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Rowena D. Nolasco
University of San Francisco, Thirtyccs@aol.com

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The Creation and Implementation of Guidelines for the Appropriate Termination of Patient-Provider Relationships

Rowena D. Nolasco, DNP(c), MSN-FNP, RN

University of San Francisco

DNP Comprehensive Project

Amy Nichols, RN Ed D

Committee Chairperson

Timothy S. Godfrey SJ, DNP, RN, PHCNS-BC

Committee Member

Ian Johnson, MD

Committee Member

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Section 1: Abstract

Primary care providers have terminated patient-provider relationships when they deem them no longer therapeutic. Healthcare providers are increasingly considering this an acceptable practice. However, the criteria for this decision remain unclear. As providers discharge *challenging* or *difficult* patients from their practices, questions to support this decision arise. Discharged patients face displacement and healthcare is disrupted. This project will (a) describe problematic patient-provider relationships and its effects, (b) identify possible alternatives to the firing of patients, (c) list appropriate reasons for termination, and (d) present recommended procedures to avoid allegations of medical abandonment. The project's product is an Appropriate Discharge or Transfer of Care Packet (ADTP) containing a questionnaire, a sample discharge letter, and the organization's written policy for termination. The project was designed as a resource to guide clinicians when the decision to fire a patient becomes necessary. The project was introduced by means of a PowerPoint presentation to two community clinics in Sacramento, California. After the presentation, the ADTP was introduced. Outcome measures were pre- and post-tests that assessed the knowledge of primary care providers on the necessary elements that should be established prior to the firing of a patient. Change was measured by comparing pre- and post-test scores for each attendee and revealed improved provider knowledge. A survey was distributed to assess providers' receptiveness to the use of the ADTP packet. A positive overall response was received. The Medical Director decided to adopt the use of the ADTP with revisions for use in three clinics.

Key words: termination of patient relationship, firing a patient, medical abandonment, problematic patients, challenging patients, difficult patients, discharging patients

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The Creation and Implementation of Guidelines for the Appropriate Termination of Patient-Provider Relationships

Table of Contents

Section I

Abstract ……………………………………………………………. 2

Acknowledgements …………………………………………………… 3

Table of Contents ……………………………………………………...4

Section II: INTRODUCTION

Background ……………………………………………………………6

Local Problem …………………………………………………………8

Intended Improvement/Purpose of Change ……………………………11

Review of the Evidence ………………………………………………. 12

Conceptual/Theoretical Framework ………………………………….. 22

Section III: METHODS

Ethical Issues …………………………………………………………..23

Setting ………………………………………………………………….24

Planning and Intervention …………………………………………….. 26

Implementation …………………………………………………….....28

Planning the Study of the Intervention ……………………………….. 33

Methods of Evaluation …………………………………………………34

Analysis ………………………………………………………………35

Section IV: Results

Program Evaluations/Outcomes ………………………………………36

Section V: Discussion

Summary ……………………………………………………………37

Barriers to Implementation/Limitations …………………………… 38

Interpretation ………………………………………………………… 38

Conclusion …………………………………………………………… 39

Section VI: Other Information

Funding ……………………………………………………………… 40

Section VII: References …………………………………………………….. 41

Section VIII: Appendices

IRB Form …………………………………………………………….. 44

Budget and Gap Analysis ………………………………………… .55

SWOT Analysis ……………………………………………………… 56

GANTT Chart ……………………………………………………….. 57

Other Materials Used for Implementation and Evaluation …… 58-70

Section II: Introduction

Background Knowledge

All primary care providers (PCPs) have the obligation to take care of some patients who are perceived as *difficult*. Providers identify problematic encounters when patients have (a) psychological disorders, (b) life stressors, (c) social isolation, (d) multiple physical problems, (e) chronic diseases, (f) the inability to communicate their own needs, and (g) unrealistic expectations (Serour, Othman, & Khalifa, 2009). In addition, challenging encounters occurred when patients (a) visit regularly but ignore medical advice, (b) insist on an unnecessary drug, (c) insist on an unnecessary test, (d) persistently complain, (e) do not express appropriate respect, (f) show dissatisfaction with care provided, and (g) are verbally abusive (An et al., 2013).

Primary care is dependent on the relationship between the patient (as a person) and the provider (as a professional). Holleman and Brody (2007) explained that a healthy patient-provider relationship maintains clear boundaries, rules, and roles. Providers strive to inculcate a cooperative relationship with their patients so that both can work together for a common goal: to maintain the patient’s health, safety, and wellbeing (Holleman & Brody, 2007).

A study by Ratanawongsa, Wright, Vargo, and Carrese (2011) highlighted how the challenging patient-provider relationship may affect provider job satisfaction, and subsequently recruitment and retention in the primary care workforce. In their study, providers estimate 15% of visits were considered frustrating or difficult. The higher this proportion was, the more likely providers reported burnout and intent to leave their profession (Ratanawongsa, Wright, Vargo, & Carrese, 2011). More difficult encounters resulted in lower job satisfaction, increased stress, more time pressure, and greater intent to leave the practice. Providers secretly hoped these patients would not return (An et al., 2013).

Burnout eventually displays itself in the workplace. Hamilton (2014) listed its signs and symptoms including marital and family stress, substance abuse, auto accidents, health issues, depression, and suicidal ideation. In the workplace, burnout affected relationships with patients and staff. Its manifestation endangered the quality and safety of patient care (Hamilton, 2014).

Moreover, disgruntled patients may initiate legal action against the primary care provider. A commentary by Rich (2008) explored what prompts patients to file claims and "lash out" at the medical provider to "pursue a financial windfall" from a provider whose malpractice liability insurance offers a "deep pocket" (Rich, 2008, p. 1143). Among these factors is the failure to establish – or the breakdown of – the professional-patient relationship, largely associated with ineffective communication.

A look into the firing of patients reveals the impact of this healthcare disruption. A study by Haggerty, Roberge, Freeman, and Beaulieu (2013) described *continuity of care* as a series of health care services "experienced as connected and coherent and is consistent with a patient's health needs and personal circumstances" (p. 262). Patients who are seen by different clinicians suffer *discontinuity* leading to failures and gaps in their care. The study highlighted the significance of a single trusted patient-provider relationship because patients indicated the importance of a continuing relationship with one provider over time. The relationship was compared to a partnership involving the sharing of power as patients are empowered to share in the medical decision-making (Haggerty et al., 2013).

Primary care providers (PCPs) of community health centers, federally qualified health centers (FQHCs) and their look-alike centers, free clinics and other healthcare organizations that provide care to the underserved population, feel the demands of this responsibility. Caring for this segment of the population has its inherent stressors due to the psychosocial and economic

factors affecting this segment of society. As a result, the recruitment and retention of health care providers suffered. The Health Resources and Services Administration (HRSA) announced that as of October 30, 2015, there were 15,714 designated health professional shortage areas (HPSA) on the national level. When categorized by discipline, 6,282 were in primary care, 4,270 in mental health, and 5,162 in dental health (Health Resources and Services Administration [HRSA], 2015). These figures illustrate the need to recruit more physicians and new graduates of Nurse Practitioner or Physician Assistant programs to primary care practice.

Local Problem

The local area covers the Stockton and Sacramento areas in Northern California. An informal survey was conducted regarding discharge practices in a large FQHC in Stockton, a major FQHC in Sacramento, and an FQHC look-alike in Sacramento. Meetings with quality improvement officers, medical directors, and chief operations officers of these healthcare organizations were held. The meetings confirmed there was a need to improve current policies and procedures for discharging *difficult* or *challenging* patients. A review of written policies indicated the lack of key elements to ensure appropriate termination of patient-provider relationships. In addition, these health centers' discharge practices were inconsistent and providers lacked understanding of what warrants the firing of a patient.

A pre-test prior to the presentation of the project was conducted in three FQHC look-alike centers in Del Paso, Southgate, and Assembly Court. The results confirmed the gap in knowledge for what constitutes an appropriate termination and what elements should be met. Pre-test scores totaled 69%.

In addition, informal discussions during provider meetings held in these locations revealed that discharge procedures were inconsistent within the clinics and throughout the

healthcare organization. There were problems with communication from providers to administration personnel regarding patients discharged. There were disagreements among providers and management regarding criteria for firing patients. More importantly, there was the lack of documentation surrounding the termination event. Among these deficiencies were (a) no copies of termination letters in patients' charts, (b) charts did not reflect that there were indications of problematic encounters, (c) there were no documented behaviors and actions demonstrated by the *challenging* patients leading to the decision to terminate the relationships, and (d) there was no effective means of communication when a patient was discharged from practice.

Patients who were discharged were not properly informed about their responsibility to find alternative health care providers. They suffered lapses in their medical care including a disruption in the refilling of prescription medications. Other discharged patients manage to schedule appointments with other providers since there was no efficient method of updating charts or disseminating the information through the organization's communication channels.

