CPI *Unrestrained* Transcription

Episode 35: Bob Durand

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Host: Terry Vittone

Terry: Hello, and welcome to *Unrestrained*, the CPI podcast series. This is your host, Terry Vittone. Today, I'm joined by Bob Durand. He is an emergency management planner and a practice leader working in the medical group support services division of Kaiser Permanente's Northern California region based in Oakland. Hello and welcome, Bob.

Bob: Hi, Terry. Thanks for having me.

Terry: You're welcome. Let me tell you a little more about our guest. Before transitioning to civilian life, Bob spent 21 years in the US Army where he assumed various leadership positions, including tier one special military ops. After his military service, Bob transitioned into security and training roles in the health care field. In his role with the health care giant Kaiser Permanente, Bob is a regional asset for 21 separate facilities. He develops national strategy and conducts security officer training for postings within the emergency department, including management of the ED environment, patient management, physical intervention leadership, and staff protection. Bob was also instrumental in the introduction and training of the Workplace Violence Prevention Program at the Kaiser Permanente San Francisco Medical Center. Bob is certified as a health care environment manager and a HIPAA Security Specialist.

But before I give too much away, let's get into our questions. Bob, would you talk about your personal history a little more and how a desire to "jump out of planes and kick in doors," as you told me in our pre-interview, led to your first role in emergency management?

Bob: Thanks, Terry. So when I was 12 years old, I really wanted to do an adventurous job in my future. That ultimately made me decide that I wanted to go into the US Army, and I wanted to do a job that was challenging and fun, and make it as tough as I could possibly make it because I wanted that challenge. And one of the things that I learned in that time is that we have the ability to do anything we want, right? And through my 21 years of experience, it helped me understand that sometimes we can take one path or we can take another path that ultimately decides where we go and how we do things.

And when I translate it into the subject of what CPI is all about, and what we do to manage health care environments for safety, is that it's very simple to overcome an at-risk patient through brute force, but using appropriate principles that allow us to de-escalate before we ever get there is much more valuable than just physically managing patients. And that history, that background of mine with the military is what ultimately helped me understand the value of de-escalation, the value of communication, and the value of interaction with our patients.

Terry: Is it because of the contrast between the military paradigm and the culture there, and then going into safety and security in health care?

Bob: The funny thing about it is that there's so many things that are the same, right? Because the military's health care system is a lot like the way Kaiser Permanente structures, right? And I guess at this point I should probably pause for a second and mention that as I express my opinions, they're my opinions, and I don't necessarily speak on behalf of Kaiser Permanente.

Terry: Okay.

Bob: And the thing being there, when I go with this, is that the health care system in the military is one where you see your primary care [physician], and your primary care [physician] is your point of contact for everything about keeping you healthy, which is the foundation of how Kaiser Permanente works. The idea being that what we do, what we have to do, to keep you healthy, and keep you happy, and keep you functioning is much more important than waiting until something is wrong to jump in and try to fix it. So the overall strategies that are employed towards the health care system that is Kaiser Permanente are very much the same types of strategies that the military utilized.

Terry: So preventative measures take precedence?

Bob: Absolutely. There's that old saying that says, "An ounce of prevention is worth a pound of cure." And it works in every single arena when we talk about this, including managing aggression.

Terry: So you come out of your 21 years of military service, and where do you land first?

Bob: Well, so the really interesting thing about that is my very last job in the military was health care recruiting, looking after and trying to find any one of the 120 allied health specialties that are out there. And during that time, I bumped into some pharmaceutical reps, and they led me to believe that being a pharmaceutical rep was the end-all, be-all in jobs. So when I left, I went into that. And I quickly realized that that's not what I wanted to do. There was not a service component to it. There wasn't a "help your fellow man" component, which is entirely about who I am. That's what led to my 21 years of service. It's ultimately led me to where I am today within Kaiser. And I got in that role, and I

realized that it was about sales. And I wanted to do something more. So I left that job, and I went into health care security.

