LYNNE CASWELL, LEGISLATIVE ANALYST
ANNA BROOME, SENIOR LEGISLATIVE ANALYST

STATE OF MAINE
ONE HUNDRED THIRTIETH LEGISLATURE
TASK FORCE TO STUDY THE PROCESS FOR BRINGING CRIMINAL CASES IN SITUATIONS OF VIOLENCE AGAINST HEALTH CARE WORKERS

November 10, 2022

Steven R. Michaud, President
Maine Hospital Association
33 Fuller Road
Augusta, ME 04330

Dear President Michaud,

The Task Force to Study the Process for Bringing Criminal Cases in Situations of Violence Against Health Care Workers recently concluded its deliberations pursuant to Resolve 2021, chapter 173. As you know, this study was prompted by the increase in violence experienced by health care workers at the hands of patients and families as the Maine Hospital Association strongly advocated for enactment of the study.

The task force is very grateful to the representatives from MaineHealth and Northern Light Health for providing data on the prevalence of violence against hospital workers within their systems. We also thank Jeff Austin for his assistance in gathering this data for the task force. Data provided to the task force included incidents per month, age of the offender, location of incidents (emergency departments and elsewhere), type of employee and other data points. The task force became aware that there is not currently a systematic or comparable system used for data collection of this type. Standard data would allow for actions and solutions that are grounded in data rather than anecdote.

In response to a unanimous task force recommendation, we are requesting that the Maine Hospital Association coordinates a group of hospital representatives to develop a standard dataset and terminology that is applicable to hospitals. That data should include incidents of violence, near misses (for example, a patient throws a chair but misses the employee), location of the violence within the hospital, type of employee injured, perpetrator (patient or family; age), type of violence, calls to law enforcement and other relevant data. We are asking that you report your progress to the Joint Standing Committee on Health and Human Services in the Maine Legislature on an interim basis by April 1, 2023 and in final form, no later than January 2, 2024. We request that the final report also includes recommendations or suggestions on who the data is reported to and what might be made publicly available. For example, there should be some data that is made public and/or available to the Legislature and other data that is more appropriate for in-house use. If legislation is needed, please include that in your reports.

Thank you for undertaking this work. Our health care workers undertake their work on behalf of serving others and are critical to the health of Maine's people. They deserve to be in a safe working environment.

Please let us know if you have any questions by contacting our staff, Lynne Caswell and Anna Broome (lynne.caswell@legislature.maine.gov and anna.broome@legislature.maine.gov).

Sincerely,

Ned Claxton

Sen. Ned Claxton
Senate Chair

Rep. Anne Perry
House Chair

cc: Task Force members
Jeff Austin, Vice President, Government Affairs & Communication, MHA

Workplace Violence Data Collection Tool Elements

Final Version 12/1/2023

The following data collection tool has been developed by the Maine Hospital Association Workplace Violence Subcommittee to quantify the number of workplace violence incidents occurring in Maine hospitals. The data collection tool has been broken down into two sections: Phase I and Phase II.

Phase I data collection are the essential elements that hospitals should collect from any employee impacted by workplace violence. These are the minimum data that can provide insight into the volume and impact of workplace violence. The collection of the information is critical to developing an appropriate response to violence in hospitals, which may include policy change, advocacy, education, and training.

Phase II data collection are elements that allow hospitals to better understand contributing factors to violence and provides more detailed information around the specifics of the incident including those involved. Phase II data will assist MHA member hospitals in understanding the steps that will be necessary to help prevent future incidents and support victims through the short -term and long-term impact of these events. Phase II data collection would be completed upon further investigation of an initial report. Hospitals may choose to collect this information for each report or select a subset of the total reports to collect additional information.

PHASE I DATA COLLECTION:

Information about Location of Event and Individual Impacted:

- Facility Type [dropdown]
  - Acute Care Hospital
  - Ambulatory Care Center
  - Long Term Care
  - Home/Home Care
  - Skilled Nursing Facility
  - Assisted Living Facility
  - Psychiatric Hospital
  - Other
- Occupational category of person impacted [dropdown]
  - Nurse (RN, LPN)
  - Physician/ Advanced Practice Provider
  - Allied Health/Technologist
  - Rehabilitation/ Therapy Services
  - Case Management/ Social Work

    - Education
    - Administration/Support Services
    - Facilities/ Plant Operations
    - Nutrition
    - Security
    - Other
- Department/office where incident took place.

