Suggested Recommendations

Hospital Violence Task Force

At the outset, we want to thank everyone for taking time out of your busy lives to focus on this issue. It is one of the most pressing issues facing healthcare broadly and hospitals in particular. Thank you.

A second comment we want to make is that we want everyone to be clear that violence is not a mental health issue. The violence our members experience is committed by the full range of people who come through our doors, not just those with a behavioral health issue. The reason so much focus has been on that issue is the additional considerations that both health care providers and the criminal justice system offer to those with behavioral health issues who commit acts of violence.

Please accept the following as recommendations from the four hospital representatives for the Task Force to consider.

I: Statutory Changes

A. The Felony Issue. Given the Task Force conversation, it appeared that a consensus was supportive of a facility-based statute where the location of the assault is the primary variable.

1. Framework. Here is the framework for how the felony issue could be approached.

Keep the existing statue (in order to protect EMTs in the field) and enact a new, distinct statute that makes it a felony to commit an assault against:

i. **any worker** (*not just health care personnel – if you want to cover the security personnel, the janitor, administrative staff*)
ii. **at any time** (*not just during the provision of emergency care – if you want to cover situations where the patient is residing in a hospital and not in an emergency situation*)
iii. **at specified facilities**
    a. All health care facilities and PNMIs and long-term care facilities, or,
    b. Entire hospitals campus only, or,
    c. Hospital emergency rooms only,
    d. Other

Obviously, you could tinker with each of these three variables in any number of ways.

2. Our Recommendation. The hospital recommendation is for a broad felony statute:

§208-F. Assault in licensed health care facilities

1. *A person is guilty of assault in a health care facility if:*

A. He intentionally, knowingly or recklessly causes bodily injury to health care facility personnel while the personnel is in a health care facility;

2. For purposes of this section, "Health care facility" means a facility, institution or entity that offers health care to persons in this State, including a hospital, health center, urgent care center, medical office, nursing home, private non-medical institution or other long-term care facility.

3. Assault in a health care facility is a Class C crime.

B. Other Statutory Changes

1. Expand Warrantless Arrest Statute to Cover Misdemeanor Assaults at Health Care Facilities.

Our understanding is that law enforcement may not arrest a person for a misdemeanor assault without law enforcement either obtaining a warrant from a court or witnessing the assault in person. As such, law enforcement may not remove a patient from the hospital if they have assaulted staff and it is a misdemeanor. (We also understand that currently there are other factors limiting arrest, such as fully occupied jails.) Persons committing a felony assault may be arrested without these two pre-conditions.

To the extent changes are not enacted pursuant to the felony proposals discussed above, the Criminal Justice Committee should review a proposal to expand Maine's warrantless arrest statute (17-A MRSA §15) to cover assaults that occur in hospital emergency rooms.

2. Direct the Criminal Law Advisory Commission to Review Section 38 (Mental Abnormality).

The task force briefly discussed the medical approach to assessing the state-of-mind of a patient and the criminal justice approach to the state-of-mind of a perpetrator. It is still a bit unclear to us as to how big a gap there is between the two approaches and exactly what the differences are.

However, even if a defendant is able to form the requisite mental state of acting intentionally, knowingly or recklessly, a primary way they can defeat an assault charge is through the affirmative defense of "mental abnormality" provided by Maine law.

The task force really did not explore this statute at all. The existing statute is quite short, old and has no definitions. It reads, in part:

§38. Mental abnormality

Evidence of an abnormal condition of the mind may raise a reasonable doubt as to the existence of a required culpable state of mind.

[Note: We excluded a second paragraph that was added to the statute in 2019 that states that gender identity issues are not evidence of an abnormal condition.]

There is some fairly extensive case law on this statute that adds guidance to law enforcement and DAs as to what this means.

