

Patient Noncompliance: Reduce Risk by Strengthening Communication

Patient noncompliance can take a variety of forms. Frequently, it presents as an obstinate unwillingness to adhere to an indicated course of therapy, exemplified by repeatedly missing appointments, rejecting obvious diagnoses and standard treatment recommendations, and refusing to follow through with consultations or take prescribed medications. It also may be expressed through disregard for practice rules, unwillingness to provide necessary information, or chronic late payment or non-payment of bills.

Habitual noncompliance typically reflects a patient's refusal to assume responsibility for his or her own health. It can be distinguished from a simple difference of opinion between patient and provider in that it manifests as a pattern of behavior, which may be characterized by a manipulative or controlling attitude, or an inclination to always blame others. Noncompliance can escalate to hostility if the patient's condition worsens, or if the practitioner or healthcare business does not submit even to irrational or counterproductive demands.

Left unchecked, such conduct may eventuate in litigation, as in the following professional liability scenario:

A 58-year-old man presented to an urgent care center with a "boxer" fracture to his right hand. He was treated by a nurse practitioner (NP), who ordered his medical assistant to apply a temporary gutter splint to the injured hand. The patient returned to the center in 11 days for a cast, as instructed. The NP documented the appearance of ecchymosis above the fourth and fifth mid-metacarpal areas, along with tenderness and decreased range of motion. X-rays were ordered, revealing a complex/oblique fracture with good position of the fourth and fifth metacarpals. A metal gutter splint was reapplied, and the patient was seen by an orthopedic surgeon two days later per discharge instructions.

Approximately one month later, the patient returned to the center and was again seen by the NP for decreased movement and edema in the fingers of the splinted hand. The patient appeared dissatisfied with the orthopedic surgeon, asserting that the surgeon had not discussed therapy or follow-up treatment with him. However, based upon the patient's responses to questions, the NP suspected he had not complied with care recommendations, such as elevating the affected extremity and taking anti-inflammatory agents as prescribed. A subsequent discussion with the patient regarding the importance of following the prescribed plan of care was thoroughly documented in the healthcare record by the NP. Additional X-rays were ordered, revealing a lack of callus formation at the site of the fracture. Accordingly, the gutter splint was left intact and the NP scheduled an appointment with another orthopedic surgeon for a second opinion.

The patient did not keep the follow-up appointment, instead returning to the initial orthopedic surgeon. Over the next few months, the patient's hand worsened as he failed to keep appointments and follow his physical therapy regimen. He was eventually diagnosed with reflex sympathetic dystrophy, caused by a prolonged tight splint. The diagnosis was confirmed by another orthopedic surgeon. One year after the fracture occurred, the patient filed a lawsuit against the treating NP, alleging negligent care and citing continued numbness, tingling, temperature intolerance and loss of grip in his right hand. The court ultimately dismissed all claims against the NP, due primarily to the detailed account of noncompliance in the patient's healthcare information record.

Sound documentation and timely intervention are critical to limiting the consequences of defiant, recalcitrant or passive-aggressive patient behavior. A carefully documented record may prove invaluable in defending against allegations of negligence or abandonment. Early identification of the signs of noncompliance is critical to reducing risk, permitting healthcare business owners to take action before the situation worsens.

DOCUMENTING MISSED APPOINTMENTS

Too often, healthcare practices treat a missed appointment merely as an annoyance and fail to note the occurrence in the patient healthcare information record. However, as missed appointments may indicate potential noncompliance, they require thorough follow-up and documentation. Healthcare businesses should have a formal written policy for managing missed appointments, which includes the following procedures, among others:

- *Prepare a daily list of missed appointments* by patient name and medical identification number.
- *Document the occurrence of missed appointments* in the progress notation of the patient healthcare information record.
- *Utilize a special template for electronic record systems or preprinted stickers for paper records.* Ready-made formats or notes facilitate documentation of missed appointments and prompt appropriate follow-up orders, such as:
 - Call patient today to reschedule.
 - Send reminder card to reschedule.
 - Send certified/return receipt letter regarding the need to reschedule.
 - Request the practitioner to review, sign and date the progress notation and order any recommended follow-up.
 - Document all patient follow-up efforts and place a copy of any written correspondence to or from the patient in the patient healthcare information record.

COMMUNICATING WITH NONCOMPLIANT PATIENTS

When treating uncooperative patients, even basic expectations must be spelled out. Standardized educational materials, appointment reminders, and other teaching and memory aids can help foster a better rapport with such patients. If written reminders fail to improve compliance, schedule a face-to-face discussion with the patient regarding mutual concerns and expectations, and document this meeting in the healthcare record.

Follow up with a letter to the patient, explaining that the primary goal of the practice is to deliver quality care and emphasizing that noncompliance with recommended treatment precludes optimal results. Both spoken and written messages to the patient should be clear, direct, polite and sympathetic.