Incident Report Information:

- Aggressor [dropdown]
    - Patient
    - Visitor
    - Employee (Lateral)
    - Other
- Type of Violence [multi-check option]
    - Physical
    - Verbal
    - Attempted Violence (near miss)
    - Written and/or Digital
- Primary Assault Description [multi-check]
    - Biting
    - Choking
    - Grabbing/Pinching/Scratching/Hair Pull
    - Harassment
    - Kicking/Hitting/Beating
    - Other
    - Posturing
    - Punched
    - Pushing/Shoving
    - Sexual Assault/Rape
    - Shooting
    - Spitting
    - Stabbing
    - Stalking
    - Throwing an Object/Breaking Object
    - Verbal Assault
- Assault Description (Free Text/Description)
- Severity of Assault [dropdown]
    - None- No Contact / Unwanted Contact w/ no injury
    - Mild – Mild Soreness / Abrasions / Scratches / Small Bruises

    - Moderate – Major Soreness / Cuts / Large Bruises
    - Severe – Laceration / Fracture(s) / Head Injury
    - Death or loss of limb
- Emotional and/or Psychological Impact [dropdown]
    - None – No emotional and/or psychological impact
    - Mild – Upset / Angry / Scared / Humiliated
    - Moderate – Moderate emotional and/or psychological impact with no missed work but return to work with modifications.
    - Severe – Significant Emotional and/or psychological impact resulting in missed or inability to return to work, interventions required.
- Response Action Taken [multiple checklist]:
    - No Security or Law Enforcement Called
    - Security Called
    - Law Enforcement Called
    - Police Report Completed
    - Physical restraints used.
    - Chemical Restraint/Medication administered.
    - Seclusion of Patient
    - Pepper Spray Used
    - Handcuffs/Shackles Used
    - De-escalation techniques
    - Emergency Call/Code

PHASE II DATA COLLECTION:

- Job Title of person impacted.
- Years in occupation (not in specific job or at facility) [dropdown]
    - <1year
    - 1-2 years
    - 3-4 years
    - 5-9 years
    - 10-15 years
    - 16-20 years
    - 21-25 years
    - 26-30 years
    - 31+ years

Information about Aggressor:

- Gender of Aggressor [dropdown]
    - Male
    - Female

    - Transgender
    - Non-Binary
    - Other
- Age of Aggressor (in years)
- County of Residence [dropdown]
    - Maine Counties Listed
    - Other

Impact of Violence:

- Emotional and/or Psychological Impact [dropdown]
    - None – No emotional and/or psychological impact
    - Mild – Upset / Angry / Scared / Humiliated
    - Moderate – Moderate emotional and/or psychological impact with no missed work but return to work with modifications.
    - Severe – Significant Emotional and/or psychological impact resulting in missed or inability to return to work, interventions required.

Contributing Factors to Violence:

- Aggressor's length of stay [dropdown]
    - Upon Arrival
    - <24 hours
    - 25-48 hours
    - 2-7 days
    - 7-14 days
    - >2 weeks
- Primary Contributing Factors [multi-check]
    - Abandoned by Guardian
    - Ambulance/Transport Unavailable
    - CCSU Bed Unavailable
    - Community Services Unavailable
    - Crisis Services Unavailable
    - Detox Bed Unavailable
    - Homelessness/Lack of Housing
    - Inpatient Bed Unavailable
    - Jail / Corrections placement unavailable
    - Long Term Care /SNF Bed Unavailable
    - PNMI / Residential Placement Unavailable
    - Psychiatric Bed Unavailable
    - Resource (Foster) Home Placement Unavailable

Maine Hospital Association

MAINE'S LEADING
VOICE FOR HEALTHCARE

December 20, 2023

Dear Senator Baldacci, Representative Meyer, and members of the Joint Standing Committee on Health and Human Services,

The Task Force to Study the Process for Bringing Criminal Cases in Situations of Violence Against Healthcare Workers (the task force) was established by Resolve 2021, Chapter 173 in response to reports that healthcare workers are increasingly the victims of violent incidents in the workplace perpetrated by patients or family members. The task force identified that there is not currently a systematic or comparable system used for data collection, and that standard data documenting the prevalence, type, location, etc., would allow for actions and solutions that are grounded in data rather than anecdote.