And when I started, in my very first interview with the contract company that provides security for the hospital I worked at, because of my background, because of my education, because of all the things that I came to the table with, I was offered a manager's job. And I said, "Thank you. I appreciate that, but that's not going to help because I don't understand the way this works. So I need to function at the lowest level first. I need to be an officer first, and I need to work my way up from there." And I did that job for a year, and then I'm transitioned as a supervisor. Then I ultimately became a manager for a security program at a hospital.

And for each one of those steps, I truly understood what it took to provide a safe, nurturing, caring environment within the health care system. And interestingly enough, when we think about security, we often think about loss prevention. We often think about access control, not letting people get to where something is protected, right? And in the health care environment, you can't do that because we have to have an open, nurturing, caring environment by nature. We want our members and our patients to come for us for help. If we close ourselves off, if we make ourselves secure as a hard target, then we are counterproductive to that.

So the focus within health care security is such a different concept. Yes, there are times where you have to have certain areas totally secured. But for the most part, we want our members and our patients to understand that this is a safe haven. And it was through that practice that ultimately led to the next level of my career which is where I am now.

Terry: Nice. What a balancing act to pull off! It's interesting that you chose to work in security. "So look, I'm not ready for the manager role yet. I need to understand this environment better before I step into that." That's very disciplined.

Bob: Thank you. And it was a hard lesson learned when I was in the army. I actually had a job where I was moved into a leadership role for a function that I'd never once worked in before. And if you were to talk to my boss at the time, he would tell you I did okay. If you asked me, I failed miserably. And I realized that in order to effectively lead, in order to effectively help others understand what they need to do, you have to be a subject matter expert [SME]. You have to be able to—and we throw this term around quite a bit—that's "lead from the front." You hear that quite a bit in corporate America. And there's a lot of times that's misunderstood.

What it truly means is helping your people understand, helping them learn, and providing them the tools to be successful. And so if you don't understand the material yourself, if you haven't fully embraced what those concepts are, you can't effectively do that. And jumping right into a leadership role with no fundamental understanding is actually very counterproductive to that.

Terry: Well, that transitions into my next question. So now you've become this SME through your experience and you go on to work at the Kaiser Permanente San Francisco Medical Center, become involved in training there, and achieve some remarkable results as well.

Bob: That's correct. So within my role as emergency management planner for San Francisco Kaiser Permanente, part of my function was the AB-508 compliance program, which that particular regulation within California requires that people who work in an emergency department are trained on 11 items as it applies to their security management plan. And I manage that program, and it's an annual requirement to do this training. And through that training program [including CPI's *Nonviolent Crisis Intervention*® training], we were able to virtually eliminate injuries within our emergency department from violent, unpredictable patients. And we are now into our fourth workplace safety year with no lost time from injuries.

And that's a significant achievement when you think about the emergency department environment that we face. We have more angry patients. We have more unpredictable patients. We have more patients who are altered because of alcohol or drugs than we had 5 years ago or 10 years ago. And the environment is just becoming more and more unpredictable. But the ultimate thing that—in fact, it's funny—I was talking with one particular clinician last week, and he said the biggest thing about this training isn't that I learn any one specific concept or any one specific measure or any one specific physical action to protect myself. It's that I gain confidence to work in the environment. And he said one of the biggest things that has led to our safety results is that our team is more confident. So when something happens—

Terry: Bob, may I interrupt you just for one second? You're speaking in regard to verbal de-escalation techniques and, say, the *Crisis Development Model*℠?

Bob: I'm referring to it all. I'm referring to the de-escalation techniques. I'm talking about how do we respond during the defensive phase when somebody is verbally aggressive or they're shutting down and shutting off contact. How do we manage when someone is at risk and they're now beginning to physically act out? Every piece of, every phase within, the *Crisis Development Model*℠—the staff is just more confident. And when someone calls out for help, instead of looking around the corner and saying, "What's going on?" everybody now goes to the environment, and then they're able to function as a team to either de-escalate, regain control, whatever the requirement is to keep everybody safe. They're able to do that better. And he [the clinician] mentioned to me that it really, truly is a team-building event—the training, that is.

