THE COVENANT
Chart

COVENANT HealthCare

COVENANT MEDICAL STAFF NEWSLETTER | SEPTEMBER 2017

Disruptive or Constructive?

Dr. Michael Fiore
Covenant HealthCare Chief of Staff

In this issue of *The Covenant Chart*, you will find several important articles, including survey results from the 2017 Covenant HealthCare Provider Engagement Survey. Participants in this survey included employed and independent physicians as well as advanced practice providers. Of interest, addressing disruptive physician behavior remains an area identified as an opportunity for improvement.

This topic has been discussed before, but it bears repeating. Disruptive physician behavior constitutes a broad array of actions or personality traits that interfere with effective clinical care. This conduct negatively affects the ability of others to provide care, and ultimately compromises the quality and safety of care for patients. The behavior pattern might be "aggressive," such as yelling, intimidating, slamming or cursing. Often times, however, the disruptive behavior is "passive-aggressive," such as intentional non-communication or miscommunication, delays in responding to pages, or participating in sarcasm and jokes at the expense of others.

A New Culture

The culture (and safety) of healthcare has evolved. Patient care is increasingly complex, requiring effective collaboration with many caretakers. Today's physician must be capable of functioning as one part of a larger system of care. Physicians can no longer behave autocratically. Disruptive behavior is no longer acceptable. Arrogant and/or demeaning attitudes create a hostile environment and an unsafe workplace.

Interestingly, physicians who display disruptive behavior are often intelligent, hard-working and high-achieving with true intentions of advocating for their patients. It becomes unfortunate, however, when these laudable intentions become misguided, leading to behaviors that negatively impact patient care.

The disruptive physician label does not apply to physicians who present constructive debate, participate in constructive arguments or disagreements, or offer constructive criticism of the medical system. It's "how" one disagrees that can cross the line into disruptive versus constructive.

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Reducing Wait Times with Real-Time Technologies

GUEST AUTHOR
John Georgakopoulos, Medical Director, Covenant MedExpress

Getting stuck in a waiting room with other sick people is no fun. It not only exposes patients to more germs, but it's frustrating for everyone and can reduce patient satisfaction. According to a recent Software Advice survey, an astonishing 97% of patients were frustrated by wait times and 41% of patients were open to the idea of switching doctors just to save time.

Thankfully, technologies are emerging to tackle this age-old problem while bringing medicine into the 21st century. These include various tools and models that enable virtual visits, improve scheduling, enhance teamwork, notify patients about wait times, and more.

The goal is to help patients wait in the comfort of their own home or elsewhere, and it is fast becoming the "new norm" as these technologies take hold.

Clockwise.MD

An example of one tool that is growing in popularity is Clockwise.MD. This web-based program provides the health-care industry with several patient engagement solutions, including online self-scheduling and check-in, virtual queuing to manage wait times, proactive patient notifications, and patient surveys for real-time feedback – all of which are HIPAA compliant.

More than 1300 facilities to date are reaping the benefits of Clockwise.MD, including urgent care facilities, emergency departments, laboratory clinics and primary/specialty care clinics.

Key benefits include:

- Patient control over appointments with on-demand scheduling.
- Improved transparency and instant notification about delays.
- Reduced waiting room time and crowding.
- Improved patient satisfaction.
- Patient retention and growth.
- Better use of office resources.
- Fast feedback to improve performance.
- Better patient flow and throughput.

Case Study

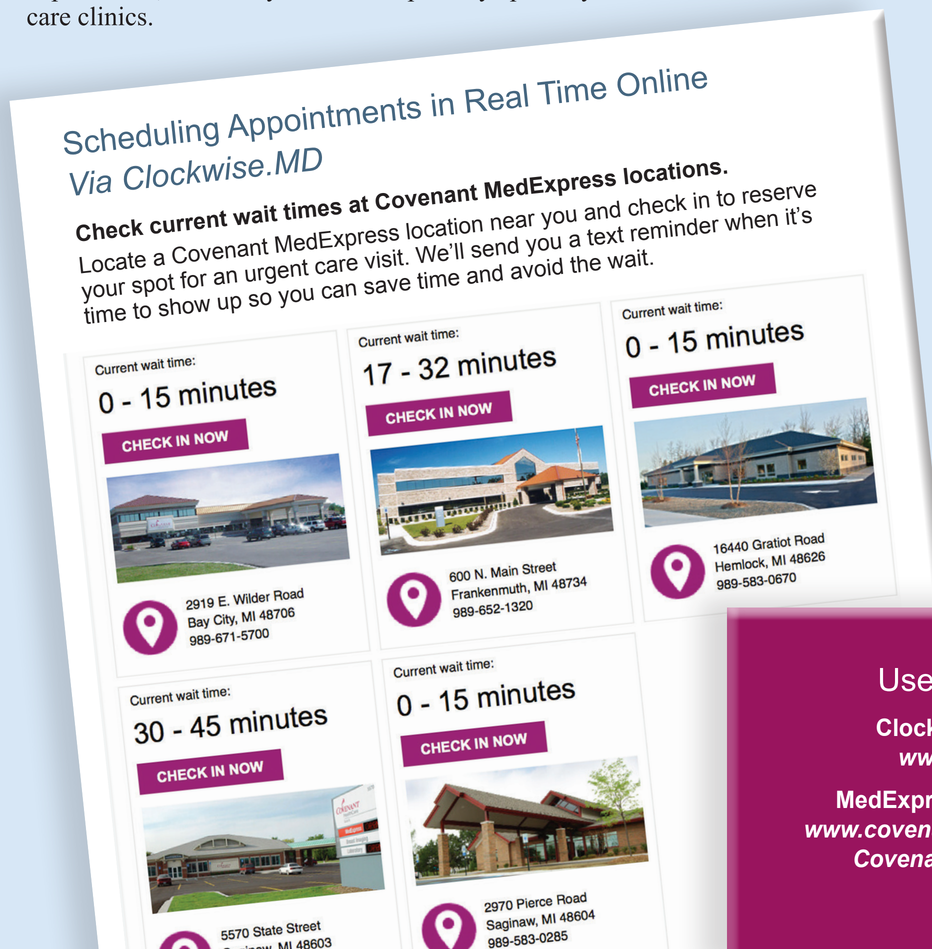
Covenant MedExpress implemented Clockwise.MD in February 2016 to allow patients to better monitor wait times before receiving care and to help decide where to seek care. This system replaced an inefficient sign-in process, providing a more accurate estimation of wait times and improved communication with the patient.

