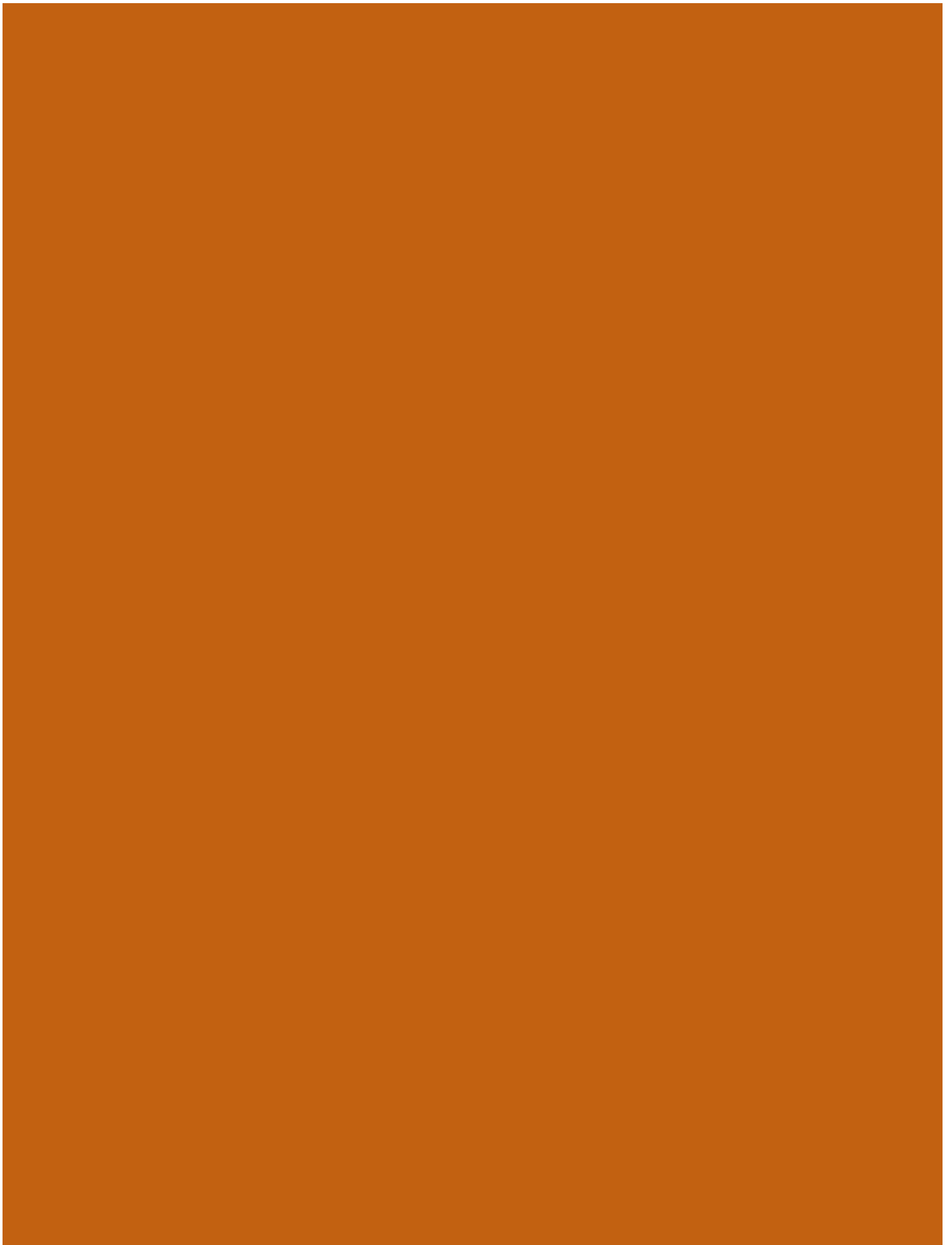
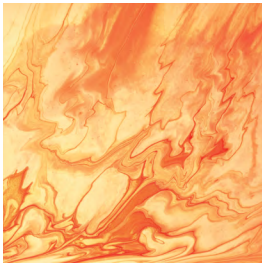


**CONSENSUS RECOMMENDATIONS OF THE
FLORIDA ACADEMIC HEALTHCARE PATIENT
SAFETY ORGANIZATION FOR THE**

**MANAGEMENT OF PATIENT
BEHAVIOR ISSUES,
BEHAVIOR AGREEMENTS,
AND DISMISSAL**



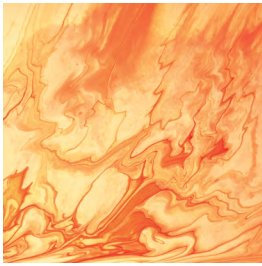




Consensus Recommendations of the Florida Academic Healthcare Patient Safety Organization for the Management of Patient Behavior Issues, Behavior Agreements, and Dismissal