Terry: And I see here that between 2013 to the present at San Francisco Medical Center, following that training, the ongoing training, you guys had zero workplace injuries from violent and unpredictable patients.

Bob: Correct, and I will caveat this, that there were two incidents where a patient spit on a staff member, and then during a restraint, one staff member was scratched. But neither one of those resulted in lost time, and the staff members were not injured. But because we do hold ourselves accountable to every possible injury, we do count those.

Terry: Okay. So at what point did you come into San Francisco Medical Center and think, "You know what, I'm going to bring some de-escalations, some CPI training, some *Nonviolent Crisis Intervention*® training into this environment"?

Bob: There's actually two reasons. One is the most simplistic and economical, and that is we use it across the board. So it was the standard training model that we were already using. Second is that, in my opinion—once again, this is my opinion—when it comes to the de-escalation material, CPI offers the best program out there. And what I mean by that is the vocabulary you've chosen to use, the method in which you teach it, and the fundamentals behind it in terms of how you work through the crisis model [*Crisis Development Model*℠] and how you work through the *Verbal Escalation Continuum*℠ allows the end user, that is the staff member, to fully understand what the risks are, and what the options are for mitigating that risk.

So we talk about someone who is experiencing anxiety and we talk about those things that can actually help them not reach that next level. And more importantly, things that we can do to not perpetuate it ourselves. Because when I talk, I tell people in our training that when somebody is showing signs of anxiety, if all of a sudden we become directive, the patient isn't the one that's escalating. We are escalating the situation.

Terry: There's the Integrated Experience going in the wrong direction.

Bob: Exactly. And that's the thing, right? And so often in the emergency department, when somebody is becoming anxious, and they're becoming agitated, and they're becoming aggressive, the automatic response is to just equal that energy, right? That's what clinicians in the ED environment are taught from day one in terms of managing. And that approach doesn't always work. So when we look at how training offers them choices in how they respond, is really, truly what allows us to have less instances where there's a potential for injury.

Terry: Around what time frame did CPI training start in San Francisco Med Center?

Bob: Ah, shoot. It was there before I got there. But that was only for the security department. When I moved into the role that I ultimately took up, the compliance training to cover the 11 items that the law [California AB-508] requires was done utilizing a different concept. When I looked at what do we have, what can we do, and where can we go, that's when we introduced the CPI model into the training.

Terry: I see. And that would be, roughly?

Bob: At the very beginning of—it was late 2012, early 2013.

Terry: So maybe part of your zero workplace injury result was that expansion of training.

Bob: Correct.

Terry: That's excellent. And how did you convince administration to grant you a training budget?

Bob: Well, I'm going to tell you, it was tough, right? Because training health care workers is expensive. By nature, their time—in any program, it doesn't matter what work segment you're in, what profession you're in, what industry you're in. The most expensive piece of any training program is the time, right? And so the actual program you select, the cost of that is negligible. It's very minimal compared to the cost of the employees' time. And so we had to look at what can we do and what's it going to cost us. And more importantly, what is it going to do for us.

And so, the first year that we did the training, we did it with unbudgeted funds, which was really tough. And I will tell you that once leadership saw the benefit, it became automatically budgeted in. We've already budgeted in the amount for training for 2017. And when you forecast that, you're able to absorb it easy. The big thing that I would tell anybody who's looking at doing it is you need to lay out up front what it's going to cost the organization, but why it's important for them to spend that money.

Terry: I see. When you started you were unbudgeted. What outcomes does administration look at and say, "We have to do this"?

Bob: The biggest thing is we're not paying for lost time. When you look at the bare bones accounting, we're not paying because a staff member got hurt. And that's a huge difference, right? We're also safer with our patients. Now, that's an intangible that you can't just look at and say, "Okay, because we didn't have to restrain this particular patient" or "There wasn't a risk of this patient getting hurt," that it saved us money. I don't think there's ever going to be a way to accurately quantify that. But just making the environment safer saves money.

