guidelines

Administrative

- Appointment cancellation/no shows
- Fees and refunds/ waivers
- Financial obligations

Patient Care

- Prescription refills
- Mutual respect
- Visit follow-up ("no shows" or lab results)

General

- Complaint handling
- Termination of the relationship
- Behavior contracting

Written Materials

Resources to address health literacy

National Institutes of Health
Turning Discovery Into Health

"Saves Lives. Saves Time. Saves Money." — NIH

https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/health-literacy

Centers for Disease Control and Prevention

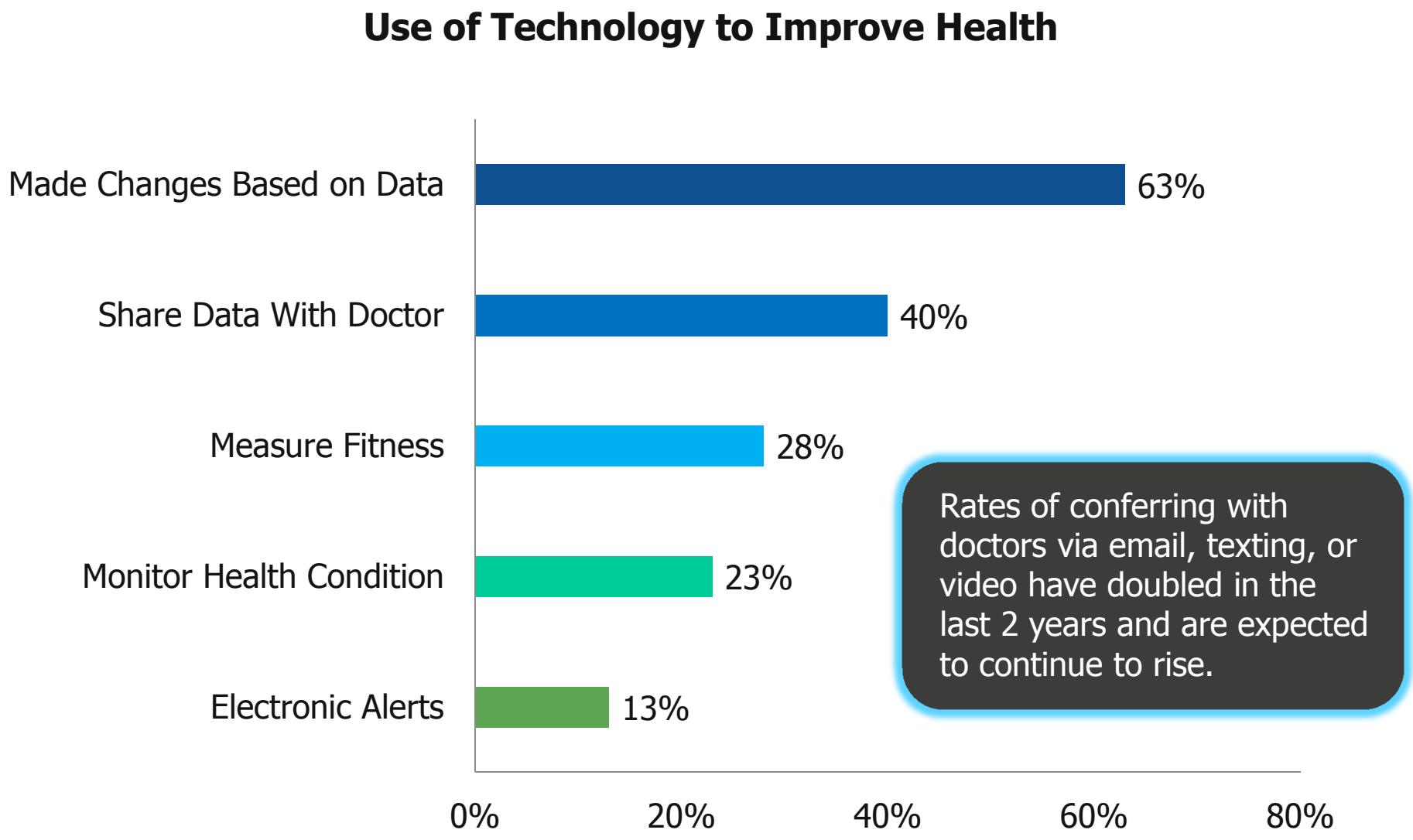
www.cdc.gov/healthliteracy/index.html

CMS.gov
Centers for Medicare & Medicaid Services

www.cms.gov/Outreach-and-Education/Outreach/WrittenMaterialsToolkit/index.html?redirect=/writtenmaterialstoolkit/

