



HIV MEDICAL ALERT

FOR PRIMARY HEALTH CARE PROVIDERS
AND HEALTH PROFESSIONALS

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HIV Medical Alert

provides clinicians with comprehensive and up-to-date information about diagnosis, treatment, and prevention of HIV.

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Approach to the Patient with Difficult Behaviors

Part 2 of 2

by **L. Jeannine Bookhardt-Murray, MD**

Introduction

Patients with HIV infection suffer from mental illness at a rate higher than found in the general population.¹ The most common disorders suffered by this group are Depression, Anxiety disorders, and Post Traumatic Stress Disorder (PTSD). Associated with mental disorders are behaviors that primary care practitioners and staff frequently encounter and find difficult to manage. A recurring theme among primary care practitioners is the need to understand and effectively address disruptive patient behaviors in the health care setting, and at the same time ensure patients are receiving quality care according to current standards. While there are a variety of difficult patient behaviors, this article addresses the volatile, explosive, demanding and threatening behaviors some patients exhibit upon entering the care setting.

Mental illness, substance abuse, organic disease, life crises, poor social conditions, or a combination thereof may all be associated with difficult behaviors. Learning to cope with these challenging behaviors has become part of the fabric of providing primary care services. The challenge is to develop and incorporate practitioner and office management strategies that will facilitate effective interaction and delivery of quality care to these patients. It may be worthwhile to adopt systemic approaches to caring for the psychologically distressed patient just as one does when

caring for patients with chest pain or respiratory distress. A non-judgmental, attentive approach may be difficult to adopt if practitioners and staff find the behaviors intimidating, threatening, or time consuming. Compassionate and effective care requires objectivity. This is easier said than done.

Why do we call patients difficult?

Whether or not the patients have a bonafide Personality Disorder, a variety of challenging behaviors are addressed and managed in the primary care setting on a daily basis. Patients with such behaviors are often referred to as “difficult patients.” It is worthwhile to point out that it is the patient’s behavior that is difficult, not the patient. Difficult patient behaviors can demand time and energy and disrupt the flow of daily activities. Disruptions such as these can negatively impact efficient and effective care throughout the day. This may create an environment where there is potential for an increase in medical errors, and a perceived or real potential safety risk for staff and other patients in the waiting areas.

Examples of behaviors that challenge the primary care setting include dramatic disturbances in the waiting room characterized by verbal and nonverbal threats toward staff, as well as loud and unreasonable demands. Unfortunately, physical attacks do occur. Other behaviors that practitioners consider difficult include manipulative behaviors such as these control tactics; repeated late shows, no shows or walking in without appointments, poor follow through with care, poor adherence practices, convoluted and inaccurate histories, sexual advances, numerous visits to numerous health care providers, drug seeking behavior. Any one patient may exhibit a number of these behaviors at any one time.

When patients present with difficult behaviors it is prudent to interact with them in a way that is supportive and understanding, yet sets limits. This may be an opportunity to identify and address mental health, substance abuse, organic conditions, or social ailments. Patients with repeated difficult behaviors should alert the provider to the likelihood that these individuals may also be experiencing difficulty with life in general. The psychological burden of living with HIV infection may render fragile and confusing emotions. Identifiable triggers for emotional distress in HIV infected patients, with or without preexisting mental disorders, include events such as learning of HIV positive status, occurrence of physical illness, or progression of illness (www.hivguidelines.org *Mental Health Care for People With HIV Infection*). Psychological distress may result in poor coping abilities, inability to organize and set priorities, poor adherence to antiretroviral therapies, and difficulty employing harm reduction practices.

From another perspective, difficult patient behaviors have negative psychological effects on those who provide their care. The number of patients with difficult behaviors seen during the day may vary, however, the impact on the environment may be costly. Staff and other patients in the area are psychologically affected by these behaviors. Staff members who fear certain patients may go to many lengths to avoid them. Staff may eventually complain of mental and physical exhaustion, or “burn-out.” The primary care setting may be seen as a vulnerable, unsafe environment causing a markedly tense atmosphere that leads to excessive employee sick days and turnover. This may result in potential problems for patient access to care, continuity of care, and quality of care. The effect of recurrent disruptive waiting room behavior may ultimately show up as lost productivity, poor retention of patients, and ultimately a plateau or decline in growth of the business. It is worthwhile to explore strategies at every level to facilitate care for this group of patients and support the front line staff providing the care.

