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Task Force to Study the Process for Bringing Criminal Cases in Situations of Violence Against Health Care Workers

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Task Force to Study the Process for Bringing Criminal Cases in Situations of Violence Against Health Care Workers

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Executive Summary

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 health care workers are increasingly the victims of violent incidents in the workplace perpetrated by patients or family members. The duty of the task force, as established in the resolve, was to review the process by which criminal cases may be brought related to incidents of violence in hospitals and other health care facilities and settings, in particular, incidents of violence involving patients or individuals related to patients assaulting hospital or medical staff. The task force recognizes that many of the perpetrators of violence against health care workers cannot be charged with a crime due to the absence of the state of mind necessary for criminal prosecution. There is no intent to criminalize behaviors that are driven by a medical condition that prevents comprehension.

The task force consisted of 13 members, four appointed by President of the Senate, five appointed by the Speaker of the House and four appointed by the Chief Justice of the Supreme Judicial Court. The task force held four meetings in the 2022 interim on the following dates: August 3rd, September 13th, September 27th, and October 13th. The meetings were hybrid meetings with some members attending in-person and others using Zoom. The meetings were open to the public for in-person attendance or viewing through the legislative live stream. Public testimony was accepted at the September 27th meeting and accepted, in writing, at any time. All the materials are on the task force website and videos of the meetings are available on the legislature's website.

Pursuant to the resolve, this report, with its findings, recommendations and suggested legislation, is provided to the Joint Standing Committee on Criminal Justice and Public Safety. The task force agreed to also share this report with the Joint Standing Committee on Health and Human Services as a number of the recommendations relate to health and human services even though that committee lacks authority to report out legislation pursuant to the study. The task force presents the following unanimous recommendations.

Criminal Code

Maine's criminal code, Title 17-A §752-C, includes an enhanced penalty for assault of an "emergency medical care provider" when that person is "providing emergency medical care". The task force determined that the scope is too limited to be an effective deterrent to violence against health care workers.

> **Recommendation:** Amend Title 17-A to include the enhanced penalty for physical assault to any person working in a hospital emergency department regardless of whether the person is providing emergency care or is an emergency medical care provider.

Prosecutors, in certain circumstances, can choose to elevate a crime so that a conviction results in a more serious penalty. The statute specifically lists the chapters and sections of the criminal code that may be elevated.

Recommendation: Amend 17-A MRSA §1604, sub-§5 to allow the penalty for conviction under the new crime of physical assault on a person working in a hospital emergency department to be elevated.

The report includes suggested legislation to implement these recommendations.

Patients Awaiting Placement

The task force identified the shortage of services, both residential and community, and in all areas including long term care, intellectual disability and autism, and behavioral health, as a primary root cause of the number of individuals stuck in hospital emergency departments. These individuals remain in the emergency department after they no longer need emergency medical treatment and lack the appropriate therapeutic environment for effective treatment. Such extended stays in emergency departments contribute to incidents of violence against hospital personnel. Although violence as a response is not appropriate or justified, it is nevertheless partly a response to the increasing frustration and shortages of services. Placements for children with behavioral health diagnoses in residential facilities with specialized services, can be particularly difficult to locate. The Department of Health and Human Services has been working on developing a secure residential treatment facility for children (Qualified Residential Treatment Programs) and the task force indicated that establishing such a facility is a high priority.

Recommendation: That the Department of Health and Human Services increase the supply of appropriate placements, both residential and community, including secure facilities.

MaineCare Reimbursement

The Department of Health and Human Services has been establishing and undergoing a rate system review process for MaineCare reimbursement rates to allow for regular updating of rates across the spectrum of MaineCare. The task force is concerned that the process does not take into account some aspects of rates that have contributed to the difficulty of placing patients/residents with co-occurring conditions.

Recommendation: That the Department of Health and Human Services broaden its MaineCare rate review process to include the following: increased or new reimbursement for bed hold days for residential facilities; days awaiting placement payments to hospitals for all MaineCare eligible individuals; behavioral add-ons; and security costs.

The task force sent a letter to the Department of Health and Human Services requesting consideration of this recommendation.

Data Standardization and Collection

Large hospital systems currently collect data within their organizations on the incidents of violence against employees although the data collected is not always comparable. There is no formal process for data collection for incidents of violence against front line staff by providers of health care services other than hospitals. Task force members believe it would be useful to have standard data that is comparable over time, between facilities and, to some extent, between types of providers.

> **Recommendation:** That a process to standardize the collection and the data for incidents of violence against health care workers be established.

The task force sent two letters to take action on this recommendation. One letter requested that the Maine Hospital Association coordinate a process of gathering a group of hospital representatives to develop a standard dataset and universal terminology that is applicable to hospitals including incidents of violence, near misses (e.g. a patient throws a chair but misses the staff member), location of the violence, type of employee, perpetrator (patient or family), calls to law enforcement and other data. The second letter requested the Department of Health and Human Services convene a group of providers, other than hospitals, to develop a similar kind of process to that undertaken by the MHA. Both letters requested an interim report due April 1, 2023 and a final report due January 2, 2024 to the Joint Standing Committee on Health and Human Services.

Law Enforcement Training

Responding to calls to investigate violence in a hospital emergency department presents unique challenges for law enforcement officers. The task force recommends adding training specific to that setting.

> **Recommendation:** That the Maine Criminal Justice Academy develops and offers training to law enforcement officers that increases their ability to investigate crimes against health care workers, particularly those that occur in hospital emergency departments.

Coordination Between Law Enforcement Officers, Health Care Providers, and Prosecutors

In areas of the state where law enforcement, health care providers and district attorneys have established a good working relationship, there is less frustration with the process and outcomes when a health care worker is a victim of violence in the workplace. In that light, the task force makes the following recommendations:

> **Recommendation**: That health care providers have a point of contact responsible to communicate with and among the victim/employee, law enforcement, district attorney's office and others involved after a violent incident in the workplace.

Recommendation: That health care providers provide staff with a work address and telephone number they may give to law enforcement and prosecutors if they do not want to disclose their personal contact information.

Recommendation: That health care providers communicate to victims/employees the privacy protections available to certain victims under 17-A MRSA §2108, sub-§4.

Recommendation: That the district attorney's office communicates with the victim and the employer's point of contact if the victim provides written consent, on a regular basis with updates on the investigation, the criminal complaint process and the outcome.

Generally, health care providers and staff are not experts in law enforcement or prosecution of crime but they are often called upon to assist law enforcement with its investigation and assist the prosecution with filing charges. The task force agreed that some sort of guidance, check list or tool be shared with providers and staff to be able to better respond after a violent incident.

Recommendation: That in the event law enforcement officers are called in response to a violent incident, the following is necessary in order to issue a summons or make an arrest:

- A statement from a qualified medical professional about the perpetrator's state of mind (who, what, when, where, how, before, during and after);
- Detailed statements from witnesses (cooperating victim not required);
- Any video or audio recordings of the incident;
- In case of arrest, medical clearance articulating that the perpetrator is mentally and physically fit for incarceration; and
- A willingness on the part of the local jail to accept the person in question.

Maine Hospital Association Work With Its Members

The Maine Hospital Association offered to follow up with its members on a number of suggestions identified by the task force. There are no further actions recommended but they are included to present a complete record of the task force's work.

Recommendation: That the Maine Hospital Association take action on the following items:

- Request an invitation to the regular meetings between the district attorneys and the Office of the Attorney General to discuss ways these parties may work together to stem the tide of violence in the health care workplace.
- Encourage its members to reach out to their local district attorney and law enforcement office to start a similar dialogue.

HIPAA

The federal Health Insurance Portability and Accountability Act (HIPAA) and state privacy laws permit a covered entity to disclose protected health information to a law enforcement officer, without authorization from the patient. The covered entity may disclose information that it believes in good faith constitutes evidence of criminal conduct that occurred on the premises of the covered entity. Despite this express exception, health care providers and organizations are generally reluctant to disclose protected health information without authorization from the patient.

Recommendation: That the Maine Hospital Association either educate or encourage its member organizations to educate their health care providers on the disclosures allowed by HIPAA and Maine privacy statutes when a patient assaults or threatens a health care worker.

I. INTRODUCTION

During the Second Regular Session of the 130th Legislature, LD 629 was enacted as Resolve 2021, chapter 173, Resolve, To Establish the Task Force to Study the Process for Bringing Criminal Cases in Situations of Violence Against Healthcare Workers. The Task Force to Study the Process for Bringing Criminal Cases in Situations of Violence Against Healthcare Workers (the task force) was charged with reviewing the process by which criminal cases may be brought relating to incidents of violence in hospitals and other health care facilities and settings, particularly incidents involving patients or individuals related to patients assaulting hospital or medical staff. A report, with findings, recommendations and suggested legislation, is due from the task force to the Joint Standing Committee on Criminal Justice and Public Safety. That committee is authorized to report out legislation in response to the report during the First Regular Session of the 131st Legislature. Resolve 2021, chapter 173 is contained in Appendix A.

The task force consisted of 13 members, four appointed by President of the Senate, five appointed by the Speak of the House and four appointed by the Chief Justice of the Supreme Judicial Court. The list of task force members is contained in Appendix B.

The task force held four meetings on the following dates: August 3rd, September 13th, September 27th and October 13th. All meetings were open to the public for in-person attendance or viewing via the legislature's live stream. Public testimony was accepted at the September 27th meeting. Written testimony was accepted at any time and posted. Recommendations were discussed at the September 27th meeting and finalized at the October 13th meeting.

The meeting agendas are contained in Appendix C. Videos of the meetings may be viewed at https://legislature.maine.gov/audio/#209. The task force website,[1] maintained by the Office of Policy and Legal Analysis, contains all written materials presented or distributed to the task force.

II. BACKGROUND INFORMATION

Most states have enhanced penalties for assault against certain categories of professionals with the most common being law enforcement personnel. According to the National Conference on State Legislatures, approximately half of the states have enhanced penalties for assault against various categories of workers in health care industries, using various terms including health care workers, medical personnel, health care providers, medical professionals, health services personnel, health care professionals, and hospital personnel.[2] Maine enacted enhanced penalties for assaults against emergency medical personnel providing emergency medical treatment in 1997. There have been several bills since 1997 introduced in the Maine State Legislature intended to broaden the scope of the law to cover additional categories of health care professionals; none of those bills have been enacted. It is in this context that the task force performed its duties.

[1] https://legislature.maine.gov/process-for-bringing-criminal-cases-in-situations-of-violence-against-health-care-workers-task-force

[2] National Conference of State Legislatures (2017), "Enhanced Penalties for Assault on Specified Personnel." Available on the task force website at https://legislature.maine.gov/doc/8715

National Data

Over the past few years, national organizations representing healthcare organizations and persons working in health care have been reporting an increase in violence against health care workers. For example, the Joint Commission issued a Sentinel Event Alert in 2018[3] citing the Occupational Safety and Health Administration (OSHA) finding that approximately 75% of nearly 25,000 workplace assaults reported annually occur in health care and social service settings and workers in health care settings are four times more likely to be victimized than workers in private industry.[4] The Sentinel Event Alert also stated that according to the National Crime Victimization Survey, health care workers have a 20 percent higher chance of being the victim of workplace violence than other workers.[5]

Similarly, the United States Bureau of Labor Statistics published data that shows that violence-related injuries are four times more likely to cause health care workers to need time off from work than other kinds of injuries.[6]

More recently, the American College of Emergency Physicians published the results of its August 2022 survey of emergency physicians.[7] The survey showed the following:

- 85% of emergency physicians believe the rate of violence experienced in emergency departments has increased over the past five years, with 45% indicating it has greatly increased;
- Two-thirds of emergency physicians report being assaulted in the past year alone;
- One-third of emergency physicians who were assaulted resulted in an injury, an increase of 6% since 2018;
- The number of emergency physicians who missed part of or their entire shift due to an assault has increased by 50% since 2018;
- Assaults are on the rise with nearly a quarter (24%) of emergency physicians reporting being assaulted multiple times a week (up from 8% in 2018); and
- Emergency physicians reported that patients committed nearly all assaults (98%).