In response to a unanimous task force recommendation, the task force formally requested, in a letter dated November 10, 2022, that the Maine Hospital Association (MHA) coordinate a group of hospital representatives to develop a standard dataset and terminology that is applicable to hospitals. Additionally, the task force requested that the final report include recommendations or suggestions on who the data is reported to and what might be made publicly available.

In response to this request, the MHA convened a group of hospital leaders holding an array of backgrounds and experiences creating the MHA Workplace Violence Committee. The members include:

- Leslie Anderson, PT, MSB, Chief Operating Officer, Cary Medical Center
- Denise Needham, PharmD, President, Pen Bay Medical Center and Waldo General Hospital
- Miranda Chadbourne, Care Team Support Manager, Maine Medical Center
- Ashley Pottle, RN, Director Patient Care Services, Redington Fairview General Hospital
- Trisha Bell, R.N., System Director for Emergency Services, Central Maine Healthcare.
- Rick Boudreau, Administrative Director of Operations, MaineGeneral Health.
- Dawn Gilbert, Director, Occupational Medicine/Employee Health, St. Mary's Hospital.
- Janine Raquet, Esq., Legal Counsel, Northern Light Health.

The Committee met on January 30th, February 28th, April 11th, May 23rd, September 26th, and November 28th, 2023.

The Committee, through consensus, produced and approved the following definition of workplace violence, which incorporates two definitions established by Occupation Safety and Health Administration (OSHA) and The Joint Commission with a goal of being broad in its application and garnering full support from all Maine hospitals. The Committee understands that hospitals may wish to expand further on this definition; however, the goal is that this statement would be broadly accepted as a baseline definition of workplace violence for the purposes of reporting and tracking incidents.

The approved definition is as follows:

"Workplace Violence is any act or threat of physical violence, harassment, bullying, intimidation, humiliation, sexual harassment, threatening behaviors that occur at the work site. This includes all behaviors impacting an employee's ability to work at their full potential. Workplace violence includes digital platforms and phone calls. It ranges from threats and verbal abuse to physical assaults and even homicide; concerning clinical and non-clinical staff, patients, or visitors."

Further, the Committee identified the baseline data that should be collected by hospitals following a workplace violence incident. The Workplace Violence Data Collection Tool was developed with input from subcommittee members and MHA Board leaders. Please see a copy of the Data Collection Tool attached to this letter.

The data collection tool has been broken down into two sections: Phase I and Phase II.

- Phase I data collection are the essential elements that hospitals should collect from any employee impacted by workplace violence. These are the minimum data that can provide insight into the volume and impact of workplace violence. The collection of the information is critical to developing an appropriate response to violence in hospitals, which may include policy change, advocacy, education, and training.
- Phase II data collection are elements that allow hospitals to better understand contributing factors to violence and provides more detailed information around the specifics of the incident, including those involved. Phase II data will assist MHA member hospitals in understanding the steps that will be necessary to help prevent future incidents and support victims through the short -term and long-term impact of these events. Phase II data collection would be completed upon further investigation of an initial report. Hospitals may choose to collect this information for each report or select a subset of the total reports to collect additional information.

In anticipation of implementation challenges, the MHA Workplace Violence Subcommittee has also developed a prototype Microsoft Form tool that will provide easy access to a reporting form following an incident. Any employee can scan a QR code, which could be made available in nursing stations and employee break rooms, and within three minutes a person impacted by violence could report the event. The online reporting form will allow hospitals to review and follow up on all reports through an easy-to-understand data summary page. The data summary page can show reporting trends in a graphic form, as well as in a spreadsheet.

In response for a recommendation on who the workplace violence incident data is reported to and what may be made be available, the Maine Hospital Association and its members request that all data collected be provided to the Maine Hospital Association for housing. The MHA would publish an annual report, at a minimum, with aggregate hospital data on workplace violence. Should additional, specific information be needed for policy purposes, the MHA will be happy to work with you.

In closing, this standardization will not only allow hospitals to better understand the prevalence of workplace violence, but also the physical, social, and emotional circumstances that impact these events, which in turn should support and strengthen ongoing training, mitigation, and response efforts.

Please let us know if you have any questions by contacting Sally Weiss, V.P., Workforce Policy and Strategic Initiatives at MHA (sweiss@themha.org).

Sincerely,

Steven Michaud
President