These consensus recommendations, developed by the Florida Academic Healthcare Patient Safety Organization (FAH PSO), are for informational purposes only and should not be construed or relied upon as the legal standards of care or a clinical practice guideline. The applicable standard for any particular patient is determined by many factors, including the patient-specific clinical data available, and is subject to change given developments in scientific knowledge, technological advances, and the evolution of healthcare. Patient behavior issues can interfere with the care and treatment rendered and the relationship with the healthcare provider. One approach to dealing with these patient behavior issues includes the use of behavior agreements, with dismissal of the patient as a sometimes necessary, but last resort. Discussions between the healthcare providers and the clinical team should inform the course of action. The ultimate decision regarding the appropriateness of any medical care and treatment for any individual patient, or patient behavior interventions, is subject to that patient's clinical presentation and the reasonable judgment of the healthcare providers, in light of all information and circumstances prevailing in the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

The FAH PSO recommends institutions review these guidelines and accept, modify, or reject these recommendations based on their own institutional resources and patient populations. Any decision not to implement any of the recommendations herein, either fully or partially, should not be construed as evidence of negligence. Any recommendations, templates, proposed policies, or documents contained herein are solely illustrative. Additionally, institutions should continue to review and modify these recommendations as the area of health care continues to evolve. Adherence to or adoption of the consensus recommendations referenced in this publication does not guarantee a successful outcome. These consensus recommendations do not include a comprehensive listing of all methods or models of managing patient behavior issues. No statement or recommendation in this report should be construed as legal advice or as the official position of any of the institutions referenced in the report. It is anticipated that these recommendations will require updating as healthcare and the management of patient behavior issues evolves.



Participants

The following healthcare providers participated in the development of these consensus recommendations. This publication does not necessarily reflect the views or opinions of any particular healthcare provider, university institution, or healthcare organization. Again, these recommendations are not intended to create nor should they be construed as the legal standard of care or a clinical practice guideline. None of the participants has any affiliations or financial involvement that conflicts with the material presented in this report.

Teresa Ayers, MA, TESOL

Clinical Risk Management Specialist
Student Health Services
University of Central Florida

Ronald Berry, MD

Director
University of Florida Student Health Care Center

Jody Brown, MD

Psychiatry Director
University of Florida Student Health Care

Christopher DeLisle, DO

Medical Director
Florida State University
University Health Services

Nasreen Ghazi, MD

Lead Clinician
Florida Atlantic University Student Health Services

LeAnn Gutierrez, PhD, MBA

Director
Florida Atlantic University Student Health Services

Tasha Lauture

Florida Atlantic University Student Health Services

Katherine R. Lindsey, MS, CHDA

Assistant Director
University of Florida Student Health Care Center

Amy Magnuson

Florida State University
University Health Services

Douglas G. Meuser, MD, FAAFP

Assistant Director
Clinical Services
University of Central Florida Health Services

Marcia Morris, MD

Psychiatry Associate Director
University of Florida Student Health Care Center

Elizabeth Powell, BSN, RN

Nurse Supervisor
University of Florida Student Health Care Center

Joseph A. Puccio, MD, FAAP

Medical Director
University of South Florida Student Health Center

Alison Schwartz, MD

Chief Medical Officer
Florida Atlantic University Student Health Services

Saara Schwartz, MD

Medical Director
Student Health Services at FIU

Jeremy Titus, RN

Psychiatric Nurse Specialist
University of Florida Counseling and Wellness Center

John E. Trainer, III, MD, FAAFP, DABFM

University of Florida Student Health Care Center

Editorial Staff**Francys Calle Martin, Esq., LHRM**

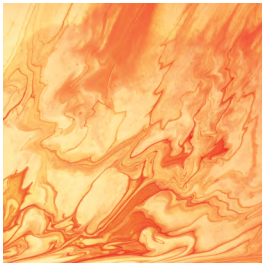
Vice President
Florida Academic Healthcare Patient Safety Organization
Content Author and Editor

Randall Jenkins, Esq.

President
Florida Academic Healthcare Patient Safety Organization
Copy Editor

Stephanie Gann

Business Analyst
Florida Academic Healthcare Patient Safety Organization

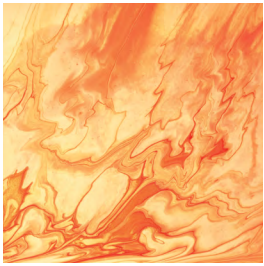


About the Florida Academic Healthcare Patient Safety Organization

In 2005, Congress developed and enacted the Patient Safety and Quality Improvement Act (PSQIA) with the intent of cultivating a culture of safety and improving healthcare, by providing federal privilege and confidentiality protections for information that is reported to a Patient Safety Organization (PSO), developed by a PSO, or which represents the analyses and deliberations of patient safety events, for the conduct of patient safety activities. The PSQIA promotes the sharing of knowledge gleaned from these patient safety activities and the sharing of best practices and recommendations that seek to improve the quality of healthcare.

The Florida Academic Healthcare Patient Safety Organization (FAH PSO), listed by the Agency for Healthcare Research and Quality on April 22, 2014, represents a significant step toward improving patient safety in the third most populous state in the United States. The PSQIA and the associated federal confidentiality protections provide the required framework to allow the sharing of sensitive patient information among medical providers located at the six different State of Florida medical universities training the next generation of healthcare providers. The FAH PSO represents Florida Atlantic University, Florida International University, Florida State University, the University of Central Florida, the University of Florida, the University of South Florida, and the respective institutions' healthcare providers working together to improve patient safety and healthcare.