When communicating with noncompliant patients by letter, consider the following risk management recommendations:

- *Send the letter by certified mail* and place a copy in the patient's healthcare information record.
- *If the patient has health insurance, copy the member/beneficiary services department on the correspondence.* Inform the health plan that the healthcare business is caring for a noncompliant patient, who may require referral to another panel physician or advanced practice provider if the behavior fails to improve.
- *In the letter, instruct the patient on how to contact the office,* in order to reschedule missed appointments or otherwise rectify the situation. Emphasize that one wishes to improve the relationship and continue to provide treatment.

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INFORMED REFUSAL

Persistent failure to heed medical advice can lead to less than desirable results for the patient, as well as potential liability exposure for providers. Business owners can counter this risk by adopting a standardized refusal-to-consent form, which serves to confirm in writing that the provider fully disclosed to the patient the risks of forgoing the proposed test, treatment or procedure. (See the supplement to this issue for a [sample informed refusal form](#).) By signing the form, patients acknowledge that they have discussed the proposed course of care with their practitioner and understand that failure to follow medical recommendations can have serious or even life-threatening consequences.

The completed refusal-to-consent form should be placed in the healthcare information record. If the patient subsequently experiences a downturn, the documentation can help protect the provider, as well as the practice or business, by demonstrating that the patient's own behavior and actions contributed significantly to the negative outcome.

TERMINATING THE PATIENT-PROVIDER RELATIONSHIP

If compliance remains an issue despite a determined effort to educate and communicate with the patient, it may become necessary to take decisive action. The decision to unilaterally end a patient-provider relationship can have legal repercussions and should not be made without proper deliberation. Irrespective of the circumstances preceding termination, providers must ensure that the patient's health status is not compromised. Treatment should continue until procedures already begun are completed and the patient is medically stable.

If the provider ends the relationship without providing reasonable notice, the patient may sue on grounds of abandonment. To prevent such allegations and satisfy ethical and professional obligations, the treating provider should observe the following safeguards:

- *Check the termination policies of the patient's health plan* prior to initiating any action.
- *Send the termination letter by certified mail* after communicating the reasons for the decision via face-to-face discussion.
- *Indicate the patient's current health status* and include any recommendations for immediate medical care.
- *Note the date the relationship will end.* Thirty days from receipt of the letter is customary.
- *Agree to provide emergency care* until the stated date of termination.
- *Suggest the patient locate another provider* by contacting the health plan's member services department or the local medical society. Provide telephone numbers or other contact information, as necessary.
- *Offer to send a copy of the patient healthcare information record to the subsequent treating provider* after the patient has executed a form authorizing release of information. Enclose such a form with the termination letter, along with a self-addressed stamped envelope.
- *Retain a copy of the termination letter in the patient healthcare information record* and carefully document any subsequent correspondence with the patient.

Patient noncompliance is too serious a risk to ignore. Healthcare business owners can help minimize liability exposure by ensuring that providers and staff respond promptly to missed appointments, communicate expectations clearly and document patients' refusal of recommended treatment. If it eventually becomes necessary to terminate a chronically noncompliant patient, the measures indicated herein can help prevent disruption of care and subsequent allegations of abandonment.

Patient Compliance: A Self-assessment Checklist

The following questions are designed to help enhance patient understanding of and adherence to treatment plans by strengthening communication, rapport and education. For additional risk control tools and information on a wide and growing range of topics, visit www.cna.com, www.hpsso.com and/or www.nso.com.

SELF-ASSESSMENT TOPIC	YES/NO	ACTION(S) NEEDED TO REDUCE RISKS
IMPROVING COMMUNICATION		
Are potential time constraints recognized at the outset of patient encounters, and are adjustments – such as double-appointment bookings and/or use of scribes – made to ensure sufficient interview time?		
Are questions posed in a constructive, problem-solving manner? For example, <i>“I see that you have not been completing your daily exercises. I wonder if they are causing you too much pain, or if there is some other reason?”</i>		
Do providers relate personally to patients, in order to build a stronger therapeutic partnership? For example, <i>“Tell me, what can I do differently to help you meet your personal health goals?”</i>		
Are providers trained in setting and adhering to the discussion agenda? For example, <i>“We are here to discuss your leg pain. The vascular studies show you have peripheral arterial disease, and I would like to talk about surgical options. Is that okay with you?”</i>		
Do patient encounters begin with a discussion of patients’ personal goals and issues, rather than a recap of laboratory or diagnostic workups? For example, <i>“First, tell me what concerns you most, and then we’ll discuss test results.”</i>		
ENCOURAGING COOPERATION AND PARTICIPATION		
Do providers explain to patients that they must take some responsibility for the outcome of their care or treatment? For example, <i>“We both want you to benefit from physical therapy, but I’m not sure you fully support our current approach. What do you think might be more effective?”</i>		
Do providers clearly and explicitly convey the severity of the problem and the risks of not properly carrying out instructions? For example, <i>“Your wound must be cleaned three times a day in the first week after surgery, in order to avoid hard-to-treat infections and permanent scarring. What questions do you have about dressing changes?”</i>		
Are underlying factors affecting compliance explored with patients in a nonjudgmental way? For example, <i>“It sounds as though you may be concerned about the medication’s possible side effects. Is that why you have not taken it as prescribed?”</i>		
Does each encounter end with the patient verbalizing at least one self-management goal in a clear and specific manner? For example, <i>“I will monitor blood glucose levels before meals and at bedtime between now and my next appointment.”</i>		
Are open-ended questions used to gauge patients’ potential resistance to change? For example, <i>“How do you think your life would be different if you stopped smoking?”</i>		
Are 10-point scales used to clarify patient priorities and/or barriers to compliance? For example, <i>“On a scale of one to 10, how important is it for you to resume normal activities without feeling back pain?”</i>		