We believe it is time for the legislature to possibly revisit this provision given the lack of statutory guidance, and even the outdated terminology. The Legislature should direct CLAC to review this statute and invite stakeholders (medical personnel, disability advocates) to participate and report back on whether they have recommendations for changes.

C. Explain the Need for Change. Whatever changes are ultimately recommended, it will be important for the Task Force report to describe the reasons for recommending changes. We believe the reasons are as follows and would like them included in the report:

1. Current law is unclear and leads to different interpretations. It is unclear what constitutes "providing emergency medical care" under the current statute. Does it cover non-medical functions that are still required to care for patients in the emergency department – e.g. food and cleaning service? For example, security personnel are enduring some of the worst violence, however they may not be covered by existing law. Is a security officer engaged in "providing emergency care" response under the statute? Some Task Force members felt non-clinical hospital personnel could never be providing an emergency response. Others disagreed
2. Current misdemeanor law is not rational for assault cases against hospital workers. Due to the nature of hospital emergency rooms, many assaults are simply not reported because prosecution is inappropriate (the perpetrator clearly lacks the capacity to understand what they are doing). When staff are victimized by someone with capacity, it is important to impose punishment. However, these "simple assault" cases can often require extra effort (expert witnesses) due to the mental illness issue.
3. Current felony cases are not resulting in significant jail time anyway. While the felony statute allows imprisonment for up to 1 year, the vast majority of imposed sentences are far below this amount (see handout from Judge Robinson).
4. Misdemeanors don't allow for meaningful plea bargains. ADA Trainor conveyed that plea bargains are an important part of the system and its easier to get results if a felony is possible. While not discussed much at the Task Force, we as health care providers want to encourage plea bargains that involve receiving care (counselling, medication management) as a condition of the plea bargain process. While some of the perpetrators belong in jail, many just need to get better and more consistent care and the plea bargain process can facilitate that.
5. The severity of the problem calls for a new response. The simple fact that 70% of workplace violence is committed against healthcare workers (not just hospitals) calls for a new approach. Furthermore, the Task Force received testimony that some perpetrators understand that arrest and prosecution is unlikely due to their behavioral health status and these individuals feel emboldened to act aggressively.

II: The Task Force Report Should Highlight "Best Practices."

The Legislature is limited in its ability to mandate others to exercise their discretion or do their job in a particular way. However, the Task Force Report can highlight best practices and direct [someone] to promote these best practices.

A. Highlight the Augusta PD Protocol in Submitting Charges to the DA

Our understanding is that Augusta PD has a protocol of submitting assault charges to the Kennebec DA in virtually all situations where the local hospital has requested them (knowing that the local hospital self-censors and does not request charges in a high number of assault situations, including when the patient's condition indicates they do not have the requisite culpable mental state). The report should describe this protocol and highlight it as a best practice.

Our understanding is that Augusta PD charges all assault cases as misdemeanors, even some that may qualify as felonies under our currently ambiguous felony statute. The protocol, again as we understand it, is that Kennebec DA then looks at the facts and the law and determines whether or not to increase the assault charge to a felony.

While we understand the rational for that process, we have a concern with the potential for "undercharging" in these cases at the time the police are called. Our primary concern is that there are barriers to law enforcement arresting an individual who commits a misdemeanor assault. There are times where immediate removal from the emergency room by law enforcement is essential and felony charges allow for immediate arrest and removal. (If the legislature would expand the "warrantless arrest" statute, this concern of ours could be mollified.)

We greatly appreciate the aspect of the Augusta PD protocol that involves the submission of charges in all assault cases to the DA and let the DA apply their expertise to sort out the appropriate path forward. However, we would like to recommend that local PD at least consider the applicability of the felony statute at the time they are called as a best practice for purposes of immediate arrest and removal.

If the felony statute is amended as we recommend, it may be much easier for local law enforcement to feel comfortable applying the law in the moment and determine that a felony likely occurred.

