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violence in the healthcare workplace

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321 Main Street, Worcester, MA 01608
e-mail: wdms@massmed.org
web: www.wdms.org
phone: (508) 753-1579

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Production and advertising sales by
Pagio Inc.
88 Winter Street, Worcester, MA 01604
(508) 756-5006
sales@pagioinc.com

Paul Giorgio, President
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Editorial

Jane Lochrie, MD



Jane Lochrie, MD

Typically thought of as “safe,” hospitals and other health care agencies are now facing an epidemic of violence. Workplace violence is one of the most complicated and serious occupational hazards facing health care workers today. Health care workers are now thinking “it could happen to me” after two nurses were attacked in Worcester-area hospitals and a surgeon at Brigham and Women’s Hospital was fatally shot.

The rate of workplace violence is four times greater in health care than any other private industry. In fact, health care workplaces account for nearly as many serious injuries as all other businesses combined. Many factors contribute to this risk, including working with patients who have a history of violence or may be delirious or under the influence of drugs or alcohol. This issue of *Worcester Medicine* examines what the Worcester health care community is doing to prevent violence in the workplace.

In the first article, Andrew Ketterer, MD, MA, an emergency medicine physician and fellow in medical education research at St. Vincent Hospital and Beth Israel Deaconess Medical Center points out that violence in the Emergency Department is common but should not be regarded as “part of the job.” The majority of violence consists of verbal threats and physical assaults without weapons; however, the threat of firearms is a perennial concern. Drug and alcohol abuse compound the problem and can increase the risk of violence.

In the second article, Jeff Smith, MD, JD, MMM, the interim president of UMass Memorial Medical Center discusses how hospital leaders are reevaluating their processes and procedures to secure their environment. The Workplace Violence Prevention Committee has recently implemented the installation of metal detectors and X-ray equipment to identify weapons in the Emergency Departments of both campuses. A less formal program encourages everyone to speak up if they see something unusual.

Trevor Bellefontaine, JD, the director of public safety at St. Vincent Hospital, reviews the guidelines from The Occupational Safety and Health Administration (OSHA) and The Joint Commission to Improve Hospital Safety. These guidelines are met through executive management teams, environment of care committees and public safety committees and have been made a top priority at St. Vincent Hospital.

He opines that the proper training of all personnel will increase the likelihood of responding effectively to a violent incident.

Gina Smith, RN, CHEP, NHDP-BC, program director of emergency management, emergency medical services (EMS) and injury prevention at UMass Memorial Medical Center, states that we may not be able to prevent all acts of violence, but we must plan to protect all in our health care facility. An active shooter situation occurs without warning and evolves quickly; therefore, a practiced response is imperative. All health care employees should be trained and prepared for such a circumstance with the objective to keep everyone safe.

The second most common dementia in people younger 65 years, neurobehavioral variant frontotemporal dementia (bvFTD), is described by Brenda King, PsyD, a clinical psychologist and behavioral health specialist. This devastating disease can lead to violent outbursts, aggression and even criminal behavior that can appear unprovoked, sudden and unpredictable. These patients are often misdiagnosed with psychiatric illness.

Mary Kate Falkenstrom, Ph.D., RN, AOCN, clinical adjunct faculty of community health, School of Nursing, Regis College, portrays the risks that home health care providers encounter in their face-to-face home visits that pose a threat to safety of the caregiver. Caregivers describe verbal abuse, sexually inappropriate behavior or leaving a home abruptly because of perceived or a direct threat to their security. She states that anger and frustration is pervasive in the home care setting.

In our medical student’s article, Laura Santoso states that these appalling statistics regarding assaults came to life for her while rotating at a community hospital, but still, she does not see violence against health care workers as a primary issue when compared to all the other problems in our current health care system. However, this does not mean that violence is acceptable.

Pharmacists are also at the forefront of workplace violence. Janelle Herren, MSE, PharmD, RPh, current Geriatric Fellow at the Pharmacy Outreach Program at MCPHS University and a former retail pharmacist, maintains that though pharmacists are at risk for robberies of controlled substances, the aggression that they deal with is more likely to be attributed to “patient rage” – customers struggling to deal with financial and insurance issues and unavailable medications. With an increasing workload, complex managed care issues and the opioid crisis, pharmacy violence continues to increase.

Please be sure to read the reprint of the *Telegram and Gazette’s* Sunday Sitdown with Dr. Michael Hirsh regarding is Goods for Guns buyback program. As always, don’t forget the Society Snippets and Legal Consult and As I See It.



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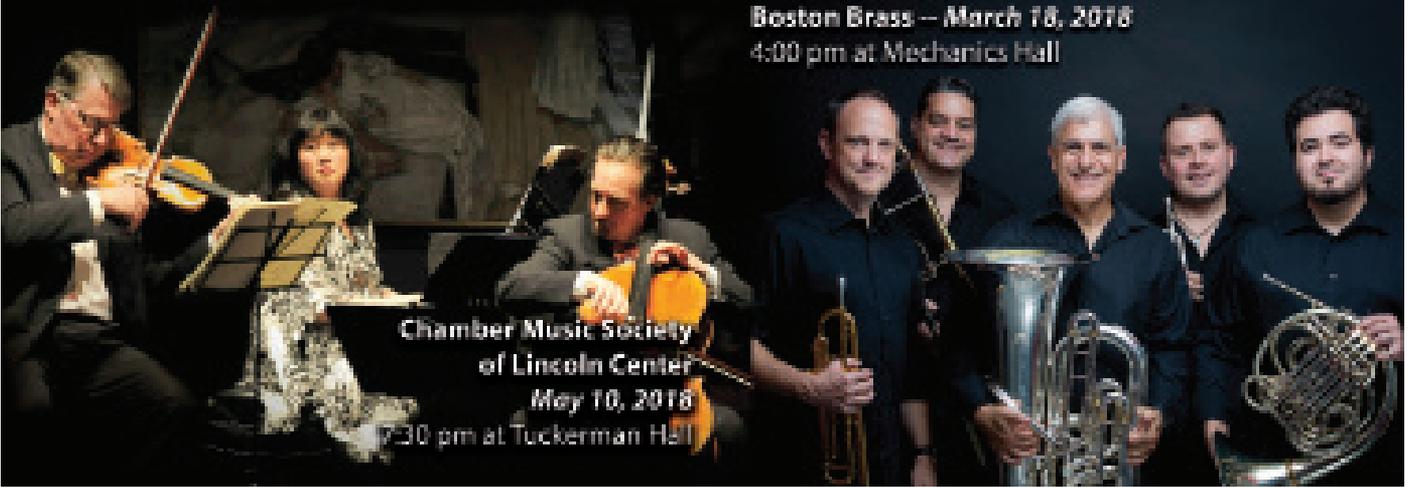
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All Quiet on the Western Front

Andrew Ketterer, MD, MA

Violence in the Emergency Department (ED) is a regular occurrence, with 75 percent of emergency medicine (EM) physicians experiencing at least one violent incident in the workplace every year. More than 70 percent of emergency nurses have been the victims of workplace violence, defined by the Centers for Disease Control as an “act or threat of violence, ranging from verbal abuse to physical assaults directed toward persons at work or on duty.” Most of these are perpetrated by patients or their visitors, and 80 percent of violent incidents occur in patient rooms.