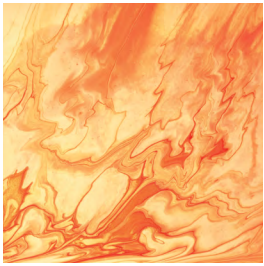


Executive Summary

In 2021, at the behest of its membership, the FAH PSO convened a Patient Behavior Work Group to arrive at an expert consensus of recommendations for effective management of patient behavior issues, including recommendations for training of healthcare providers, documentation of concerns, and the development of policies to guide healthcare providers and facilities when dismissal of a patient becomes indicated. The FAH PSO sought to create these recommendations supported by a subject matter expert panel, review of the available literature, and identification of professional practices of healthcare providers actively involved in the provision of these services.

This Work Group began with a review of the latest scientific evidence, guidance, and opinion statements from relevant professional societies on the appropriate and effective management of patient behavior issues in the ambulatory setting. Further insights were gathered from subject matter experts in Medicine, Psychiatry, and Student Health.

The following recommendations reflect the aim, mission, and consensus opinions of the Patient Behavior Work Group. These recommendations offer guidance to healthcare providers and facilities in their efforts to provide safe, effective, and evidence-based healthcare. Specific resources will differ for and within each institution. These recommendations are supported by the literature available at the time of publication.



Reasons to Consider a Patient Behavior Agreement or Dismissal of Patient

When determining whether to utilize a patient behavior agreement or dismiss a patient, a team approach with discussion by the healthcare team is recommended. The healthcare provider should never feel that they are solely responsible for the decision or that their concerns are not being addressed by the administration. A team approach may help to identify the best interests and alternatives for the patient's care, the healthcare provider, and the facility. The healthcare team should also recognize and be mindful of the special needs and characteristics of each individual patient. For example, patients with diverse cultural backgrounds may communicate concerns differently. Or, the patient may have a chronic illness that requires additional consideration and planning for purposes of an agreement.

The following are some of the most frequently encountered patient behavior issues, but any event that raises the consideration of a behavior agreement or dismissal should be discussed by the healthcare team.

- **Failing to present for appointments**

The number of missed appointments may vary depending on the patient's circumstances. For example, if the patient fails to present for 3 appointments in 1 year, this may not only present a strain to facility resources, but may also result in potential harm to the patient as failing to present may interfere with their progress and treatment. Special consideration should be given to patient's underlying concerns as this may be a cause of their inability to present for appointments on a timely or consistent basis. For example, patients may have social or socioeconomic issues that impact their resources and ability to present for appointments.

Note: In a university student health setting with students paying a fee for their student health services, dismissal of the patient may also result in a demand for reimbursement of those fees. Therefore, these patient circumstances may also merit discussion with administration prior to final actions.

- **Repeatedly presenting without a scheduled appointment**

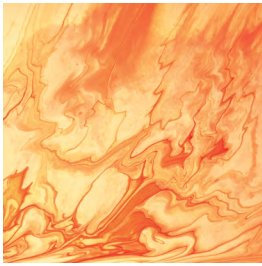
This includes patients who do not present with an urgent or emergent medical condition and who repeatedly present without an appointment. This can be disruptive to or interfere with facility operations.

This is to be distinguished from patients who walk in with an urgent or emergent medical condition. For example, a patient may present without an appointment if they are having acute mental or medical health concerns that require immediate attention.

- **Repeated failure to comply with medical treatment and recommendations**

A patient that presents for appointments but is unwilling or unable to follow the healthcare provider's recommendations and pursue the treatment prescribed may also be dismissed from the care of the facility. This is because their inability to comply with treatment recommendations may pose a significant risk to the patient.

Each patient and their treatment plan is specialized and particular to that patient. As such, some patients may require an additional investment of time and resources to optimize their treatment plan.



Reasons to Consider a Patient Behavior Agreement or Dismissal of Patient *(continued)*

- **Repeated failure to comply with medical treatment and recommendations *(continued)***

The cause of their non-compliance may vary. The reason for their non-compliance should be explored and providers may continue to work with these patients to continue to reduce or eliminate harm to the patient as a result of their inability to follow recommendations. Proposed templated language for this type of behavior may include that there is “no therapeutic alliance,” “no adherence to the plan by the patient,” or “not complying with treatment recommendations which may result in harm.”

Patients who choose not to comply should be distinguished from patients who cannot comply with treatment recommendations as a result of lack of resources. Should the patient require access to resources in order to comply with treatment recommendations, the healthcare team should explore referral to social work, case management, or other similar resources.