Here is how it works. Using an online portal, patients can view the current wait time in real time at each of the five MedExpress locations and choose which clinic to visit based on the wait time (see the image below). They can then schedule an appointment (a sign-in time) online for the current day to save a place in line. They are required to appear 15 minutes in advance to complete the sign-in process.

Providing their mobile number allows the patient to receive updates about changes to their scheduled appointment, reminder texts as the time approaches, or rescheduling confirmations. Clockwise.MD effectively tracks the patient from the moment they sign in to the moment they are discharged, and provides accurate wait times throughout the visit.

MedExpress is already witnessing a decrease in wait times and more efficient throughput for patients – all of which is expected to improve patient satisfaction and efficiency.

For more information, contact Dr. Georgakopoulos at 989.395.5389 or JGeorgakopoulos@chs-mi.com.



Useful Resources

Clockwise.MD website:
www.clockwise.md

MedExpress website example:
www.covenanthealthcare.com/main/CovenantMedExpress.aspx

Staying on Top of Endometrial Cancer

GUEST AUTHOR
Dr. Gregory Sutton, Medical Director, Gynecologic Oncology Program

The incidence of endometrial cancer in the United States is increasing. There were about 40,000 new cases in 2005, and in 2017 there is an anticipated 61,380 new cases with 10,920 projected deaths from the disease.

Risk Factors and Evaluations

Low parity, infertility, anovulation, polycystic ovaries, diabetes, hypertension and obesity are all known risk factors for endometrial cancer. The epidemic of obesity in the U.S. may be largely responsible for the increasing numbers of women diagnosed with this cancer annually. The most common symptom is peri- or post-menopausal bleeding. However, many pre-menopausal women who are anovulatory will have no bleeding until endometrial hyperplasia or frank carcinoma occur.

Since there is no screening test for endometrial cancer, any abnormal bleeding should be evaluated by pelvic examination, vaginal ultrasound and endometrial biopsy.

Treating Young Women

The average age of women diagnosed with endometrial cancer is 60. That said, young women who develop endometrial hyperplasia or low-grade cancers may be successfully treated with systemic progestogen therapy or the use of progesterone-containing intrauterine devices, thus preserving fertility.

Long-term monitoring of these patients is essential since the underlying risks of anovulation and obesity may not be reversed, leading to recurrence. A recent study from Sweden indicates that bariatric surgery may reduce the risk of endometrial cancer by nearly 50%.

Surgical Options

The surgical approach to endometrial cancer has been revolutionized by robotic surgery and sentinel lymph node detection. Although vaginal or laparoscopic hysterectomy are cost-effective ways to treat benign gynecologic conditions, the Gynecologic Oncology Group showed conclusively that the ability to complete minimally invasive surgery for endometrial cancer fell precipitously with increasing body mass index (BMI).

Robotic operations allow hysterectomy and staging in patients who are not candidates for laparoscopic or vaginal surgery. Many women undergoing these procedures may be discharged the day of surgery. The use of sentinel lymph node detection using indocyanine green dye and Firefly technology coupled with pathologic ultrastaging of lymph nodes is probably as effective in detecting metastases as traditional pelvic lymphadenectomy with less morbidity.

Histologic Factors

It has long been known that African American woman with endometrial cancer are more likely to have high-risk histologies such as serous, clear cell and carcinosarcomas. Because of this, mortality in African American woman with endometrial cancer is higher than it is in Caucasian women. When the diagnosis of a high-risk histology is made, PET scanning may be helpful in detecting extrauterine spread before surgery is undertaken. Virtually all patients with high-risk histologies will require adjuvant therapy with radiation and chemotherapy.

In patients with endometrioid or "low-risk" histology, immunostaining for mismatch repair genes should be performed to exclude the diagnosis of Lynch Syndrome. Lynch Syndrome accounts for about 2 to 5% of all endometrial cancers and in families with the syndrome, endometrial cancer is as common as colon cancer. Hysterectomy is thus a consideration in women from such families.