Several patient factors make the ED particularly susceptible to violence. The declining availability of community mental health systems makes emergency departments the de facto centers for acute psychiatric clearance and treatment. Gang violence or community unrest can spill over into the ED. The high prevalence of alcohol and drug abuse often requires the ED’s services for medical clearance of alcohol- and drug-related arrests. The list goes on, but because the ED is often the connection point between the hospital and the community, emergency care providers can become victims of society’s ills in the course of duty.

Drug and alcohol abuse often complicate the care of patients in the Emergency Department and can increase the risk for violence. The street drug PCP is particularly famous for this: A dissociative hallucinogen, its effects can include a state of violent agitation and “superhuman” strength. Violent patients intoxicated with PCP often require physical restraint by multiple security personnel and high doses of sedative medications. Fortunately, PCP has lost its former popularity, although some regions of the country are seeing a resurgence of this drug. Many other stimulants, including cocaine, methamphetamine, bath salts and ecstasy, can produce similarly dangerous states of agitation. Most common, however, is alcohol intoxication. Alcohol usually does not cause violence on its own, but the disinhibition produced by alcohol intoxication can impair judgment and can make violent outbursts more likely in susceptible individuals. This is most pronounced when the patient is in the ED unwillingly, such as when he or she is brought in by police or has acute psychiatric comorbidities.

The structure of the ED also plays a role in workplace violence. For those patients entering through the waiting room, the frustrations of long wait times can compound the already heightened emotions accompanying illness or injury. Dissatisfaction with care is an under-recognized cause of violence in the Emergency Department, and as EDs across the country see more patient boarding and longer wait times, this aspect is playing an ever-increasing role in the verbal or physical violence experienced by emergency care providers.

The risks associated with workplace violence in the ED are multiplied by the presence of weapons. Certain aspects of the ED designed to improve patients’ access to care may also inadvertently allow for easier entry of guns and knives, such as open walk-in entry areas and waiting rooms. A study in 2008 estimated that 20 percent of EDs in the United States have guns or knives brought in on a daily or weekly basis. While the majority of ED workplace violence consists of verbal threats and physical assaults without the use of weapons, the threat of firearms is a perennial concern.

When hospital-based shootings happen, a third occur in the ED or in the surrounding area, such as the ambulance ramp, waiting room or ED parking lot. One study found that up to 26 percent of major trauma patients are armed with lethal weapons, 4 percent of which were firearms. Of additional concern is the finding that of firearm incidents in the ED, 50 percent involved a security personnel member’s firearm, suggesting that the mere presence of weapons in this environment can be a threat to patient and staff safety.

Many measures have been taken to improve staff safety in the ED, but large gaps still exist. Most states have specific legal measures protecting nurses and emergency medical technicians from violence, and 33 states have made it a felony to physically assault a nurse in the ED. No federal standard exists regarding legal protection of health care providers, however, and while the Occupational Safety and Health Administration provides recommendations regarding hospital workplace safety measures, there are no federal requirements that hospitals adhere to these.

Provider training is another potential area for improvement. Emergency care providers are trained in the management of acutely agitated or dangerous patients, but such training is uneven at best. Resident physicians in emergency medicine are taught the appropriate use of chemical restraints such as the ubiquitous “five and two” cocktail (5 milligrams of haloperidol, an antipsychotic, and 2 milligrams of lorazepam, a sedative), and most hospitals have protocols regarding the use of physical restraints. However, no formal training in verbal de-escalation is required by the Accreditation Council for Graduate Medical Education, and there are no formal or universal training regimens regarding self-protection in the event of a physical altercation. This means that physician training in these functions is largely dependent upon personal exposure to agitated or violent patients. Rarely does this training emphasize recognition of the verbal or physical cues that presage violence.

Violence in the Emergency Department remains a persistent and alarming reality. Because ED utilization is increasing, these incidents will likely become more common. Although improved recognition of workplace violence in the ED has led to the development of state laws aimed at protecting emergency care providers, not all of these laws contain specific protections for nurses, who are at highest risk for violence, and few include specific protections for physicians. Further improvements in nurse, physician and staff training in verbal de-escalation and personal safety also need to be developed. The problem of violence in the Emergency Department is multifaceted, but it should not be regarded as simply part of the job. Many uncertainties exist in the course of duty as an emergency care provider; the threat of violence should not be among them.

Andrew Ketterer, MD, MA, is an emergency medicine physician and fellow in medical education research at Saint Vincent Hospital and Beth Israel Deaconess Medical Center.

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A Focus on Healthcare Violence

Trevor J. Bellefontaine, JD



Trevor J. Bellefontaine, JD

Say the words “workplace violence” and the typical thought that comes to mind is one of an active shooter scenario, but, in fact, workplace violence runs the gambit from active shooter situations to the ever-increasing problem of verbal and physical assault. In the midst – especially in health care, where emotions run high – are domestic violence, mental health issues and the opiate crisis. Having a plan and preparing for these ugly issues is key to a healthy outcome.

The most horrendous stories of workplace violence are those involving weapons in a health care setting. In Massachusetts health care, in recent years, we’ve seen a patient attack a nurse with a knife, a visitor gun down a doctor and a prisoner wrestle a gun away from a corrections officer, subsequently shooting him in the leg. However, the FBI statistics indicate that less than 3 percent of all U.S. health care institutions have seen an active shooter incident. This is also supported in studies from several health care associations; of the 5,564 registered U.S. hospitals,¹ from Jan. 1, 2006-Dec. 19, 2016 “there were 416 instances of a firearm discharge in a U.S. hospital,”² less than 2 percent of hospitals. While shootings in health care settings are rare, workplace violence, unfortunately, is not. Violence in health care settings is proportionally greater than in any other occupation. According to the Bureau of Labor Statistics (BLS), health care workers were the victims of 52 percent of all reported workplace violence incidents.

The Occupational Safety and Health Administration (OSHA) and The Joint Commission have developed guidelines to help improve hospital safety. OSHA established that health care settings are at higher risk for workplace violence than any other industry. And while the organization does not have a specific regulation governing health care workplace violence, it has included language under the General Duty Clause, which dictates that health care settings will establish the following:

- Management commitment and worker participation.
- Worksite analysis and hazard identification.
- Hazard prevention and control.
- Safety and health training.
- Recordkeeping and program evaluation.

These goals are met in a variety of ways from institution to institution. Through Executive Management Teams, Environment of Care Committees and Public Safety Committees, issues of workplace safety are now a top priority. These committees are comprised of a multi-disciplined health care membership that review incident-driven issues and concerns identified through rounding.

The Joint Commission (TJC) has also developed guidelines to address workplace violence. These guidelines mirror the OSHA guidelines in requiring “top down” attention in establishing safety protocol. Leaders are charged with establishing a culture of safety and quality encompassing all that enter their health care facility. Environment of

Care elements require a written plan to manage risk; monitor and report incidents affecting patients, visitors and staff; and take corrective action to mitigate workplace violence. The most recent program, Assault Halt, recommends proactive measures be taken in establishing a positive culture of improving safety that includes all levels of the health care team.

From the OSHA and TJC guidelines, we’ve seen improvements on how we manage workplace violence. Through improved communication to patients and visitors on behavioral expectations, hospitals are setting the tone in regard to everyone’s right to be treated with respect and compassion. We’ve also seen increased funding for improvements in health care institutions’ physical security controls, such as panic alarms, increased access controls, high-definition cameras and trending toward metal detectors in Emergency Departments.