An important consideration in the firing of patients is the possible allegation of medical abandonment. In a case report presented by Fishbain, Lewis, Gao, Cole, and Rosomoff (2009), a physician initiated the firing of a patient resulting in the allegation of medical abandonment. The case report presented a chronic pain patient who had violated her chronic pain medication agreement evidenced by a false police burglary report (patient claimed her medications were stolen). The physician sent a termination letter by certified mail along with alternative providers who may be willing to take over her care. The patient was also provided with four prescriptions to cover medication needs for the next 30 days. Ten days after the letter was delivered, the

patient called her mother threatening suicide. The police were dispatched to her home, but she shot herself before they arrived.

Two years after the suicide, the patient's family initiated a malpractice suit for alleged physician negligence. The basis of negligence was the opinion of the plaintiff's medical expert. Among the allegations were (a) the patient's pain management was inappropriate, (b) the pain management plan led to the patient's addiction, (c) the pain management plan directly led to her death, and (d) the patient was medically abandoned (primary allegation) (Fishbain et al., 2009).

The case report provided an outline of procedures providers should consider adopting in their practice in order to prevent and protect against the allegation of medical abandonment. These are (a) the termination must be a mutual agreement, (b) the termination must occur with reasonable notice (meaning notice adequate to give the patient sufficient opportunity to secure alternate care), and (c) the termination must occur when there is no necessity for continued care (Fishbain et al., 2009).

The above-mentioned case depicted a common occurrence in the three health centers whereby patients on chronic opioid analgesia violate a stipulation on their pain management agreement leading to termination. Providers discussed that most problematic patient encounters stem from chronic pain management patients.

In view of these problems, a creation of guidelines was necessary to (a) provide a means to document problematic patient encounters, (b) explore alternatives to firing a patient, (c) list criteria for termination, and (d) provide standard procedures for terminating when necessary. A reliable and efficient method should be set up to alert the medical staff and PCPs of the organization regarding the termination of a patient.

Intended Improvement and Purpose of Change

Exploring both sides of the patient-provider relationship and its challenges is necessary. Primary care providers must seek ways to manage, sustain, and improve complex relationships with patients. Forrest (2012) called for healthcare professionals to consider various factors that may contribute to a difficult patient's behavior and to recognize that such behavior may be a sign that his or her needs are not being met (Forrest, 2012).

The Appropriate Discharge or Transfer of Care Packet (ADTP) is the project's product. The ADTP qualifies as a quality-improvement project in the current healthcare setting. The ADTP meets the criteria for an evidence-based change of practice project (see Appendix A). The project's aim was to improve the process or delivery of care and there was no intention of using the project for research purposes. The presentations of the project were conducted in the Del Paso and the Southgate sites. The Southgate presentation involved both Southgate PCPs and Assembly Court PCPs. There was no funding received from federal agencies or research-focused foundations.

The purpose of the ADTP is to assist primary care providers in their decision to discharge or transfer patients from their care. The packet contains (a) the healthcare organization's updated termination policy, (b) a questionnaire and checklist, and (c) a sample discharge of transfer of care letter. By following the guidelines recommended in the ADTP, providers will meet compliance standards and avoid allegations of medical abandonment.

Currently, the health care organization's policy on the termination of patient-provider relations needed to be updated. The ADTP will meet this need. Moreover, the intervention will uphold ethical standards of practice and ensure all key elements are present to protect PCPs from allegations of medical abandonment.

The PICO question of this project was: "Among *challenging* or *difficult* patients who receive care in this organization, will the use of the ADTP packet ensure all alternatives have been considered prior to discharging these patients and will all requirements be met to avoid allegations of medical abandonment compared to those who have been discharged without the use of the ADTP? The AIM statement of this intervention was: "Among the *challenging* or *difficult* patients who receive care in this organization, there will be no inappropriate discharge or transfer of patient care with the use of the ADTP within six months of implementation."

Review of the Evidence

A literature search for all English-language studies on the termination of patient-provider relationships was performed. The author searched Medline, CINAHL, PubMed, The Cochrane databases, and Wikipedia. The following keywords used were "*difficult patients*", "challenging patient", "termination of patients", "firing of patients", "medical abandonment", and "continuity of care". The date delimitations were publications from the year 2000 to the present. A 15-year period was decided due to the limited availability of information. The word "*termination*" was construed as an "end-of-life" topic while "firing" included research studies on cardiac procedures.

Inclusion criteria were research studies or systematic reviews in peer-reviewed journals. Other countries such as New Zealand, Great Britain, and Australia were included as their healthcare system and setting had similarities to the United States. There may have been differences in socio-cultural norms but the challenges of caring for the underserved population carried the same stressors among the countries.

In addition, other publications were reviewed on topics such as (a) patients receiving opioid medication to address chronic pain, (b) patients with post-traumatic stress disorder, (c)

patients with attention deficit hyperactivity disorder, (d) patients with bipolar disorder, and (e) patients with schizophrenia. Other topics to assist PCPs were reviewed such as (a) motivational interviewing, (b) cost of medical malpractice claims, (c) burnout among primary care providers, and (d) trauma informed patient care.

The author attended two conferences: (a) Pri-Med Conference in April 9 and 10, 2015 which included a live educational activity on safe opioid prescribing, specifically "Proven Methods to Counsel Patients on Extended Release and Long-Acting Opioids and Achieving Positive Outcomes" and (b) "Trauma Informed Patient Care" in June 9 and 10, 2015. Other grey literature included brief news articles and editorials on (a) chronic pain management, (b) drug enforcement agency bulletins, (c) stress in the primary care setting, (d) improving PCP practice settings, and (e) violence in the healthcare setting.

Exclusion criteria were studies and publications that had prevalence and incidence from articles prior to the year 2000. This was to ensure that statistics were within the past 15 years and information remained relevant to current practice settings.

The initial literature search yielded 451,659 articles when search terms used were "termination" and "firing a patient". Publications were narrowed down to 136,648 results when only "firing a patient" was used. The publications were further streamlined to 553 when "ending doctor-patient relationship" was searched. Articles consisted of qualitative studies, legal publications, and continuing education materials.

In order to find robust publications on the topic of firing patients, a search was conducted on "challenging" or "problematic" patients. Publications on more effective ways of addressing these patients' needs were searched. The decision to choose topics on "motivational interviewing", "trauma informed patient care", "integrated behavioral therapy", and "chronic

pain patients" were based on issues surrounding *difficult* patients and the reasons most patients are terminated from primary care practices.

Communication training. The first study appraised was a randomized controlled trial (RCT) of communication training with primary care providers to improve patient-centered communication skills in discussing their patients' health risks. In this study by Helitzer et al. (2011), 28 PCPs participated in a baseline simulated patient interaction and randomized into intervention and control groups. Intervention providers received training focused on patient-centered communication about behavioral risk factors. Immediate efficacy of training was evaluated by comparing both groups. Over the next three years, all providers participated in two more sets of interactions with patients. Long-term effectiveness was assessed using the interaction data collected at six and 18 months post-training. The intervention group significantly improved in patient-centered communication and communication proficiencies immediately post-training and at both follow-up time points. The authors suggested that discussion of adverse childhood events as root causes of chronic diseases should be part of PCP communication training (Helitzer et al., 2011).

The Rapid Critical Appraisal Checklist for Randomized Clinical Trials (Appendix B) was used in reviewing this study (Melnyk & Fineout-Overholt, 2011). Seven out of nine questions on the checklist appraising the validity of results were met. These were (a) subjects were randomly assigned to the intervention group and the control group – two groups of PCPs were randomized to receive training or serve as a control. The intervention group received a full day training with simulated patients, and optional workshops to reinforce strategies for engaging patients, (b) explanations were given for why subjects did not complete the study – reluctance to raise difficult topics without prospective treatment options, opening a "Pandora's Box" without

sufficient training, and limited or brief patient visits, (c) follow up assessments were conducted long enough to fully study the effects of the intervention – the intervention group was followed for 24 months, (d) the subjects were analyzed in the group to which they were randomly assigned, (e) the control group was appropriate – provider distribution by treatment group, practice type, and gender were similar to the intervention group, (f) the subjects in each of the groups were similar in demographic and baseline clinical variables, and (g) instruments used to measure outcomes were valid and reliable – used the Roter Interaction Analysis System (RIAS), a widely used coding system with demonstrated reliability and predictive validity in studies of patient-provider communication. A random sample of 10% of all the tapes were re-coded by a second coder.

Pre-training differences were tested for significance using independent group *t*-tests to ensure that there were no pre-treatment differences between the intervention and control groups. The efficacy of training was tested with two split plot analyses using pre- and post- training as repeated measures and group membership as a between-subjects factor. For both variables, Cohen's *d* was calculated as the difference between the time one and time two means for each group. The providers who received training showed significant improvements. The interaction significance tests: proficiencies summary score, $F(1,24) = 5.86$, $p < .05$, $d = 1.60$; patient centeredness summary score, $F(1,24) = 7.67$, $p < .05$, $d = .86$. There was a significant difference between the intervention and control group in the discussion of adverse childhood events, Wald's $X^2\ (1) = 6.01$, $p < .001$.