In addition to mismatch repair deficiency, many endometrial cancers exhibit microsatellite instability, a characteristic which may suggest a place for drugs such as pembrolizumab.

Summary

Endometrial cancer is an increasingly common malignancy. This increase is likely linked to the obesity epidemic. To help prevent this cancer, physicians should continue to encourage weight control, diet and exercise for their patients. Physicians should also remain attentive to women with obesity and peri- and postmenopausal bleeding.

For more information, contact Dr. Gregory Sutton at 989.583.5060 or gregory.sutton@chs-mi.com.

RESOURCES

WHAT	LINK
Disparities in Uterine Cancer Epidemiology, Treatment and Survival Among African Americans in the United States, Gynecologic Oncology, September 2013	*www.ncbi.nlm.nih.gov/pmc/articles/PMC4074587*
National Cancer Institute Statistics: Endometrial Cancer	*www.seer.cancer.gov/statfacts/html/corp.html*
The Effect of Body Mass Index on Endometrial Cancer: A Meta-Analysis	*www.ncbi.nlm.nih.gov/pubmed/26026348*

New Dental Guidelines for Prophylaxis Antibiotics

GUEST AUTHORS
Dr. Kimberly Wagner and Dr. Lisa Wade, Covenant Medical Group, Family Medicine

Physicians across the United States routinely prescribe prophylaxis antibiotics prior to routine dental procedures to reduce the risk of bacteremia-induced infections in two groups of patients: those with prosthetic joint replacements and those with underlying heart conditions that can expose them to infective endocarditis (IE).

In January 2015, however, updated clinical practice guidelines based on a 2014 systemic review of dental and medical literature were published in the *Journal of the American Dental Association* (JADA). This update recommends a more conservative approach for prescribing antibiotics prior to procedure to reduce the risk of adverse anaphylactic reactions and drug-resistant bacteria while still protecting certain subpopulations of patients.

Despite the update, antibiotics are still being over-prescribed for routine dental procedures. According to the Centers for Disease Control, at least 2 million people in the U.S. alone are infected with drug resistant bacteria and of those, 23,000 people die annually.

To help reverse this dangerous trend, please take a minute to review the 2015 guidelines below so that antibiotics are prescribed only when absolutely required and still work when needed the most.

2015 Guidelines

You can review the full clinical practice guidelines, along with commentaries, via the links provided in the sidebar. In summary, prophylaxis antibiotics are recommended for patients with:

- A history of complications associated with their joint replacement surgery. For this group, antibiotics are recommended for dental procedures requiring gingival manipulation or mucosal incision.
- Underlying cardiac conditions that put them at a high risk for adverse outcomes, including infective endocarditis (IE) – an uncommon complication from bacteremia. Underlying conditions range from prosthetic heart valves and materials to previous IE episodes and congenital heart disease. For this group, antibiotics are recommended for dental procedures requiring manipulation of gingival tissue or the periapical region of teeth, or perforation of the oral mucosa.
- Poor oral hygiene and gingival bleeding after routine activities.
- Compromised immune systems and other serious health conditions.
- Similar comorbid conditions.

Research has revealed these key reasons for updating the guidelines:

- Evidence shows that dental procedures are not associated with prosthetic joint implant infections, and that antibiotics do not prevent them.
- Most cases of IE actually occur from exposure to random daily activities – such as brushing, flossing, chewing and use of toothpicks – versus lack of antibiotic treatment.
- Only an extremely small number of IE cases could have been prevented by antibiotics. For these subsets, premedication should be considered only when the benefits outweigh the risks.
- When antibiotics are prescribed for at-risk patients, infection can still occur due to antibiotic resistance and failure.
- Adverse reactions from antibiotics often exceed the benefits, reinforcing the need for caution.
- Good oral hygiene and health can deliver more preventive value than antibiotics.

According to the

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23,000 people die annually.

Taking Action

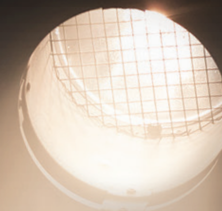
Before automatically prescribing antibiotics prior to all dental procedures, take a minute to review the current guidelines and your patient's history. Your professional evaluation, combined with the individual needs of your patient, will help determine the best treatment plan.

In this way, you can help prevent unnecessary antibiotic usage so when critical reasons arise for antibiotics, they are effective for your patient and population health.

For more information, contact Dr. Wagner at 989.583.0295 or kimberly.wagner@chs-mi.com.

Key Resources and Links

- **Clinical Practice Guidelines, American Academy of Pediatric Dentistry**
  www.aapd.org/media/Policies_Guidelines/G_AntibioticProphylaxis.pdf
- **ADA Oral Health Topics, Antibiotic Prophylaxis Prior to Dental Procedures**
  www.ada.org/en/member-center/oral-health-topics/antibiotic-prophylaxis
- **ADA Oral Health Topics, Antibiotic Stewardship**
  www.ada.org/en/member-center/oral-health-topics/antibiotic-stewardship
- **JADA Editorial for Orthopaedic Surgeons**
  www.jada.ada.org/article/S0002-8177(16)30965-5/abstract
- **Commentary from American Heart Association**
  www.jada.ada.org/article/S0002-8177(14)62745-8/pdf



THE CHART SPOTLIGHTS

Congratulations Physicians of the Month!

