Meeting the Challenge
Managing Difficult and Noncompliant Patients
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 Swenson (Patch Staff) - May 7, 2016 6:59 pm ET

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
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
By Jamie Valentine, Producer
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.

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

- Primarily inadequate patient assessment, most often involving a narrow diagnostic focus: 71%
- Involves technical competency issues; claims often arise when a recognized complication occurs in combination with inadequate informed consent: 43%
- Inadequate informed consent process; failure to properly educate patients about follow-up instructions and medication regimens: 37%
- Primarily patient noncompliance with treatment regimens; also involves patient dissatisfaction with care: 24%
- Insufficient documentation of clinical findings/rationale for treatment: 20%

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

Situational issues
- Language and literacy issues
- Multiple people in the exam room
- Breaking bad news
- Environmental issues

Healthcare Team
- Angry or defensive physicians
- Fatigued or harried physicians
- Dogmatic or arrogant physicians

Patient characteristics
- Angry, defensive, frightened or resistant patients
- Manipulative patients
- Somatizing patients
- Grieving patients
- “Frequent fliers”

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

Noncompliant patients might:

- Miss appointments
- Not pay bills
- Also be difficult patients
- Be fearful
- Be dealing with other social factors
# 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

<table>
<thead>
<tr>
<th>Administrative</th>
<th>Patient Care</th>
<th>General</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Appointment cancellation/no shows</td>
<td>• Prescription refills</td>
<td>• Complaint handling</td>
</tr>
<tr>
<td>• Fees and refunds/waivers</td>
<td>• Mutual respect</td>
<td>• Termination of the relationship</td>
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<tr>
<td>• Financial obligations</td>
<td>• Visit follow-up (“no shows” or lab results)</td>
<td>• Behavior contracting</td>
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Written Materials
Resources to address health literacy


www.cdc.gov/healthliteracy/index.html

Patient Engagement Through Technology
Use of Technology to Improve Health

- Made Changes Based on Data: 63%
- Share Data With Doctor: 40%
- Measure Fitness: 28%
- Monitor Health Condition: 23%
- Electronic Alerts: 13%

Rates of conferring with doctors via email, texting, or video have doubled in the last 2 years and are expected to continue to rise.

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

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 . . .”

Informed refusal

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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

<table>
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<tr>
<th>Question</th>
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<tr>
<td>Is the relationship worth preserving?</td>
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<td>Is the patient acutely ill?</td>
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<td>Is the behavior ongoing, or was it an isolated incident?</td>
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<tr>
<td>Can the problematic behavior(s) be changed?</td>
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<tr>
<td>Is the person who has the problematic behavior the patient or a family member/significant other?</td>
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<tr>
<td>Do certain factors — such as intellectual immaturity, health illiteracy, or comorbidity — inhibit the patient from understanding that the behavior is hindering an effective relationship?</td>
</tr>
<tr>
<td>What measures have been taken so far to correct the behavior?</td>
</tr>
</tbody>
</table>
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.

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Last Stop: Termination
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.

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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