Two of the nine questions on the checklist were not met. The subjects and providers were not blind to the study group, and it is not known if the random assignment was concealed from the individuals who were first enrolling subjects into the study. Other appraisal points were

(a) the important outcomes were measured, (b) there was no discussion of the intervention's risks as there was more emphasis on the benefits, and (c) the intervention may be feasible in most clinical settings. The introduction of communication training for PCPs is valuable since this intervention improved communication skills with difficult patients. However, healthcare organizations may not shoulder this expense depending on the cost and time demands on PCPs.

Motivational Interviewing. The most recent definition of Motivational Interviewing (MI) given by its developers is "a collaborative conversation style for strengthening a person's own motivation and commitment to change" (Miller & Rollnik, 2013, p.12). The second study appraised was a systematic review and meta-analysis by VanBuskirk and Wetherell (2014), which synthesized the findings from random controlled trials (RCTs) of motivational interviewing (MI) for health behavior outcomes within primary care populations (VanBuskirk & Wetherell, 2014). The research question was "Is MI effective in improving behavior modification in patients seeking treatment for health conditions in primary care settings, as compared to treatment-as-usual or other interventions, in RCTs?" (VanBuskirk & Wehterell, 2014, p. 769).

Studies were included if MI was used as the primary technique of the intervention. MI could be delivered by clinicians, doctors, nurses, or other trained professionals. Studies were included if they used a RCT design in which participants were randomly assigned to participate in at least one experimental and one control condition. The control condition was permitted to be treatment-as-usual, waitlist control, or another intervention. Other inclusion and exclusion criteria were described in the study. There were 272 articles identified for initial screening. This number was reduced to 246 after duplicates were removed. Another 220 records were removed to include only full-text articles. Of the 26 remaining, two were excluded due to non-primary

care population, four removed due to MI not being the primary intervention, another three excluded for non-RCT reason, four removed for not a health behavior change outcome, and one for not having an appropriate control. There were 12 studies included in the qualitative synthesis and meta-analysis.

The studies were synthesized by outcome subgroup and meta-regression analyses were conducted to determine potential moderators accounting for heterogeneity within samples. Mean effect sizes ranged from .07 to .47; significant effect sizes were found for the adherence subgroup of studies (p = .04) and all outcomes combined (p = .02). Professional credentials of intervention deliverer were found to significantly moderate the association between MI and effect size in substance use subgroup (p = .0005) and all outcomes combined (p = .004). Mean effect sizes were largest in outcomes related to weight loss, blood pressure, and substance use.

This systematic review and meta-analysis investigated the effectiveness of MI in RCTs conducted in primary care populations. The majority of studies used MI to intervene on substance use issues. Of the 12 studies reviewed, seven targeted a substance use-related outcome. The other five targeted diet and exercise, medication adherence, and colorectal screening. Across all 12 studies, nine demonstrated that MI was more effective at achieving targeted outcomes than were control conditions (e.g. usual care, didactic pamphlets).

The Rapid Critical Appraisal Questions for Systematic Reviews (Appendix C) was used in reviewing this study (Melnyk & Fineout-Overholt, 2011). The results of the review were deemed valid due to (a) in phase 1, the practice question was addressed by the type of research design and in phase 2, inclusion and exclusion criteria were detailed, (b) there was a detailed description of the search strategy to find all relevant studies, (c) the review described how the validity of the individual studies were assessed including random assignment to study groups and

complete follow–up of subjects, (d) the results were consistent across studies, and (e) the patient data or aggregate data were used in the analysis.

The results will assist decision-making in healthcare organizations as to whether MI will be an additional training recommendation for its PCPs. It is important to note the qualifications or proficiency of the interventionists (using MI). Of the 12 reviewed studies, seven studies did not describe the MI-specific training given to providers. The training time ranged from 8 hours to 4 weeks, suggesting that there were a wide variety of training practices among studies.

Trauma informed patient care. A large body of literature has covered the mechanisms by which adverse childhood experiences influence adult health status. The third study appraised was by Mandelli, Petrelli, and Serretti (2015). This is a meta-analysis of the literature to assess the effective role of childhood traumas as risk factor in the onset of depressive disorders in adults (Mandelli, Petrelli, & Serretti, 2015).

The study aimed to test the specific and exclusive childhood traumatic experience contribution of sexual, physical and emotional abuse, neglect, significant loss and other family adversity to major depression (Mandelli et al., 2015). The types of studies included were those that evaluated depression in adulthood, accounting for childhood trauma by means of an evaluation tool or clinic interview. The participants were men and women of any race, ethnic or religious group, socio-economic status, and aged at least 18 years (adults).

The types of assessment tools used were structured interview or self-report questionnaires (Mandelli et al., 2015). Most frequently employed method to diagnose depression was based on the Diagnostic and Statistical Manual criteria (DSM-III-R, DSM-IV, DSM-IV-TR). Among the most frequently employed interviews was the Structured Clinic Interview for DMS (SCID-I), the MINI International Neuropsychiatric Interview (MINI), or the Schedule for Clinical Assessment

in Neuropsychiatry (SCAN). In some studies diagnosis of depression was based on self-rated scales such as the Patient Health Questionnaire (PHQ).

The study illustrated the extensive search methods, data collection, and analysis. Data were analyzed by RevMan, with Mantel-Haenszel as statistical method and random effect as analysis model. Odds ratio (OR) and 95% confidence intervals (CI) were calculated and carried out for types of child stressors divided by category. Meta-regression was performed to control for potential confounders and moderating variables.

Results revealed emotional abuse showed the strongest association with depression (OR=2.78), followed by neglect (OR=2.75), and sexual abuse (OR=2.42). Significant associations were also found for domestic violence (OR=2.06) and physical abuse (OR=1.98). In post-hoc analysis, emotional abuse and neglect showed the strongest associations with depression as compared to other kinds of child trauma.

The authors concluded that the findings support the role of neglect and emotional abuse as significantly associated to depression. Sexual and physical abuse or violence in the family may be unspecific risk factors for mental disturbance. Other kinds of trauma may play a less relevant role in risk of adult depression, but should not be underestimated.

The Rapid Critical Appraisal Questions for Systematic Reviews (Appendix C) was used in evaluating this study. The following appraisals included (a) the studies were contained in the review RCTs, (b) the review contained a detailed description of the search strategy, (c) the review described how the validity of individual studies were assessed, (d) the results were consistent across studies, (e) the aggregate data were used in the analysis, and (f) the intervention or treatment effect was large (OR) as above.

Other appraisals include (a) limitations in terms of recall bias since assessment of childhood trauma was done retrospectively by means of structured interview or self-report questionnaire, (b) over-reporting in depressed patients have been observed, and (c) there may be other factors such as genetic predisposition for increased risk of depression.

The results of this study will be helpful for healthcare organizations caring for the underserved population. It is important to consider trauma informed patient care when evaluating patient outcomes since exposure to early childhood adverse events affects engagement.

Chronic opioid analgesic therapy. A systematic review by Minozzi, Amato, and Davoli (2012) of international studies aimed to assess the prevalence of opioid treatment in patients with chronic back pain was selected for this project. The study assessed the incidence or prevalence of opioid dependence syndrome in adults (with or without prior history of substance abuse) following treatment with opioid analgesia for pain relief. A secondary objective was to assess any differences in the prevalence and severity of dependence syndrome with the different types of opioid analgesics, different routes of administration, and durations of treatment.

Systematic reviews and primary studies were included in this publication if they reported data about incidence or prevalence of opioid dependence syndrome (as defined by DSM-IV or ICD-10) in patients receiving strong opioids (or opioid-type analgesics) to treat acute or chronic pain due to any physical condition.

The results were extracted from 17 studies involving a total of 88,235 participants. The studies included three systematic reviews, one RCT, eight cross-sectional studies and four uncontrolled case series. Most studies included adult patients with chronic non-malignant pain, two also included patients with cancer pain, and one study included patients with a previous

history of dependence. Incidence ranged from 0 to 24% (median 0.5%); prevalence ranged from 0 to 31% (median 4.5%). The authors concluded that the available evidence suggests that opioid analgesics for chronic pain conditions are not associated with a major risk for developing dependence.

The Rapid Critical Appraisal Questions for Systematic Reviews (Appendix C) was used in evaluating this study. The following appraisals were (a) the studies were contained in the review RCTs, and (b) there was an extensive bibliographical search of published, unpublished, and ongoing studies. Almost 2,000 titles and abstracts were scrutinized and very few assessed and reported data on the development of dependence. Results of only 17 studies were included. Authors used AMSTAR checklist for systematic reviews to assess the methodological quality of the studies included, the Cochrane criteria for RCTs and CCTs, and the Newcastle-Ottawa Quality Assessment Scale for cohort and case-control studies. For the case series, the authors used the GRADE methodology. The results were consistent across studies and the patient data and aggregate data were used in the analysis.