JUNE

Dr. Ryan D. Stevenson

PATIENT COMMENTS:

"Dr. Stevenson is an outstanding doctor."

"Covenant HealthCare is very fortunate to have Dr. Stevenson."

"I think Dr. Stevenson is a great new young doctor."

JULY

Dr. Trasi L. Crumrin

PATIENT COMMENTS:

"I think Dr. Crumrin is amazing."

"This was my first appointment with Dr. Crumrin. I was very impressed with her knowledge."

"This provider is the best provider I ever had. She is very pleasant to talk to and answers all your questions completely."

AUGUST

Dr. Loai F. Marouf

PATIENT COMMENT:

"Extremely pleased with my visit and care."

"Dr. Marouf is a very caring, kind and competent cardiologist. I feel fortunate to be under his care."

"This doctor was very courteous and professional and made me feel at ease."

Balancing Innovation with Standardization
The "Clinical Quality Product Value Analysis" Solution

GUEST AUTHOR
Toni Young, MSN, BSN, RN, Clinical Quality Product Value Analysis Administrator, Supply Chain Management

Why does Covenant HealthCare purchase certain brands of products? Who and what influences those decisions? Can we reduce costs without sacrificing innovation? How can you request new products and technologies?

Answers to those questions rest in the Clinical Quality Product Value Analysis (CQPVA) program – a collaborative effort between Covenant administration, supply chain management (SCM) and physicians to reduce clinical and operational variability in the products and technologies we use and purchase. Too much variability leads to more brands and higher inventories while increasing learning curves and a greater risk for error – all of which lead to added costs. Standardization, if done well, helps reduce those costs while improving quality, safety and consistency.

Strategic Collaboration

CQPVA is an outgrowth of the Covenant HealthCare strategy to "Pursue Operational and Financial Excellence." Because it drives high patient quality too, CQPVA also supports the strategy to "Position Covenant as the Regional Leader in Quality."

Initiated in March 2015, CQPVA is centered around physician collaboration. Physicians are on the front lines with patients and often can best understand the benefits of certain products or new technologies. On the other side of the coin, experts in SCM recognize the nuances of purchasing, supply chain and other variables that impact quality and cost.

Together, physicians, SCM and administration make a powerful team, balancing the need for standardization with the necessity of innovation. They started by structuring a robust CQPVA program that features three pillars of success:

1) Cross-disciplinary teams of physicians, SCM and administrative experts
2) Best practice protocols
3) Well-informed decisions based on **what is best** for the patient and hospital

Once that structure was in place, they officially launched CQPVA in January 2016.

CQPVA Teams

Today, the CQPVA program has grown to approximately 65 people across four teams: Cardiovascular, Surgical, Medical Surgical Supplies and Non-Clinical. Each team is staffed with knowledgeable clinical, SCM and administrative experts. With the exception of Non-Clinical, each has a physician champion too.

For example, the Cardiovascular CQPVA team has nearly 20 members, including an executive sponsor, five physicians, CQPVA and contract administrators, and experts from purchasing, distribution, education, Interventional Radiology, Cath Lab and Cardiac Electrophysiology.

Each month, these teams meet to evaluate new product and technology requests, and to assess existing products for opportunities to standardize. For example, in an attempt to reduce the number of cardiac rhythm management (CRM) manufacturers from five to three, the Cardiovascular team is exploring the pros and cons of each brand.

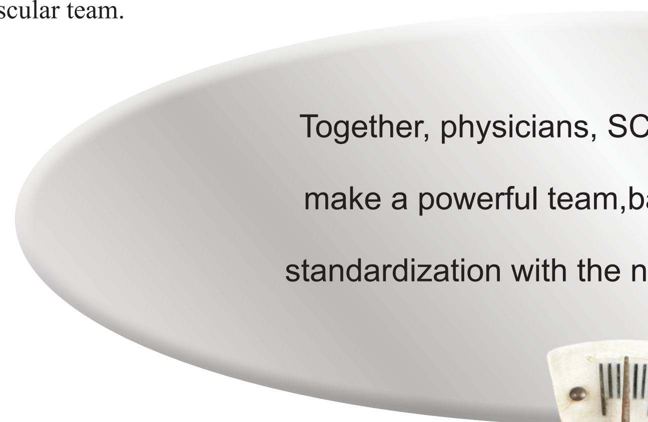
All decisions are based on quality, cost and reimbursement. Quality criteria, for instance, can range from length of stay to readmission rates.