The report should also recommend that law enforcement not discourage victims from filing complaints because "*nothing will happen*." If no prosecution results from a complaint, so be it. Victims should be heard and supported and not discouraged by law enforcement from filing a complaint.

Finally, the Task Force should recommend that law enforcement counsel hospital victims of violence that they may use the hospital contact information (hospital address and phone number) rather than personal contact information, when filing a complaint form with the police, if they are concerned about their safety. Hospitals should be recommended to create a point of contact for law

enforcement and prosecutors who need to communicate with victims and witnesses as cases move forward.

B. Highlight the Kennebec DA Protocol of Communication with the Local Hospital

Our understanding is that the Kennebec DAs Office communicates with their local hospital on a set schedule to provide the hospital with status updates on the charges that were filed with that office. The purpose of the meeting, as we understand it, is not to influence the course of the prosecutorial review, but simply to 'close a feedback loop' that enables the hospital to know what is going on and show hospital staff that the DA is actively considering these charges. Such communication is more helpful to hospitals than you may think. Assaults on hospital staff are traumatic and exhausting to respond to; knowing that complaints are reviewed and considered carefully, and prosecuted where appropriate, provides victims and staff closure.

We believe it is important to highlight in the report, by contrast, the written response of the Ellsworth PD regarding prosecutions in that county that was provided to the Task Force. In response to questions posed by this Task Force, the Ellsworth PD wrote, "*Our DA's office has been clear that they will not pursue criminal charges for assault on hospital staff if the patient suffers from mental illness and in most cases if there is no actual physical injury*."

C. Hospital Best Practices

Hospitals must support local police departments and District Attorneys by providing documentation of the events that lead to the assault, including physician assessments of the mental state of the patient. Specifically, hospitals should be encouraged to have the clinical team document when they believe a patient who committed an assault has the mental state to be potentially criminally responsible for his or her actions, as well as whether the patient has medical clearance to be transferred to a jail. Medical confidentiality laws should not be a barrier to providers sharing this information with police and prosecutors in a timely manner. Augusta PD also indicated the need for getting medical clearance information to be able to remove a patient from a healthcare setting and take them into custody. There may be a "best practice" medical clearance form that could be shared.

III. Financial Considerations

Some conversations focused on the possible need for financial resources.

A. Direct DHHS to Explore Four Financial Proposals.

1. <u>"Bed Hold" Payments for PNMIs.</u> When a PNMI resident enters a hospital, there is a possible negative financial impact for the PNMI until that resident returns. Depending on the length of the absence, financial pressure can mount to fill that empty bed. A bed hold payment might be useful in mitigating that pressure.
2. <u>Days Awaiting Placement Payment for Hospitals.</u> The corollary to a bed hold payment is that hospitals are frequently not paid for providing services to that PNMI resident while in the ED. Many of the individuals who are violent do not need hospital-level care but get "stuck" in the hospital because there is no safe disposition plan. Medicaid does not pay anything to the hospitals for extended 'residential' stays in the hospital emergency room until a proper placement is found.

If PNMIs should be paid for empty beds, hospitals should be reimbursed for beds occupied by individuals who should be receiving alternative levels of care but who are stuck in the emergency room for which no reimbursement is made today.

3. Cost Reimbursement for PNMI Security-related Expenses. DHHS should explore development of a rule that allows for "cost-based" reimbursement for a limited set of security and staffing related expenses at PNMIs. For example, the Task Force was presented with the concept of bolted-down furniture as a security feature. We understand that some PNMI rules now allow for additional negotiated reimbursements, but a set schedule of cost-based reimbursed enhancements might make this process easier.
4. Cost Reimbursement for Hospital Security. Most Medicaid reimbursement for hospital emergency room services are set at 72% of the cost of the service by rule (the current MaineCare reimbursement rate for emergency room services is 83.7% of the Medicare rate; the average Medicare rate for emergency room services is approximately 86% of cost). DHHS should explore allowing a cost-reimbursement for security services, including employed security, contracted security, and physical plant (e.g., cameras) in the emergency room and report back to the HHS Committee.