These improved policies, procedures and physical controls are a tremendous help in reducing risk associated with workplace violence, but without a vigilant focus on personnel involvement in protecting themselves from falling victim to assaults, we’ll realize short gains in stopping workplace injuries. James Kendig, field director for The Joint Commission’s Division of Accreditation and Certification Operations, said health care personnel need to know the signs that might help detect an impending volatile situation. “This means recognizing when an individual is escalating in anxious, defensive or aggressive words, behaviors or actions,” said Kendig, who added that this requires proper training and role-playing.

“The right training can provide the means for workers to regain their composure, recall at least some of what they have learned and commit to action,” Kendig said. “A properly trained individual will more likely respond effectively to a workplace violence incident.”³

These incidents happen quickly and are typically over in a very short amount of time. (The stabbing of a nurse at a local hospital was over, from attack to apprehension, in 22 minutes). The assessment of a person’s propensity toward violence must begin at the door. While the vast majority of the people that enter our health care institutions are good patients and visitors, the remainder must be met with greater focus. Starting with the evaluation of clinical indicators, indicators such as altered mental status, whether attributed to a medical condition or drug and alcohol abuse, should trigger a guarded approach. Then, recognizing the indicators above in regard to escalating behaviors should increase the health care staff’s concern, and additional resources should be engaged. All staff entrusted with patient care (one of the top criteria identified by OSHA for at-risk employees) should be trained in de-escalation techniques. And finally, staff should not engage patients or visitors about whom they have concerns by themselves. All clinical staff need to be empowered to ask for additional help when any of the above conditions exist. Our plan needs to be to deliver the best humanistic care but remain cautious of complacency.

Trevor J. Bellefontaine, JD, is the director of public safety at Saint Vincent Hospital. Bellefontaine is the chapter chairman of the Massachusetts Central/Western Chapter of the International Association of Healthcare Security and Safety. Bellefontaine holds a Juris Doctor degree from Suffolk University Law School.

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- ³ The Joint Commission Environment of Care News, April 2016, Volume 19, Issue 4.

Workplace Violence Prevention

Jeff Smith, MD, JD, MMM



Jeff Smith, MD, JD, MMM

Recent acts of violence at hospitals in Central Massachusetts and those from around the state and country magnify the troubling trend of workplace violence happening in the health care industry. This has caused hospital leaders to reevaluate their processes and procedures to ensure their caregivers are working in the most secure environment possible. Though workplace violence is not unique to our industry, it is refreshing to hear conversations on prevention coming to the forefront in hospital planning and training.

At UMass Memorial Medical Center, we have been working on this issue for quite some time and are fully committed to providing a safe workplace for our caregivers and patients. We continue to strengthen our Workplace Violence Prevention Program with a cross-functional team to keep our patients, families and staff safe and secure.

In addition, we have a Workplace Violence Prevention Committee, co-chaired by Maria Michas, MD, MPH, associate vice president and medical director, Employee Health Services/Occupational Injury Care and Wellness, and Sharon Gaynor, senior director, Employee Health Services. The committee has representatives from across the medical center and UMass Memorial Medical Group, including campus police, emergency medicine, employee health, facilities, human resources, psychiatry, risk management, nursing, safety and the Employee Assistance Program. The committee is tasked with reviewing our current policies and protocols and developing a comprehensive strategy to reduce or mitigate the threat of violence in the workplace

In July, we held a Workplace Violence Prevention Forum with all interested UMass Memorial Medical Center staff to discuss this important issue. While we had management and security as the lead panelists, the questions and feedback from our staff was invaluable. During these very important conversations with our people, we heard their concerns and listened intently as they identified potential long-term and quick-fix solutions to consider that could make our environment safer and more secure for everyone.

One of the more visible outcomes of this forum is the installation of metal detectors at the entrance to our Emergency Departments at our Memorial Campus in November and University Campus in December. This is an added layer to our safety and security precautions for patients

and staff. The detectors have a walk-through area for people while a security team checks all backpacks, purses and packages prior to entrance.

New signage in our parking areas inform all visitors of our policy of no weapons on our campuses, giving people the opportunity to secure a weapon in their vehicle. At the metal detectors, individuals who do not wish to be screened must remain in the outer lobby. If weapons are found, they are taken and secured with our police department while the individual is on campus.

Our ongoing Workplace Violence Prevention Program has many components including:

- A daily safety briefing that addresses any issues that may affect our patients and caregivers.
- Monthly meetings of the Workplace Violence Prevention Committee.
- Reviewing and updating our policies to assure we are current with concerns, prevention and action.
- A risk assessment of all units that determines any gaps in our program.
- Safety and security is a key topic at our New Caregiver Orientation and is a required module for all caregivers as part of their annual required education.
- Non-violent crisis intervention training has been, and is currently, available to all caregivers.
- Crisis Prevention Intervention and active-shooter training are held annually.

Through our organizational Idea System – used by all departments to brainstorm process improvement measures – we are continually working to foster an environment where everyone feels empowered to speak up and offer their opinion on how we can work better. “Everyone, every day” is our mantra. We believe we can leverage this concept by engaging our caregivers to play an important role in the prevention of workplace violence. So, in addition to the formal steps outlined above, we have a less formal program that challenges our people to speak up when they notice something unusual. It is simply called, “If you see something, say something.” We plan to remind our people of this simple concept through various communication channels. Our goal is to create a sense of awareness in our caregivers that safety is everyone’s job.

We take the safety of our employees, patients and families very seriously and will continue to search for new ways to keep them safe and to prevent any violence.

Jeff Smith, MD, JD, MMM, executive vice president and chief operating officer of UMass Memorial Medical Center, was selected in November to serve as the hospital’s interim president.

Planning for the Unthinkable: Responding to an Active Shooter at your Health Care Facility

Gina Smith, RN, CHEP, NHDP-BC



Gina Smith, RN, CHEP, NHDP-BC

In recent years, health care organizations have seen an increase of violent behavior within their facilities. More and more individuals are armed, and guns are on the rise. Active shooter incidents have occurred in movie theaters, places of worship, schools and, yes, hospitals. We may not be able to prevent all acts of violence, but we must plan and protect all those in our health care facility from a threat of violence and the consequences that may follow. The active shooter event, referred to by many health care facilities as “Code Silver,” may be over in 10 to 15 minutes, leaving

little time to react. We must be prepared. We must have a plan.

Today, emergency planners of health care facilities are faced with identifying hazards and planning for many types of emergencies that may impact patients, visitors and staff. These hazards or threats can include natural weather events such as hurricanes, tornadoes, floods and snow/ice storms, as well as security risks and emergencies. Due to the weather tracking and technology of today, events such as snowstorms and hurricanes can often be forecasted, and prepared for, sometimes days in advance. Threats such as hostage and/or active shooter situations often occur with little to no warning.

Many health care facilities have developed Emergency Operation Plan (EOP) for hazards that may impact their day-to-day operations. An active shooter situation is one of those incidents that often occurs with no warning; therefore, a pre-planned and practiced response is a must to ensure the safety of patients, visitors and staff. The active shooter or “Code Silver” plan can reside as an annex to the Health Care Emergency Operations Plan.

An active shooter, as defined by the U.S. Department of Homeland Security, is an individual actively engaged in killing, or attempting to kill, people in a confined or populated area. In most cases, active shooters use firearms and there is no pattern or method to their selection of victims. Active shooter situations are unpredictable and evolve quickly.