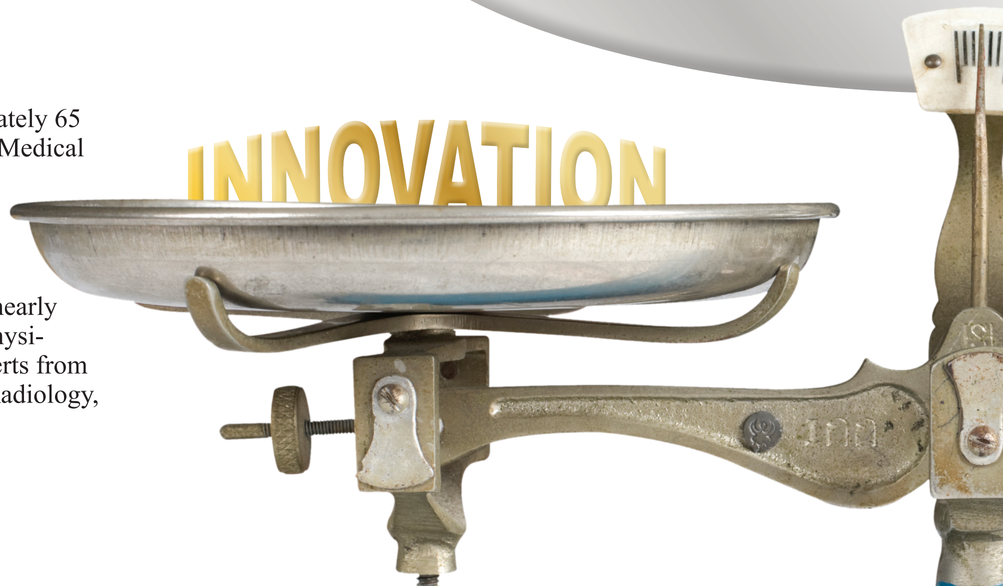
If the request is declined, and the requestor is not satisfied with the decision rationale, it may be sent to the CQPVA Steering Team for further review.

CQPVA in Action

Typical steps for requesting a new product or technology include:

1. Submit a form request on the Covenant Intranet (see sidebar). This site is checked daily by the CQPVA administrator.
2. The administrator will use a set of rapid decision process criteria to evaluate the request. For example, if it is simply a request to replace an item that is no longer available, it can usually be processed by the administrator.
3. If the request requires deeper analysis, it is channeled to the relevant CQPVA team for evaluation. For example, a new cardiac stent request would be presented to the Cardiovascular team.





4. An assigned project manager will perform a detailed cost-benefit analysis, contacting the vendor for necessary information. The analysis includes a thorough review of pricing, existing products and contracts, affiliated group purchasing organization (GPO) contracts, inventory / logistics needs, and more.
5. The request is then presented at the respective team's monthly meeting. The requestor is invited to give a 5- to 10-minute presentation; the team will then evaluate the overall patient care/cost benefit.
6. Steps 1 through 5 above typically take 1-2 months depending on complexities of the request.
7. If barriers occur, the request may be sent to the CQPVA Steering Team for further review and dispensation.

Driving Value

With CQPVA, decisions are no longer top-down or made in silos. And while vendors are consulted, they no longer dominate the process. Instead, decisions occur where they should – within a cross-disciplinary team of physicians, SCM and administrative experts.

This unprecedented level of collaboration is:

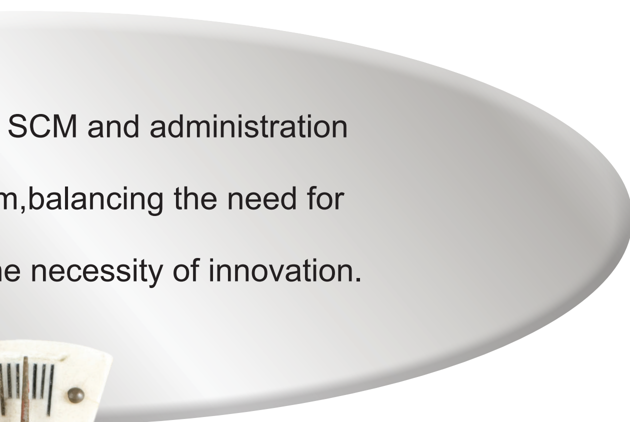
- Strengthening relationships and building bridges across the organization.
- Prompting many physicians to send vendors directly to the CQPVA team for assessment, freeing up scarce time.
- Enabling Covenant to remain and grow as an independent, innovative healthcare system by ensuring quality patient care while reducing waste and costs.
- Starting to balance prudent new technology choices with important standardization efforts.
- Saving money that can be channeled to other resource needs. Three physician-supported product conversions, for example, analyzed by the three clinical CQPVA teams, netted close to $200,000 of the greater than $500,000 in annualized supply expense savings achieved since the program's start in January 2016.

Looking Ahead

CQPVA success depends on collaboration with physicians; much more is achieved together than independently. Physician participation on the respective CQPVA teams ensures smart, patient-centered decision-making, while judicious requests for new products and technologies keep Covenant innovative and progressive.

If you have questions or are looking for ways to get involved, see the contact details below. If you have specific requests, be sure to use the form and process outlined in this article.

For more information, contact Toni Young, CQVPA Administrator, at 989.583.4277 or ayoung@chs-mi.com.



SUBMITTING A

New Product or Technology

REQUEST

1. Go to the CQPVA internet page at *www.covenanthealthcare.com/Main/cqpva.aspx*.
2. Access the submission form:
   - Any physician can open the form by clicking on "New Initiative Request Form-Microsoft Word" in the first paragraph.
   - Employed physicians, however, can also click on the "New Initiative Request Form" option in the second paragraph, and follow the authenication instructions.
3. Complete and submit the form to *www.CQPVA@chs-mi.com*.
4. Look for a response in your email box within a few days.
5. You will be asked to present at a meeting; a CQPVA administrator will work with you on a meeting presentation.
6. You will be notified about approval or denial by phone and/or email.