The results of this study will be helpful to PCPs of FQHCs in managing patients with chronic pain syndromes. PCPs should consider the use of opioids because of their proven effectiveness in treating pain and addressing quality of life in suffering patients. Clinical practice guidelines recommend that adherence monitoring is crucial to avoid abuse of these types of drugs and encourage appropriate use. This involves the initiation of drug screening, pill counts, and patient care agreements.

The aforementioned studies were highlighted because they provided evidence that *difficult* or *challenging* patients' needs may not be properly assessed by PCPs. Lack of communication skills, factors that affect patient engagement, and controversies surrounding

chronic pain management are barriers to the provision of quality care and a healthy patient-provider relationship. The difficulties become overwhelming for both parties and termination becomes inevitable.

Conceptual/Theoretical Framework

The theoretical framework used for this project was Hildegard Peplau's *Interpersonal Relations* in nursing. D'Antonio, Beeber, Sills and Naegle (2014) presented Peplau's view of interpersonal relationships as the foundational framework for nurses' work. They highlighted the value of relationships in the process of behavior change that maximizes health and establishes the mutual engagement between the clinician and patient. The terms '*self-awareness'* and '*personal identity and individuality'* became guiding principles in nursing. Furthermore, '*patient-centered care'*, '*partnering with patients'*, and '*strengthening of patients' and families' autonomy*' are catch phrases that have become part of healthcare standards (D'Antonio, Beeber, Sills, & Naegle, 2014).

Among the writings of Peplau that D'Antonio et al. (2014) discussed was the nurses' common reaction to patients: frustration and anger. Working conditions today require that nurses examine their own responses to *difficult* or *challenging* patients and learn to navigate through the heart of conflicts in their practice (D'Antonio, Beeber, Sills, & Naegle, 2014).

This theoretical framework guided the project's intention to meet standards of care, to explore all possible alternatives to attain the best possible health outcomes for the patient, and to protect the PCP in the process of terminating a relationship when needed. The framework allows the PCP to take a step back and take time for self-awareness. This will ensure a thorough evaluation of the patient's needs.

The theoretical framework protects PCPs through self-awareness. As PCPs start to build relationships with patients, boundaries are defined and the path to health is established. PCPs stand firm on their decisions based on their own values, beliefs, knowledge, and professional judgment. PCPs have the right to sever ties if a relationship is negative, abusive, or if they feel their own values are compromised.

Section III. Methods

Ethical Issues

Beneficence, as described by Grace (2014), is "the duty to provide a good or to benefit persons" and "the duty to maximize benefits and minimize harm to patients" (Grace, 2014, p. 29). In this case, practicing beneficence is illustrated by the PCP's efforts to do due diligence, to avoid termination of the relationship, and to focus on the patient as a whole rather than the negative (*challenging* or *difficult*) behavior.

Non-maleficence is displayed in providers' motto to "above all, do no harm". Grace (2014) further aligns non-maleficence with accountability. Providers must take responsibility for anticipating foreseeable harms so that they are minimized. This accountability includes realizing when optimal care can no longer be provided (Grace, 2014).

Grace (2014) defined autonomy in the healthcare setting as maintaining "an attitude of respect for persons regardless of the incidental characteristics of any given human being" (Grace, 2014, p.22). Autonomy also refers to the patient's right to self-determination. However, Grace clarified that providers are responsible for evaluating what the patient needs and provide the information to assist the patient to share in the decision-making process (Grace, 2014).

Justice, according to Grace (2014), is practiced when providers are cognizant of the inequities in the healthcare setting and the community, and is willing to address them (Grace,

2014). Providers have a professional responsibility to promote justice for the most vulnerable (in this case, the *difficult* patient) who remains most at risk for not receiving quality care.

Setting

The setting is a community health center located in Sacramento, California. The health center attained its FQHC look-alike designation in 2008. The health center received grant funding in 2010 under Section 330 of the Public Health Services Act through the Bureau of Primary Care at the Health Resources and Services Administration of the U.S. Department of Health and Human Services (HRSA). There were 40% of health center patients who were uninsured in 2010. The health center capacity expanded under the Patient Protection and Affordable Care Act (2010) and increased access to care for the underserved patients in the communities.

Its mission is to improve patient health outcomes by providing the highest quality healthcare services in a non-discriminatory and cost-effective manner targeting the most vulnerable and underserved with cultural sensitivity for its patients' unique needs. Its values are summed up in the acronym HEAL – health, excellence, accountability, and leadership (Health and Life Organization [HALO], 2014).

This healthcare organization operates four Community Clinics (CC) serving as medical home to nearly 30,000 individuals and over 10,000 monthly encounters. The clinics accept patients with Medi-Cal, Medicare and most private insurances. In addition, they offer a sliding fee based on the Health and Human Services Federal Poverty Guidelines. Patients are not denied services due to inability to pay (Halo, 2014).

The services they offer are primary care, obstetrics and gynecology, family dental care, pediatrics, behavioral health, podiatry, chiropractic care, and internal medicine. They are expanding their operations and adding another facility within the next few months (Halo, 2014).

The clinics have career opportunities available for physicians, physician assistants, family nurse practitioners, dentists, and behavioral therapists. They have enlisted a staffing agency but have not filled the positions as of this time (Halo, 2014).

The HRSA data included the three clinic sites as a Health Professional Shortage Area (HPSA). The Southgate clinic HPSA scores were: 15 for primary care, 18 for mental health, and 16 for dental health. The Del Paso clinic HPSA scores were: 15 for primary care, 18 for mental health, and 16 for dental health. The Assembly Court Clinic HPSA scores were: 15 for primary care, 18 for mental health, and 16 for dental health. HPSA scores range from 1 to 25 for primary care and mental health, and 1 to 26 for dental services. Higher scores suggest higher priority in assigning clinicians (National Health Service Corps, 2015). Each PCP for these clinics encounters 25 to 30 patient visits per day (Halo, 2014). Considering 15% were *difficult* encounters, based on the study by Ratanawongsa et al. (2011), this estimate is equal to 3.75 to 4.5 challenging encounters per day.

The Medical Director is new to this organization. He established a Grand Rounds meeting for providers. This is a monthly PCP meeting held during the lunch period. The Grand Rounds are an hour-long meeting. They are not mandatory. Lunch is provided for all the PCPs and staff. The agenda for the meeting is distributed by inter-facility email. The Medical Director presides over the meeting and all PCPs can bring their current issues and concerns. The Medical Director uses this time to share updates or reminders about the practice such as (a)

documentation of immunizations, (b) reminders on colon cancer screening, (c) staffing issues, or (d) results of a recent audit.

The Chief Executive Officer and Medical Director approved the presentation of the project to PCPs during their "Grand Rounds". There were two presentations planned. The first was held at the Southgate facility, which involved the PCPs for both Southgate and Assembly Court. The second was held at the Del Paso facility for all the PCPs in that location.

The Medical Director recently established a Quality Improvement Team. This is fairly new to the organization. The exact make up of the team was not available at the time of both presentations.

Planning the Intervention

Grinspun, Melnyk, and Fineout-Overholt (2011) presented that the creation of guidelines are based on the best available evidence in order to assist practitioners with decisions regarding interventions for specific clinical conditions across a broad range of diagnoses and situations (Grinspun, Melnyk, & Fineout-Overholt, 2011). Moreoever, guidelines are designed to allow some flexibility in their application. These guidelines are considered tools to reduce unnecessary variations in clinical practice. However, guidelines may reflect conflicting ideas, pose dilemmas for users, and may hinder the advance of quality care. Despite limitations, guidelines help an organization's "growing pains" and there is increasing emphasis on the development of guidelines, its implementation, and evaluation (Grinspun et al., 2011).

This project aims to develop a guideline to assist PCPs in their decision to terminate a patient-provider relationship. Grinspun et al. (2011) listed the following criteria used by organization for the creation of guidelines: (a) the topic is clinically important, affecting large numbers of people with substantial morbidity or mortality (the burden of illness); (b) the topic is

complex and requires clinical practice clarity; (c) there is evidence of substantive variation between actual and optimal care; (d) there are no existing valid or relevant guidelines available to use; (e) there is evidence available to support evidence-based guideline development; and (f) the topic is central to healthy public policy and serves to introduce innovation.

The guidelines were developed using informal consensus, formal consensus, and evidence-based methodologies. The process of developing the guideline panel included multi-disciplinary stakeholders: (a) CEO, (b) Medical Director, (c) a behavioral therapist, (d) physicians, (e) physician assistants, (f) nurse practitioners, (g) a psychiatrist, and (h) a Director of Quality Improvement. The panel members were selected so that they can bring different experiences, expertise, and perspectives on the topic.