- **Disruptive behavior**

Disruptive behavior may be somewhat subjective, and dependent on the specific healthcare provider or facility. Depending on these circumstances, disruptive behavior may include:

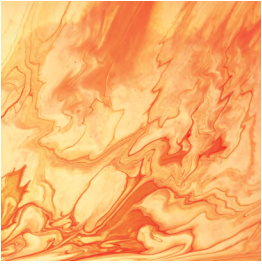
- Verbal or physical abuse of the healthcare providers or staff
- Destruction of healthcare facility property
- Misuse of property, services, or documents of clinic, including forgery, theft of prescriptions or medications, or intentionally misidentifying or misrepresenting their identity or medical history
- Use of contraband while on clinic property (including alcohol, illegal drugs)
- Failure to respect the boundaries of the provider-patient relationship and personal space with the intent to intimidate or harass

For example, a patient may repeatedly call after hours or email the provider despite the provider asking the patient to use a patient portal. However, some exceptions should be made for patients that require increased monitoring, but that level of care should also be documented.

- Disruptive behavior by the patient’s surrogates, including parent, spouse, or caregiver
- Otherwise materially interfering with the operations of clinic

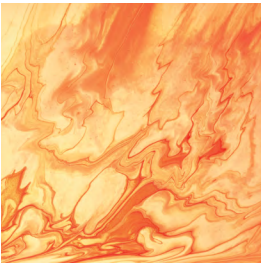
- **Breakdown in the provider-patient relationship**

There will be occasions where the provider-patient relationship is irrevocably broken and it is in the best interest of the patient, the healthcare provider, and the facility that the patient not return.



Disruptive Behavior of the Patient Surrogate

In situations where it is not the patient, but a surrogate of the patient, that is engaging in the disruptive behavior, the process of addressing the behavior may need some alteration and flexibility. The patient is not at fault, nor should they be held responsible for the actions of the surrogate. However, the behavior of that surrogate should also not be permitted to impact the care of the patient, the wellbeing of the healthcare providers, or the operations of the healthcare facility. Although the patient does not generally bear responsibility for the actions of their surrogate in these situations, the response should be similar, utilizing the tools discussed in these recommendations. Disruptive individuals may also be asked to remain outside of the treatment room if it would be beneficial to the patient's care and treatment. The surrogate may also be asked to wait outside of the facility, or otherwise isolate themselves and their disruptive behavior from treatment areas. A surrogate may also be asked to sign a behavior agreement and this discussion, including the behavior leading up to this discussion, should be documented in the patient's medical record.

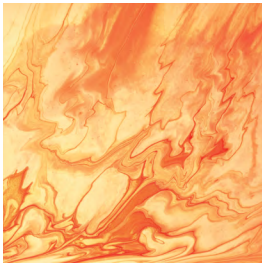


Documentation of Patient Behavior Events

According to the American Society for Healthcare Risk Management, when a patient is displaying disruptive behavior the healthcare staff should document the date, time, a description of the behavior, as well as noting that the patient was informed the behavior was inappropriate and cannot continue. When documenting this behavior the physician should write a factual description of what happened while avoiding any editorial comments in the patient record. When documenting the behavior be sure to include any of the patient's or family member's rude, threatening, or inflammatory statements in quotations. Vulgar language may be documented saying something to the effect that, "while using vulgar language, the patient ..." without referencing the exact vulgar words used. The level of detail used may depend on the comfort level of the healthcare provider and the policies of the facility where the event took place. Front office staff who interact with the patient and their family may also document disruptive behavior in the medical record, as a patient's interactions with any member of the healthcare staff may have an impact on their relationship with the healthcare providers and facility. Depending on the type of software utilized, front office staff are often able to document in portions of the medical record dealing with messages and appointments.

Each time the disruptive or inappropriate behavior occurs, it should be documented in the medical record to establish a pattern of behavior. The documentation should include the ongoing problems, and the effects the behavior is having on the patient and others in the facility, documentation of the steps taken to resolve the conflict, and documentation of the patient's response to the steps taken. Behavior events can often have an impact on the care and treatment of the patient, and impact patient safety throughout the healthcare facility. There is no need to reference patient safety event reports in the patient's medical record. Further, there should be no finger pointing in the medical record toward any of the healthcare staff, or even the patient. The medical record is not the venue for this type of discussion and the initial information thought to be correct may turn out to be inaccurate. The patient may request a copy of their medical record and may then have an inaccurate picture of the care they were provided or the impact of the patient behavior incident. Remaining factual in the description of the event, with an understanding of the event's impact on the patient's well-being, should be the intent of the documentation.

Often surrounding the disruptive or inappropriate behavior, the patient may also seek to assert a complaint against the healthcare provider or facility. Any complaints by the patient should also be documented in the patient safety event reporting system. If the patient has submitted a written complaint this should be attached to the entry in the event reporting system. Complaints often require additional investigation and a formal response. Additionally, it is highly recommended that a provider not openly criticize another provider's care. However, if a provider has concerns, they should discuss it with the colleague and their administration rather than enter it into the medical record.