[3] Physical and verbal violence against health care workers, Sentinel Event Alert, The Joint Commission, Issue 59, April 17, 2018 (https://www.jointcommission.org/resources/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-59-physical-and-verbal-violence-against-health-care-workers/#.Y2QGynZKiUk)

[4] Id., citing Occupational Safety and Health Administration. Guidelines for preventing workplace violence for healthcare and social service workers. (OSHA, 3148-04R). Washington, DC: OSHA, 2015

[5] Id., citing Harrell E. Workplace violence, 1993-2009. Washington, DC: Department of Justice, Bureau of Justice Statistics, National Crime Victimization Survey, 2011.

[6] Id., citing United States Department of Labor. Census of Fatal Occupational Injuries (CFOI) – current and revised date. Washington, DC: Bureau of Labor Statistics, 2014.

[7] American College of Emergency Physicians 2022 Survey (https://www.emergencyphysicians.org/article/er101/poll-ed-violence-is-on-the-rise)

Maine Workers Compensation Claims in Health Care Settings

Maine Department of Labor

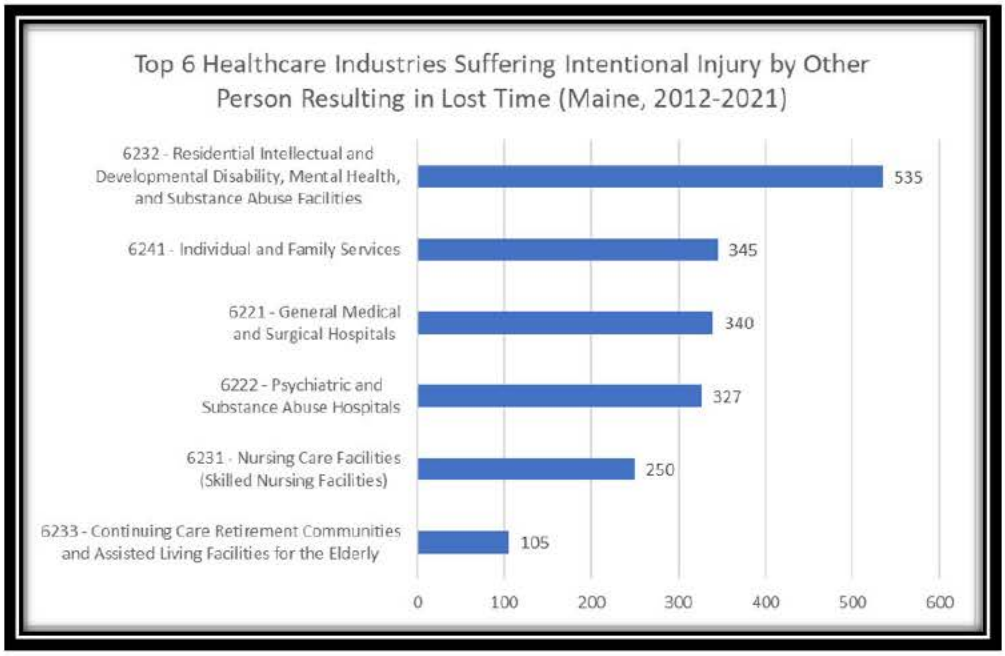
Maine law requires private and public sector employers to complete and submit to the Maine's Workers' Compensation Board the "First Report of Injury" form within seven days of an employer receiving notice or knowledge of an injury to an employee arising out of, and in the course of, the employee's employment that has caused the employee to lose a day's work (referred to as "lost time").[8] The Workers' Compensation Board submits these claim forms to the Maine Department of Labor (MDOL), Bureau of Labor Standards which uses the U.S. Bureau of Labor Statistics' Survey of Occupational Injury and Illness program to produce and report statistics from these claims. The MDOL publishes the data on work related injuries, illnesses and fatalities on an interactive data dashboard.[9]

At the August 3rd meeting, the MDOL, Bureau of Labor Statistics presented statistics to the task force drawn from the lost time claims submitted by private sector employers for the 10 year span of 2012 – 2021. The following data and conclusions are derived from the information and charts presented to the task force and included in the MDOL report submitted to the task force and attached as Appendix D.[10]

- During this 10-year period, there were 3,091 claims filed across all industries for lost time due to intentional injury by another person ("intentional injury lost time claim"). Of these, 69% (n = 2,140) were submitted by employees in the public and private sectors of the healthcare and social assistance industry.
- An intentional injury lost time claim is the fifth most common claim filed by an employee in the healthcare and social assistance industry. By contrast, in the public administration industry, which includes police officers and prison wardens, intentional injury is the 13th most common reason for a claim.
- Approximately 70% of intentional injury claims filed by a healthcare and social assistance employee were perpetrated by a health care patient. The vast majority of these claims are due to hitting, kicking, beating or shoving.
- No correlation was found between COVID-19 hospitalizations in Maine and the intentional injury lost time claims filed by the healthcare and social assistance industry between 2020 and 2022.
- The MDOL suggested that the slight upward trend in the number of intentional injury lost time claims filed by healthcare and social assistance employees could be explained by an increase in total employment in Maine's healthcare industry.

[8] https://legislature.maine.gov/statutes/39-A/title39-Asec303.html
[9] https://www.maine.gov/labor/labor_stats/workinjuries.html
[10] The MDOL report may also be accessed at https://legislature.maine.gov/doc/8751

- The chart below, from page six of Appendix D, identifies the top six healthcare and social assistance industries experiencing intentional injury lost time claims.



- The overall lost time claims for healthcare and social assistance workers follows a frequent pattern seen across most industries: low injuries to teens; a sharp increase with a maximum in the mid to late 20s; a decrease through the 30s; and a rise again and ultimate peak in the early to mid-50s. Intentional injury lost time claims for healthcare and social assistance workers did not follow this pattern. The age group with the highest number of intentional injury claims was not employees over age 50, but employees between the ages of 20-24 (n = 417) with the number of claims decreasing in each subsequent age group (employees between the ages of 25-29 filed 357 claims and those between the ages of 30-34 filed 288 claims). The MDOL suggested several reasons for this difference, including lack of training or experience with assessing and responding to patients who show signs of hostility or violence by younger workers.

<u>Riverview Psychiatric Center and Dorothea Dix Psychiatric Center</u>

The Department of Health and Human Services (DHHS) submitted the following data to the task force. This data, collected monthly through July 2022, shows the number of lost time claims filed by staff injured as a result of intentional and unintentional patient behavior.

Riverview Psychiatric Center

Year	2020	2021	2022
Total	28	36	8

Dorothea Dix Psychiatric Center

Year	2020	2021	2022
Total	7	11	9

Incidents of Violence Reported by Health Care Providers

The task force requested and received information from a variety of healthcare providers. This data includes intentional injury lost time claims as well as employee reports of disruptive behavior events including verbal and physical acts of aggression that do not result in bodily harm or lost time.

Maine Hospital Systems

Northern Light Health (NLH) and MaineHealth provided testimony and written information on the prevalence of violence within Maine's hospital systems, including the following:

- The number of violent incidents reflected in the data is significantly higher than the number of lost time claims shared by the MDOL because the majority of violent incidents in a health care setting does not result in lost time;
- The number of violent incidents has increased over time;[11]
- NLH averaged 70 patient disruptive behavior incidents per month during the preceding 16 months with a high in 2021 of 800;[12]
- MaineHealth averaged 73 incidents of physical or verbal assault each month from November 1, 2020 and April 30, 2022;[13]
- According to NLH data, 99% of the offenders were patients;[14]
- Aggressive behavior is seen in both adult and pediatric (under age 18) patients;[15] and
- Repeated aggressive behavior in an emergency department is most common among patients under age 17.[16]

Anecdotal evidence was also shared with the task force that suggests a connection between the number and severity of violent incidents and those persons in the emergency department waiting for placement in a residential setting.

Other Health Care Providers

There is a general perception from anecdotal evidence that incidents of violence against health care workers has increased in facilities other than hospitals although there is no formal collection or tracking of data. At the task force's September 13th meeting, organizations representing providers of services and some larger service providers were asked for any available data on incidents of violence against front line staff. The task force heard from the Maine Health Care Association, providers of nursing facilities and assisted living facilities, the Maine Association for Community Service Providers (MACSP), providers of services to individuals with intellectual disabilities, autism and brain injury, the Alliance for Addiction and Mental Health Services (Alliance) and the Behavioral Health Community Collaborative.

[11] NLH Workplace Safety report, p. 5. https://legislature.maine.gov/doc/8749
[12] NLH report, p. 3
[13] MaineHealth Report, p. 5. https://legislature.maine.gov/doc/8750
[14] NLH report, p. 2
[15] NLH report, p. 5
[16] NLH report, p. 6

Nursing facilities and assisted living facilities did not have data to share with the task force but they did share that incident reports are completed and used to see if there was a teachable moment involved, reports are forwarded to a safety committee to look at trends, and facilities stressed the importance of de-escalation training.

Behavioral health providers, as represented by Alliance Executive Director, Malory Shaughnessy, are seeing increases in incidents against direct care workers in residential facilities as well as increases of client against client violence. Betsy Sweet from the Behavioral Health Community Collaborative told the task force that one provider, Shalom House, had one violent incident requiring law enforcement in the decade prior to 2017 but there were six incidents requiring law enforcement between 2017 and 2022. In response to increasing incidents, Shalom House hired security. Both presenters also commented that acuity had increased, residential and community services were in increasingly short supply, and violent incidents are stressful for all involved – hospitals, providers, staff, clients/patients, and families.

Jennifer Putnam, Executive Director of Waban Projects, a provider of 19 group homes as well as medical management services for individuals with intellectual disabilities or autism told the task force that violence towards direct care workers is viewed through a lens of client frustration and an inability to communicate. Workers have an annual requirement to participate in de-escalation training. Ms. Putnam stated that anecdotally, crisis and emergency services are called more frequently than before, generally due to the challenges of staffing shortages. She stated that a particular challenge for staff of group homes is that crisis beds for the intellectual disability population are full for months at a time.

Regulatory Structure and Compliance

Hospitals and other health care facilities including residential and community services are governed by a plethora of federal and state laws, regulations, and licensing requirements, as well as accrediting organizations. Many of these are patient-focused but the following apply to keeping staff safe, including from violence.