Patient Engagement Through Technology

Age of digitization



Source: Monegain, B. (2015, October 15). Deloitte: Consumers using more healthcare technology. *Healthcare IT News.* Retrieved from http://www.healthcareitnews.com/news/deloitte-consumers-using-more-healthcare-tech

Development, selection, and evaluation of IT tools

Mobile App Rating Scale: A New Tool for Assessing the Quality of Health Mobile Apps

http://mhealth.jmir.org/2015/1/e27/

Accessible Health Information Technology (IT) for Populations with Limited Literacy:

A Guide for Developers and Purchasers of Health IT

https://healthit.ahrq.gov/health-it-tools-and-resources

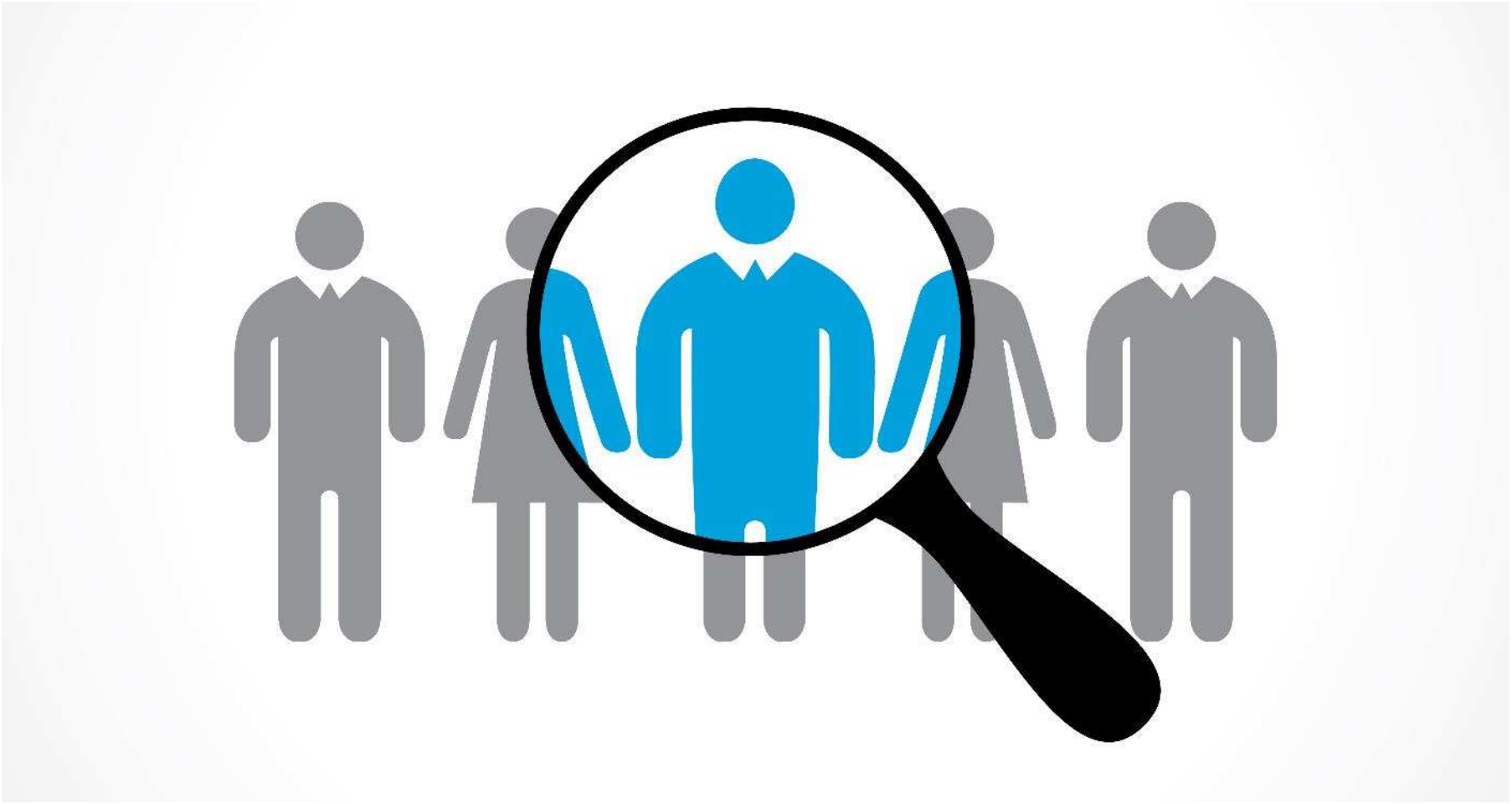
Published online 2014 Sep 24. doi: 10.1007/s13142-014-0293-9