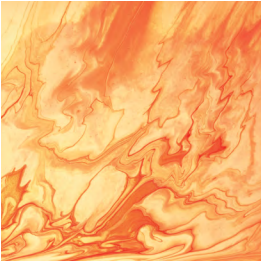


Documentation of Patient Behavior Events

(continued)

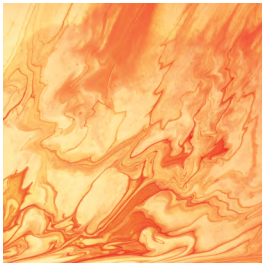
DOCUMENTING PATIENT BEHAVIOR EVENTS IN THE MEDICAL RECORD

Behavior Event Information	Should I include this in the medical record?
Objective facts about the incident	Yes, include in the medical record. Be brief and objective. Include the date and time of the event, as well as any health-related factors that may have contributed to the behavior.
Conversations with the patient	Only statements relevant to care should be in medical record. Generally profane or offensive statements may be referenced in general terms.
Non-compliance, failure to follow care instructions	Only statements relevant to care should be in medical record. Generally profane or offensive statements may be referenced in general terms.
Conflicts among administrators or providers	Do not document in the patient's medical record.
Incident Reports: Includes Complaints and Patient Safety Reports	Only enter in the patient safety event reporting system.
Risk management referrals	Only enter in the patient safety event reporting system.
Other legal information	Only enter in the patient safety event reporting system.



Patient-Centered Considerations

Medical conditions that could be contributing to the patient's disruptive behavior, such as drug and alcohol use disorder, or psychiatric conditions, should also be documented. These may be relevant to the event as well as to the patient's care and treatment. These underlying conditions may also be relevant to how the event will be treated and whether it will result in a behavior agreement or dismissal. Certainly, if the patient has exhibited behavior that is explained by the underlying condition in the healthcare provider's opinion, then their behavior should not be used to disrupt the provider-patient relationship. Disruptive behavior in the clinic setting may include aggressive or inappropriate language, threats to healthcare providers and staff, or other patients, as well as theft, abuse, or destruction of equipment. Though some disruptive behavior may be explained by a specific patient's condition, it may be considered unacceptable despite the patient's underlying condition, especially if it compromises the care of that patient and all other patients of that practice and facility. It is, of course, also unacceptable if it threatens the health and safety of any of the healthcare staff. It also leads to an erosion of the relationship between the patient and the healthcare provider. Where there is abuse or a lack of respect for the provider or institutions, there is a breakdown in the trust that is implicit in this relationship.

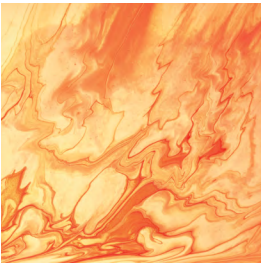


Patient Behavior Response Protocols

IMPORTANT: if the provider feels a threat of imminent harm to themselves or others, they should call Security if available and/or 911 and any potential subjects of the violence should leave the immediate area of the disruptive individual.

If the patient is otherwise disruptive, disrespectful, offensive, etc., but is not posing an immediate danger to anyone in the area, the following opportunities should be explored:

Active listening and reflection	In some cases, it may be possible to deescalate unwanted behaviors through listening strategies, by ensuring the patient or visitor feels heard, legitimizing concerns, and reassuring them that these will be addressed. "Reflection" is defined as "stating the observed emotion," i.e. "I see you're worried that X" or "...upset about Y."
Verbal warning	Discuss the unacceptable behavior with the patient. This verbal warning should be provided by the healthcare provider.
Team intervention	Two or more members of the healthcare team meet with the patient to discuss patient responsibilities, including the responsibility to comply, and the potential consequences of a failure to do so.
Behavior agreements	For unacceptable/disruptive behaviors the healthcare team may consider having the patient sign a behavior agreement stating that they will comply with behavior expectations. This process is managed by clinic administration.
Patient dismissal	Where warranted by no-shows, non-compliance, or serious or repeat disruption, patients may be barred from non-emergent care. This process is managed by clinic administration.



Patient Behavior Agreements

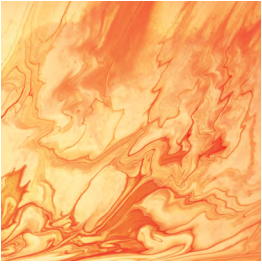
Where the patient's disruptive behavior has not yet reached an irreparable level requiring dismissal, the facility may elect to utilize a Behavior Agreement. Patient Behavior Agreements may also be called Partnership Agreements, to reflect the common goals between patients and the healthcare teams to partner in optimal care and treatment. These agreements are intended for use in outpatient settings, and may include both verbal and written warnings. The goal of these agreements is to ensure that patient behaviors comply with the healthcare treatment setting and that healthcare teams make every reasonable effort to avoid the dismissal of the patient and the end of the Provider-Patient relationship. The requested behavior or change of unacceptable behavior should be a behavior that the patient can reasonably comply with and sustain. A discussion of these behaviors and the proposed changes with the patient may illuminate the causes of the behavior and ways in which the healthcare team can support those changes in ways that are likely already incorporated into clinic operations. Whether or not the patient signs the agreement, the expectations of acceptable behavior remain the same, as do the consequences of failing to comply with those expectations.