All health care facility employees should be trained and prepared for an active shooter situation. Thankfully, there are many resources available to aid health care facilities with their training needs. As we know, health care facilities can include hospitals, health clinics, hospices, provider’s offices and more; therefore, it is important to adapt these trainings and resources to customize a plan that works best for each facility.

As with any threat or hazard, the emergency response planning team

should begin with goals, objectives and an action plan for an active shooter situation. Protecting patients, visitors and staff should be a key objective.

Planners are encouraged to invite internal and external stakeholders to the planning sessions. The external stakeholders could include local fire and police services as well as EMS (emergency medical services).

Any health care facility emergency plan annex should be more than just a document or file. The Active Shooter Annex will serve as an important tool for all staff to guide them through the response. It is important that educational sessions and materials related to the plan are provided to all staff and practice sessions and drills are conducted. Venues for education can include: new employee orientation, staff meetings, leadership retreats and online learning platforms. Informational materials can be shared through internal webpages, handouts, Active Shooter Response pocket cards and quick guides.

In large health care facilities, communicating any emergency plan can be challenging. The response plan should be clear and easy to follow. Plans may include easy-to-remember phrases to help the learner remember the response plan. Many active shooter response plans use the Department of Homeland Security’s “Run-Hide-Fight” phrase. Other phrases you may see in active shooter response plans include: “Locate-Lockdown-Leave-Live” or “Get Out-Hide Out-Call Out-Take Out.” Each of these refer to very similar response actions, with different, easy-to-remember phrases. Common response guidance referred to in these phrases includes:

- Evacuate the area if it is safe to do so. Leave your belongings behind. Do not try to move wounded people. Prevent others from entering the area
- If it is not safe to evacuate, find a place to hide out of shooter’s view. Barricade door, silence cell phone/pager.
- If you cannot run or hide, and only if your life is in imminent danger, fight back. Be aggressive: throw items, yell and improvise weapons. Commit to your actions.
- Call 911 only when safe to do so. When law enforcement arrives, raise hands and keep them visible. Remain calm and follow instructions. Do not yell, scream or point. Do not make quick movements towards officers.
- Knowing about your health care facility’s response plan for an active shooter is critical! Have a plan. Be prepared!

Example of Resources:

- Active Shooter Preparedness-: <https://www.dhs.gov/active-shooter-preparedness>
- Planning for Active Shooter Incidents: <https://www.calhospitalprepare.org/active-shooter>
- Gina Smith, RN, CHEP, NHDP-BC, is the program director of Emergency Management, Emergency Medical Services (EMS) and Injury Prevention at UMass Memorial Medical Center.

Frontotemporal Dementia: Unexpected, Difficult to Diagnose, and Often Presents a Risk for Violent Aggression

Brenda J. King, PsyD



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The word “dementia” can strike fear in the heart of many, particularly at mid-life, when time seems to speed up as roles and responsibilities seem to pile up. Folks at midlife talk of having “senior moments” or wondering if that name they couldn’t remember is a sign of terrible things to come. Losing memories and functioning as we age can seem like one of the worst possible things that could happen.

But often, we take some reassurance in thinking of dementia as a disease that takes hold after the busyness and distraction of midlife, when we are older and more frail. We tend to think that a person with dementia who becomes aggressive or violent is likely to be a nursing home resident or hospital patient in distress or in pain. Most people

at midlife believe that the effects of dementia, although scary, are safely far off in their aged future. However, while relatively rare, two types of dementia do occur in persons younger than 65: Alzheimer’s dementia and frontotemporal dementia. And these dementias can bring with them changes in personality and functioning that can include aggression toward others and can even be dangerous to loved ones.

Approximately 10 percent of people aged 65 and older have a dementia, and approximately 4 percent of people younger than 65 have a diagnosis of some type of dementia. For those younger than 65, Alzheimer’s dementia, typically a variant known as younger-onset or early-onset Alzheimer’s dementia, is the most common dementia. Neurobehavioral frontotemporal dementia (bvFTD), also known as Pick’s disease, is the second most common in people younger than 65, and it is the most likely dementia to be diagnosed in adults between 45 and 60 years old.

The frontotemporal dementias are three types of neurodegenerative disorders that affect the frontal and temporal lobes of the brain, resulting in progressive language, motor and behavioral deteriorations. Two of the variants affect primarily language and motor ability, and the neurobehavioral variant (bvFTD) affects mainly behavior.

When the frontal lobe is affected by a disease or injury, the person may appear to be well but will lack the ability to plan, understand consequences or behave in socially appropriate ways. This can result in changes in the way that the person may interact with others, perhaps saying rude or obscene things, being unable to contain emotions or becoming impulsive. For some persons with bvFTD, the decline in frontal lobe functioning can lead to violent outbursts and aggression that can appear unprovoked, sudden and unpredictable. This can happen when persons with bvFTD feel frustrated or face a situation that presents an obstacle to getting what they want, and it can occur when there seems to be no reason at all.

Midlife mood or personality changes can present a challenge and can be diagnosed as psychiatric illness, which is common among those ultimately diagnosed with bvFTD. BvFTD itself is identified by progressive changes in behavior, mood and personality, including such behaviors as impaired decision-making, apathy, a new onset of binge eating, erratic driving or even criminal behaviors. Because of the types of symptoms, persons with bvFTD can often be diagnosed with major depressive disorder (MDD), other mood disorders or a psychotic disorder.

In a study done by Lund University in Sweden that looked at instances of

violence and dementia, the researchers found that although more persons with Alzheimer’s dementia are likely to become physically aggressive, persons with bvFTD tend to become violent more often, earlier in the disease process, and they are much more likely to strike out at strangers and without provocation.

While persons with Alzheimer’s Dementia tend to lash out at caregivers when they are in pain or frustrated with an interaction, persons with bvFTD are much less predictable when it comes to aggressive outbursts. Being younger, often quite healthy physically and generally physically stronger than persons with advanced Alzheimer’s dementia, persons with bvFTD who display aggression can often present a dangerous situation to those around them. This combines to result in unpredictable and often serious violence by persons who may appear perfectly healthy and who may not have any previous psychiatric or mental health diagnoses. This can put not only family members and strangers at risk, but also health care workers and other professionals who have no way of anticipating an aggressive outburst or physical attack.

With Alzheimer’s dementia, risk factors appear to be consistent with other cardiovascular risks, so engaging in heart healthy activities, including healthy eating and physical exercise, as well as supportive social relationships and learning new things, may help to minimize the impact of effects and progress of Alzheimer’s dementia. However, the only known risk factor for neurobehavioral frontotemporal dementia appears to be family history, but little is known about how it may be inherited, and it is a progressive disease with no cure.

Most persons diagnosed with bvFTD have had symptoms for years before they receive a diagnosis, and the best intervention that we have now is accurate diagnosis to help with treatment planning and resources to support the person and their caregivers.

So, at midlife, a time when we might worry about losing keys and losing patience, it is important that we not dismiss changes in behavior as simply reactions to stress. While reducing stress can have positive impacts, new changes in mood and personality, such as apathy, elation, irritability, compulsions, loss of social appropriateness, erratic driving or even a loss of empathy, can be signs that something else may be a causing or contributing to these changes.

Talking with a primary care practitioner about these kinds of changes in oneself or a loved one, and discussing any family history, can be the first step to an accurate diagnosis and appropriate care.