Hockenberry, Brown, and Melnyk (2011) presented Evidence-Based Practice (EBP) objectives and strategies in the transformation of a clinical environment. The six objectives were: (a) to develop a mental framework; (b) to establish a motivating image for change; (c) to create specific goals; (d) to gain administrative support; (e) to establish a leadership team; and (f) to involve experts and EBP mentors in clinical practice (Hockenberry, Brown, and Melnyk, 2011).

The first objective was met in the development of this project prospectus. A written summary was submitted and approved by the supervising physician who was also involved in the clinical practice setting. Brainstorming was achieved through informal discussions with a behavioral therapist and a physician.

The second objective was accomplished with the presentation of the case study involving a chronic opioid analgesic therapy (COAT) patient who committed suicide. This also captured

the PCPs' attention and alerted them to the missing elements in their current practice. The scenarios presented to the PCPs addressed a need to make changes in their current practice.

The third objective was accomplished in the development of specific goals, including timeline and deliverables. These were presented to the CEO of the healthcare organization. This gained administrative support, the fourth goal (see Appendix K).

The fifth and sixth objectives, establishing a leadership team and involving experts and EBP mentors, were challenging due to time constraints and the workload of PCPs. A meeting with a Senior Provider Relations Representative of a third-party payer (medical group) was not available. The geographic locations of the three clinics were a major reason there was difficulty with the formation of a team.

Implementation of the Project

Integrating EBP into the clinical environment involved eight objectives with their corresponding strategies as outlined by Hockenberry et al. (2011). The first objective was to establish formal implementation teams. This was accomplished after the project presentation and the Medical Director forwarded the ADTP to the Quality Improvement Team. This would ensure clinical applicability, feasibility, and adoption into practice.

The second objective was to build excitement. The ADTP packets were introduced in the presentations. The folders were purposely red in color. This was so that PCPs can "STOP" before deciding to terminate a patient. Red is also closely associated with the feelings of anger and frustration – feelings that may surface when caring for a *difficult* patient. The ADTPs were examined and PCPs felt they were easy to use. The completed survey reflected a positive attitude toward the packets (see Appendix D).

The third objective was to disseminate the evidence. The presentation by means of Power Point slides during Grand Rounds met this objective. PCPs were encouraged to voice concerns and ask questions about the packet. The presentation brought about subsequent discussions on problematic patient encounters and recent experiences in firing a patient. The ADTP packets were given to each attendee. They were encouraged to evaluate the contents and provide feedback. A business card was attached to the ADTP folders so that the author would be easily accessed by e-mail.

The fourth objective was to develop clinical tools. Although the guidelines had been created, the healthcare organization would be revising some components. At this time, the checklist/questionnaire (Appendix H) will be scanned into patient's charts once completed.

The pilot test was the fifth objective. The planned pilot site was the Del Paso clinic due to patient population, diversity, acuity, and geographic location. One PCP is a family nurse practitioner with a background in psychiatry (a psychiatrist in the Philippines).

The sixth objective was to preserve energy sources. This would be accomplished by engaging the support of the medical assistants and receptionists as well. Smaller test areas would be implemented. Informal training on the use of the questionnaire would be made available for two PCPs. All other PCPs who may encounter a *difficult* patient would be assisted in the use of the guidelines in the ADTP.

The seventh objective was the development of incremental project steps. It was necessary to achieve the components of the packet in small stages to allow for easier and speedier evaluation by the Medical Director. There was significant demand on his time as a new Medical Director. He was required to attend at least two meetings a day. He had numerous

telephone conversations that were brief. The completion of the project in incremental stages was important.

The eighth objective was to celebrate success. The staff involved in the initiation of the ADTP use would be acknowledged. The CEO and Medical Director were both acknowledged during the presentation for their support in the process of introducing the project to the healthcare organization. There would be more opportunities to recognize the successes of the entire project during future Grand Rounds. Results of the project's impact would be shared with all staff members in the future Grand Rounds.

A GAP analysis was completed to depict the current situation, the future state desired, and the interventions and methods needed to bridge this gap. The current situation is described as: (a) having a written policy for discharging patients that needs to be updated; (b) PCPs identified a knowledge gap regarding the criteria for discharging patients; and (c) PCPs are not aware of the proper channels and procedures for discharging patients and informing administrative staff. In addition, not all PCPs have additional training on communication technique, motivational interviewing, trauma informed patient care, or chronic pain management.

The future state desired will be: (a) PCPs will be guided by the ADTP packet when considering termination and when they decide to terminate a patient; (b) there will be available resources to do due diligence in addressing *difficult* patients needs; and (c) adequate personnel for integrated behavioral therapy, psychiatrists, substance abuse treatment, medical social workers, case managers, and pain management providers.

The interventions and methods to bridge the gap would include: (a) updating the organization's written policies; (b) establishing the guidelines for discharging patients; (c) update charting by means of electronic medical records (EMR) training; (d) training in communication

techniques such as MI; (e) training in chronic pain management; and (f) training in trauma informed patient care. (Appendix I).

The first item in the ADTP completed was the written policy. The unrevised health policies of two health care organizations were reviewed. These included a "No Show Policy", an "Appointment Scheduling and Missed Appointments Policy", a "Patient's Rights Statement", and a "Physician-Client Termination". Revisions were made to incorporate the above-mentioned policies. The updated policy was completed in one week. The supervising physician and manager provided input and recommendations prior to its final draft. The final draft was forwarded to the supervising physician and Medical Director for approval (see Appendix E).

The next item in the ADTP were the questionnaire and checklist. The questionnaire was formatted similar to an incident report form. A completed form details the encounter that led the PCP to consider discharge from practice or transfer of care (one provider requesting to transfer patient's care to another provider within the organization). The checklist is a form with possible alternatives for providers to consider, if necessary, prior to discharge or transfer of care. For example, a behavioral health specialist may be consulted for a patient with an unspecified mood disorder. Both forms were completed in ten days with input from the supervising physician and a behavioral specialist. These forms were forwarded to the Medical Director for approval.

A final revision was made so that both questionnaire and checklist would be incorporated in one form. This would make it easier for PCPs to use the form and would not require more time to complete (Appendix H).

The next item in the ADTP is a general information sheet for providers containing a list of alternatives available prior to discharge or transfer of care, and a list of the appropriate reasons for discharge from practice. This was forwarded to the Medical Director for final approval. This

was completed in two weeks. A GANTT chart illustrating the timeline of the project and deliverables was created to serve as a reminder of deadlines (see Appendix K).

The ADTP was assembled with the above-mentioned components. The author planned to present the project to all providers in the next "Grand Rounds" meetings at the Southgate clinic and the Del Paso clinic. However, the meetings were postponed and the project was delayed for one month.

The presentation was produced using Power Point slides (see Appendix I). Since the time allotted for presenting was only 15 to 20 minutes, during the lunch break, the presentation was designed to be concise. A total of 13 slides were shown. A meeting room was available and projector was set up. The PCPs came in with their lunch and completed the Pre-Test prior to the presentation.

The presentation was started after all PCPs completed their tests. At slide number 12, the ADTP (packets) were distributed and explained. At the conclusion of presentation, questions and comments were encouraged. A Post-Test and a survey of the presentation were distributed to the PCPs.

Cost Summary

Cost for the materials of the ADTP is estimated at $292.19. This will cover expenses for the creation of the packets for thirty PCPs in the organization. This will include cost for binders, paper, printing, and labeling. There will be no added compensation or wage expense for those involved in the project since all activities will be done during regular hours of operation. (see Appendix I).

The author will spend approximately 145 hours completing this project. The value of this time and work is approximately $7,250.00. This amount is based on a lower tier amount of $50.00 per hour compensation of a nurse practitioner in a primary care setting.

The value of this project lies in the prevention of a medical malpractice claim. 'Abandonment' may be grounds for professional negligence or malpractice (as in the case of underservicing) (McQuoid-Mason, 2015). One case filed against the organization can cost as much as $250,000. In California, recovery for non-economic damages are limited to $250,000. Non-economic damages compensate the plaintiff for "pain, suffering, inconvenience, physical impairment, disfigurement, and other non-pecuniary damage" ("Wikimedia Foundation, Inc.," 2015, p. 8).

Planning the study of the intervention

A Pre-Test was completed prior to the presentation of the project. The Pre-Test was used to assess the PCPs knowledge of the appropriate reasons to terminate a patient. It would test knowledge on steps that must be taken prior to termination. It would test knowledge of the responsible parties deciding on the termination. The questions were constructed in a multiple-choice format. The Post-Test was identical to the Pre-Test. An improvement on the scores would indicate increased understanding regarding the process of terminating a patient-provider relationship.

A survey was distributed after the presentation to assess the attendees' receptivity. The survey was designed to use a Likert Scale. The purpose was to allow the PCPs to express the direction and strength of their opinion about the presentation and project (Garland, 1991). The responses included "strongly agree" (SA), "agree" (A), "undecided" (U), "disagree" (D), and "strongly disagree" (SD) (see Appendix D).