The Behavior Agreement will generally outline the specific types of disruptive behavior that are not permitted at the facility and which the patient or their surrogate has exhibited. The agreement may also provide specific examples, dates, and descriptions of the behavior witnessed in the past and that is not permitted. The patient or the surrogate, if applicable, is asked to execute the agreement as a condition of continued treatment at the facility. Depending on the process that works best for your facility, the provider or clinic administrator should also sign the Behavior Agreement to evidence that they have discussed the behavior with the patient. The patient should also be informed that failure to comply with the Behavior Agreement may result in their dismissal from the facility or practice, and all affiliated facilities, for non-emergent care. The fully executed agreement should be scanned and attached to the patient's medical record. If they decline to sign, this should be documented on the letter and a copy of the letter, with the noted declination, should also be scanned and attached to the patient's medical record. Some facilities may also elect to make execution of the Behavior Agreement a condition of continued treatment. Therefore, if the patient or their surrogate declines to sign the Behavior Agreement, they may be immediately dismissed from the clinic. This is, of course, dependent on the severity of the behavior at issue. The consequences for declining to sign the Behavior Agreement may also be dependent on your institution's policies. For example, the University Administration may take a disruptive event into consideration as a violation of the Code of Student Conduct and may consider this grounds for a potential dismissal from that University. Therefore, the decision to utilize a Behavior Agreement or other forms of addressing patient behavior issues, may be removed from the healthcare facility's authority.

If a Behavior Agreement is utilized, it may contain the following language, or substantially similar language, as well as a description of the behavior that led to this agreement:

"I understand that I am personally responsible for my behavior while at this facility.

- failing to present for appointments
- not complying with treatment recommendations which may result in harm
- speaking in a loud voice
- rude behavior
- use of profanity including abusive or inappropriate language



Patient Behavior Agreements *(continued)*

- threats to healthcare providers and staff, or other patients
- abuse or destruction of equipment
- specify other _____

are disrespectful, disrupt the provider-patient relationship, interfere with efficient clinic operations and, therefore will not be tolerated. If I am unable to avoid any and all of these negative behaviors, I understand I may be dismissed from this clinic and all affiliated clinics.”

The Behavior Agreement may be modified to reflect the specific behavior at issue. It is not a legally binding contract. It may, however, serve to bring that person’s behavior into focus and to emphasize that there are consequences to that behavior. The discussion surrounding the Behavior Agreement should also be documented in the medical record.

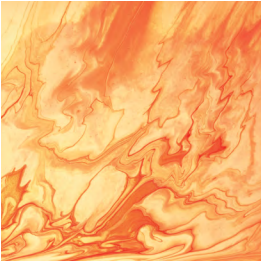
PATIENT DISMISSAL

If disruptive or negative behavior continues after a Behavior Agreement is obtained, it may be necessary to end the provider-patient relationship. Depending on the size of your facility, and the issues for which the patient is seeking care, you may seek to dismiss the patient from just one clinic site or from all clinic sites within your system. However, if the patient is in an acute phase of treatment, dismissal must be delayed until the acute phase has been resolved. Further, if your clinic is the only source of a particular specialized medical care, you must continue care until the patient can be safely transferred to another practitioner or facility who is able to provide treatment and follow-up. A patient’s disability cannot be the reason for ending the provider-patient relationship unless the patient requires care or treatment for that disability outside of your expertise.

When ending a provider-patient relationship the patient should be put on notice, in writing, that they must find another provider. The written notice should be mailed to the patient via certified mail, with a return receipt requested. Keep copies of the letter and the original certified mail receipt (even if the patient declines to sign for the certified letter) in the patient’s medical record. If the patient participates in your facility’s electronic medical record portal and has elected to receive communication through that platform, they may also receive the dismissal letter via that portal. If possible, following dismissal, the patient’s access to the portal and the medical records should allow them to access their medical records or direct them to the records custodian should they require further access. In addition, and if possible, portal access should be limited so that the patient may not send further messages to the healthcare provider via the portal. The dismissal of the patient, and any conversations with the patient regarding that dismissal, should be documented in the medical record.

The notice of dismissal should include:

- The reason for dismissal.** Although stating the specific reason for dismissal is not required, in certain circumstances it is acceptable to use phrases like “inability to achieve or maintain rapport.”
- Effective date of dismissal.** The dismissal should provide the patient with at least 35 days to find another provider. Generally, 30 days is required, but physical correspondence may be delayed and the addition of 5 days is for the benefit of the patient.



Patient Behavior Agreements *(continued)*

The notice of dismissal should include *(continued)*:

- Continued care provisions.** Offer suggestions for continued care but do not recommend another healthcare practitioner by name. You may also refer the patient to their local health department or medical society for assistance in locating another provider.
- Patient responsibility.** Remind the patient that it is their responsibility to follow-up and continue medical care.
- Medication refills.** Explain that medication will only be provided up to the effective date of dismissal.