For more information on Alzheimer’s dementia and frontotemporal dementias:
www.alz.org/dementia/fronto-temporal-dementia-ftd-symptoms.asp
www.alz.org/health-care-professionals/differential-diagnosis-ftd.asp

Brenda J. King, PsyD, is a clinical psychologist and behavioral health specialist at Summit ElderCare PACE program and adjunct faculty in the Graduate Studies in Counseling Psychology Program at Assumption College.

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Mitigating Risk in Home Health Care

Mary Kate Falkenstrom, PhD, RN, AOCN



Mary Kate Falkenstrom, PhD,
RN, AOCN

Many patients are eligible to receive hospital-level care in their home through services provided by home health care (HHC) organizations. Almost 15 million patients received and completed an episode of home health care in 2013,⁷ and the projected trend is for more such care to be provided in the home.^{1,10} It is the norm for HHC providers such as a registered nurse (RN) to be alone with one or more individuals in a home without direct access to peers, administration or security personnel.^{1,10,11} Face-to-face encounters with patients or others in the home can pose a threat to the safety of providers.

HHC providers have reported being yelled at, shouted at and sworn at during in-home encounters.⁶ In one study (N = 738), 63 percent of HHC RNs (n = 465) reported a minimum of one incident of verbal abuse, threat of physical harm to themselves or their vehicle, or physical assault during an in-home encounter.² In another study, 100 percent of HHC RNs recounted in detail at least one encounter in the home that did not go well. Both male and female RNs described incidents of verbal abuse, sexually inappropriate behavior or leaving a home abruptly because the RN perceived a direct threat to their safety.³ Many health care organizations have implemented preventive measures such as designated times for multidisciplinary case conferences, flagging medical records, in-depth training with law enforcement, embedding mental health workers and security personnel within clinical units, installing metal detectors and enforcing disruptive behavior policies.^{3,8} However, interventions that purely harden an environment have limited applicability in the HHC setting. HHC RNs describe themselves as a guest in a patient's home,^{3,11} and some view zero tolerance policies as more relevant to facility-based care.³

HHC RNs proceed with a heightened awareness when caring for patients who (a) signed out of the hospital against medical advice, (b) were reported to have acted out during a hospital stay, (c) have a history of substance or alcohol abuse, (d) have a psychiatric diagnosis like post-traumatic stress disorder or a cognitive impairment or (e) have health conditions caused or aggravated by trauma such as a gunshot, a history of incarceration or evidence of domestic abuse. Providers, when they arrive at a home, need to rapidly, unobtrusively scan outside and inside for evidence of drug paraphernalia, unsecured weapons, sources of odors, presence of others and barriers that would prevent an exit from the home or area.³ Technology has made it possible to provide patient care remotely, thus preventing direct threats to HHC RNs during face-to-face encounters in the home. However, in the Wälivaara et al. study, RNs advocated that the face-to-face encounter in the home is still necessary for certain tasks and situations.¹¹ RNs described it as “necessary in order to get a holistic picture of the person and their situation at home,” as well as the opportunity to assess “mood and atmosphere in the family.”¹¹ RNs sensed their presence in the home relieved anxiety, showed support and was perceived as “an expression of the nurse’s appreciation of them as persons,” particularly in instances where the RN traveled a distance to meet with them.¹¹

A qualitative approach was used in the Wälivaara et al. study to explore the experiences of HHC RNs.¹¹ The participating nurses used language

such as security, presence, time, respect and seeing (the person) to describe a good encounter. A good encounter was defined as a balance between being personal and being professional. Trust, confidence and respect were described as a “prerequisite for a genuine encounter.”¹¹ The potential for harm to an RN was associated with encounters that “never reach a personal level.”¹¹

A qualitative approach was similarly used by Falkenstrom to explore nurse-patient HHC encounters that did not go well.³ The emerging themes were (a) objective language, (b) navigating the unknown, (c) looking for reciprocity in the encounter, (d) mitigating risk and (e) the interconnecting theme of acknowledging that not all nurse-patient encounters will go well. Three types of patient encounters were derived from the data: (a) A constructive encounter was defined as “when two or more human beings, the nurse, on the one side, and the patient, caregiver, or both, on the other, interact to achieve a mutually agreed-upon outcome”; (b) A non-constructive encounter was specified as “when one or more human beings (patient or caregiver) obstruct efforts to achieve at least one positive outcome”; and (c) A destructive encounter was delineated as “when one or more human beings (patient or caregiver) direct anger at or physically aggress toward another human being.”³ In non-constructive and destructive encounters, lack of reciprocity, resistance to the RN’s proposed solutions and anger directed at the RN personally emerged from the data as cues an encounter was escalating.

HHC RNs routinely employ a variety of strategies to establish a working relationship^{3,9,11} and to “create a good encounter”¹¹ (p. 77). But not all encounters will go well. Patient anger and frustration are reported as pervasive in the HHC setting.³ It is disheartening that RNs in some practice settings sense their own rights and safety are compromised by patient satisfaction programs, view violence as part of the job and believe reporting an incident of violence will not make a difference.⁵ Preparation, minimizing the unknown, looking for reciprocity and being sensitive to cues that an encounter is not going well are critical to mitigate risk during face-to-face encounters.³ Organizations need to prioritize initiatives to teach empirically supported, real-time negotiating skills, de-escalation techniques and self-defense.

Mary Kate Falkenstrom, Ph.D., RN, AOCN, is a clinical adjunct faculty member of Community Health at the School of Nursing at Regis College.

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A Medical Student's Perspective on Violence in the Wards

Laura Santoso



Laura Santoso

As a rotating medical student, there were months when my primary source of news was conversations in the hospital. With little free time after work, there were periods when I did not read any articles on my own and, consequently, learned about several events only long after they happened. However, I knew within hours when a pair of Boston anesthesiologists were shot and killed in their home and when a Southbridge nurse was stabbed by a patient earlier this year. On the wards, violence against health care workers was a discussion I had much more frequently than I had anticipated.

Hearing about these tragic events was difficult to swallow. But I wondered, relative to average rates of violence in the country, how large of a role profession really played. Is there really a problem with violence against health care workers, or does turning nurses and doctors into martyrs just sell a better story?

I quickly learned that assault in the hospital is an experience so common that it is astoundingly ordinary for health care workers. The United States Government Accountability Office reports that workers in hospitals and residential care facilities are five to 12 times more likely to experience violence than workers overall, even more frequently than police in some states.¹ Surveys by the American Nurse Association and others report that 25 percent to 30 percent of nurses have experienced physical assault by a patient or a patient's family member in the past year, with even more experiencing verbal assault.^{2,3} The trend also appears to be worsening: The Joint Commission has reported an increase in violence from 2.0 incidents per 100 beds in 2012 to 2.8 incidents per 100 beds in 2015.⁴ The Emergency Department and workers with repeated direct contact with patients, such as nurses and nursing assistants, are at higher risk of being targeted.

These statistics came to life for me during my very first few weeks at a community hospital, where I heard more Code Grays over the intercom than I could bother to count. A Code Gray is the hospital emergency code for an aggressive person or violent situation. One nurse told me every detail of the day an angry patient lunged at her face with a pen, lamenting that it is only a matter of time before someone is injured. She could not have been more right – a patient succeeded in piercing the lip of a different UMass nurse in September. In the hospital, emotions run high and many patients are cognitively impaired from conditions like delirium, dementia, psychosis, drug intoxication or withdrawal. While the challenges of the hospital can often bring out the best in people, some days the chaos creates the perfect atmosphere for utter breakdown.