The survey was used to assess: (a) if PCPs thought the presentation provided valuable information for their practice; (b) if the elements of the packet (ADTP) are easy to follow; (c) if they will refer to this packet (ADTP) when discharging or transferring care; (d) if they will explore other options prior to discharging or transferring care; and (e) if they would recommend this presentation (and ADTP) to other colleagues. They were given the option to write their name. They identified their clinic location and the date of the presentation.

Methods of evaluation

The implementation of the ADTP use will be evaluated using the Plan-Do-Study-Act cycle (PDSA)(Institute for Healthcare Improvement [IHI], 2003). As the HCO starts adapting the ADTP in their practice, meetings will be held to closely study the results of its use. Insights, recommendations, and other ideas can be made to improve on the ADTP. This process will continue serially over a period of an estimated six months until it is refined.

The Institute for Healthcare Improvement (IHI) provided key elements of the Breakthrough Series for achievement breakthrough improvement (IHI, 2003). The key elements to be used for evaluating the change process in the use of the ADTP answer the questions: (a) What are we trying to accomplish? (Aim). In this project, the aim was to minimize or avoid the inappropriate discharge of *difficult* patients; (b) How will we know that a change is an improvement: (Measures). Keeping track of the use of the ADTP, flagging discharge patient's charts, monitoring number of patients referred to IBH, psychiatry, MSW, or case managers, will provide the numbers. This is the way we can monitor if there is an improvement; and (c) What changes can we make that will result in improvement? (Changes). This is where the teams will identify key changes that may need to be done to revise the ADTP to fit the HCO's needs. The changes are the items that will be tested.

It was anticipated that the ADTP will be used by providers in the discharge of patients or transfer of care. A goal of 95% ADTP will be expected. Providers will be “satisfied” to “very satisfied” with the ADTP as a step-by-step approach. These responses will be captured in a survey four months after implementation, and every six months thereafter.

For project closure, a retrospective review will be initiated. A *restropective* is a methodology that analyzes a past project event to determine what worked and what did not work. It helps develop lessons learned in the process, and creates an action plan so that lessons learned can be used to improve project management for future projects (Larson and Gary, 2011).

In the *retrospective,* an independent facilitator will use questionnaires as a starting point to conduct the post-project retrospective. Two sets of questionnaires will be used: (a) Project Process Review – a review of the intent of the project, objectives, selection criteria, scope (see Appendix L); (b) Organizational Review – since the project performance is influenced by the organizational structure, this questionnaire will assess what fundamental organizational culture properties affect the successes and failures or become a hindrance to project teams (see Appendix M). The survey questions will make it easy, quick, and inexpensive to develop and collect data. The independent facilitator will be responsible for archiving the *retrospective* (such as a repository) so that it can be accessible for future project management.

Analysis

The healthcare organization’s use of the ADTP packet will be monitored. Important data will be gathered such as: (a) number of discharges; (b) use of ADTP packet in those discharges; and (c) how many patients were referred to other support personnel prior to discharge.

The number of discharges will be tracked by using the EMR. Medical Assistants will flag discharged patients’ charts. The ADTP questionnaire will be scanned into the chart. By

flagging charts and scanning the questionnaire, the organization can monitor the use of the ADTP. Integrated behavioral therapy staff will have a means of monitoring patients who were referred to them prior to being discharged. They will also keep track of patients referred to a Drug or Alcohol Program, to a psychiatrist, and to a medical social worker. The information will be tracked using an Excel spreadsheet (see Appendix N).

The monitoring and recording will be gathered after the first four months of ADTP implementation, after six months, and after one year. These will serve as the baseline measures. The measures will continue to be tracked every six months thereafter.

IV. Results

Program Evaluation/Outcomes

The PCPs' knowledge of termination procedures was evaluated by means of a Pre-Test (see Appendix F) and Post-Test (see Appendix G). The scores were tallied and showed improvement. Pre-Test scores averaged 69% while Post-Test scores averaged 97%.

The PCPs' response to the presentation and the ADTP were evaluated. There were 12 surveys returned. The results were: (a) for item one – the presentation provided valuable information for my practice, nine SA and three A; (b) for item two – the elements of the packet are easy to follow, eight SA and four A; (c) for item three – I will refer to this packet when discharging or transferring care, seven SA and five A; (d) for item four – I will explore other options prior to discharging or transferring care, six SA, four A, one U, and one D; and (e) for item five – I would recommend the presentation and packet to other colleagues, seven SA and five A (see Appendix D).

The improvement noted in the Pre and Post Tests indicated the presentation was a success in providing guidelines and other information for PCPs when deciding on termination. The

favorable and positive responses gathered from the survey indicated that the PCPs were receptive to the project and implementation of ADTP use. The Medical Director will be forwarding the ADTP to the organization's Quality Improvement Team for revisions and implementation.

Section V. Discussion

Summary

In summary, the project – the creation of guidelines to assist PCPs in the discharge of *difficult* patients, has evolved from a simple checklist to a questionnaire. Based on the literature, the problem of caring for *difficult* or *challenging* patients encompasses more than the patient's behavior or attitude. PCPs realize there is a need to use a multi-faceted approach to achieve patient engagement. PCPs have the ethical obligation to do due diligence.

However, there may come a time when the patient-relationship no longer becomes therapeutic and the decision to terminate is clear. The ADTP sought to assist PCPs through the process.

Relation to other evidence

The information gathered through the use of the ADTP will assist PCPs in knowing the most frequent reasons for challenging patient encounters and most common reasons for discharging a patient from practice. By following the guidelines, PCPs will have sufficient documentation of the problematic patient encounters and efforts to maintain a therapeutic relationship. The guidelines will meet criteria so that the decision to discharge a patient will be done appropriately.

In efforts to do due diligence, documentation will provide information for which strategies worked and which strategies were ineffective. As the highlighted studies showed,

providing training for PCPs will enhance their capabilities in caring for *challenging* patients so that target health outcomes are achieved.

Barriers to Implementation/Limitations

One significant barrier to the introduction of the project was the HCO choice. The first FQHC approached for the project was not receptive. The second HCO, an FQHC look alike was open to the project but time constraints affected the schedule planned for implementation.

The project presentation was limited to a lunch period, which was one hour. This time was not sufficient for more questions and clarifications. However, the presentation elicited an important discussion among the attendees, besides their firing – managing *challenging* patients.

Additional meetings will be necessary to assist the HCO team (quality improvement team) in making revisions to the ADTP. This may prove challenging since the author is not a member of this organization. The ADTP (packet) contained a business card with the author's contact information including e-mail address so that PCPs may continue to ask questions or clarify concerns about the forms.

Interpretation

A SWOT analysis of the current state provided a useful technique to understand the strengths and weakness, and identified the opportunities that may be available and the threats that may occur. Among the strengths of the current state are: (a) willingness for change and improvement; (b) supportive Medical Director; (c) use of EMR; (d) established health care organization; (e) project will not incur significant cost; (f) PCPs are knowledgeable; (g) PCPs agree there needs to be a change in the process of discharging patients; (h) available integrated behavioral therapy; and (i) adequate support staff (receptionists, medical assistants, office managers).

Among the weaknesses of the current state are (a) under-staffed PCPs, (b) time constraints due to fully booked schedules, (c) *difficult patients*; (d) communication channels are not clear, (e) distance between health clinic locations, (f) separate PCP meetings for the organization, (g) need more behavioral therapists, (h) need more social workers or case managers, (i) a new Medical Director, (j) needs a psychiatrist, and (k) a new quality improvement team.

Among the opportunities are: (a) to establish EBP change; (b) to improve communication channels; (c) to develop teamwork; (d) to include additional training for staff; (e) to streamline procedure for discharging patients; (f) to learn how to effectively make improvements; (g) identify leaders; and (i) boost morale.

Among the threats are: (a) turnover – some PCPs may choose to quit; (b) quality improvement team may choose another project; (c) delay due to other priorities such as state surveys or JCAHO accreditation.

Conclusion

It has become apparent that PCPs need more training in communication techniques, such as motivational interviewing. Other articles presented the “BREATHE OUT” technique or the use of mediators during difficult patient encounters. Since more strategies have become available to PCPs, it is surprising that these are not incorporated in Nurse Practitioner programs.

New PCPs will most likely begin their careers in FQHCs. Additional training and continuing education on Chronic Pain Management and Trauma Informed Patient Care will be beneficial when caring for the underserved population.