Some situations require additional steps or delay of dismissal. Ending the provider-patient relationship is more easily accomplished in a clinic setting where the patient is not likely to have an acute problem requiring immediate attention. Patients who are admitted to the hospital and are evidencing behavior issues may not be stable enough for dismissal or transfer and therefore, the relationship is more difficult to end. Some patient situations may require an immediate dismissal. These generally involve situations where the patient or their surrogate have threatened or exhibited violent or threatening behavior.

The dismissal letter may come directly from the provider, or depending on the circumstances and the structure of the facility and relationship with the patient, the dismissal letter may also be signed by the clinic administration. Dismissal from a specific healthcare location, or an entire healthcare system, is also dependent on your structure and on the disruptive event. Further, the length of dismissal may also be contingent on reason for the dismissal and at discretion of healthcare provider or administration.

Depending on your healthcare facility, varying levels and types of institutional review and endorsement may be necessary to dismiss a patient from care. In addition, your facility may have collected fees or payment for future medical care. If dismissal is necessary, the patient may be entitled to a full or partial refund of the those fees. You should contact clinic administration and legal counsel for the facility should you need specific guidance on review of the dismissal and reversal of any fees or payments already collected.

CONCLUSION

Setting forth consistent processes on the handling of patient behavior concerns, addressing the underlying causes of patient behavior issues, documenting concerns in the medical record, and communicating both rights and responsibilities with patients, can help reduce continued patient behavior issues. As always, healthcare providers consider the patient's underlying issues and whether the behavior warrants additional assistance or resources, and whether a dismissal is absolutely necessary. Utilizing these recommendations, behavior agreements can be tailored to the specific circumstances of the patient's behavior. If dismissal becomes necessary, written notification to the patient of interim care and medication refills can assist in defining the end of the provider-patient relationship and a transition to another provider.

Template for Patient Dismissal Letter

January 1, 2022

**VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED
AND VIA PATIENT PORTAL**

Dear Patient:

We regret to inform you that your medical care at our clinic will be ending effective _____ [35 days from the date of the letter]. After that date, you will not be eligible to receive your medical care at this clinic. Between now and _____ [35 days from the date of the letter], we will provide you emergency care only while you find another healthcare facility and provider to assume your care. If you are a current user of the electronic patient portal, this healthcare facility will no longer respond to your inquiries using the electronic patient portal.

Please understand that we make this determination only after a thorough evaluation of the circumstances surrounding your behavior. We are taking this action because _____ [specify the reason(s)] which is not conducive to either ideal medical care and treatment or the efficient management of our medical practice.

We recommend that you take immediate steps to establish regular medical care with another healthcare facility and provider. If you have a difficult time finding a new healthcare provider, we suggest that you call the local medical society or health department for recommendations. With your written permission, we would be happy to forward your medical records to another healthcare provider.

Sincerely,

Clinic Administrator

cc: Medical Record
Clinic Manager
Clinic Medical Director

Partnership Agreement Template

January 1, 2022

VIA CERTIFIED MAIL – RETURN RECEIPT REQUESTED AND VIA PATIENT PORTAL

Dear Patient:

We are reaching out to you following recent incidents of disruptive behavior. Our goal is to partner with you to provide you safe care and treatment. We have noted the following disruptive behavior during recent visits to our Clinic, including:

- Refusal to follow COVID screening protocols
- Verbal or physical abuse of the healthcare providers or staff
- Destruction of healthcare facility property
- Misuse of property, services, or documents of clinic, including forgery, theft of prescriptions or medications, or intentionally misidentifying or misrepresenting their identity or medical history
- Use of contraband while on clinic property (including alcohol, illegal drugs)
- Failure to respect the boundaries of the provider/patient relationship and personal space with the intent to intimidate or harass
- Disruptive behavior by the patient's surrogates, including parent, spouse, or caregiver
- Otherwise materially interfering with the operations of clinic

These behaviors impact our ability to provide care for you, other patients, and do not follow the clinic rules established to maintain the safety, security, and privacy of all our patients, families, and our healthcare team.

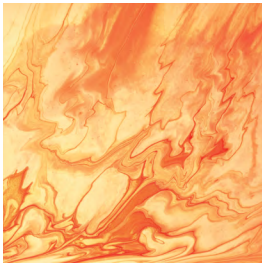
We have attached a Partnership Agreement for your review and signature. We ask you bring this signed agreement to your next visit to discuss with our clinic administration. The purpose of this agreement is to provide an environment that is supportive and respectful for patients, family members, friends, and staff in which to deliver high quality healthcare.

We would be glad to discuss any questions or concerns at a mutually convenient time.