General Duty Clause

The Occupational and Safety Health Act of 1970 requires employers to protect employees from workplace violence under the "general duty clause" in 29 U.S.C. §645(a).[17] This federal law states that "[e]ach employer – (1) shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees." The Occupational and Safety Health Administration also issues advisory guidelines, specific to health care and social service workers, for preventing workplace violence. These guidelines apply to hospitals, residential treatment facilities, clinics, mental health centers, group homes, and field work settings and they were most recently updated in 2016.[18]

[17] https://www.govinfo.gov/app/details/USCODE-2010-title29/USCODE-2010-title29-chap15-sec654
[18] https://www.osha.gov/sites/default/files/publications/osha3148.pdf

The Joint Commission

The Joint Commission (TJC) is an organization that accredits health care organizations including acute care and critical access hospitals, nursing homes and other organizations. Accreditation from TJC is recognized in Maine for the purposes of licensing. The Joint Commission also issues standards that apply to all TJC-accredited hospitals and critical access hospitals to prevent workplace violence. New standards became effective January 1, 2022.[19] These new violence prevention standards are a response to rising incidents of violence against health care and social service workers. Accredited hospitals must adopt systems that include leadership oversight, policies and procedures, reporting systems, data collection and analysis, post-incident strategies, training, and education to decrease workplace violence. Katie Fullam Harris, from MaineHealth, pointed out to the task force that TJC defines workplace violence more broadly than physical violence and includes, for example, verbal aggression, threatening and bullying.[20]

Hospital Safety Plans

The Maine Department of Health and Human Services (DHHS) licensing requirements for hospitals are contained in Chapter 405 of Title 22 of the Maine Revised Statutes and in department rules. In general, hospital and nursing facility licensing requirements are focused on the rights of a patient or client to receive care in a safe setting and remain free from harm by staff or other patients or family members. Licensing requirements do not address worker safety. However, Title 22, §1832 requires hospitals to annually adopt a safety and security plan that protects patients, visitors and employees of the hospital from aggressive and violent behavior, including a reporting process.

Workplace Safety

The task force received presentations from Ali Worster of Northern Light Health (hospitals) on August 3rd and from Michelle Belhumeur of Continuum and Mary Jane Richards of North Country Associates (nursing homes and residential care) on September 13th.[21] Ms. Worster discussed NLH's compliance with federal and state laws and regulations, as well as NLH's efforts to prevent violence against workers, de-escalation and active shooter training, establishment of local and system-wide violence prevention committees, physical safety (for example, security, line of sight awareness and wearable security devices), and efforts to encourage staff to report and press charges including education to counteract attitudes that violence is part of the job. Ms. Belhumeur and Ms. Richards discussed training efforts and management programs in long term care facilities to prevent violence against workers (and other residents) as well as efforts to establish good relationships with local law enforcement.

[19] https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/wpvp-r3_20210618.pdf
[20] https://legislature.maine.gov/doc/8750
[21] Please see https://legislature maine.gov/audio/#209 for August 3rd and September 13th for presentations; also https://legislature.maine.gov/doc/8756 from Northern Light Health.

EMTALA

The Emergency Medical Treatment and Labor Act (EMTALA),[22] enacted in 1986, requires hospitals with emergency departments to provide a medical screening examination to any individual who comes to the emergency department requesting a screening, stabilize that individual, and transfer or accept the person as needed regardless of the individual's ability to pay. EMTALA applies to any hospital that accepts Medicare reimbursement and to all individuals (not only Medicare beneficiaries). Task force members representing hospitals reminded all task force members that even when an individual is known to a hospital for a pattern of violent behavior, and staff at the hospital believe that the individual is carrying out acts of violence intentionally, knowingly or recklessly, if that individual presents at the emergency department, a medical examination would still need to be conducted to ensure there is not an emergency before removing that individual from the hospital premises. This prevents an emergency department from seeking a protection from abuse order from a court, or a no-trespass order to protect against a person known or likely to be violent.

Patients Awaiting Placement

The numbers of individuals stuck in hospital emergency departments after they no longer require a medical level of care has been noted as a perpetual issue by the task force and is recognized as a primary cause of increasing violence against hospital workers. The chairs of the task force, as members of the Health and Human Services Committee, also commented that this was an issue that has been repeatedly raised and discussed by that committee. Individuals in this situation are waiting for more appropriate therapeutic placements for effective treatment causing frustration, and in turn, leading to violence. There are shortages of residential and community options of all types – long term care, intellectual disability and autism, crisis services, and behavioral health – which affect both child and adult services. Although this has been an issue for some time, it has worsened with the pandemic and labor shortages.

Brenda Gallant, the Long Term Care Ombudsman, and Danielle Malcolm, the Home Care Ombudsman within Long Term Care Ombudsman Program (LTCOP) presented data regarding discharges and referrals in the long term care settings. The LTCOP serves residents of long term care facilities, including nursing facilities and private non-medical institutions (PNMI), individuals seeking home care services, as well as patients in hospitals who need access to long term care services. The LTCOP is a requirement of the federal Older Americans Act.

Ms. Gallant and Ms. Malcolm presented to the task force on September 13th. They stated that referrals from hospitals, adult protective services, and families/patients numbered 200 open cases a year for the last three years but there had been 198 so far in 2022. The majority of individuals the LTCOP worked with who were stuck in hospitals, had come from the community and 22% had come from a nursing or residential care facility that they could not return to. Ms. Gallant reminded the task force that a resident/patient being unable to return to the facility was not always because the facility refused to take them. For example, it may be that the medical situation that caused the individual to go to the hospital affected their acuity and the facility is no longer appropriate. Other reasons include the individual not wanting to return to the facility, or

[22] 42 U.S.C. §1395-dd

the individual posing a risk to other residents. According to the LTCOP, since 2016, behavior is the most common barrier for finding a facility, resulting from dementia diagnoses, mental health and traumatic brain injury. For the LTCOP cases, 32% of patients stuck in hospitals have behavioral barriers to accessing services. Within that group, 52% have a dementia diagnosis and is their most common referral. Forty-seven percent have a mental health issue and 13% have a traumatic brain injury.

The task force noted the particular tragedy of children with behavioral health issues being stuck in hospital emergency departments for extended periods awaiting service. Task force members representing both hospitals and law enforcement noted that there is a particular lack of children's residential facilities in the state and that has led to 67 children (both in and not in state custody), as of September 2022,[23] being served out of state at significant expense for the state and significant inconvenience to families. Legislators on the task force on the Health and Human Services Committee noted that they had dealt with a number of bills and received several briefings on this topic. The DHHS has been working on developing a secure residential treatment facility for children (Qualified Residential Treatment Program – QRTP) and the task force would like it to come to fruition.

Public Law 2021, chapter 191 requires hospitals to collect data on the number of children waiting more than 48 hours for an appropriate level of behavioral health treatment in a hospital emergency department.[24] Lisa Harvey-McPherson and Katie Fullam Harris presented data, at the September 13th meeting, that the hospitals have been reporting to the DHHS since December pursuant to that law.[25] Northern Light Health reported that there is always a child in an emergency department in all hospitals in the system but 50% of them were at EMMC. There were 138 child patients between November 2021 and July 2022 with an average length of stay of 10.4 days and a range of two to 99 days. MaineHealth hospitals recorded 369 child patients in the emergency department over the same time period with an average length of stay of 5.2 days and a range of two to 37 days. Both systems also reported that their psychiatric hospitals, Acadia and Spring Harbor, were also seeing increased lengths of stay for children as those children were also unable to be discharged due to a lack of available community services.

The lack of in-state services for children is not unique. Jennifer Putnam, Executive Director of Waban Projects, stated that a lack of specialized group homes for individuals with intellectual disabilities and behavioral health issues results in many of those individuals receiving services out of state. In this light, MACSP had proposed LD 1574, a bill that would have allowed for behavioral add-on payments in MaineCare reimbursement rates with the intent of allowing residential facilities to serve high needs individuals.[26] MaineCare rates that do not allow for additional reimbursement for specialized services or additional staffing were identified by the task force as contributing to shortages. Facilities of all types have reported empty beds due to an inability to hire sufficient staff.

[23] https://www.maine.gov/dhhs/ocfs/data-reports-initiatives/childrens-behavioral-health
[24] http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=HP0084&item=3&snum=130
[25] https://legislature.maine.gov/doc/8851
[26] http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=HP1171&item=2&snum=130

The task force noted that Resolve 2021, chapter 80[27] requires the DHHS to develop a vision and comprehensive statewide strategic plan to serve people in Maine with behavioral health needs throughout their lifespans. For the purposes of the plan, behavioral health includes a wide range of mental disorders and illnesses, substance use disorder and developmental disabilities including autism spectrum disorder. Under the resolve, the department is required to submit the plan to the joint standing committee of the Legislature having jurisdiction over health and human services matters by December 7, 2022.

There was considerable discussion among task force members about the regulatory requirements for facilities to take back patients who were residents. The DHHS provided a memo with information on these requirements.[28] Regulations require a nursing facility or assisted housing facility that sends a resident to an acute care hospital to allow the resident to return to the facility after the hospital stay unless the resident has exceeded the bed hold requirements or met criteria for a facility-initiated emergency discharge. A facility can initiate an emergency discharge if the resident is a danger to themselves or others within the facility. The same requirements apply to PNMI Appendix E providers (behavioral health). Residents or guardians have appeal rights if the PNMI discharges a resident or refuses to take them back. Regulations do not currently require the department to track how many residents are subject to an emergency discharge. (See DHHS memo).

However, task force members representing hospitals said they were increasingly frustrated by facilities who would not take patients after they no longer needed a hospital level of care. Hospitals cannot discharge patients unless there is a safe plan of care and only receive reimbursement in limited circumstances. Title 22, §3174-AAA allows for reimbursement to acute care hospitals for each day after the tenth day that a MaineCare eligible individual is in the care of a hospital while awaiting placement in a nursing facility. This reimbursement does not apply to a patient who is waiting for any other type of services or who is not MaineCare eligible. Task force members also pointed out that the facilities are also in a difficult position when a resident is in the hospital as the facility still needs to maintain the staff even when the bed is unoccupied and although there is MaineCare reimbursement for bed hold days, it is for room and board and not direct care (since the resident is not receiving care). This situation potentially results in pressure to fill a bed rather than hold a bed.

Maine's Criminal Code

The data shared by MDOL and the reports from Maine's largest health care providers identified physical assault as the most common act of violence perpetrated upon health care workers with verbal assault, as the second most common incident type. Maine's criminal code, Title 17-A, criminalizes these actions, in §207, §209 and §752-C.

[27] http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=SP0412&item=3&snum=130
[28] https://legislature.maine.gov/doc/8853

Under §207, a person is guilty of a Class D crime (punishable by one or both of the following: imprisonment of less than one year[29] or a fine not to exceed $2,000[30]) if they intentionally, knowingly or recklessly cause bodily injury or offensive physical contact to another person. Section 209 creates the Class D crime of criminal threatening; a person is guilty of criminal threatening if he/she intentionally or knowingly places another person in fear of imminent bodily injury.

Since 1997, Maine's criminal code has offered an enhanced penalty for an assault of an "emergency medical care provider" when the person is "providing emergency medical care" under §752-C. Conviction under this section is a Class C crime with possible imprisonment for up to five years[31] and a fine of up to $5,000.[32] According to data provided by Maine's Judicial Branch, during the 5-year period of 2017-2021, there were 88 charges statewide under this statute with a total of 12 convictions (See Appendix E). This is a small percentage of the 1,130 intentional injury lost time claims filed by health care workers during this same time period.[33]

Elements of a Crime; Standard of Proof

For successful conviction of a crime, the State must prove each and every element of a crime beyond a reasonable doubt. There must be no other reasonable explanation based on the evidence presented. The decision maker in criminal cases is usually a jury who must reach a unanimous decision for conviction. For an assault under §207, the prosecution must prove the following elements: that the person acted intentionally, [34] knowingly[35] or recklessly; [36] and that their actions caused bodily injury or offensive physical contact to another person. For assault under §752-C, the prosecution must prove two additional elements: that the victim was an "emergency medical care provider"; and that the assault occurred when the victim was "providing emergency medical care".