IV. Data / Further Research

There was a fair amount of discussion about one of the 'root causes' of violence, namely, patients who are brought to a hospital emergency department who need other services (often PNMI-level residential services). Following are our suggestions on this topic.

A. Direct DHHS to Collect and Report Data on "Emergency Discharges" from PNMIs.

DHHS, Division of Licensing and Regulatory Services described the ability of residential care facilities to discharge their residents on an emergency basis in its memo dated 9/6/22 and presented at the second meeting. We need to know more about how many of these discharges occur, the emergency reason for the discharge, from which PNMIs they are being discharged, and most importantly, what level of services or supports they need that the PNMI cannot provide.

B. Direct DHHS to Explore Whether the PNMI(E) regulatory oversight can be extended to other PNMIs.

Much of the DHHS 9/6 memo provided at the second meeting described PNMI(E) regulatory oversight. Our understanding is that the PNMI(E) residents are adults with severe and persistent mental illness who are subject to the terms of the AMHI consent decree. Accordingly, the regulatory requirements for these individuals developed differently than for the other PNMIs. For example, it is our understanding that PNMI(E) providers cannot discharge residents without a safe disposition plan that is approved by DHHS. However, there would appear to be no reason that the PNMI(E) regulations, which many believe is the most robust, could not be extended to other PNMIs. It is possible that there are other related factors, such as the reimbursement structure for PNMI(E) facilities that need to be considered. DHHS should report-back its findings to HHS Committee.

C. Direct DHHS to Resolve the PNMI Referral Questions Raised by Community Providers.
Representatives of community providers expressed concern that not enough information was being provided to their members to fully or accurately assess the individuals who are referred to them for services. This concern should be fully explored and resolved and DHHS should report back to the HHS Committee their findings.

D. PNMIs Should Have an Obligation to Catalogue All Violent Incidents.
Hospitals have an existing state regulatory obligation to catalogue all incidence of violence that occur in their facilities. It is for that reason that the two health systems were able to provide detailed data on incidents at the first meeting. It became clear during the second meeting that all PNMIs are not collecting this data. (The statement from AAMHS was that: "*There is currently no tracking mechanism for this data across the field. Most individual agencies do not track this data in a formal way*.") They should be directed to do so. We don't recommend that the data be reported to any third party, such as DHHS, at this time because there is no clear regulatory use for that data. But policymakers may request this information from time to time – for example, for task force purposes such as ours - and it should be available.

E. Request MHA Help Hospitals Standardize Hospital Violence Collection Data
Hospitals are obligated to collect and catalogue data under two regulatory standards, state law and accreditation. It appears that not all hospitals may be using entirely consistent reporting criteria and definitions. The Governor should ask the MHA to convene a hospital work group to develop standardized terms and report back to DHHS on that work.

F. Request a that DHHS Review Staffing Needs at PNMIs to Address Residents who Display Aggressive Behavior
PNMIs stated that they do not have adequate resources to "staff up" when a resident needs additional support to address safety. DHHS should undertake a review of its payment policies to ensure that funds are available to meet immediate staffing needs and thus prevent hospitals EDs from becoming holding facilities for individuals who do not need hospital-level care, but do need secure living arrangements.

G. Require that DHHS Develop a Secure Residential Treatment Facility for Children
The Office of Child and Family Services noted the need for a secure residential treatment facility in its most recent plan. To date, we are not aware that any progress has been made. Such a facility is desperately needed to better serve children who have aggressive behaviors and are currently getting stuck in our hospitals – and often assaulting our workers and creating damage to the facilities. They are in the wrong setting, and the Department must address this gap in care immediately.

Conclusion

We understand that not all of these issues were discussed at the last meeting, but our hope is you can consider these for review at the final meeting. These are important issues to us. Thank you.