Terry: When you can point to zero workplace injuries from violent and unpredictable patients at the San Francisco Med Center ED from 2013 to now, that's certainly a metric that stands out that one would point to as a very desirable outcome so far as lost time. And just for the overall environment, the staff has got to feel more confident and secure in fulfilling their role.

Bob: That is correct.

Terry: Now, in our pre-interview, you talked about a training philosophy that you shared with trainees, and I really like this phrase: "More sweat, less blood." Could you talk about that for me, Bob?

Bob: So one of the things that I see quite often, and this is not just health care, it's across the board in training, right? And that is we plan our training because we're trying to package it, right? We're trying to create the least amount of impact on our employees. We want to make it easy for them to attend. We want to make it easy for them to go through the learning process. And I am absolutely opposed to that, right? [Making the learning process too easy.] Now, I want to make it easy in terms of them scheduling. I want to make it available to them, right? I want to make it so that they don't have a problem getting to a class. But once in the class, I want to challenge them. So when we talk about doing scenarios for verbal de-escalation, when you make somebody uncomfortable like they would be in a real situation, they can learn from it, and they can grow, right?

When we talk about going through the physical defensive techniques, or the techniques that are used to regain control of somebody who's out of control, when we make those as realistic as we possibly can, we help the person learn how they truly can defend themselves, how they can truly make the environment safer by quickly and efficiently regaining control of somebody who's out of control. And ultimately, the one thing I've preached from day one in my security experience is when someone gets to a point where they are now a physical threat to anybody, the longer they are in that status, the greater the risk of injury. So once we make the decision where we've got to regain control of somebody physically, we've got to do it quickly, efficiently, and as a team because if we don't do that, someone can get hurt.

Additionally, there's not really an option to fail, right? You have to be successful or someone gets hurt, right? So in doing all of the training, the harder that you can make it on someone, the more challenging that you can make it on someone, the more involved you get them in that training, when they walk out of that classroom, they're going to be more confident, right? When they're faced with a similar situation in their environment, and I used ED because that's where I focused myself, is that when they get into that environment and they're dealing with somebody who's unpredictable or violent, they're better able to keep themselves safe because they've already experienced it.

Terry: Right. So in other words, that simulation, making it as close to, as tense, and as adrenaline-fueled as an actual encounter in the ED might be what really buys down that reaction once they actually experience it in real action.

Bob: That is absolutely correct. And that actually helped. When I was looking at developing our program, I actually went back to CPI and I said, "What do you have that can help me?" And that's where I then attended *Applied Physical Training*℠. And that helped me fully understand how to teach that material to the best of my capability.

Terry: I see. So you went after the advanced course. You sought that out.

Bob: Correct.

Terry: Excellent. And did you provide that training for a portion of your staff, or was it an optional thing? How did you blend it?

Bob: So what we did is we made the choice for our 2015 certification. We taught that material, right? So what we did is we offered all the de-escalation material as a—we discussed it during staff huddles, and all those things. We brought it up, and we allowed them to kind of work that through that way. But when they came into the classroom, we focused on that. That was the material we taught in the classroom that particular year.

Terry: I see. So the physicals were the emphasis for that.

Bob: Correct.

Terry: I see. I'm wondering, Bob, how [California] SB 1299 impacts your strategies. I mean, do you see your training as a—what does this legislative mandate do? Is it a one-size-fits-all kind of—that's almost a pejorative phrase, but I mean do you customize by high, low, or medium?

Bob: Right. So a couple things to reiterate before I go into my opinions on this. And that is, one thing is very—we are still working it through. With Kaiser Permanente, we still do not have our training plans solidified. And the reason being is that we're trying to make sure that we do two things. And that is one, meet the requirements of the regulations, right? But more importantly, we're trying to figure out a way to make sure that even those that don't fall under the regulation are still protected by what's the intent of this law.

Over the last several months, certain areas were taken out of scope of the law. And the big thing for us about that is that workplace violence is a trend everywhere now. It's not just in one specific area of any one specific organization. And we don't want to leave our areas that are out of scope unprotected. So we're still trying to work through exactly how we're going to deliver the best training we can to the widest area. Okay, that's the first piece.