2017 Provider Engagement Survey Results

Dr. Michael L. Schultz, Vice President of Medical Affairs / Chief Medical Officer

The 2017 provider engagement survey results are in and remain above benchmark. While the response rate was strong, we did see a slight decline from 55% in 2015 to 52.8%. Participation from Covenant HealthCare-employed physicians actually increased by 6%, yet participation from the following groups declined as follows:

- Covenant Employed Advanced Practice Providers (APPs): 25.7% decrease
- Independent Physicians: 7.6% decrease
- Independent APPs: 5.1% decrease

Thanks to everyone who provided their valuable feedback; it is crucial to achieving healthcare excellence. Below is a summary of results, which are also being shared in various venues with both employed and independent groups.

Survey Context

As with 2015, survey results were calculated according to two survey paths – one for all physicians and APPs employed by Covenant HealthCare, and another for all independent physicians and APPs who practice here.

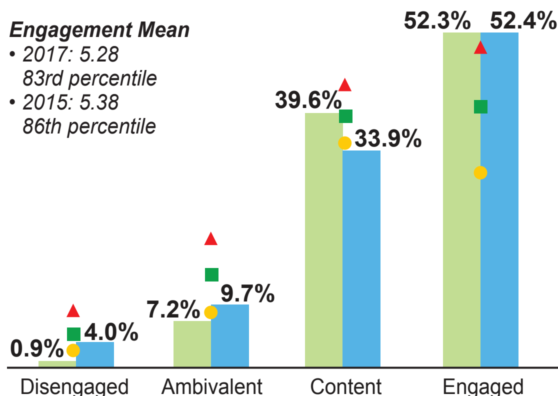
- Level of **Engagement** was measured for the Covenant-employed group. Engagement rankings run from being highly engaged and loyal to the organization with the desire to go above and beyond, to being content, ambivalent or disengaged.
- Level of **Alignment** was measured for all independents. Alignment rankings run from being highly aligned strategically to the organization with a strong commitment to admit or refer patients, to being loyal, at risk (lower loyalty) or disaffected.
- To be ranked in the Engaged or Aligned categories, respondents had to answer “Strongly Agree” to at least two of the survey answer options, and no less than “Agree” to any item.

FIGURE 1

We Continue To Outperform the Benchmark, Despite Some Areas of Decline (Physician Data Only)

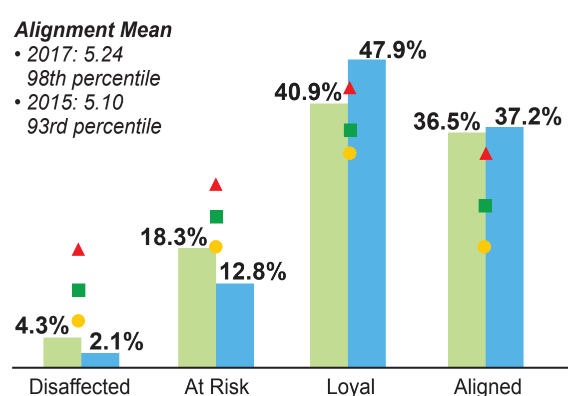
EMPLOYED PHYSICIANS

Overall Engagement Relative to ABC Benchmark[1]
2015 N = 111
2017 N = 124



INDEPENDENT PHYSICIANS

Overall Alignment Relative to ABC Benchmark[2]
2015 N = 115
2017 N = 85



2015 2017 25th percentile Median 75th percentile

[1] Benchmark contains 30,000 responses.
[2] Engagement N reflects removal of respondents who indicated they intend to retire or move out of the region in the next three years.

Results Summary

Figures 1-2 offer views of key, high-level findings:

- Figure 1 shows how Covenant continues to raise the bar for 2017, outperforming the Advisory Board Company (ABC) national benchmarks for engagement and alignment. We perform better than most institutions surveyed across categories, with most Covenant-employed respondents selecting the positive categories of Engaged or Content and most independents selecting Loyal or Aligned.
- More specifically in Figure 1 when compared with 2015, Covenant-employed respondents show slight increases in the categories of Disengaged and Ambivalent, and a decrease in Content, yet more selected Engaged. Independents, on the other hand, show improvements in all categories, with declines in Disaffected or At Risk and increases in Loyal and Aligned.
- Figure 2 reinforces how physicians and APPs alike continue to rank at the more positive end of the spectrum, in either the Engaged or Content range for Covenant-employed respondents or in the Loyal to Aligned range for independents.