[29] 7-A MRSA §1604, sub-§1, ¶D
[30] 17-A MRSA §1704, sub-§4
[31] 17-A MRSA §1604, sub-§1, ¶C
[32] 17-A MRSA §1704, sub-§3
[33] Appendix E, p. 7 and p. 4
[34] 17-A MRSA §35, sub-§1 defines "intentionally" as: "[a] person acts intentionally with respect to a result of the person's conduct when it is the person's conscious object to cause such a result" and "[a] person acts intentionally with respect to attendant circumstances when the person is aware of the existence of such circumstances or believes that they exist."
[35] 17-A MRSA §35, sub-§2 defines "knowing" as: "[a] person acts knowingly with respect to a result of the person's conduct when the person is aware that it is practically certain that the person's conduct will cause such a result" and "[a] person acts knowingly with respect to attendant circumstances when the person is aware that such circumstances exist."
[36] 17-A MRSA §35, sub-§3 defines "recklessly" as: " [a] person acts recklessly with respect to a result of the person's conduct when the person consciously disregards a risk that the person's conduct will cause such a result" and "[a] person acts recklessly with respect to attendant circumstances when the person consciously disregards a risk that such circumstances exist" and [f]or purposes of this subsection, the disregard of the risk, when viewed in light of the nature and purpose of the person's conduct and the circumstances known to the person, must involve a gross deviation from the standard of conduct that a reasonable and prudent person would observe in the same situation."

Law Enforcement Involvement

The task force was briefed on when and how law enforcement officers respond to a violent event in a health care setting. Sometimes an officer is present before the violent event such as when they bring a person to the emergency department for medical treatment and that person then assaults staff. In those instances, the officer is able to respond to the violence in the moment, and may even witness the event. In other instances, the officer is called during or after a violent event. In those instances, the law enforcement officer may be asked to help prevent further violence and later to investigate to determine whether a crime was committed.

The topics related to law enforcement involvement in cases of violence against health care workers prompted more in-depth discussions on the topics and issues set out in the remainder of this section.

Arrest v. Summons

Maine's criminal code specifies when a law enforcement officer may arrest a person suspected of committing a crime as opposed to issuing a summons directing the accused to appear in court to answer the allegations of criminal activity. A law enforcement officer may arrest without a warrant, any person:

- who has committed or is committing in the officer's presence any Class D or Class E crime;
- who the officer "has probable cause to believe has committed or is committing" any Class A, Class B or Class C crime; and
- who the officer "has probable cause to believe has committed or is committing" assault or criminal threatening "if the officer reasonably believes that the person may cause injury to others unless immediately arrested." [37]

Based on these requirements, an officer responding to violence in a health care setting would not be allowed to arrest a person who commits an assault under §207 or criminal threatening under §209 (Class D crime) unless the assault or criminal threatening occurred in the officer's presence. If the assault was against an "emergency medical care provider" when the person is "providing emergency medical care," the officer would be able to arrest the accused because it is a Class C crime, provided the officer had probable cause to believe the accused did commit the crime. An arrest under any of these three statutes is also permitted if the officer has probable cause to believe the person may cause injury to another unless arrested.

The task force heard testimony from health care providers and staff about their frustration when law enforcement did not arrest a perpetrator and remove them from the premises. Arresting the perpetrator and removing them from the health care setting was desired to protect staff and other patients from future violence and to send a strong message that violence against health care workers is unacceptable.

[37] 17-A MRSA §15. This section includes additional criteria permitting arrest.

Chief Jared Mills and Sheriff Kevin Joyce both spoke to this issue and described some of the reasons an individual is not arrested. Chief Mills described instances when there was no arrest because the perpetrator needed a level or type of medical or behavioral treatment not available in a jail. Another example, given by Chief Mills and supported by testimony given by Sheriff Joyce, is when the local county jail is limiting intake to persons committing serious offenses such as murder, sexual assault and kidnapping due to significant staffing shortages.

Submitting a Charging Statement

Once safety is restored, the law enforcement officer begins an investigation of the criminal act. This usually involves taking statements from the perpetrator, the victim and all witnesses, and the collection of physical evidence including any recordings of the event. The investigation also involves the officer evaluating and, if available, collecting evidence of the perpetrator's state of mind immediately before, during and after the event to establish whether the perpetrator had the state of mind required for conviction.

At some point after the initial investigation, the law enforcement officer decides whether to send a charging statement to the local district attorney. Several factors are considered by the officer in making this decision with the following being of particular concern for those representing healthcare providers and staff:

- not filing charges when there is sufficient evidence of the crime because the victim is unwilling to participate;
- not charging an assault under §752-C even when it was an assault on "emergency medical care provider" who was "providing emergency medical care" at the time;
- not filing charges when the perpetrator is receiving behavioral health treatment or is perceived acting due to their behavioral health condition without first getting an assessment of their state of mind from a qualified professional; and
- not charging an assault under §752-C because the hospital personnel assaulted is not considered an "emergency care provider" such as a security officer or an environmental services worker or they were not engaged in "providing emergency medical care" but engaged in other needed activities such as cleaning, nutrition services or communicating with a patient.

The task force heard testimony that it is very common for a health care worker to decline to press charges against a patient. The healthcare worker may believe their primary role is to help the patient and that pressing charges is contrary to that role or they recognize the patient is acting based on a medical or behavioral health condition does not meet the state of mind requirement for criminal prosecution. They may also be reluctant to provide their personal information to law enforcement for fear that the perpetrator will retaliate against them if charges are filed. Finally, they may be unwilling to take time off from work to participate in the prosecutorial process. From the law enforcement and prosecutor's perspective, there is a strong belief that a victim's testimony is a critical component for conviction but there is also a strong reluctance to retraumatize a victim by forcing them to participate in the criminal process.

With respect to law enforcement not forwarding a charging statement under §752-C but submitting a charging statement for prosecution under the lesser assault under §207, Chief Mills explained that the officer may charge the lesser crime to increase the probability of conviction. A conviction under §752-C requires proving two additional elements at the "beyond a reasonable doubt" standard, that the assault was against an "emergency medical care provider" and that the assault occurred while that person was "providing emergency medical care". Although the penalty under §207 is less, conviction of that lesser crime is considered preferable to a verdict of not guilty under the enhanced crime of §752-C. Chief Mills also pointed out that, even though a law enforcement officer might submit a charging statement to the prosecutor for assault under §207, the prosecutor has the discretion to change the charge to §752-C if they are confident they can make the case.

Determining State of Mind

As mentioned above, the required state of mind for assault under both §207 and §752-C, is that the perpetrator acted intentionally, knowingly or recklessly. The task force members representing the health care industry and persons providing public testimony stated that there are many instances of violence when they do not call law enforcement because they assess the perpetrator as lacking control of their physical body or the capacity to understand their actions. Finding law enforcement officers unwilling to assist in prosecuting those few perpetrators likely to be held criminally responsible was a common frustration shared with the task force and by task force members. Law enforcement, in contrast, explained that unless there is a written assessment from a qualified medical professional on the perpetrator's state of mind, the law enforcement officer must rely on his or her professional judgment on whether the required state of mind can be shown to the degree required for conviction.

To assist the task force in better understanding this complicated and critical matter, two forensic psychiatrists were invited to explain assessing the perpetrator's state of mind. Dr. M. Ed Kelley, MD, Chief Medical Officer, Behavioral Health, St. Mary's Regional Medical Center and Dr. Chris Racine, Psychiatrist, Acute Psychiatric Unit, Maine Medical Center presented at the September 13th meeting.

Dr. Kelley and Dr. Racine both stated that healthcare providers do not want to criminalize mental health behaviors but they do believe that people should be held accountable for their behaviors. Dr. Kelley gave detailed testimony on how capacity is determined by the medical profession; capacity is the ability to know right from wrong and to control one's behaviors. Some of the questions asked when assessing a person's capacity is whether they understand the choices they are making, that there are different choices they can make, and that their actions have consequences on others. Dr. Kelley then discussed these questions in relation to a variety of diagnoses. He explained that a person with severe dementia and severe delirium may not be able to comprehend, in the moment, right from wrong or the consequence of their actions. But a person in a less advanced stage of dementia may still comprehend their actions. Similarly, an adult with an intellectual disability with an IQ of 70 is likely to comprehend both issues and could be held accountable, whereas a person with a lower IQ may not comprehend their actions, and therefore is not legally responsible.

Psychosis and mania were also discussed and are considered complicated because a person may be experiencing psychosis or mania and yet still know right from wrong. For example, a person may hear voices telling them to harm others but still understand that acting on those voices is wrong and would harm others. In contrast, a person experiencing psychosis may have voices telling them they are about to be killed compelling them to act in self-defense against a person who, in reality, has no intention of causing harm. Similarly, some forms of mania create such an acute level of impulsivity, a person does not have the time to consider whether their action is right or wrong but just acts.

With respect to personality disorders such as borderline personality disorder or antisocial personality disorder, a person has extreme reactions to daily life, but their illness does not affect their ability to know right from wrong. Similarly, general emotional states such as depression, anxiety or trauma rarely eliminate a person's ability to know right from wrong or control their actions.

During Dr. Racine's presentation, the task force learned more about the process of assessment used to determine whether to ask law enforcement to file charges. As described by Dr. Racine, the decision to involve law enforcement and press charges is taken very seriously. As a whole, the industry is highly biased toward protecting a patient's right to seek and receive treatment, particularly when seeking help in an emergency department. According to Dr. Racine, the assessment of the perpetrator's state of mind includes extensive interviews, a review of the patient's records, and consultation with outside providers who know the perpetrator.

Because the medical community often evaluates the perpetrator's state of mind before reaching out to law enforcement, there was significant frustration expressed about law enforcement officers deciding to not submit a charging statement because of their own assessment of the perpetrator's state of mind. Although experienced in making such an assessment in many situations, law enforcement officers do not generally have the same level of expertise as a medical provider or a prosecuting attorney when the perpetrator has a mental health diagnosis or is experiencing a mental health crisis at the time of the violent incident. Some task force members suggested that all of Maine's prosecutorial districts should adopt a standard best practice that the prosecutor and not the law enforcement officer should determine whether the perpetrator had the requisite state of mind for prosecution. Because of the independent nature of Maine's prosecutorial districts, the task force did not make a formal recommendation on this matter.

Victim Confidentiality

When a law enforcement officer investigates a crime, the victim is asked for their address and telephone number. Contact information is necessary for several reasons. The defendant has a well-established right to face their accuser so they must be able to identify the victim. Both the law enforcement officer and the district attorney's office must also be able to communicate with the victim while investigating, assessing and prosecuting the defendant.

Task force members representing hospitals noted that staff members who are victims of workplace violence have concerns with sharing their personal information, in particular their residential address and personal telephone number for fear of retaliation. The task force was informed of a practice in some hospital settings of victims being told to use the address and telephone number of the employer. Members of the task force, representing hospitals, law enforcement and prosecutors all agreed that using employer's contact information is an appropriate option and this option should be communicated to victims by all involved.