The second piece is—I want to reiterate it again: what I'm about to mention with you is my opinion. And so, first off, different areas absolutely have different risks. I'll use a couple different clinics that are synonymous with any health care organization, right? An audiology group is a very low risk area, right? The people who are there are there for a very specific reason. They're generally not anxious or agitated when they're seeking care. They're generally not altered when they're seeking care, and the risk is low, right? So training for them doesn't necessarily need to be the same as training for an emergency department, right?

And emergency departments in health care facilities are some of the highest risk groups because of the nature of the patient population and the nature of families who accompany people to the emergency department. By nature, people in emergency departments are stressed, right? In some cases, they're altered. In many cases, they're agitated out of fear or some other issue, right? I think about when you look at the person who arrives at the

emergency department agitated and altered because of whatever they've done with themselves, that's one population; that's one risk. But a family member who arrives with their loved one having a heart attack is anxious. They are stressed. They are on edge. They need every bit the same care that their loved one probably needs, right? It's a different form of care but they still need it, right?

So by nature, emergency departments are higher risk. And so everything falls within that spectrum of the emergency department and that audiology clinic, right? And determining what training you offer to different areas really will make the difference of how you budget your time, you allocate your resources, and most importantly, offer the most effective training to the correct group.

Terry: Speaking of the correct groups, I heard when we talked previously that it's your sense that all physicians should participate in de-escalation training. We like that thought, certainly. Could you tell our listeners what leads you to that conviction?

Bob: So the biggest reason why I believe this is physicians are the frontline care, just like nurses, just like technicians, just like a number of other parts of the care continuum. They often put themselves in close contact, one-on-one, in closed rooms with someone who might be aggressive or agitated, right? And so by the nature of their work, especially when we talk about privacy, and we're talking about making sure that we are offering the patient everything that they are afforded, which includes privacy, physicians often put themselves in situations where they are in closed rooms, doors closed. They are private with their patients as they should be, right? That leaves them exceptionally vulnerable. And a lot of times, when the patient is agitated, when they are anxious, when they are aggressive, the physician is the target of those [feelings].

Terry: And so it makes sense then for them to have a full skillset of de-escalation techniques that are readily at hand and practiced when they are in this private situation.

Bob: Exactly. And additionally, a lot of the tools that they learn during this helps them when they go to set limits. Because physicians are increasingly being put in positions where they have to set limits with patients.

Terry: Give me an example.

Bob: Well, in the emergency department now, we have an epidemic in the United States, right? And that is we have people who are increasingly drug-seeking. And often, the physician in the emergency department is the one that has to tell that patient no, right? And so the way that they do that, the way that they approach that, the way that they set those limits when they are faced with those, really can determine an outcome in terms of managing somebody who might be significantly unpredictable.

Terry: Well, I mean if they're seeking, and say—because we read about the opioid epidemic for instance. It used to be religion, they said, was the opiate of the masses. Now it seems that opiates are the opiates of the masses.

Bob: You are absolutely correct.

Terry: So you've got someone there [potentially] in withdrawal and the physician has to say no. That's dangerous.

Bob: It is. It's absolutely dangerous because that patient is now unpredictable. That patient is a wild card. Their next action is totally unpredictable because most often, they immediately become defensive, and they immediately become aggressive, and they immediately become a threat. And so how the physician manages that through limit setting, through a myriad of other tools that they can use, helps them maintain their own personal safety.

Terry: Wow. I could see that especially with somebody who, as you say, is altered or seeking to get altered, that you would have to have some skill, some finesse, and some practice indeed at dealing with that sort of demand.

Bob: Correct.

Terry: I'm trying to put myself in this scenario and imagining how you would stay rational yourself when you knew that someone was desperate.

Bob: Exactly. So one thing I applaud many health care workers in the emergency department, and that is, their job helps them learn that, right? Their job helps them learn to be rationally detached, and allows them to objectively look at those situations, right? In some cases, that actually hinders because they are more straightforward; they're more blunt; they're more direct. And in some cases, that actually serves against them, right? By learning the techniques of limit setting, by learning a myriad of other tools, they're able to use a different approach based on the situation.