Mental Health And Substance Abuse Assessments In the Primary Care Setting

An essential part of care for people with HIV infection includes assessments for mental health, substance abuse, and cognitive impairment. The New York State Department of Health AIDS Institute Mental Health Guidelines include routine assessments at the initial visit, annually and more often if clinically indicated. Mental health and substance abuse assessments may reveal underlying treatable disorders in patients with unacceptable behaviors. Routine evaluations can help primary care practitioners sort out which patients need referrals to mental health professionals. Co-morbid psychiatric disorders, complicated by drug dependence, put patients at risk for poor physical outcomes, and increased risk of suicide.^{2,3} Insomnia, lethargy, poor concentration, mental slowing, or mood swings are examples of symptoms frequently experienced by people with HIV infection. The challenge is to sort out whether these symptoms are the result of the direct effect of HIV on the brain or indirectly due to other causes.^{4,5} A pitfall in caring for patients with difficult behaviors is to attribute the behaviors to mental illness, and personality disorders, when there may be an organic etiology. It is important to note that drug intoxication, or withdrawal, or frank delirium requires prompt medical evaluation. Patients who walk into primary care settings with difficult behaviors that distract practitioners may result in inadequate evaluations, delays in diagnosis, and ineffective management. Aberrant behaviors may be seen with HIV and non-HIV related central nervous system conditions such as infections, tumors, or structural brain damage. Patients with general medical conditions, such as thyroid disease, hepatic encephalopathy, adverse drug reactions, or inadequately controlled pain may also present with difficult behaviors. Difficult or aberrant behaviors may indicate existence of a Personality Disorder. Although Personality Disorders do not respond to psychopharmacology, routine assessments will help identify treatable symptoms.

Behavior Management Strategies Useful In Primary Care Settings

Mental health care of people with HIV infection occurs routinely in primary care settings. The spectrum of care and variety of mental health services provided depends on the setting, as well as the practitioners' level of knowledge, skill, and comfort. Effective treatment of this patient population requires collaboration among providers throughout the continuum of care. Practical approaches to managing disruptive behaviors can be incorporated into day-to-day care. Intuitive care of this group of patients can be enhanced with training and collaboration among providers of care and administrators. Effective interaction with patients who have difficult behaviors can be developed at different levels, and designed to fit various scenarios. The following strategies may be helpful in your setting:

Primary Care Practitioners lead the way in setting the example for effective interaction with patients who have difficult behaviors.

- **Address disruptive behaviors** immediately.
- **Train frontline staff** to interact with patients in a compassionate manner. Staff will follow your lead.
- **Acknowledge patients' feelings.** In turn, help the patients understand the effect of their behavior on you and on the staff.
- **Use appropriate verbal and nonverbal communication** at all times. Highlight the behavior that is disruptive in a non-judgmental manner.
- **Listen to the patient and address the concerns.** Keep focused on the problem and keep the patient focused on the problem. Address problems that can be immediately resolved and make a plan with the patient to address more complicated long-term problems.

- **Do not take the behavior personally.** Attack the problem, not the patient.
- **Ask yourself questions** such as “Now, how can I best help this patient at this moment?” Avoid getting caught up in the emotions of the moment; especially avoid anger.
- **Remain objective** and give the patient control whenever possible. For example, “We cannot see you right now, however, if you would like to wait that is fine, or we can see you first thing in the morning. Which would you prefer?” Allow the patient to make the choice. Set limits, yet be flexible enough to work with the patient.
- **Prescribe drugs judiciously;** avoid easily abused drugs. Realize that some “drug seeking” behavior is due to inadequately controlled pain. Pain may need to be reassessed and adequately controlled.
- **Give compliments** when the patient behaves in an acceptable manner (“I am glad you waited to see me today. I really appreciate the way you handled the unusually long wait”).
- **Let the patient know you are glad they came in** for care and discuss acceptable behaviors. Encourage follow up and promote continuity of care.
- **Increase frequency of visits** if necessary to establish and maintain a healthy rapport with the patient.
- **Remain consistent** with rules and expectations and give the patient time to change.
- **Demonstrate support** and appreciation for your staff in front of the patient.
- **Talk to the staff affected by the patients’ behaviors** and help them understand that this is a part of the work. Design systems that will give staff the support they need throughout the day. Replay the scenario and discuss what can be done differently in the future.
- **Share the care of the patient** with other professionals and service providers so that no one provider of care is left to deal with the difficult behaviors. Patients with difficult behaviors often have complex problems and primary care practitioners should be able to focus on the management of the medical conditions.

Clinical managers and supervisors are often called upon to resolve conflicts.

- **Designate in advance key individuals** who can be called upon to help. Frontline employees need to have someone whom they can contact to obtain immediate assistance.
- **Crowded waiting rooms** are often filled with tensions and anxieties for patients and staff. Expect disruptive behaviors during the busiest and most crowded hours of operation. Work with the staff to spot potential trouble and have them call in time to help prevent escalation of emotions. Clinical managers might consider being most accessible and visible during these hours.
- **Design behavior contracts** to help patients understand your agency’s requirements and what they can expect from you. Outline what you expect from the patient.
- **Involve mental health and substance abuse providers** in case conferences.
- **Increase frequency of case conferences** with case managers, nurses, mental health providers, substance abuse providers or others involved in the care of the patient in question.

Senior managers play a key role in evaluating systems and processes that affect day-to-day operations.