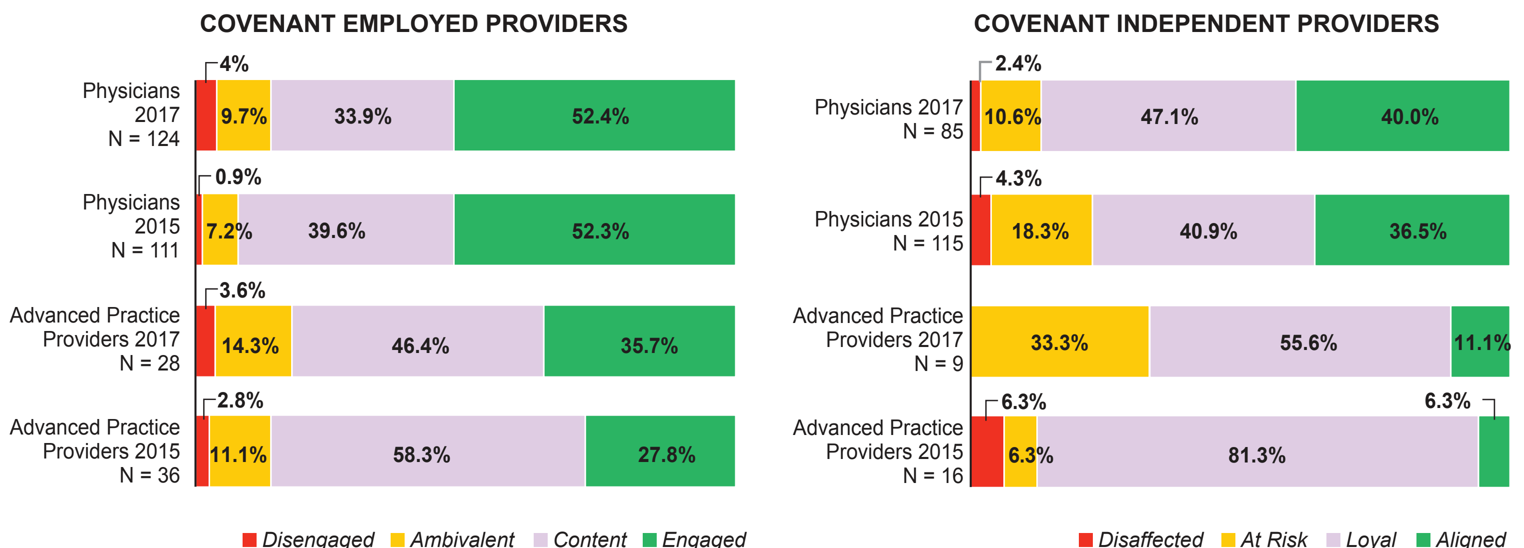
Action Plan

The 2017 survey results along with open-ended feedback have driven the following areas of focus for Covenant HealthCare:

- **Driving Epic Improvements:** An Information Technology (IT) Three-Year Strategic Plan includes a number of Epic improvements to enhance efficiency and accuracy.
- **Addressing Disruptive Behavior:** This area will remain a focus for some time as we take steps to identify and change these behaviors (see Dr. Fiore's article on page 1). The root causes need to be addressed, not the least of which is healthcare worker burnout. Continued engagement with *Our Covenant* (the Shared Vision and Compact) is planned this year, which also supports these efforts.
- **Improving APP Engagement**: Covenant will be exploring potential new medical staff structures to better address APP governance, including credentials and quality improvement.

For more information about survey results, contact Karen Schafer, Director of The Office of Physician Relations & Regional Outreach, at 989.583.4045 (kschafer@chs-mi). You may also contact Dr. Schultz at 989.583.4103 or mschultz@chs-mi.com for medical staff concerns.

FIGURE 2
Scores for All Providers Are at Positive End of Spectrum



Survey source: Advisory Board Survey Solutions' Database

Learning Nonviolent Crisis Intervention® Skills

GUEST AUTHOR
Thomas Curpenski, Security Coordinator, Covenant HealthCare

Studies show that acting-out behaviors and violence are on the rise in the workplace, including healthcare organizations. Such situations create tension, distress and potential danger to patients and staff – all of which counteract the very purpose of our existence, which is to heal and do no harm.

Many organizations, including Covenant HealthCare, have been educating staff about the impact of disruptive, aggressive behaviors and how to respond to and report these situations. They have also been teaching staff important Nonviolent Crisis Intervention (NCI) skills from the Crisis Prevention Institute (CPI) to help diffuse escalating behavior.

Nonviolent Crisis Intervention

NCI training, conducted by certified CPI instructors, is centered on safe, respectful and non-invasive methods for managing hostile and anxious behaviors before they become dangerous.

It helps staff understand how their own actions, behaviors and responses can impact a crisis situation for better or worse. Verbal and nonverbal communication skills, empathetic listening, rational detachment, personal safety and basic defensive techniques are just a few of many skills that are taught.

People act out for a reason and for most, it is a one-time event caused by stress and anxiety. Understanding the causes, recognizing the signs and learning how to respond accordingly can make a big difference in averting a crisis.

Benefits to Staff and Patients

Reducing conflict helps create a safe and pleasant work environment that enhances both workplace and patient satisfaction.

NCI training will help physicians and other healthcare staff:

- Feel more confident when facing difficult situations.
- Build trust with the patient by thoughtfully alleviating anxiety.
- Protect and cultivate therapeutic relationships with those in their care.
- Sustain a calm, compassionate and caring environment.
- Show by example that they have the best interest of patients and family members at heart, further enhancing communications.

ABOUT

Crisis Prevention Institute

The Crisis Prevention Institute (CPI) was established in 1980 for human service professionals to address the need for training and managing disruptive and assaultive behaviors. Nonviolent Crisis Intervention is the company's cornerstone program and is based on the core philosophy of providing for the Care, Welfare, Safety and Security℠ of those involved in a crisis situation. Since 1980, over 10 million human services professionals have participated in CPI training programs. For more information, please see: www.crisisprevention.com.