Terry: Bob, now that you've become a regional asset for Kaiser Permanente and you manage 21 different facilities, how do you extrapolate that role that you had at San Francisco General and make it fit into all these different facilities? I mean they have to have significant differences.

Bob: Oh, absolutely. So a couple things. One is that my role as a practice leader allows me to offer tools. Because I don't have—I guess the word would be oversight, right? My role is more of a—I offer help. I offer solutions. I help them understand where they are, where they need to go, and that sort of thing. And it allows me to objectively look at the programs and give them feedback as to where they are and where they can potentially go. So that's part of it.

The other piece is that the locations of our medical centers and the things that each one of them does within their communities varies widely. And so there is no one-size-fits-all for them in terms of a practical solution for what we can do for them.

Terry: Give me a sense of what some of those facilities do and how they're different.

Bob: It literally is based on geography or based on the local climate of the counties in which they serve. And some of the counties, I guess, for example, San Francisco Kaiser—is not a dumping ground for law enforcement when they have someone who needs medical care who is unpredictable, unstable or is a risk, right? There's a county facility that accepts all those patients, right? So while there's risk, it's not as high as some of the other facilities because we have other facilities where there aren't other choices, and that hospital is the one that gets that DUI who needs medical care, who is in police custody. Or they get that patient who was recently 5150'd, which in California is the 72-hour psychiatric hold, when the police have instituted that order and they bring them to the hospital.

[Note: The code for the psychiatric hold is 5150 from this legislation: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=5150]

So that does happen at some facilities who aren't the big receivers for those [patients], but there's facilities where they're the only medical center in their community that accepts those. So those ones [facilities] are the ones that are at higher risk. And that's the big difference.

Terry: And how would you say the training for these 21 centers as far as de-escalation techniques or CPI training, is that in place in a large number of these?

Bob: Yes. We're working on expanding it, actually. We're looking at different ways we can deliver the material to more people. And part of our solution for SB 1299 is going to be widening out the scope of who gets the training.

Terry: I see. So you're going to—well, that's good news, to train more people as part of the philosophy that you were speaking of earlier, that everyone, every facet, from audiology to the ED deserves the same level of competence and training when it comes to de-escalation techniques.

Bob: Correct.

Terry: So any last thoughts today, Bob? Talk about who inspired you professionally. And what created that—I guess it's maybe hard to answer what led you to such a service-driven orientation and the desire to help people.

Bob: Well, it's been throughout my life. I've had some amazing military leaders who coached me through my time. I had some leaders who sat me down and said, "This is what you can really do for the world," and so on. And then I had some mentors in the health care world.

And the funniest thing is that when I went into the health care world post-army, I spoke army; I spoke Department of Defense. I was a soldier, right? And I can tell you that there were some times where my vocabulary wasn't the same as the vocabulary of health care. And so I had mentors who helped me learn how to communicate and how to teach with the most impact through utilizing terminology that's prevalent in the health care world, right? And I can tell you that when it comes to structuring a training program, you need to make sure that as a fundamental trainer, everything is geared to how well you deliver the material, how well you help.

And I'm not real big on quotes because I often forget who said them, but I do remember this one very specific one that sticks out at me, and it says, "If you can't explain something to a five-year-old, you don't fully understand it yourself." And so I try to make sure that when I'm teaching something, when I'm delivering something, when I'm orienting somebody to something, that first off, I understand it. Because I can stand up and I can read a slide and I can say, "Do this; do this; do this." But that doesn't help somebody learn, right? When you're trying to help someone learn the concepts, you need to make sure that you've taken time to fully understand the material yourself and then deliver it in a way that helps the end user, the person that's going to benefit from it, truly understand it.

Terry: Well said. All right, Bob. Well, today my guest has been Bob Durand. He's the emergency management planner and practice leader for Kaiser Permanente's Northern California region. Bob, thank you so much for joining us today on *Unrestrained*.

Bob: And once again, thank you very much for having me.

Terry: All right. And thank you for listening.