Prosecution

Maine has eight prosecutorial districts representing all Maine's 16 counties. Each district has a district attorney (DA) elected every four years by the voters in the respective counties. During the term of office, a district attorney may only be removed by a majority vote of the sitting justices of the Supreme Judicial Court, upon a complaint filed by the Attorney General.[38]

State law establishes the general responsibilities of the DA. For example, the DA, or someone acting under the district attorney's direction, is required to prosecute all criminal cases and be present at the trial of any such case before a court in the counties within the district,[39] unless the DA has dismissed the criminal case.[40] The decentralized nature of the DAs in Maine results in each DA having the authority to determine how to meet the general statutory obligations. Each DA decides whether to focus the limited resources on certain types of criminal or civil violations, who and how cases are evaluated for possible prosecution, and whether to go to trial or to settle.

This individualized nature of each district was a source of frustration for the health care providers who participated in the task force process. They advocated for a collaborative process with law enforcement and prosecutors to establish standards of practice or process that could be used across the state. They argued that such standards, however general, would facilitate an effective use of resources for all parties, an increase in arrests and prosecutions, and thereby a decrease in violence.

Examples of successful collaboration were shared with the task force, particularly the collaboration between the Augusta Police Department, the Kennebec County District Attorney's Office and MaineGeneral Health.

Arrest and Prosecution as Deterrents to Crime

The task force had several conversations about using the threat of arrest or the imposition of a serious penalty as a deterrent to crime. The task force was informed, by Deputy DA Tarpinian, of national research that indicates the certainty of being caught is a more effective deterrent than the threat of any punishment.[41]

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[38] 30-A MRSA §257
[39] 30-A MRSA §283
[40] 30-A MRSA §284
[41] https://nij.ojp.gov/topics/articles/five-things-about-deterrence

HIPAA

A concern was expressed to the task force that the confidentiality provisions of the federal Health Insurance Portability and Accountability Act (HIPAA) and state confidentiality laws may deter a health care provider from disclosing information to law enforcement on the perpetrator's state of mind at the time of the violent incident. As discussed above, evidence that the perpetrator was able to form the requisite state of mind (i.e. intentional, knowing or reckless) is needed for a conviction of assault or criminal threatening under 17-A MRSA §207, §209 and §752-C.

There is a provision in HIPAA regulations that permits a health care provider to disclose certain protected health information (PHI) without a written authorization from the patient. That provision in 45 CFR 164.512(f)(5) states: "a covered entity may disclose to a law enforcement official protected health information that the covered entity believes in good faith constitutes *evidence of criminal conduct* that occurred on the premises of the covered entity" (emphasis added).

Maine law, 22 MRS §1711-C, sub-§6, ¶E-1, specifically incorporates this federal standard and permits disclosure "to report a suspected crime against the health care practitioner or facility or to report information that the health care facility's officials or health care practitioner in good faith believes constitutes *evidence of criminal conduct* that occurred on the premises of the health care facility or health care practitioner" (emphasis added).

III. RECOMMENDATIONS

At the final meeting of the task force, members voted unanimously (of those present) to make the following recommendations to the Joint Standing Committee on Criminal Justice and Public Safety. A copy of this report will also be shared with the Joint Standing Committee on Health and Human Services as several of the recommendations relate to the health care system which is under the purview of that committee.[42]

Criminal Code

The task force determined that the scope of Title 17-A, §752-C is too limited to be an effective deterrent to violence against health care workers. One clear limitation is that this statute, and its enhanced penalty, only applies when the victim is an "emergency medical care provider" who is injured while "providing emergency medical care." These two elements exclude many emergency department employees as well as all health care workers in settings other than an emergency department. For example, a person in an emergency department who assaults custodial staff, security staff, or administrative staff might not be convicted of the Class C crime under §752-C because the person injured is found not to be an "emergency medical care provider." Similarly, if a person in an emergency department assaults a nurse while they are awaiting placement and not receiving emergency care, they too might be convicted of the Class

[42] The joint rules do not grant authority to the Joint Standing Committee on Health and Human Services to report out legislation pursuant to the task force report.

C crime under §752-C because although the injured person is an "emergency medical care provider" it might be argued that they were not "providing emergency medical care" at the time of the assault.

To close this gap in applicability so that the enhanced penalty available under §752-C applies to anyone working in an emergency department, the task force recommends expanding the scope of §752-C to include anyone working in an emergency department. The task force did discuss expanding the scope beyond emergency departments, but consensus on that proposal was not reached.

> **Recommendation:** Amend Title 17-A to include the enhanced penalty for physical assault to any person working in a hospital emergency department regardless of whether the person is providing emergency care or is an emergency medical care provider.

Prosecutors, in certain circumstances, can choose to elevate a crime so that a conviction results in a more serious penalty (see 17-A MRSA §1604, sub-§5). The statute specifically lists the chapters and sections of the criminal code that may be elevated. The task force recommends that the new provision in the criminal code providing an enhanced penalty for physical assault on any person working in a hospital emergency department should be included in §1604, sub-§5.

> **Recommendation:** Amend 17-A MRSA §1604, sub-§5 to allow the penalty for conviction under the new crime of physical assault on a person working in a hospital emergency department to be elevated.

Draft legislation to implement these two statutory recommendations are attached as Appendix F.

Patients Awaiting Placement

The task force identified the shortage of services, both residential and community and in all areas including long term care, intellectual disability and autism, and behavioral health, as a primary root cause of the number of individuals stuck in hospital emergency departments. These individuals remain in the emergency department after they no longer need emergency medical treatment and lack the appropriate therapeutic environment for effective treatment. Such extended stays in emergency departments contribute to incidents of violence against hospital personnel. Although violence as a response is not appropriate or justified, it is nevertheless partly a response to the increasing frustration and shortages of services. The duties in the resolve relate to criminal prosecution of violent acts against hospital and other health care workers and task force members noted that their membership is therefore focused on persons from the criminal justice system rather than the health care system. However, members noted that the patients awaiting placement issue is crucial to the conversation but solving it would take resources, including workforce, to allow for a fully staffed continuum across community and residential services and across long term care, behavioral health including substance use disorder, intellectual disability and autism, and crisis services. Currently, even in facilities with existing empty beds, there is insufficient staff to staff those beds and so they remain empty.

Placements for children with behavioral health diagnoses, some of whom also have intellectual disability or autism, in residential facilities with specialized services, can be particularly difficult to locate. As noted above, there is an increasing number of children served out of state as well as children in the emergency department waiting longer than 48 hours for services. In addition, there are currently no secure residential treatment options for children in Maine. The Department of Health and Human Services has been working on developing a secure residential treatment facility for children (Qualified Residential Treatment Program – QRTP) and the task force indicated it would like to see such a facility established.

With respect to behavioral health, the task force noted that Resolve 2021, chapter 80 requires the Department of Health and Human Services to develop a vision and comprehensive statewide strategic plan to serve people in Maine with behavioral health needs throughout their lifespans. For the purposes of the plan, behavioral health includes a wide range of mental disorders and illnesses, substance use disorder and developmental disabilities including autism spectrum disorder. Under the resolve, the department is required to submit the plan to the joint standing committee of the Legislature having jurisdiction over health and human services matters by December 7, 2022.

> **Recommendation:** That the Department of Health and Human Services increase the supply of appropriate placements, both residential and community, including secure facilities.

MaineCare Reimbursement

The Department of Health and Human Services, Office of MaineCare Services, has been establishing and undergoing a rate system review process for MaineCare reimbursement rates to allow for regular updating of rates across the whole spectrum of MaineCare. In the past, some sections of MaineCare have seen increases and others have had none for many years. This process is encapsulated in Public Law 2021, chapter 639.[43] The task force is concerned that the rate review process does not take into account some aspects of rates that have contributed to the difficulty of placing patients with co-occurring conditions (for example, individuals needing long term care with dementia, or children with an intellectual disability or autism and a behavioral issue).

The Long Term Care Ombudsman and her staff noted that the most common barrier for finding a long term care facility for a patient or client is a behavioral diagnosis. Jennifer Putnam, from Waban Projects, noted that the Maine Association of Community Service Providers had proposed LD 1574, a bill that would have allowed for behavioral add-on payments in MaineCare rates to allow residential facilities to be able to afford to serve high needs individuals but it was not enacted. The task force identified a number of areas that fall outside the MaineCare rate review process that, if addressed, could increase successful placement of individuals into more appropriate therapeutic environments than hospital emergency departments.

[43] http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=HP1377&item=3&snum=130

Recommendation: That the Department of Health and Human Services broaden its MaineCare rate review process to include the following: increased or new reimbursement for bed hold days for residential facilities; days awaiting placement payments to hospitals for all MaineCare eligible individuals; behavioral add-ons; and security costs.

The task force wrote a letter to the Department of Health and Human Services to request the Office of MaineCare Services take action on this recommendation. The letter requests attention to the following:

- *Bed hold days payments.* The task force understands that there are federal restrictions on the level of payments to nursing facilities and PNMIs for days in which the occupants of those beds are in hospital. For example, Appendix C and F facilities are reimbursed for up to 30 bed hold days but only for the room and board portion and not for the direct care portion; for facilities the reimbursement amount is not sufficient to maintain staffing levels. Appendix B, D and E facilities are not directly compensated for bed hold days but the department states that the rates include occupancy rates to support a period of time when members are out of the facility (for B and D facilities, that results in approximately 30 days). The request is for the department to consider how best to reimburse for bed hold days to allow the facility to keep the bed available for the occupant while in the hospitals while retaining staff.
- *Days awaiting placement payments for hospitals.* Current law in Title 22, §3174-AAA allows for reimbursement to hospitals other than critical access hospitals for each day after the tenth day that a MaineCare eligible individual is in the care of a hospital while awaiting placement in a nursing facility. There is an annual maximum funding cap of $500,000 per year for this purpose and the law has a sunset date of December 21, 2023. The task force recommended that the current law be broadened to allow for any MaineCare eligible person, including children, rather than only nursing facility eligible individuals. (Representative Anne Perry, chair of the task force, submitted a bill to achieve this purpose including striking out the sunset date.)
- *Behavioral add-ons in reimbursement rates.* The task force requests that the department of Health and Human Services review reimbursement rates to allow for additional reimbursement for PNMIs to provide services for individuals with co-occurring behaviors.
- *Security costs.* Hospitals have increasingly hired or contracted for security personnel without a means of recouping those costs; the task force requests that the department investigates the ability for MaineCare reimbursement to include a portion of security costs.

The letter sent by the task force is attached in Appendix G.

Data Standardization and Collection

As discussed above, the Maine Department of Labor produces and reports statistics drawn from the workers compensation lost time claims submitted by private sector employers when an employee misses work due to an injury at work. Northern Light Health and MaineHealth are collecting data within their organizations for their own purposes and using their own

methodologies. Both organizations presented data to the task force based on employee reports of disruptive behavior and staff abuse at the first meeting of the task force. The task force asked organizations representing providers of health care services, other than hospitals, for any data on incidents of violence against front line staff and learned that there is a general sense that there has been an increase in violent incidents but that data is not being collected or tracked in any formal way.