SELF-ASSESSMENT TOPIC	YES/NO	ACTION(S) NEEDED TO REDUCE RISKS
ENCOURAGING COOPERATION AND PARTICIPATION (CONTINUED)		
Do providers strive to achieve a mutually acceptable plan of care with hesitant patients, using the following strategies, among others:		
<ul style="list-style-type: none"> ▪ Uncovering specific patient concerns, such as out-of-pocket costs? 		
<ul style="list-style-type: none"> ▪ Identifying practical or logistical difficulties that may hinder compliance, such as lack of reliable transportation to and from the healthcare facility? (See below for additional related strategies.) 		
<ul style="list-style-type: none"> ▪ Encouraging patients to get a second opinion, if desired? 		
Are written protocols in place for responding to difficult patients, including documentation procedures for the following situations:		
<ul style="list-style-type: none"> ▪ Repeated prescription refill requests of questionable nature? 		
<ul style="list-style-type: none"> ▪ Narcotic use and general pain management in drug-seeking patients? 		
<ul style="list-style-type: none"> ▪ Appointment or procedure cancellations? 		
<ul style="list-style-type: none"> ▪ Unacceptable behavior, such as belligerent voice-mail messages, yelling or cursing at staff? 		
<ul style="list-style-type: none"> ▪ After-hours patient calls? 		
<ul style="list-style-type: none"> ▪ Refusal to consent to recommended treatment? 		
<ul style="list-style-type: none"> ▪ Neglecting to take medications, do exercises or make necessary lifestyle changes? 		
<ul style="list-style-type: none"> ▪ Terminating the patient-provider relationship? 		
Are providers and staff trained to communicate with hostile, manipulative or uncooperative patients?		
ENHANCING PATIENT EDUCATION AND UNDERSTANDING		
Are barriers to communication – such as low health literacy, cognitive impairment or limited English – assessed and documented?		
Are qualified and credentialed interpreters available when necessary?		
Do providers use the “teach-back” technique to ensure understanding of proposed treatments, services and procedures – e.g., not only asking patients if they have any questions about their medications, but also requesting that they describe in their own words how to take them?		
Has the healthcare business or practice considered the benefits of hiring a health coach, health navigator and/or case manager? (See “Case Management: Six Principles to Enhance Care Delivery,” CNA Vantage Point®, 2013 – Issue 2.)		
Are patients asked to paraphrase in everyday words the medical information they have been given, including:		
<ul style="list-style-type: none"> ▪ Their diagnosis and health status? 		
<ul style="list-style-type: none"> ▪ The recommended treatment or procedure? 		
<ul style="list-style-type: none"> ▪ Risks and benefits of the recommended therapy? 		
<ul style="list-style-type: none"> ▪ Associated patient responsibilities? 		
Do providers ask patients at discharge time to repeat critical instructions, and are their responses noted in the patient healthcare information record?		

SELF-ASSESSMENT TOPIC	YES/NO	ACTION(S) NEEDED TO REDUCE RISKS
HELPING PATIENTS MANAGE LOGISTICS		
Do healthcare information records note whom patients can rely upon to help them meet their general healthcare needs (e.g., spouse, relatives, paid caregivers, friends, etc.)?		
Are patients asked whether they can get to appointments via automobile or public transportation, and are responses documented in the patient care record?		
If a patient lacks the physical or mental capacity to perform such essential tasks as changing dressings or picking up prescriptions, has a relative or friend been asked to assist, with the permission of the patient or legal guardian?		
ISSUING REMINDERS/MONITORING COMPLIANCE		
Are patients reminded of upcoming appointments, including referrals and laboratory visits, via telephone and/or email? Are these reminders documented in the patient healthcare information record?		
Are electronic alerts used to remind patients with a history of noncompliance about screening and monitoring requirements?		
Are blind or visually impaired patients informed of subscription services that use wireless devices to deliver reminders to take medications or perform vital self-care activities?		
Are follow-up and referral appointments scheduled and entered in the computer system before patients leave the facility?		
Does written policy require documentation of no-shows, as well as telephone follow-up within 24 hours?		
Is there a written policy for terminating the patient-provider relationship if the patient is chronically noncompliant and fails to respond to reminders and other messages?		



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