Evaluating and selecting mobile health apps: strategies for healthcare providers and healthcare organizations

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4286553/

Proactive Strategies

Screening



Strategies following decision-making

Decline

- Do not charge for visit.
- Tell the patient you cannot meet their needs.
- Advise the patient to find another doctor.

Accept

- Be clear about boundaries, limitations, and expectations.
- Stick to the plan.
- Document thoroughly.

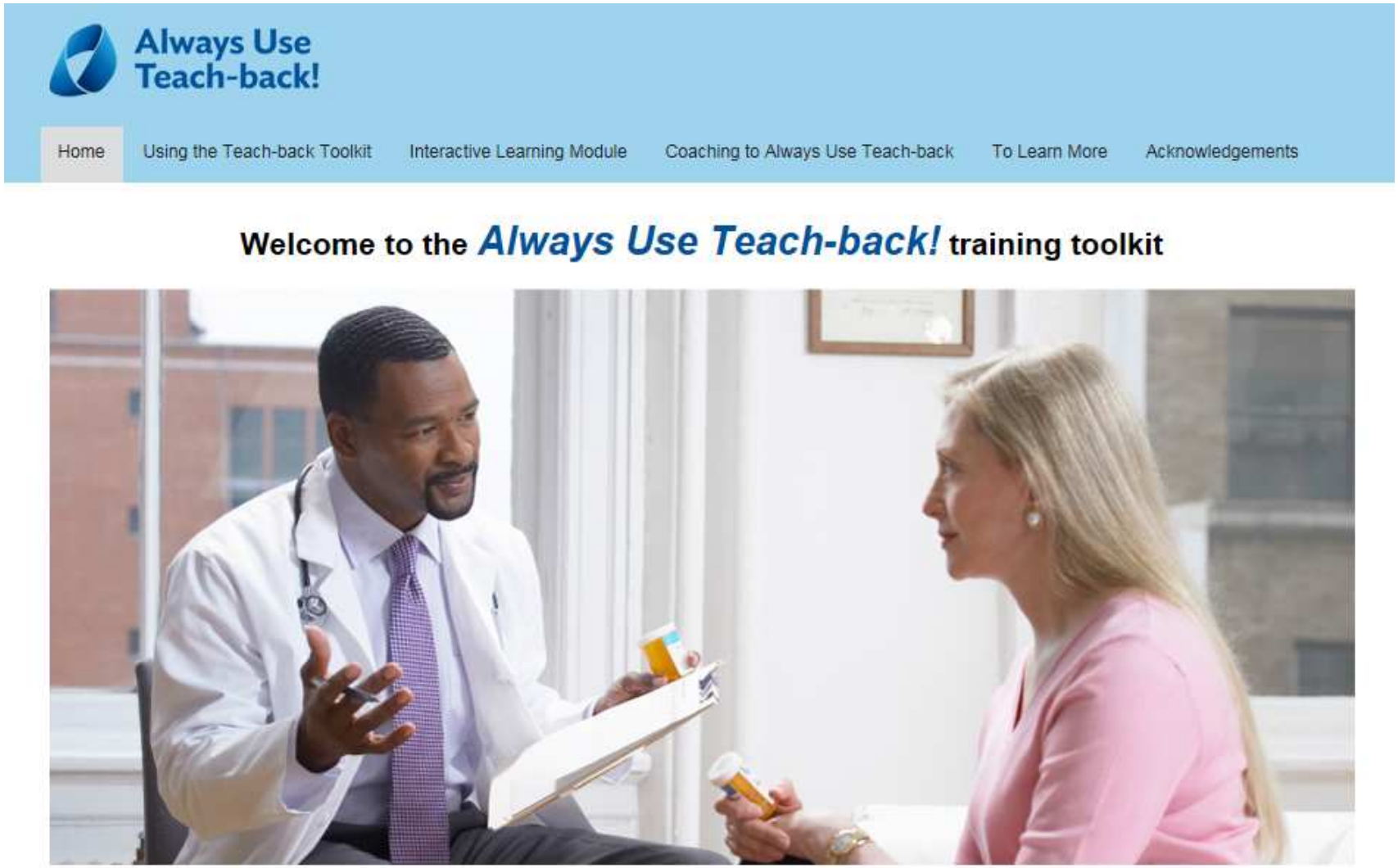
Strategies for Managing the Relationship