The task force discussed the dearth of standard data collection around incidents of violence against health care workers. When data does exist, it is not always comparable and there are sectors of the health care industry for which no data is collected at all outside of the workers' compensation data. Task force members believe it would be useful to have standard data that is comparable over time, between facilities and, to some extent, between types of providers. Standard data would allow for actions or solutions that are grounded in data rather than anecdote.

> **Recommendation:** That a process to standardize the collection and the data for incidents of violence against health care workers be established.

The task force wrote two letters urging action be taken on this recommendation. First, the task force requested that the Maine Hospital Association coordinate a process of gathering a group of hospital representatives to develop a standard dataset and universal terminology that is applicable to hospitals including incidents of violence, near misses (for example, a patient throws a chair but misses the staff member), location of the violence, type of employee, perpetrator (patient or family), calls to law enforcement and other data. The task force also requested that the MHA and the group make suggestions on whom the data should be reported to and its public availability (for example, the Department of Health and Human Services or the Legislature) as well as any legislative changes that might be needed. The letter requested that the MHA report its findings to the joint standing committee of the Legislature having jurisdiction over health and human services matters with an interim report due April 1, 2023 and a final report due January 2, 2024. The MHA expressed a willingness to take on this task at the final task force meeting on October 13, 2022.

The task force wrote a second letter to the Department of Health and Human Services requesting that it convene a group of providers, other than hospitals, to develop a similar kind of process to that undertaken by the MHA. Given the injury data collected by the Maine Department of Labor for individuals working in health care industries related to residential facilities and nursing facilities, task force members stated that a standard dataset and universal terminology should apply to all health care services rather than only hospitals. The letter requested that the department, with the assistance of providers, develop a standard dataset and universal terminology to report violent incidents, such as the number of incidents, near misses, location of the violence, type of employee, perpetrator, calls to law enforcement, and other relevant data. The task force requested that the department make suggestions on who the data should be reported to and its public availability. The task force requested that the Department of Health

and Human Services report its findings to the joint standing committee of the Legislature having jurisdiction over health and human services matters with an interim report due April 1, 2023 and a final report due January 2, 2024.

The letters sent by the task force are included in Appendix G.

Law Enforcement Training

As discussed above, law enforcement officers play a critical role in the criminal justice process by preventing future crimes and assisting in successful prosecution. Because they are called upon to help the public in every imaginable setting, the officers must develop an ability to react in a nuanced way depending on the specific situation. Health care settings, particularly hospital emergency departments, present unique challenges for law enforcement.

As a condition of continued employment, a law enforcement officer must complete in-service training as prescribed by the board of the Maine Criminal Justice Academy on an annual basis.[44] An officer must complete 20 hours of mandatory subject area training and 20 hours of elective training.[45] To improve the ability of law enforcement officers to investigate violence in a hospital emergency department, the task force recommends adding training that is specific to that setting.

> **Recommendation**: That the Maine Criminal Justice Academy develop and offer training to law enforcement officers that increases their ability to investigate crimes against health care workers, particularly those that occur in hospital emergency departments.

Encourage Better Communication and Coordination Among Law Enforcement Officers, Health Care Providers and Prosecutors

The task force discussions revealed that in those areas of the state where health care providers, law enforcement officers and district attorneys had established a collaborative working relationship, there was less frustration and misunderstanding about the process and possible outcomes when a health care worker is the victim of violence in the workplace. The task force was able to learn details of one such relationship as the task force had members representing Maine General Hospital, the Augusta Police Department and the Kennebec County District Attorney's Office. Some of the details included a periodic meeting between representatives from the Kennebec County DA's office and Maine General's general counsel where they discussed the status of investigations and prosecution of violence incidents in Maine General's hospital as well as its affiliate organizations. The periodic meetings allowed for more efficient and effective processing of cases and better communication with the victim and hospital administration. Knowledge that regular communication is viewed positively by all parties, the task force makes the following recommendations:

[44] 17-A MRSA §2804-E (https://legislature maine.gov/legis/statutes/25/title25sec2804-C.html)
[45] https://www.maine.gov/dps/mcja/training/mandatory/law.htm

Recommendation: That health care providers have a point of contact responsible to communicate with and among the victim/employee, law enforcement, district attorney's office and others involved after a violent incident in the workplace.

Recommendation: That health care providers provide staff with a work address and telephone number they may give to law enforcement and prosecutors if they prefer not to disclose their personal contact information.

Recommendation: That health care providers communicate to the victims/employees the privacy protections available to certain victims under Title 17-A, §2108, sub-§4.

Recommendation: That the district attorney's office communicates with the victim and the employer's point of contact if the victim provides written consent, on a regular basis with updates on investigation and criminal complaint process.

Maine Hospital Association Work With Its Members

The Maine Hospital Association offered to follow up with its members on several suggestions identified by the task force. Listed below are the steps MHA agreed to take. The task force is not recommending any further action on these, but includes them to present a complete record of its work.

Recommendation: That the Maine Hospital Association take action on the following items:

- Request an invitation to the regular meetings between the district attorneys and the Office of the Attorney General to discuss ways these parties may work together to stem the tide of violence in the health care workplace.
- Encourage its members to reach out to their local district attorney and law enforcement office to start a similar dialogue.

Information Necessary for Prosecution

Generally, health care providers and staff are not experts in law enforcement or prosecution of crimes. Yet, because of the prevalence of violence in the health care workplace, they are often called upon to assist law enforcement in its investigation, or assist the prosecution in filing charges. To promote efficiency in an investigation and increase the likelihood that criminal charges will be brought and successfully pursued when appropriate, the task force members and others who testified before the task force, all agreed that some sort of guidance, a check list, or other tool should be shared with the providers and staff so that they are better able to respond after a violent incident. The following recommendation includes the necessary steps considered essential by law enforcement and prosecutors.

Recommendation: That in the event law enforcement officers are called in response to a violent incident, the following is necessary in order to issue a summons or make an arrest:

- A statement from a qualified medical professional about the perpetrator's state of mind (who, what, when, where, how, before, during and after);
- Detailed statements from witnesses (cooperating victim not required);
- Any video or audio recordings of the incident;
- In case of arrest, medical clearance articulating that the perpetrator is mentally and physically fit for incarceration; and
- A willingness on the part of the local jail to accept the person in question.

HIPAA

HIPAA is a complex federal law that restricts the release of protected health information (PHI) by health care providers and organizations. Penalties for violating HIPAA can include significant financial penalties (See 45 CFR, Part 106, subpart D). Health care providers and organizations are generally very reluctant to disclose protected health information without a written authorization from their patient. If that patient commits a violent act, they may be unwilling to provide such an authorization, effectively shielding them from criminal liability for such actions.

As mentioned above, both federal and state laws provide a remedy to this barrier by permitting disclosure of PHI without an authorization by a covered entity to a law enforcement officer what the covered entity believes in good faith constitutes evidence of criminal conduct that occurred on the premises of the covered entity. Despite this express exception, health care providers are reluctant to provide such information to law enforcement and prosecutors. To facilitate the charging and conviction of violence against health care workers, the task force recommends that the Maine Hospital Association educate its member organizations on the privacy exemptions.

Recommendation: That the Maine Hospital Association will either educate or encourage its member organizations to educate their health care providers on the disclosures allowed by HIPAA and Maine privacy statutes when a patient assaults or threatens a health care worker.

APPENDIX A

Authorizing Legislation: Resolve 2021, c. 173

Resolve, To Establish the Task Force To Study the Process for Bringing Criminal Cases in Situations of Violence against Health Care Workers

STATE OF MAINE

———

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-TWO

———

H.P. 465 - L.D. 629

Resolve, To Establish the Task Force To Study the Process for Bringing Criminal Cases in Situations of Violence against Health Care Workers

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, the issue of violence against hospital and medical staff has increased in recent years; and

Whereas, hospitals are unclear what the options are for prosecution when victims are unwilling to bring cases; and

Whereas, the work of the Task Force To Study the Process for Bringing Criminal Cases in Situations of Violence against Health Care Workers needs to begin prior to 90 days after adjournment in order for the task force to have enough time to review the circumstances and make recommendations; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Task force established. Resolved: That the Task Force To Study the Process for Bringing Criminal Cases in Situations of Violence against Health Care Workers, referred to in this resolve as "the task force," is established.

Sec. 2. Task force membership. Resolved: That, notwithstanding Joint Rule 353, the task force consists of 9 members appointed as follows:

1. Two members of the Senate appointed by the President of the Senate, including members from each of the 2 parties holding the largest number of seats in the Legislature;

2. Two members of the House of Representatives appointed by the Speaker of the House, including members from each of the 2 parties holding the largest number of seats in the Legislature;

3. Two members who are representatives of entities knowledgeable about or involved in providing hospital, medical or mental health services, appointed by the President of the Senate;

4. Two members who are representatives of entities knowledgeable about or involved in providing hospital, medical or mental health services, appointed by the Speaker of the House; and

5. One member representing law enforcement officers, appointed by the Speaker of the House.

The task force shall also invite 2 members of the judicial branch and 2 members representing district attorneys designated by the Chief Justice of the Supreme Judicial Court to serve as members of the task force.

Sec. 3. Chairs. Resolved: That the first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the task force.

Sec. 4. Appointments; convening of task force. Resolved: That all appointments must be made no later than 30 days following the effective date of this resolve. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members, the chairs shall call and convene the first meeting of the task force. If 30 days or more after the effective date of this resolve a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the task force to meet and conduct its business.

Sec. 5. Duties. Resolved: That the task force shall review the process by which criminal cases may be brought related to incidents of violence in hospitals and other health care facilities and settings, in particular, incidents of violence involving patients or individuals related to patients assaulting hospital or medical staff.

Sec. 6. Staff assistance. Resolved: That the Legislative Council shall provide necessary staffing services to the task force, except that Legislative Council staff support is not authorized when the Legislature is in regular or special session.

Sec. 7. Report. Resolved: That, no later than November 2, 2022, the task force shall submit a report that includes its findings and recommendations, including suggested legislation, to the Joint Standing Committee on Criminal Justice and Public Safety. The joint standing committee is authorized to report out legislation to the First Regular Session of the 131st Legislature.

Sec. 8. Outside funding. Resolved: That the task force shall seek funding contributions to fully fund the costs of the study. All funding is subject to approval by the Legislative Council in accordance with its policies. If sufficient contributions to fund the study have not been received within 30 days after the effective date of this resolve, no meetings are authorized and no expenses of any kind may be incurred or reimbursed.

Sec. 9. Appropriations and allocations. Resolved: That the following appropriations and allocations are made.

LEGISLATURE

Study Commissions - Funding 0444

Initiative: Allocates funds from outside sources for the costs to the Legislature of the Task Force To Study the Process for Bringing Criminal Cases in Situations of Violence against Health Care Workers.