Despite familiarity with assault, health care workers may have some of the worst instincts to protect themselves. It is a pillar, if not the main purpose, of the medical profession to aid others. In times of conflict,

the characteristics developed for the job often lead health care workers to step towards a problem instead of away. However, a side effect of this culture is that protecting oneself may at times be undermined. A seasoned nurse once described to me how it has taken almost her entire career to learn when to walk away from her patients. While taking a step back may be a clear choice for a worker when the patient is rude and threatening, leaving the room can feel like a move of abandonment when the combative patient is elderly and confused. My suspicion is that the majority of violent health care incidents are of this less malicious nature. Furthermore, I do not imagine many of my peers, including myself, see violence against ourselves as a primary issue when compared to all the other major problems in our current health care system. Unfortunately, the normalcy of assault may be one reason many incidents go unreported.

However, a high tolerance for difficult work in medical professionals does not mean violence is acceptable or that the well-being of health care workers is dispensable. Although there is inherent risk in health care, the safety of both workers and patients should always be paramount, and regulations should reflect that. I believe this aligns with the broader, necessary shift in perspective commencing in the medical field where the wellness of the clinician is prioritized. While enforcing security with armed officers became especially controversial after a patient was shot by a guard in Houston last year, there are many other tangible steps to creating a safer environment. This includes bolstering prevention programs and safety protocols, implementing training, increasing reporting, providing assistance with legal issues and physically designing spaces to maximize safety.

The issue of violence in health care feels especially sensitive at a time when the national conversation about violence is booming. It is hard not to feel a gnawing sense of unrest with increasing news of mass shootings, police brutality and domestic violence. None of this is acceptable. While violent crime in the U.S. has decreased since the 1990s, we are challenged to take a closer look where violence has been elsewhere exposed. Health, law enforcement, social services and other sectors will ultimately enact various strategies to protect different groups of victims. For many reasons, the way a policeman responds to a person approaching with a knife is vastly different from the way a nurse or doctor would. It is interesting to think about the role of training and differing priorities as we research and reflect on how to change the national climate of violence. While there will always be difficult patients in the hospitals, I hope that we continue to address the cultural and structural enablers of violence in our country to take better care of individuals on both sides of the bedrail.

Laura Santoso is a fourth-year medical student at the University of Massachusetts Medical School.

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Violence in the Community Pharmacy

Janelle Herren, MSE, PharmD, RPh

Community pharmacists are often described as the “health professional most accessible to the public.” With pharmacies on every corner that are open increasingly long hours, most people are never far from a pharmacist for medications and advice on minor ailments. We take pride in our willingness to spend time with a community member in need. However, with that accessibility comes an increasing risk of violence to the pharmacist, a risk that the CDC claims differs from that experienced by other health care workers.¹

Certainly, community pharmacists face a greater risk of robberies due to the theft of controlled substances, a result of the opioid addiction crisis.¹ Those searching for a fix are increasingly unable to get pills due to stricter measures to limit access to prescription narcotics. Because there has been little progress made in dealing with addiction and dependency, as it becomes more difficult to procure pills, both addicts and criminals are turning to pharmacy robbery as an easier means to satisfy their needs.²

Most pharmacists would agree, however, that the workplace violence and aggression we deal with on a daily basis is not robbery, but is more likely attributable to “patient rage” – customers struggling to deal with financial and insurance issues, Medicare rejections and unavailable medications. Often, the people we see are not at their best, faced with sudden illness and overwhelming financial issues. According to a 2010 survey by Rahim, et al., the three most frequent aggressive incidents experienced by pharmacy students in a community pharmacy rotation were verbal abuse in person (40 percent), verbal abuse on the phone (39 percent) and a refusal to cooperate with instructions (34 percent).³ However, many community pharmacists can also recall increasingly violent instances of being called obscene names, spit on, verbally threatened or physically assaulted over the counter when a frustrated customer loses control or is under the influence of a medication that can increase aggressive behavior.

There are also larger issues that contribute to the frustration of customers. The managed care process allows customers to pick up many of their medications for little to no cost, and they do not understand the true cost of the medications.⁴ These customers are left reeling when they are presented with a \$55 copay for a medication that may, in fact, cost hundreds of dollars. The direct-to-consumer marketing ploys of the pharmaceutical companies are also a challenge, presenting medications as easily accessible. These customers approach the pharmacy expecting those medications to be immediately available at little to no cost, only to run up against the realities of insurance rejections, prior authorizations, quantity limits and special orders. They then take out their frustration on the pharmacist, who is often caught in the middle and left trying to explain the complexities of the insurance world to an already angry and frustrated customer.⁴ These emotional stresses are often exacerbated by the conditions found in retail pharmacies, including long wait times, understaffing and the aforementioned insurance and drug availability issues.

The pharmacist’s ability to handle these emotional and potentially violent situations is not well-documented,^{1,2} which may be one reason that pharmacy violence tends to be a topic of little discussion or urgency. In 2009, the National Institute for Occupational Safety and Health (NIOSH) initiated a study of violence specifically against pharmacists in an attempt to collect data and provide recommendations on prevention, but these results have yet to be published.³ RxPATROL, a joint effort between the pharmaceutical industry, pharmacy community and law enforcement, exists to collect pharmacy crime information, but for now,

reporting of pharmacy violence is largely anecdotal and incidents of verbal abuse and assault are rarely reported.^{2,5}

Pharmacy students are often taught that empathy is critical to building relationships with customers and increasing their understanding of their medications. They are rarely taught how to manage the emotional stress of customers and how to manage their own responses to an emotional or stressful situation or protect their own safety.³ This anxiety and stress experienced by pharmacists is increasingly associated with poor job satisfaction and job burnout and makes it especially difficult to respond to a stressful situation with patience and empathy.⁴

With an ever-increasing workload, complex managed care issues and the opioid crisis, pharmacy violence continues to increase, and pharmacists and companies need to work together to find solutions, which may include:

- Prioritizing personal safety and conflict resolution training and establishing strategies for dealing with verbal abuse.⁴
- Implementing systems in individual stores to warn staff about potentially aggressive or abusive customers, such as placing notes in a patient profile or keeping incident reports.⁴
- Providing appropriate staffing levels and support, especially during rush hours, to reduce the stress and anxiety experienced by both customers and pharmacy staff.¹
- Practicing good communication, such as explaining to customers how long their prescription will take when they drop off a new prescription and giving realistic expectations of current wait times.⁴

Awareness of your customer base can also provide alternatives that can help to diffuse a potentially angry or frustrated customer. If you practice in an area where the average income is low or you have Medicare or Medicaid customers who might be feeling additional financial stress, educate yourself and your staff on how to resolve their specific issues or know the location of a local free clinic for referrals. It can also be helpful to have assistance phone numbers available, including state prescription assistance programs, to help customers with the financial challenges of paying for medications.

Additional research and education is necessary to protect pharmacists from an increasingly aggressive workplace. While no one wants to return to the days of high counters and glass barriers separating us from people seeking our help, the safety of the pharmacist must be a priority equal to the needs of the customers.

Janelle Herren, MSE, PharmD, RPh, is the current Geriatric Fellow at the Pharmacy Outreach Program at MCPHS University and a former retail pharmacist.