More specifically, they will learn:

- What causes anxiety and aggression, including the precipitating factors of acting-out.
- How to respond to various stages of anxiety, aggressive behavior, acting out and tension in a calm, mature manner.
- The art of listening empathetically to discern what people are really trying to say.
- How their nonverbal (paraverbal) communication skills – such as tone, volume, cadence and personal space – are critical to de-escalation.
- How practicing rational detachment helps them stay in control by not taking the behavior personally.
- Hands-on defensive techniques that cause no harm to visitors or patients, such as how to break away if someone grabs you, chokes you or pulls your hair.

A Proven Strategy

A 2013 survey of 680 certified CPI instructors showed that 91% of respondents applied their NCI skills within the first two to three months after training. This led to the following results:

- 48% decrease in the use of restraints (e.g. handcuffs)
- 55% decrease in physical aggression from the instigator
- 55% decrease in caregiver injuries
- 78% increase in overall quality of care

Today, many hospitals are applying NCI training with great success, such as Mission Health of Asheville, N.C., Mayo Clinic Health System of Eau Claire, Wisc., Yale-New Haven Hospital of New Haven, Conn., and Covenant HealthCare.

Training at Covenant

Covenant has been offering NCI training by two certified CPI instructors since 2007. The training typically involves a six- to eight-hour session in which lecture is combined with real-life enactments. Workbooks and reference tools are also provided, and the session can be modified to meet the specific needs of individuals or teams.

Groups at Covenant that have participated include:

- All Security staff
- Pastoral Care staff
- Nurses and nursing assistants
- Day Care staff
- Autism Center staff

Covenant is seeing more win-win situations as the skills are applied. When you can talk someone down who is highly agitated and upset, versus letting it escalate to where physical restraint is needed, it is always a success. While there is no magic wand that can make every problem disappear, when NCI skills are practiced the odds greatly improve.

If you are interested in this training, please see the contact information provided below.

To sign up for Nonviolent Crisis Intervention training, please contact the Covenant HealthCare Security coordinators at 989.583.4240 and ask for Thomas Curpenski (tcurpenski@chs-mi.com) or Patrick Wisniewski (pwisniewski@chs-mi.com).

Nonviolent Crisis Intervention
A Success Story

In early 2017, Security at Covenant HealthCare was called to an escalating crisis situation. A patient was verbally abusive to staff and the attending physicians. The patient was calling everyone swear words and mocking their appearance. Staff ended up responding with anger and frustration and called Security.

When Security entered the patient's room, the patient jumped off the bed and started walking towards the officer stating, "You know why you're a security guard? Because you're too stupid to be a police officer." The officer's response was, "I became a security officer to help people like you; what can I do to make things better for you?" That calm response from the officer caused the patient's tone and posture to change. The patient said to the security officer, "I feel like everyone here is just barking at me and looking down at me; you're the first person to talk nice to me."

The officer had applied several Nonviolent Crisis Intervention skills to de-escalate the situation, proving that behavior affects behavior. If the officer had responded with yelling and swearing, the situation would have become much worse. Instead a dialogue was started and then handed back to the nurses.

Extraordinary care for every generation.

Covenant HealthCare
1447 North Harrison
Saginaw, Michigan 48602

The Covenant Chart is published four times a year. Send submissions to Hannah Schultz
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Disruptive or Constructive, continued from page 1

Engagement Is Key

The most effective way to advocate for patients or recommend health system improvements is to increase engagement and participate in the operations and activities of the medical staff.

While the engagement survey suggests a perception by some medical staff that inadequate attention is given to disruptive physician behavior, we need to acknowledge that physician disciplinary action is generally not within the scope of hospital administration responsibility or authority. Physician behavior is primarily a medical staff issue. As such, it remains the responsibility of the medical staff, through our elected leaders and representatives, to address physician behavior. We need to keep each other accountable and lead by modeling desirable and effective behaviors.

Covenant Actions

Covenant HealthCare has made significant strides in addressing disruptive physician behavior. A formal Disruptive Practitioner Policy for Practitioners and Allied Health Professionals was implemented in 2013. This policy outlines definitions for acceptable and unacceptable practitioner conduct, as well as processes for reporting and procedures for interventions.

Disruptive behaviors are identified and addressed at various levels, including the Department Chair, Chief of Staff, Vice President of Medical Affairs (VPMA)/Chief Medical Officer (CMO), the Medical Staff Quality Improvement Committee (MSQI), and the Medical Executive Committee (MEC). These physician leaders are elected peers of the Active Medical Staff with the exception of the VPMA/CMO.

In the 2016 calendar year, MSQI received 221 issues, more than double the volume from five years previously. Detailed discussions were had with 16 different physicians. Outcomes included corrective action, referral to the MEC Alternate Action Committee, and ongoing interventions with the VPMA and Ad Hoc committees.

It is important to note that, as with any corrective action plan, confidentiality is maintained to respect the practitioner and the medical staff. Because of this non-disclosure, there is often a mistaken perception that the reported behavior has not been addressed.

Your Actions

Covenant HealthCare, along with its elected physician leaders, remains committed to pursuing a culture of safety and satisfaction, free from behavioral disruptions. Each of us plays an important role, so please take the time to become engaged with Covenant quality improvement efforts. Also, hold each other accountable and lead by example by modeling professional behavior.

Sincerely,

Dr. Michael Fiore
Chief of Staff