OTHER SPECIAL REVENUE FUNDS	**2021-22**	**2022-23**
Personal Services	$440	$440
All Other	$560	$810

OTHER SPECIAL REVENUE FUNDS TOTAL	$1,000	$1,250

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

APPENDIX B

Membership List: Task Force to Study the Process for Bringing Criminal Cases in Situations of Violence Against Health Care Workers

TASK FORCE MEMBERS

Senator Ned Claxton – Chair	Member of the Senate, appointed by the President of the Senate
Representative Anne C. Perry - Chair	Member of the House, appointed by the Speaker of the House
Senator Richard Bennett	Member of the Senate, appointed by the President of the Senate
Representative Amanda Collamore	Member of the House, appointed by the Speaker of the House
Kristine Chaisson	Representatives of entities knowledgeable about or involved in providing hospital, medical or mental health services, appointed by the President of the Senate
Renee Guignard	Representatives of entities knowledgeable about or involved in providing hospital, medical or mental health services, appointed by the President of the Senate
Chief Jared Mills	Member representing law enforcement officers, appointed by the Speaker of the House
Jim Bailinson	Members who are representatives of entities knowledgeable about or involved in providing hospital, medical or mental health services, appointed by the Speaker of the House
Dr. Michael Melia	Members who are representatives of entities knowledgeable about or involved in providing hospital, medical or mental health services, appointed by the Speaker of the House
Honorable Andrew Robinson	Member of Judicial Branch, appointed by the Chief Justice
Amanda Doherty	Member of Judicial Branch, appointed by the Chief Justice
Brendan Trainor	Member Representing District Attorneys, appointed by the Chief Justice
Frayla Tarpinian	Member Representing District Attorneys, appointed by the Chief Justice

APPENDIX C

Meeting Agendas

AGENDA
Augusta 3, 2022

9:00 am **WELCOME AND INTRODUCTIONS** (co-chairs)

09:20 am **BACKGROUND INFORMATION** (OPLA Staff)

1. RESOLVE 2021, CH. 173
2. EXISTING CRIMINAL STATUTES & RELEVANT LEGISLATIVE HISTORY
   17-A MRSA §§ 207, 209, 752-C
3. OTHER STATES CRIMINAL STATUTES (NCSL material)
4. National Efforts:
   - H.R. 1195 - Workplace Violence Prevention For Health Care and Social Service Workers Act (H. Report 117-14)
   - National Efforts, AHA letter to DOJ 03.24.22 urging DOJ to: prioritize prosecution; and support legislation modeled on 49 USC §46504 (interference with flight crew/attendants)

09:40 am **INCIDENTS OF VIOLENCE IN HEALTHCARE SETTINGS**

1. MDOL – Victor Tardiff, Director, Research & Statistics Division
2. MHA – Lisa Harvey McPherson, VP, Government Relations, Northern Light Health & Katie Fullam Harris, Chief Government Affairs Officer, MaineHealth
3. RPC & DDPC - DHHS, written only

10:15 pm **DATA: ASSAULT ON AN EMERGENCY MEDICAL CARE PROVIDER[1]: CHARGED / PROSECUTED / SENTENCED**
JUDICIAL BRANCH DATA - Hon Andrew Robinson

10:30 am **REGULATORY OVERVIEW – STATE, FEDERAL & ACCREDITATION AGENCIES**

1. MDOL, PUBLIC AND PRIVATE FACILITIES - Steven Greeley, Director, Workplace Safety and Health
   - MDOL Oversight of Public Healthcare Facilities

[1] 17-A MRSA §752-C

- OSHA Oversight of Private Healthcare Facilities – General Duty Clause[2] & OSHA Guidelines[3]

2. DLC, PRIVATE FACILITIES - Bill Montejo, Director
   - Applicable Federal laws & regulations
   - State Laws & Regulations, including 22 MRSA §1832
   - The Joint Commission[4] & Other Accreditation Agency Standards
3. PROVIDER Perspective – Jeff Austin, VP Government Affairs, Maine Hospital Association

11:30 pm CRIMINAL INVESTIGATION AND PROSECUTION

1. COMPLAINTS & INVESTIGATIONS, Chief Jared Mills
2. PROSECUTION, Deputy District Attorney Frayla Tarpinian and Brendan Trainor
3. COURT'S PERSPECTIVE, Hon. Andrew Robinson
4. PROVIDERS' PERSPECTIVE, Jeff Austin, VP Government Affairs, Maine Hospital Association
5. HIPAA Implications 45 CFR §164.512 (Hospital Counsel & Prosecutors)

LUNCH BREAK (1 hour)

01:30 pm DISCUSSION & NEXT STEPS (Task Force Members)

1. MEMBERS' PERSPECTIVE
2. WHAT ARE WE MISSING?
3. NEXT MEETING AGENDA
   - Materials and presentations
   - Public comment?

3:00 pm ADJOURN

[2] 29 USC §654
[3] OSHA Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers 2015
[4] The Joint Commission Standards effective 01/01/22

AGENDA
September 13, 2022
(hybrid)

9:00 a.m.	**WELCOME AND INTRODUCTIONS**
9:15 a.m.	**DATA ON VIOLENCE IN OTHER HEALTHCARE SETTINGS**
9:30 a.m.	**PATIENT AWAITING PLACEMENT**
10:15 a.m.	**LAW ENFORCEMENT INVOLVEMENT AND INCARCERATION**
10:45 a.m.	**LEGAL CONCEPTS AND ISSUES**
11:30 a.m.	**ASSESSMENT OF PERPETRATOR**
12:30 p.m.	**LUNCH**
1:30 p.m.	**DISCUSSION & NEXT STEPS**
3:00 pm	**ADJOURN**

NEXT MEETING: Tuesday, September 27, 2022, 9:00 am – 3:00 pm
Public Testimony (in-person and remote)

AGENDA
September 27, 2022
(hybrid)

9:00 a.m. **WELCOME AND INTRODUCTIONS**

9:15 a.m. **PUBLIC TESTIMONY (**in person and remote)

Immediately following **COMMITTEE DISCUSSION**

- *Recap of issues and information received*
- *Identification of findings and possible recommendations*

3:00 pm **ADJOURN**

NEXT MEETING: Thursday, October 13, 2022, 9:00 am – 3:00 pm

NOTE: *Staff will compile the list of potential recommendations discussed during this meeting for the October 13th meeting. Task Force members should be prepared to vote on and to add specific detail to the potential recommendations at the October 13th meeting.*

AGENDA
October 13, 2022
(hybrid)

9:00 a.m.	**WELCOME AND INTRODUCTIONS**
9:15 a.m.	**RECOMMENDATIONS AND JUSTIFICATIONS/FINDINGS**
3:00 pm	**ADJOURN**

APPENDIX D

Maine Department of Labor Slides

MAINE DEPARTMENT OF LABOR
August 3, 2022

Injury Rates

In order to find injury rates, The Bureau of Labor Standards relies on a federal partnership with the Bureau of Labor Statistics though their Survey of Occupational Injury and Illness (SOII) program. That data is reported on a yearly basis, and the following statistics come from the most recently completed survey year of 2020.

Maine Statewide, all industry, private sector only

- For every 20,000,000 person-hours worked, or for every 10,000 full time equivalent workers (employees working 40 hours per week, 50 weeks per year), there are 3.0 instances of intentional injury perpetrated by a person other than the injured worker
- Approximately 70% of these cases were perpetrated by a health care patient
- Female workers (rate 5.3) are almost 5 times more likely to suffer these types of injury events than male workers (rate 1.1)
- Workers aged 20-24 (rate 7.2) and 25-34 (rate 5.5) are much more likely to suffer these types of injury events than all other age groups, with the next highest being workers aged 35-44 who had an injury rate of only 2.9.

For the private sector Healthcare and Social Assistance industry only**,** the injury rate for these specific types of violent injuries are almost 5 times higher than the all-industry rate, at 14.3 cases per 10,000 FTEs

Information for prior years is omitted since they must be compiled individually, though they can be provided upon request or interest by the committee.

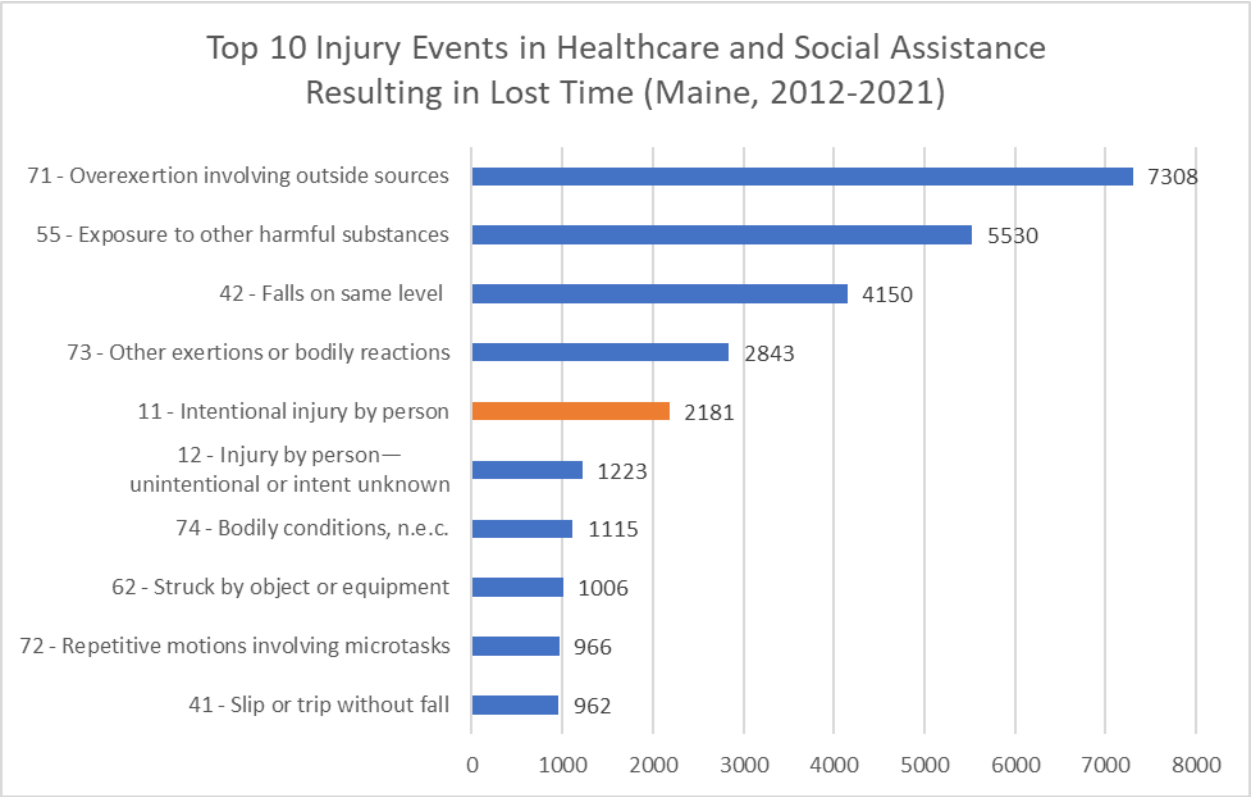
Injury Counts

Maine law mandates that employers are responsible for completing the First Report of Injury (FROI) form and submitting it to their workers' compensation insurance company within 10 days of the first day of disability or the date they were aware of disability, whichever is later. If the employee has physical limitations due to the injury or illness and loses consecutive hours equal to a regular workday because the employer cannot accommodate those restrictions, a FROI must be filed with the Workers Compensation Board (WCB) within 7 days after an employer's notice or knowledge that an employee has lost hours equal to a regular workday regardless of actual wage loss. These claims are hereafter referred to as "Lost Time" claims and are electronically sent from the WCB to the Bureau of Labor Standards (BLS) where we combine information found on the FROI along with our own injury and illness coding schemes to produce workplace injury and illness statistics.