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Reflections after 50 years in Medicine

Mary E. Constanza, MD

I recently retired from clinical medicine after a career that included clinical practice, clinical research and teaching. Pursuing all three interests simultaneously seemed to me to have positive effects on each commitment.

I fear ours is the last generation to be “permitted” to be involved simultaneously in research, teaching and clinical care as I remember so many of our teachers at Rochester were. I remember, too, how inspiring I thought they were. The current shift to chairs of academic departments who are bench types and big grant-holders with little or no clinical interest or involvement seems to me to be one of the saddest results of medicine becoming a “bottom-line” business run by cost-conscious suits with little respect for the value of the physician-patient relationship and apparently with only passing concern for the effects of this on physicians and other health care personnel.

The result of widespread lack of concern for clinicians was highlighted in the recent monthly journal of the Worcester Medical Society, which focused on clinician “burnout.” The articles described “burnout” as rampant, not only among physicians but also among medical students, residents, nurses and pharmacists. Recent issues of the *New England Journal of Medicine*, *JAMA*, etc., are all addressing these strange new phenomena. The most cited causes of “burnout” are: too much paperwork, too many patient visits scheduled in too brief a time to deliver the care clinicians want to give, multiple insurer demands for documentation, too much micro-management, etc. To help us cope with “burnout, most of our professional organizations are advising us to learn relaxation techniques, to exercise more and to join discussion groups as a way to refresh ourselves.

But the fault, dear friends, lies not with us but with those who are running health care: the health care insurers, Big Pharmacia, the health care investors and anyone who puts making money ahead of putting health and the patient at the center.

I don’t believe yoga and gripe sessions are going to help us much with “burnout.” What will help medicine in general – and us in particular – is for all of us health care workers to UNITE and UNIONIZE. Only that kind of unity and strength has a chance of returning medicine to the full-time pursuit of improving and maintaining the health of our patients. Then, we just might not “burn out” ...which, as the fiscally astute have pointed out, really doesn’t help their bottom line.

Mary E. Costanza, MD, is a Professor of Medicine Emerita at University of Massachusetts Medical School.

Comments may be sent to wmdms@massmed.org or mailed to Worcester District Medical Society, 321 Main Street. Worcester, MA 01608

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Hospital Mergers – A New Landscape?

Peter J. Martin, Esq.



Peter J. Martin, Esq.

Hospital price variation not based upon differences in the quality of care provided has been a public policy focus of the Health Policy Commission for a number of years. One outcome of that effort is a process by which the HPC may review proposed hospital mergers for unwanted effects on hospital prices. Another result is a statutory proposal currently being considered that would penalize some high-cost hospitals for exceeding a hospital spending target. The proposed merger between Lahey and Beth Israel Deaconess hospitals, currently under enhanced HPC review, affords us an opportunity to see

how these two approaches might work together. Will the trend toward provider consolidation be allowed to continue because of regulatory constraints on hospital pricing, or will those regulatory measures in effect eliminate market-based efforts to reduce costs?

Beginning in 2013, the HPC has had the ability to subject certain health provider transactions to heightened scrutiny if there are concerns about the effect of the transaction on the provider market or on health spending benchmarks. The process begins when the provider submits a Notice of Material Change that describes the proposed transaction and its anticipated effects; if the HPC believes that the proposal is “likely to have a significant impact on the Commonwealth’s ability to meet the health care cost growth benchmark, or on the competitive market,” then it may conduct a heightened “Cost and Market Impact Review.” This is the process now applied to the Lahey-Beth Israel merger, which may take many months to complete.

The proposed Lahey-Beth Israel merger has been described as a market-based effort to combat the so-called “Partners Effect.” This effect is demonstrated, for example, by the fact that in 2014, Partners’ hospitals received a third of all commercial insurance payments made to Massachusetts hospitals. The proposed merger, by creating a large competitive hospital system in eastern Massachusetts, arguably would take market share from Partners and result in lower commercial reimbursements to both systems. One concern expressed about the proposal is that, in fact, market share will be taken not from Partners but from community hospitals. Another concern is the more general skepticism that hospital mergers actually reduce prices. The HPC’s CMIR review will cover, among other issues, the effect of the proposed merger on total medical expenses, the prices charged for services relative to others in the market and the merged entity’s market share, as well as the accessibility and quality of services.

In 2014, the HPC subjected Partners’ proposed acquisition of South Shore Hospital to the enhanced Cost and Market Impact Review. The HPC rejected the transaction on the grounds that: it would increase health care costs by many millions of dollars annually, would result in

the combined entity having half of the market share for inpatient acute care services in the relevant market, both parties had above-median payment rates with payors and the acquisition would increase their ability to negotiate even higher reimbursements, and total medical expenses would increase more than savings expected to result from proposed population health management initiatives. The focus of this review was on the market effects of the proposed transaction. The conclusion of the review was that it would not have the desired market effects. Now, the same type of review will be applied to an aspirant competitor to Partners.

The impending CMIR of the Lahey-Beth Israel transaction takes place in the context of the consideration of a Senate bill that would, if enacted in its present form, penalize high-cost hospitals if a statewide target in hospital commercial health care spending growth is exceeded. As currently proposed, the three hospitals that most contributed to that excessive cost growth would be penalized. The Senate bill also calls for health insurers to certify that their hospital reimbursements do not fall below a floor (proposed to be 90 percent of statewide relative prices) and if they do, to be subject to a financial penalty. The proposal has been criticized for not imposing a cap on hospital reimbursements and for potentially encouraging hospitals to increase their prices to just below the level at which penalties might be assessed on them.

In the CMIR process, the HPC asks whether a particular action in the marketplace, such as a corporate combination, is likely to have desirable market outcomes such as decreased prices or increased service accessibility. If such outcomes appear unlikely, the HPC can seek the assistance of the Attorney General to block the transaction. The Senate bill simply identifies undesirable market outcomes, such as excessive spending growth or differential prices paid for the same services, and penalizes those it deems to have benefitted from those outcomes. In the CMIR process, the market is given an opportunity to work but the government may block the proposed transaction; under the Senate proposal, market dysfunction is a given and is attended by governmental intervention in the form of penalties.

How will these two approaches be applied to the Lahey-Beth Israel transaction? Will the potential imposition of financial penalties under the Senate proposal, if enacted, make it easier for the HPC to approve the transaction because certain of its potential undesirable market effects may thereby be eliminated or reduced? More broadly, will Massachusetts continue to take a market-based approach to the ongoing trend of provider consolidation, or will it focus instead on reimbursement controls and overall spending growth targets? The HPC, in its 2016 Cost Trends Report issued in February 2017, stated as its first policy recommendation the “fostering a value-based market in which payers and providers openly compete.” It also noted a “strong consensus that hospital mergers lead to higher prices in the vast majority of cases.” It seems clear that “open competition” is and will continue to be subject to state-imposed guardrails. What is less clear is whether a managed marketplace will continue to have a place for significant provider combinations.

Peter J. Martin, Esquire, is a partner in the Worcester office of Bowditch & Dewey, LLP, his practice concentrating on health care and nonprofit law.

Sunday Sitdown: Dr. Michael P. Hirsh, Surgeon and Co-founder, Goods for Guns Buyback Program

Paula J. Owen, Telegram & Gazette Correspondent



Dr. Michael P. Hirsh

Dr. Michael P. Hirsh, a passionate advocate on the subject of gun violence and using preventive methods to address the issue, believes physicians belong in the middle of the gun debate.