Section VI. Other Information

Funding

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Appendix A

*Evidence-Based Change of Practice Project Checklist**

Project Title: Appropriate Discharge or Transfer of Care Packet	YES	NO
The aim of the project is to improve the process or delivery of care with established/accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.	/	
The specific aim is to improve performance on a specific service or program and **is part of usual care.** ALL participants will receive standard of care.	/	
The project is **NOT** designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control. The project does **NOT** follow a protocol that overrides clinical decision-making.	/	
The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment, or evaluation of the organization to ensure that existing quality standards are being met. The project does **NOT** develop paradigms or untested methods or new untested standards.	/	
The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does **NOT** seek to test an intervention that is beyond current science and experience.	/	
The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP	/	
The project has **NO** funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.	/	
The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., **not** a personal research project that is dependent upon the voluntary participation of colleagues, students and/or patients.	/	
If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: "*This project was undertaken as an Evidence-based change of practice project at X agency and as such was not formally supervised by the Institutional Review Board*".	/	

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

Appendix B

Rapid Appraisal Questions for Randomized Controlled Trials

1. Are the Results of the Study Valid?

   a. Were the subjects randomly assigned to the experimental and control groups?
   b. Was random assignment concealed from the individuals who were first enrolling subjects into the study?
   c. Were the subjects and providers kept blind to study group?
   d. Were reasons given to explain why subjects did not complete the study?
   e. Were the follow-up assessments conducted long enough to fully study the effects of the intervention?
   f. Were the subjects analyzed in the group to which they were randomly assigned?
   g. Was the control group appropriate?
   h. Were the instruments used to measure the outcomes valid and reliable?
   i. Were the subjects in each of the groups similar on demographic and baseline clinical variables?

2. What are the Results?

   a. How large is the intervention or treatment effect (NNT, NNH, effect size, or level of significance)?
   b. How precise is the intervention or treatment (CI)?

3. Will the results help me in caring for my patients?

   a. Were all clinically important outcomes measured?
   b. What are the risks and benefits of the treatment?
   c. Is the treatment feasible in my clinic setting?
   d. What are my patients'/families' values and expectations for the outcome that is trying to be prevented and the treatment itself?

Appendix C

Rapid Critical Appraisal Questions for Systematic Reviews

1. Are the Results of the Review Valid?

    a. Are the studies contained in the review RCTs?
    b. Does the review include a detailed description of the search strategy to find all relevant studies?
    c. Does the review describe how validity of the individual studies were assessed (e.g. methodological quality, including the use of random assignment to study groups and complete follow-up of the subjects)?
    d. Were the results consistent across studies?
    e. Were individual patient data or aggregate data used in the analysis?

2. What were the Results?

    a. How large is the intervention or treatment effect (OR, RR, effect size, level of significance)?
    b. How precise is the intervention or treatment (CI)?

3. Will the Results assist me in caring for my Patients?

    a. Are my patients similar to the ones included in the review?
    b. Is it feasible to implement the findings in my practice setting?
    c. Were all clinically important outcomes considered, including risks and benefits of the treatment?
    d. What is my clinical assessment of the patient and are there any contraindications or circumstances that would inhibit me from implementing the treatment?
    e. What are my patient's and his or her family's preferences and values about the treatment under consideration?
    f. What is my clinical assessment of the patient and are there any contraindications or circumstances that would inhibit me from implementing the treatment?
    g. What are my patient's and his or her family's preferences and values about the treatment under consideration

Appendix D

The Appropriate Discharge or Transfer of Care
of Patients from your Primary Care Practice

SURVEY

*Total of 12 attendees

Strongly Disagree (SD), Disagree (D), Undecided (U), Agree (A), Strongly Agree (SA)	SD	D	U	A	SA
1) The presentation provided valuable information for my practice				3	9
2) The elements of the packet (ADTP) are easy to follow				4	8
3) I will refer to this packet (ADTP) when discharging or transferring care				5	7
4) I will explore other options prior to discharging or transferring care		1	1	4	6
5) I would recommend this presentation (and ADTP) to other colleagues				5	7

Name (Optional) Date of attendance:

____

Practice Location

____

Appendix E

HEALTHCARE ORGANIZATION
SECTION: ADMINISTRATIVE
TITLE: TERMINATION OF PROVIDER-PATIENT RELATIONSHIP

POLICY:

Primary care providers may decide to terminate a provider-patient relationship unquestionably if the patient: (a) demonstrates abusive behavior; (b) refuses to meet monetary billing responsibility; (c) repeatedly chooses not to follow provider's advice and treatment; and (d) seeks other provider consults unknown to the primary care provider as in the case of patients on chronic opioid analgesia therapy.

Violence or threats of violence in the healthcare setting by a patient should be grounds for automatic and immediate removal from the organization's patient panel.

PROCEDURES:

Three overriding legal obligations must be meticulously honored when discharging a difficult or challenging patient from the provider's practice. These are: (1) the termination of services must be a mutual agreement, (2) the termination must occur with reasonable notice, giving the patient sufficient opportunity to secure alternate care, and (3) the termination must occur when "continued attention" is not necessary.

Provider duties and conduct

1. Medical Review
   The provider should review with the patient his/her medical history and treatment progress leading to his/her current medical condition. When a difficult patient is involved, emphasis should be placed upon compliance problems and the adverse medical implications.

2. Recommend
   A course of treatment should be proposed to the client explaining how the particular treatment plan presents the most appropriate course of action to address the patient's current physical and/or mental wellbeing.

3. Information and Warning
   The patient must be provided with information and warning about the benefits and risks for a proposed treatment, alternative treatments (if available), and the risks of not following or discontinuing a treatment plan.

4. Continuity
   The provider should offer to implement the chosen treatment plan. If the patient refuses, he/she should be provided with a list of names and addresses of other area providers qualified to deal with the client's needs.

5. Confirmation with Patient
   When the medical risks associated with the termination of relationship is significant, the provider should follow the final procedural steps in the ADTP (Appropriate Discharge or Transfer of Care Packet). These procedures assist in performing due diligence, comply with legal obligations, and uphold ethical standards of practice.

Appendix F

THE APPROPRIATE DISCHARGE OR TRANSFER OF CARE OF PATIENTS FROM YOUR PRIMARY CARE PRACTICE

Pre-Test

1. **Who makes the decision to terminate a patient-provider relationship? (choose 1)**

   a. __X_ the primary care provider (PCP)
   b. _____the COO
   c. _____the CEO
   d. _____the clinic manager
   e. _____the Medical Director
   f. _____anyone involved in the patient's care (anyone in the clinic setting)

2. **Which of the reasons listed below would be considered an "appropriate" reason to discharge a patient from you practice? (place a check mark on choices)**

   a. __X__violation of a COAT agreement (Chronic Opioid Analgesia Therapy)
   b. __X__violence or threats of violence
   c. __X__abusive behavior
   d. __X__refusal to meet monetary billing responsibility
   e. __X__repeated failure to follow the providers' advice and treatment
   f. __X__other provider consults unknown to the PCP

3. **To avoid allegations of medical abandonment, what must be followed prior to the termination? (place a check mark on choices)**

   a. __X___a reasonable amount of time for patient to find another PCP
   b. __X___termination must occur when "continued attention" is not necessary
   c. _____approval of your organization's Ethics Committee
   d. __X___a termination letter sent by certified mail
   e. __X___decision was discussed with the patient
   f. _____ security escort out of the premises

Name (optional) ________________________________Date of Attendance_______________

Practice Location ____

Appendix G

THE APPROPRIATE DISCHARGE OR TRANSFER OF CARE OF PATIENTS FROM YOUR PRIMARY CARE PRACTICE

Post-Test

2. **Who makes the decision to terminate a patient-provider relationship? (choose 1)**

   g. _____the primary care provider (PCP)

   h. _____the COO

   i. _____the CEO

   j. _____the clinic manager

   k. _____the Medical Director

   l. _____anyone involved in the patient's care (anyone in the clinic setting)

4. **Which of the reasons listed below would be considered an "appropriate" reason to discharge a patient from you practice? (place a check mark on choices)**

   g. _____violation of a COAT agreement (Chronic Opioid Analgesia Therapy)

   h. _____violence or threats of violence

   i. _____abusive behavior

   j. _____refusal to meet monetary billing responsibility

   k. _____repeated failure to follow the providers' advice and treatment

   l. _____other provider consults unknown to the PCP

5. **To avoid allegations of medical abandonment, what must be followed prior to the termination? (place a check mark on choices)**

   g. _____a reasonable amount of time for patient to find another PCP
   h. _____termination must occur when "continued attention" is not necessary
   i. _____approval of your organization's Ethics Committee
   j. _____a termination letter sent by certified mail
   k. _____decision was discussed with the patient
   l. _____ security escort out of the premises

Name (optional) ________________________________Date of Attendance________________

Practice Location ____

Appendix H

Appropriate Termination of Patient-Provider Relationship Questionnaire

Patient Name: ____

DOB: ____

Primary Care Provider: ______________________________________ MD PA NP (encircle one)

DATE OF INCIDENT: ____

Please encircle description(s) applicable to problematic patient encounter(s):

Psychological Disorder	Increased Life Stressors	Social Isolation
Multiple Physical Problems	Chronic Disease	Persistent Complaints
Unrealistic Expectations	Inability to Communicate Needs	Shows dissatisfaction with care provided
Visits regularly but Ignores medical advice	Insists on an unnecessary test	Insists on being prescribed an unnecessary drug
Does not express Appropriate respect	Verbally Abusive	Drug-seeking behavior/ Argues about opioid drug