Sincerely,

Health Center Administrator

Enclosure: Partnership Agreement



Resources

Davis K, et al., “Challenging Patient Encounters (for Medical Students)”, Texas Medical Association, <https://www.texmed.org/WorkArea/DownloadAsset.aspx?id=32034> (last accessed July 2022)

Brightwell J, et al., “Terminating Patient Relationships”, The Doctors Company, <https://www.thedoctors.com/articles/terminating-patient-relationships/> (last accessed July 2022)

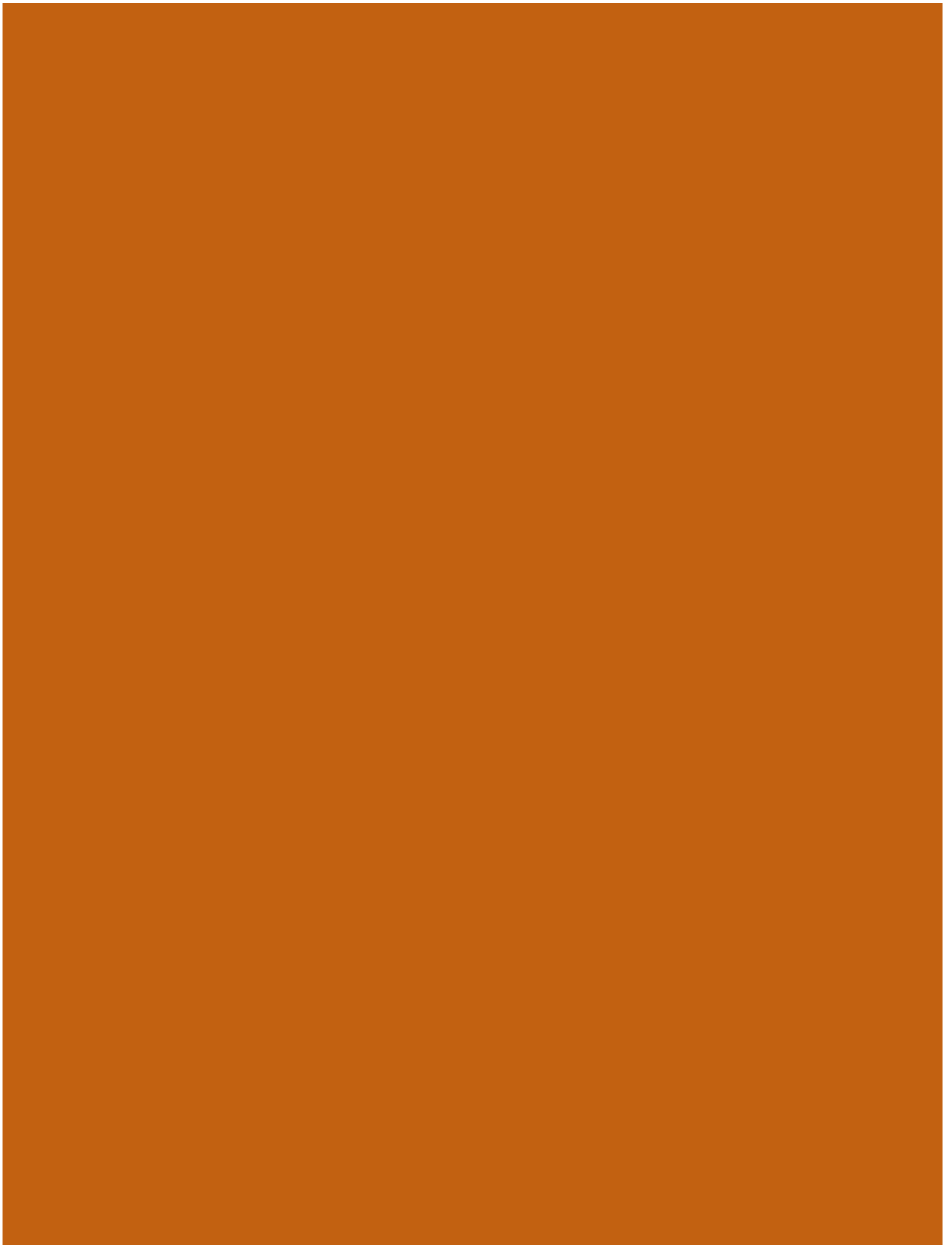
Cahill R, “Patient Relations: Anticipate and Address Challenging Situations”, The Doctor’s Advocate, Third Quarter 2021, <https://www.thedoctors.com/the-doctors-advocate/third-quarter-2021/patient-relations-anticipate-and-address-challenging-situations/> (last accessed July 2022)

Santoso JT, Yibirin E, Crigger M, Wan J, ElNaggar AC. “Incidence and contributing factors to termination of the patient-physician relationship.” *Gynecol Oncol Rep.* 2016 May 31;17:42-4. doi: 10.1016/j.gore.2016.05.011. PMID: 27355000; PMCID: PMC4909815.

Finelli E, “Legally Terminating a Physician-Patient Relationship”, <https://www.physiciansweekly.com/legally-terminating-a-physician-patient-relationship> (last accessed July 2022)

American Medical Association: Code of Medical Ethics Opinion 1.1.1: Patient-Physician Relationships, <https://www.ama-assn.org/delivering-care/ethics/patient-physician-relationships> (last accessed July 2022)

MedPro Group, Guideline: Terminating a Provider-Patient Relationship, https://www.medpro.com/documents/10502/2837997/Guideline_Terminating+a+Provider-Patient+Relationship.pdf (last accessed July 2022)





Florida Academic Healthcare Patient Safety Organization

201 Southeast 2nd Avenue, Suite 209 • Gainesville, FL 32601

352-273-7006