Co-founder of Goods for Guns, a gun-buyback program that is spreading across the state and country, the 63-year-old Northborough resident still vividly remembers holding the heart of one of his best friends in his hand during emergency surgery years ago after the friend was shot in a violent armed robbery in front of a New York City hospital where they were both training in surgery.

A surgeon-in-chief of the UMass Memorial Children's Medical Center and professor of surgery and pediatrics at the UMass Medical School in Worcester, Dr. Hirsh was "surgeon of the week" last week but took time out from his unpredictably busy schedule to talk to a reporter about gun violence.

Dr. Hirsh, a native New Yorker, has been married 38 years to Julianne Hirsh, a retired assistant in the Worcester Public Schools and now master gardener. The couple have two children: Scott Hirsh, 34, and Estelle Hirsh, 29, who is a medical student at UMass Medical School, where her father works.

Why did you start the gun-buyback program?

"My first introduction into the world of gun violence, I guess, was my baptism by fire as a surgery resident at Columbia-Presbyterian Hospital. Having grown up in New York City in Washington Heights, it was a transitional neighborhood, pretty uniformly Holocaust survivors and escapees from Germany, Jewish mostly. That is where my parents came after they were released from the concentration camp. It was never a super-violent neighborhood and there were never gunshots at that time. "When I got back from Harvard Medical School, I started my residency there. The crack cocaine epidemic had hit New York City and the Heights had become a very important engine for the production of crack cocaine and distribution. With that came the inevitable gang and drug wars between rival drug producers, and everybody started to carry firearms. As a surgery resident on a trauma team, I would see three, four, five gunshot wounds a day and I became quite adept at being a trauma resuscitator and surgeon from that experience. But it is one

thing to have that be on unknown victims and people I didn't have a connection to.

"On Nov. 2, 1981, one of my best friends in the surgery program, John Chase Wood II, who was a surgery resident a year behind me, got a call that his then 3-month-pregnant wife, who lived in one of the tenements around Columbia-Presbyterian Hospital where most of us lived because that was what we could afford, was having trouble with nausea. John loaded his coat up with a mainstay of nutrition in the operating-room lounge – saltine crackers – and asked us to hold his beeper for him as he ran out, grabbing her saltines.

"What we learned 20 years later is that a 15-year-old boy accosted him and asked him for money. When John pulled his pockets inside out and said all he had was crackers, the boy felt disrespected from that action and shot him in the chest. While I was holding John's beeper, I had to respond to his trauma (calls). It went off and it was for him and we were not able to save him. It was one of those, what we would call now, 'adverse events' that left me very traumatized.

"What turned things in a positive direction for me and for many of us at Columbia was the fact that my chief of surgery got Sarah Brady to come and talk to us six months after her husband, Jim Brady, who was press secretary for (U.S. President) Ronald Reagan, was wounded by a gunshot wound to the head during an assassination attempt on Reagan. Sarah Brady came into an assembly of staff at Columbia. We were angry at the community because it came to pass in front of our emergency department and witnessed in front of many people who wouldn't give up the shooter. We were scared Columbia was not a safe place and, for the grace of God, we could have been John Wood.

"Sarah told us that all causes that make people angry or violent enough to do that to people is beyond our pay grade – all of the things that today are known as social determinants of wellness. That was beyond our pay grade, so to speak. She said one thing that elevates anger to lethality was an overabundance of guns and easy access to them. That got me thinking in terms of nowadays and the term of that philosophy 'lethal means reduction' – reducing the access to things that turn events into homicides or suicides or domestic violence incidents.

"You hear people talk about the old days with knife fights and 'you brought a knife to a gunfight.' It wasn't the way people interacted, even in situations where there was conflict, until guns flooded the market in the '70s and '80s. I finished my career at Columbia realizing I wanted to go into pediatric surgery, which meant another two fellowships in Philadelphia, where I was on every day 24/7. I couldn't do much in the way of prevention there and, like New York, the crack cocaine epidemic hit Philadelphia. I was training at St. Christopher's Hospital for Children in North Philadelphia and it was becoming an open gun battle.

"When I finished there in 1986, I came up to UMass in Worcester when it was in its early days. Truthfully, the drug problem and the gun problem hadn't really reached here. I got the injury-prevention bug along the way from training with a doctor in Columbia, Dr. Barbara Barlow, known as the Mother Teresa of injury prevention. She was given a huge grant to clone her program around the country. When I moved to Pittsburgh, I was lucky enough to become her first clone.

"The neighborhood we were in, we wanted to talk about gun violence.



Dr. Michael P. Hirsh

The city was in the middle of a huge gang war because of crack cocaine. I got there in 1992, and in 1993, on Mother's Day, there was a softball game held at a local park in north Pittsburgh and there was a crazy bat-wielding melee between rival gangs. They all dropped their bats and came back with guns. There were 15 gunshot wounds in the next two days, all amongst this population. The hospital sent me out to go to a community meeting and all they wanted to do was lambaste the hospital for seemingly profiting off of this trauma, saying the more cases there were, the more money we made. They didn't want to hear about other programs. All they wanted to know was what were we doing about guns."

Where was your first buyback held?

"Right next to two department stores in downtown (Pittsburgh). We (Dr. Matthew Masiello and I) pitched it to the hospital and agreed to buy gift cards from both stores. We publicized it and held it two consecutive Saturdays. We asked the gun task force, 'How many guns do you think we're going to get?' They said, 'We've been open five years and got 30. You got some publicity. You might get 100,' and that's what we planned for. We got 900 the first Saturday and 500 the second and we totally ran out of money. We had med students with us and we would give them our ATM cards and they would run across the street to see how much they could get out of our accounts and go into the department stores and convert it to gift certificates and bring them back. It went on until both of us were tapped out. The hospital administration saw what was going on and said they would handle whatever number of guns we got and would sustain us. 1994 was the first year and we've been doing it for 23 years."

When did you start the program in Worcester?

"I moved back to Worcester in 2001 and immediately started to talk to the district attorney and police chief. There was a bigger problem in Worcester. Crack cocaine had hit Worcester and there were gangs – currently, there are 32. The police were only too happy to try it. The wonderful thing about living in this community is how open-minded the district attorneys, police chiefs, city managers or mayors have been to this. They never question my agenda as being anti-gun or anti-Second Amendment. They accepted me on face value. When you hold your friend's heart in your hand, it changes you in a way that makes you understand the terrible consequences of when guns are in the wrong hands."

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Source: www.telegram.com/news/20171125/sunday-sitdown-dr-michael-p-hirsh-surgeon-and-co-founder-goods-for-guns-buyback-program

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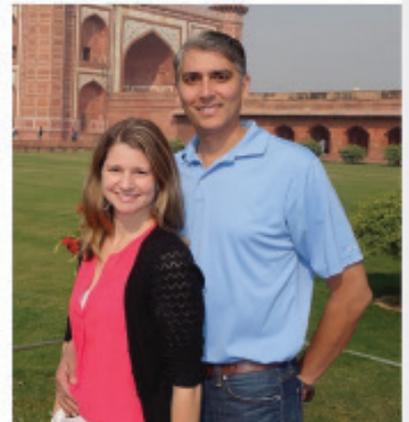
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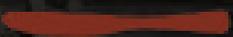


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