Does not perform laboratory orders without explanation

Does not perform imaging studies ordered without explanation

*Demonstrated physical or verbal threat/violence

*Refusal to meet monetary billing responsibility

*Consults with other providers PCP is unaware of (i.e. multiple opioid prescribers)

Others not mentioned above:

____

____

*Automatic and immediate removal from the health care organization's patient panel is appropriate

Please describe details of incident:

____
____
____
____
____
____
____

Witness present? Name(s): ____

Alternatives to Discharge:

___________ Referral to IBH/Psychiatry Services

___________ Referral to Drug or Alcohol Program

___________ Referral to Medical Social Worker

___________ Transfer care to other PCP within the health care organization: Receiving PCP was informed and agreed to accept patient

Decision to Discharge

__________ From provider's practice

__________ From healthcare organization

Termination Checklist:

_______ Patient is aware/agrees with plan

_______ At least 1-month notice for patient to secure alternate care

_______ Termination when no "continued attention" is necessary

_______ Send Termination of Relationship Letter: sent by **CERTIFIED MAIL** with return receipt requested (indicate specified date for 30-day notice) and offer to continue medical treatment for that time period; letter will indicate records will be transferred to new PCP, will stress importance of continued medical care and potential consequences of not getting care, offer contact information of other PCPs in the area for care.

All steps taken prior to this decision have been completed with the guidance and approval of the medical and administrative board of this healthcare organization.

Appendix I

***Budget*:**		***Actual***
Oxford all-in-one Portfolios (30)	$ 164.70	$ 15.00
Ream of Printer Paper (1)	6.49	6.49
Ink Cartridge (1)	46.00	138.00
Label Maker	25.00	8.88
Miscellaneous	50.00	50.00
	------------	------------
Total	**$ 292.19**	**$218.37**

Prices from http://www.staples.com(budget)

GAP ANALYSIS

CURRENT SITUATION	BRIDGE	FUTURE STATE
1. Written policy for discharging patients needs revision.	Update written policies Create and implement guidelines	1. Use of the ADTP packet to ensure appropriate discharge of patients from practice.
2. PCPs gap in knowledge regarding criteria for discharging patients	Methods: for charting and communicating	2. Available resources to do due diligence to help *difficult* patients
3. PCPs gap in knowledge regarding process to discharge	Training: communication/MI Pain Management Trauma Informed Patient Care	3. Adequate staffing : Behavioral therapists, Psychiatrists MSW, Pain Management Provider, Addiction Treatment

Appendix J

SWOT ANALYSIS

STRENGTHS

WILLINGNESS FOR CHANGE AND IMPROVEMENT

SUPPORTIVE MEDICAL DIRECTOR

USE OF EMR

ESTABLISHED HCO

PCPS AGREE TO CHANGE

BEHAVIORAL THERAPISTS

LOW COST PROJECT
ADEQUATE SUPPORT STAFF

WEAKNESSES

UNDER-STAFFED PCPS
TIME CONSTRAINTS

NUMBER OF DIFFICULT DIRECTOR PATIENTS

POOR COMMUNICATION CHANNELS

SEPARATE MEETINGS

DISTANCE BETWEEN CLINICS

NEW MEDICAL DIRECTOR

OPPORTUNITIES

TO IMPROVE COMMUNICATION

TO DEVELOP TEAMWORK

TO STREAMLINE PROCEDURES

TO LEARN HOW TO MAKE CHANGES

TO IDENTIFY LEADERS

BOOST MORALE

THREATS

PCP TURNOVER

QUALITY IMPROVEMENT TEAM DELAY DUE TO OTHER PROJECTS

OTHER PRIORITIES

Appendix K

Timeline of DNP Project with Milestones

University of San Francisco

Rowena D. Nolasco

DATE	Summer 2015	August	September	October	November	December
	Meet with C. Sharifi		Pre-Implementation	Implementation	Evaluation-Analysis	Preparation for Graduation
18-Jul	Organize Research					
	USF Library					
8-Aug		Meet with CEO				
		of Healthcare Facility				
		Administrative Office				
		Present: Medical Director				
			Planning, Revising			
21-Aug		Meet with Dr. Nichols	Policy, Questionnaires			
			Prepare PowerPoint			
7-Sep			all printed materials			
12-Sep			Meet with Dr. Nichols	ADTP Packets		
22-Oct				Presentation at Southgate		
				Section 1, 2 & 3		
				Appendices (Part 1)		
24-Oct				Meet with Dr. Nichols	Follow up with	
					Medical Director	
					Complete Paper	
3-Nov					Submit to Dr. Nichols	
10-Nov					Submit to Dr. Godfrey	
20-Nov					Presentation of Project	
18-Dec						Graduation
						Ceremony
						at University of
						San Francisco
						Celebration

Legend:

- Deliverables (yellow)
- Milestones (blue)
- Final Paper (orange)

Appendix L

Retrospective Project Process Review Questionnaire

ITEM COMMENT

1. Where the project objectives and strategic intent of the project

Clearly and explicitly communicated?

2. Where the objectives and strategy in alignment?
3. Where the stakeholders identified and included in the planning?
4. Were project resources adequate for this project?
5. Were people with the right skill sets assigned to this project?
6. Were time estimates reasonable and achievable?
7. Were the risks for the project appropriately identified and assessed before

   Project started?
8. Were the processes and practices appropriate for this type of project?
9. Did outside contractors perform as expected?
10. Were communication methods appropriate and adequate among

    All stakeholders? Explain.
11. Is the customer satisfied with the project?
12. Are the customers using the project deliverables as intended?
13. Were the project objectives met?
14. Are the stakeholders satisfied their strategic intents have been met?
15. Were schedule, budget, and scope standards met?
16. Is there any one important area that needs to be reviewed and improved

    Upon? Can you identify the cause?

*Larson & Gray, 2011

Appendix M

Retrospective Process Organizational Culture Review

ITEM	**Comment**
1. Was the organizational culture supportive for this type of Project?	
2. Was senior management support adequate?	
3. Were people with the right skills assigned to this project?	
4. Did the project office help or hinder management of the project? Explain.	
5. Did the team have access to organizational resources (people, funds, Equipment?	
6. Was training for this project adequate? Explain.	
7. Were lessons learned from earlier projects useful? Why? Where?	
8. Did the project have a clear link to organization objectives? Explain.	
9. Was project staff properly reassigned?	
10. Was the Human Resources Office helpful in finding new assignments? Comment.	

*Larson & Gray, 2011.

Appendix N

				Referral for Patient			Discharged from Practice		Transfer of Care		Reason or Comments
Patient Name		DOB	IBH	Psychiatry	MSW	Drug/Alcohol	YES	NO	YES	NO	

Appendix O

Appropriate Discharge or Transfer of Care from Primary Care Practice

Guidelines for the Termination of Patient-Provider Relationships

Rowena Nolasco, MSN-FNP

Objectives:

- ❖ To identify “difficult” or “challenging” patients
- ❖ To describe behaviors demonstrated by them
- ❖ To present the impact on PCPs, HCO, and community
- ❖ To present appropriate reasons for termination
- ❖ To explore alternatives to termination
- ❖ To present guidelines – ADTP packet

The "Difficult" or "Challenging" Patient
zahn
"I may be a hypochondriac, but I'm a very SICK hypochondriac!"

Behaviors

- Visit regularly but ignore medical advice
- Insist on an unnecessary drug
- Insist on an unnecessary test
- Persistently complain
- Do not express appropriate respect
- Show dissatisfaction with care provided
- Verbally abusive

Patient-Provider Relationship

- A healthy patient-provider relationship maintains clear boundaries, rules, and roles
- Both can work together for a common goal: maintain the patient's health, safety and wellbeing
- Dependent on the relationship between the Patient (as a person) and the Provider (as a professional)

Job Satisfaction

- 15% of visits considered frustrating
- Burnout – intend to leave their profession
- STRESS!!!
- Impacts health and wellbeing, family life
- Fear of legal action

Time to Sever the Relationship?

Abusive behavior *

Refusal to meet monetary billing responsibility

Repeated failure to follow provider's advice/ treatment

Other provider consults unknown to PCP

Violence or threats of violence

No-shows

Impact of this Disruption in Care

- Suffer *discontinuity*
- Failures and gaps in care
- Vicious cycle
- Increased healthcare costs
- Waste healthcare resources

Alternatives to "Firing"

- ❖ Integration of behavioral and medical care
- ❖ Open communication skills – Motivational Interviewing
- ❖ Collaborative care – Drug/Alcohol Program, Medical Social Worker, Case Manager
- ❖ Trauma Informed Patient Care

ADTP Packets

- Copy of organization's policy
- Questionnaire
- Sample Discharge Letter
- Optional: self-addressed stamped envelope to mail "Request for Medical Records" Form