- **Evaluate systems and cultures** that may present barriers to effective care of patients with difficult behaviors.
- **Develop systems** that ensure patients are seen in a timely, efficient, and organized manner.
- **Design a protocol** for managing difficult patient behaviors and provide training for staff.
- **Develop a code** to be used by staff when paging over the loud speaker or calling by phone (such as “code blue” and location). Have a team of trained and willing individuals to respond immediately to the call for help.
- **Install panic buttons** that will alert security of problems.
- **Physical barriers** may be needed in free access areas.
- **Develop a policy and procedure for dismissing patients.** Extreme difficult behaviors such as physical attacks, threats of real harm, and repeated explosive behaviors require close scrutiny. Staff safety as well as the safety of other patients in the waiting room is high priority.

Summary

Difficult patient behaviors present formidable challenges to the delivery of quality medical care. Patients with difficult behaviors should be evaluated for general medical conditions, psychiatric disorders, and substance abuse. Unacceptable behaviors may be an indication of difficult social problems, such as homelessness, domestic violence, or intimate partner violence.

The behaviors that practitioners perceive as difficult or maladaptive may represent behaviors adapted for survival outside of health care settings. These behaviors are unlikely to change. Therefore, practitioners should focus on helping patients maximize healthy behaviors. A team approach with consistent messages about appropriate behaviors in the health care setting is useful. When there is a concern about serious mental disorders, referral to a psychiatrist is in order. Patients with mental disorders and active substance abuse should be referred to MICA programs (Mentally Ill Chemical Abusing).

The primary care practitioner and psychiatrist should communicate in order to provide optimum care. Communication should flow both ways. Primary care practitioners realize that whenever patients drop out of mental health or substance abuse care, the care and treatment planning falls on their shoulders. It is important that primary care practitioners be informed of patient progress, missed appointments, changes and adjustments in medications, psychiatric hospitalizations, and drug rehabilitation efforts.

Case managers can often provide critical input into the care and follow up of patients. They have frequent interaction with patients and are aware of missed appointments, changes in medications, and difficulties that may arise that interfere with adherence to medical advice and treatments. Interactions with patients who exhibit disruptive behaviors may be seen as an opportunity to learn more about patients’ needs and expectations. The emotional well-being of patients with HIV infection impacts coping skills, and allows the individual to more appropriately adhere to treatment regimes, attend scheduled appointments and engage in healthier behavior that will support positive outcomes. A comprehensive approach to these patients that emphasizes sound care for each individual supported by the healthcare team will maximize outcomes.

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Author

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Continuing Education Test

HIV Medical Alert August 2003, Vol. 7 Issue No. 3: Mental Health — HIV Part II

To earn credit:

1. Read the CME article.
2. Review the objectives
3. Study and apply the content to the objectives and to your practice.
4. Complete the Post-Test.
5. Return the completed test and evaluation form as directed at the bottom of the evaluation page.

Objectives: At the conclusion of this activity, the learner will be able to:

1. List difficult behaviors commonly displayed in the primary care setting by patients with mental illness.
2. Discuss the HIV Mental Health guidelines, which encourage regular Mental Health and Substance Use assessment.
3. Describe useful strategies that improve interaction with patients who exhibit difficult behaviors.

Note: This CME activity and quiz is designated for 1 credit. CME credit expires May 15, 2005.

Select the best answer for each of the following.

1. Numerous episodes of difficult patient behavior in people with HIV may result in:
 - a. poor adherence to antiretroviral therapies
 - b. an increase in the spread of HIV
 - c. stagnant business growth
 - d. high employee turnover
 - e. All of the above
2. How often should Mental Health and Substance Use Assessments be conducted to determine underlying disorders in patients living with HIV/AIDS?

3. The most common mental disorders suffered by patients with HIV are: [Check all that apply.]
 - a. Depression
 - b. Anxiety disorders
 - c. Post Traumatic Stress Disorder
 - d. Obsessive-Compulsive Disorder
 - e. All of the above
4. Drug seeking behavior can be due to inadequately controlled pain.
 - a. True
 - b. False
5. Systems that effectively address difficult patient behavior include these important features:
 - a. A *Code* policy and a panic button to prompt an immediate response
 - b. Restraints
 - c. Patient dismissal policy
 - d. Involvement of mental health and substance abuse providers in case conferences.
 - e. All but b

Evaluation of CME Activity

HIV Medical Alert August 2003, Vol. 7 Issue No. 3: Mental Health ~ HIV Part II

	Excellent	Good	Fair	Needs Improvement
Overall Activity				
1. Was the subject matter well balanced in fact and theory?	1	2	3	4
2. Was the format clear and easy to read?	1	2	3	4
3. Did subject matter have sufficient detail?	1	2	3	4
4. Was subject matter valuable for practical application?	1	2	3	4
5. Were objectives listed on test page met?	1	2	3	4
6. Was the writer clear in content, sequence and style?	1	2	3	4
7. Overall program was? _____				

Comments/Topic Suggestions:

PLEASE PRINT CLEARLY TO ASSURE ACCURATE DOCUMENTATION OF CME CREDIT

Profession: Physician PA NP CNM RN LPN Other _____

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(please sign legibly for CME records)

Return the completed test and evaluation form by December 31, 2003 to:

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