Managing the visit

- Start with an agenda
- Use verbal cues
- Address the patient's emotions up front
- Address your own emotions
- Have a seat
- Be prepared for "Oh, by the way . . ."

Source: Lutton, M. E. (2004, July). Sticking the landing: How to create a clean end to a medical visit. *Family Practice Management.* Retrieved from http://www.aafp.org/fpm/2004/0700/p51.html

Teach-back



Teach-back toolkit: http://www.teachbacktraining.org/

Informed refusal

MedPro Resource

Informed Refusal: A Review (www.server5.medpro.com/documents/11006/16730/Informed_Refusal_A_Review.pdf)

Behavior Contracting

Behavior contracts

Using a behavior contract might be beneficial when working with patients who have:

- Patterns of inappropriate behavior
- Manipulative behavior
- Continued noncompliance
- Financial barriers
- Drug-seeking or addictive behaviors

A behavior contract also might be beneficial when dealing with families or caregivers who have challenging behavior.

Before the behavior contract

Is the relationship worth preserving?

Is the patient acutely ill?

Is the behavior ongoing, or was it an isolated incident?

Can the problematic behavior(s) be changed?

Is the person who has the problematic behavior the patient or a family member/significant other?

Do certain factors — such as intellectual immaturity, health illiteracy, or comorbidity — inhibit the patient from understanding that the behavior is hindering an effective relationship?

What measures have been taken so far to correct the behavior?

Before the behavior contract (continued)

Is the problematic behavior objectively documented in the patient's medical record as it occurs? Does the documentation avoid disparaging remarks and subjective statements? Are quotes used when possible?

Are you willing to follow through with the terms of the contract if it is violated (e.g., terminate the relationship)?

Has a threat of harm or actual harm occurred to you or your staff? If yes, implementing a behavior contract may not be appropriate. You may want to consider terminating the provider–patient relationship.

MedPro Resource

Behavior Contracts (www.server5.medpro.com/documents/11006/16738/Behavior+Contracts+Guideline_10-2013.pdf)

Last Stop: Termination

Professional organization opinion

ADA American Dental Association®
America's leading advocate for oral health

The American Dental Association does not have an official position related to termination of patient relationships; however, the American Medical Association offers a good starting point.

AMA
AMERICAN MEDICAL ASSOCIATION

Physicians have an obligation to support continuity of care for their patients. While physicians have the option of withdrawing from a case, they cannot do so without giving notice to the patient, the relatives, or responsible friends sufficiently long in advance of withdrawal to permit another medical attendant to be secured.

http://www.ama-assn.org//ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8115.page

Terminating the provider–patient relationship

Consistent with practice policies

Sufficient and objective documentation that supports the decision

Phase of treatment

Written notice elements

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

MedPro Resource

Terminating a Provider–Patient Relationship (www.medpro.com/documents/10502/359074/Terminating+the+Provider-Patient+Relationship+Guideline.pdf)

Administrative considerations

- Send letter by (a) certified mail with return receipt requested and (b) by first class mail
- Retain letter in the patient's record with signed receipt
- Notify staff to place patient's name on "no schedule" list

Note: Some managed care organizations require additional steps before discharge.

What if the patient terminates the relationship?

- Confirm with letter
- Certified with return receipt requested and first class mail

"This is to confirm that you have terminated the relationship with . . ."

Summary

Not all patients are a good fit for your practice. Screen and choose carefully.

Noncompliant patients are a challenge to the practice. Identify issues (situational, provider/staff, and patient) and develop plans to address them accordingly.

Patients might be difficult for a variety of reasons. Listening to and trying to understand the patient's situation may improve provider–patient interactions.

Consider using alternative approaches (i.e., technology) to meet the needs of your patient populations.

Document all attempts to address noncompliance and/or difficult behavior.

Terminate the relationship only as a last resort, unless threats are involved.

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