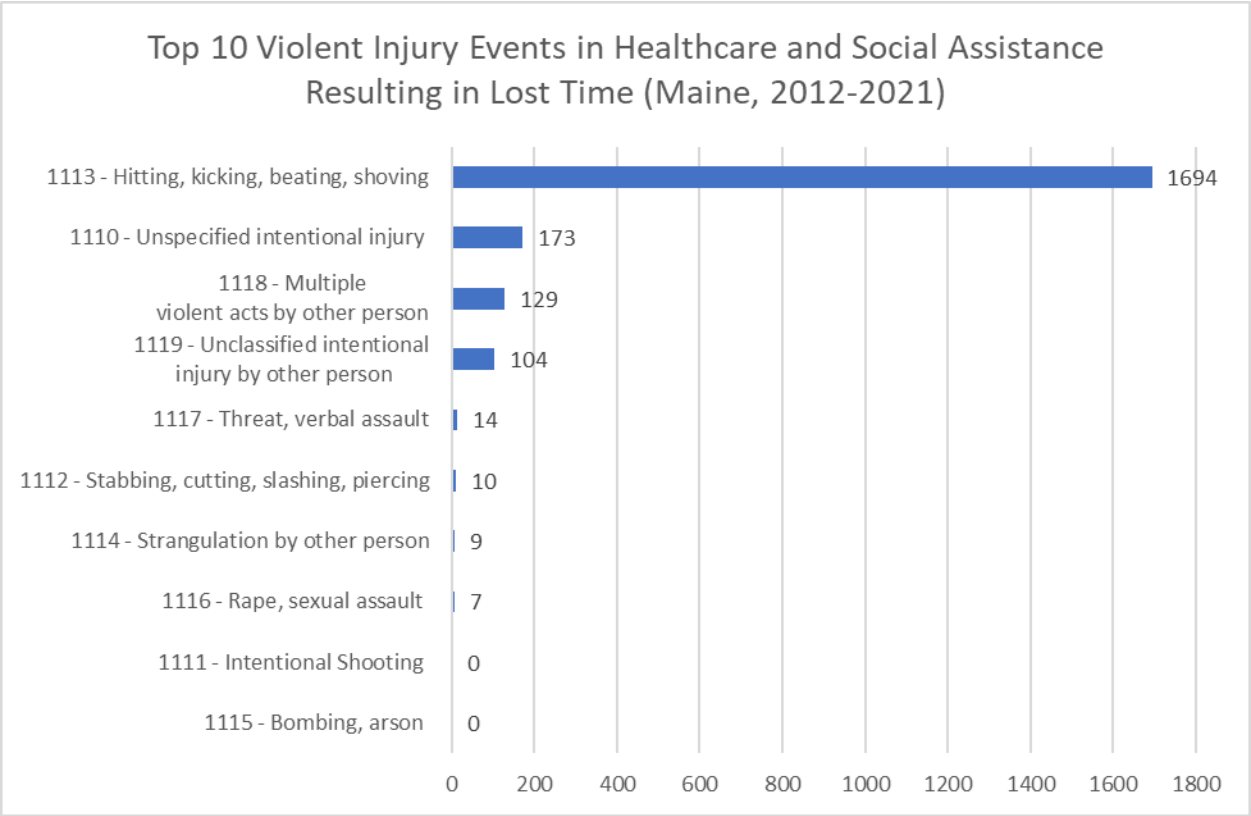
All following information in this report is an analysis of the Lost Time claims we have coded from the WCB.

Between 2012 and 2021, there have been approximately 140,000 lost-time FROIs coded by the BLS. While we have a record of all lost time claims filed in the timeframe, we are not able to use this information to calculate injury rates. We do not receive information from employers stating how many hours of occupational exposure each injured or ill employee had, nor the total number of hours worked by employees who are not injured or ill. That information must be found through the federal SOII program, and due to the Confidential Information Protection and Statistical Efficiency Act (CIPSEA), we are much more limited in what data we are allowed to discuss from that partnership.

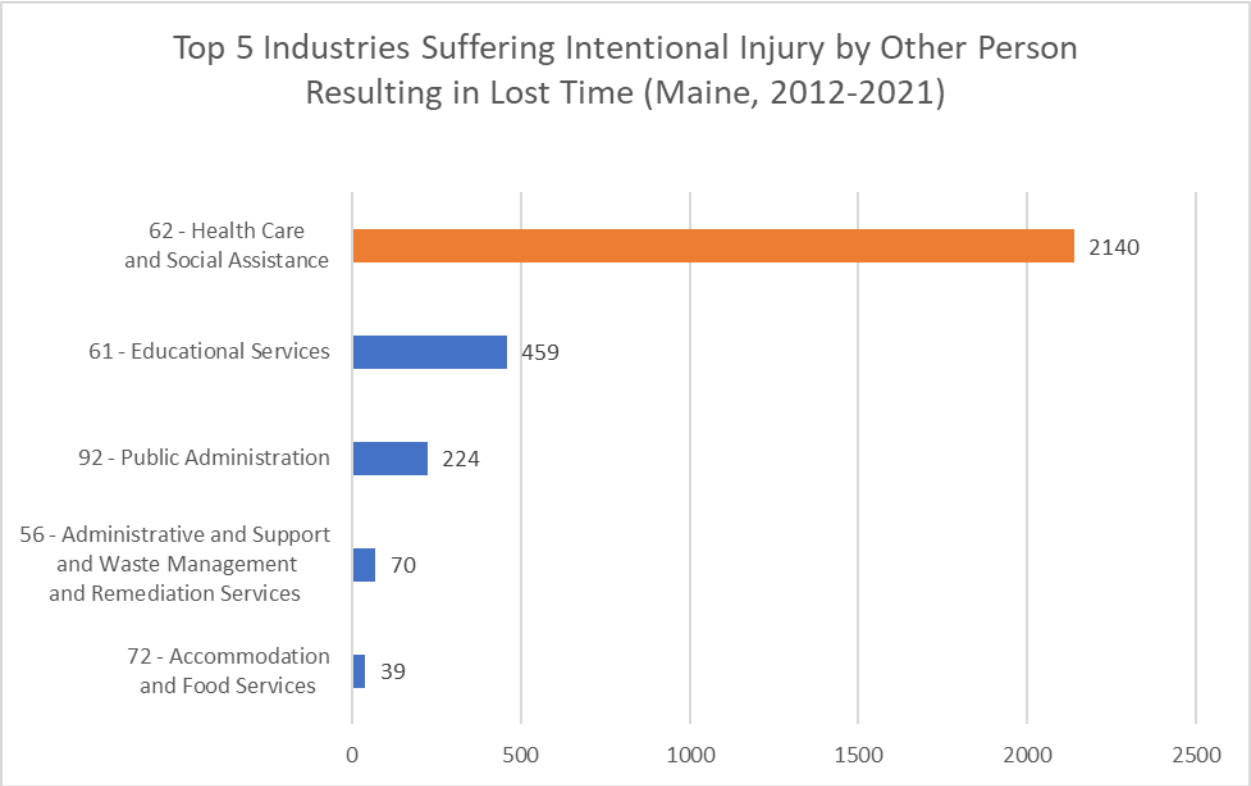
Before getting into specific demographic breakdowns of these types of injuries, it's good to contextualize violence within the healthcare industry.



Between 2012 and 2021, there were 32,062 injuries and illness in Maine's healthcare industry which resulted in days away from work, representing 22.9% of all lost time injuries across Maine. Of these, 2,181 were instances of intentional injury by a person. This represents 6.8% of all injuries within the industry. 41 of those intentional injuries by a person were instances of self-harm, bringing the total number of intentional injuries perpetrated by another person to 2,140. This equates to just over 4 instances of violence in Maine's healthcare system every week for the past 10 years resulting in injuries serious enough to cause days away from work.

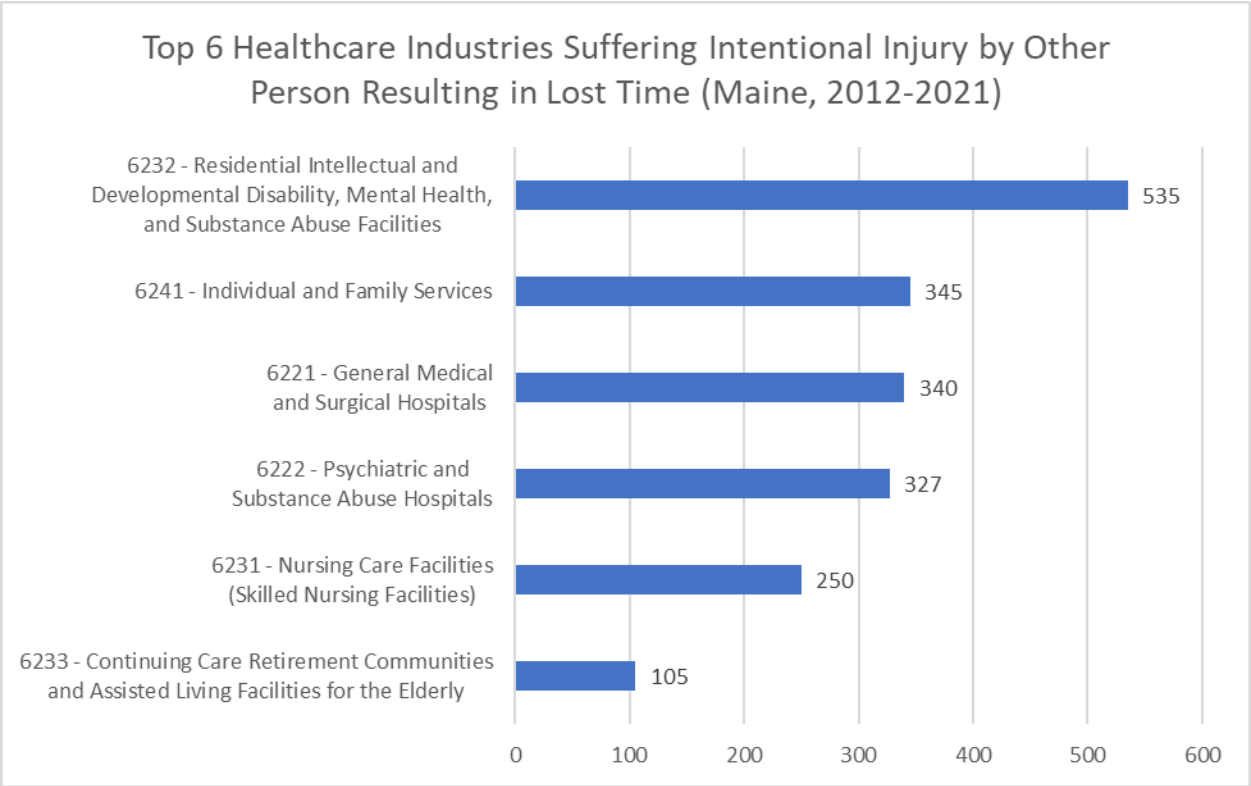


Looking at these 10 classifications of intentional injury, hand-to-hand incidents are far and away the most common way in which people lash out against healthcare and social assistance workers. The Unspecified Intentional Injury category records instances where coders can deduce intentional violence from the injury narrative but are unable to determine what kind of violence was perpetrated. The Unclassified Intentional Injury category is an “All-Other” group for known violence events which do not fit into one of the other 8 named groups. For the most part, these are instances of a person throwing an object at the injured worker.



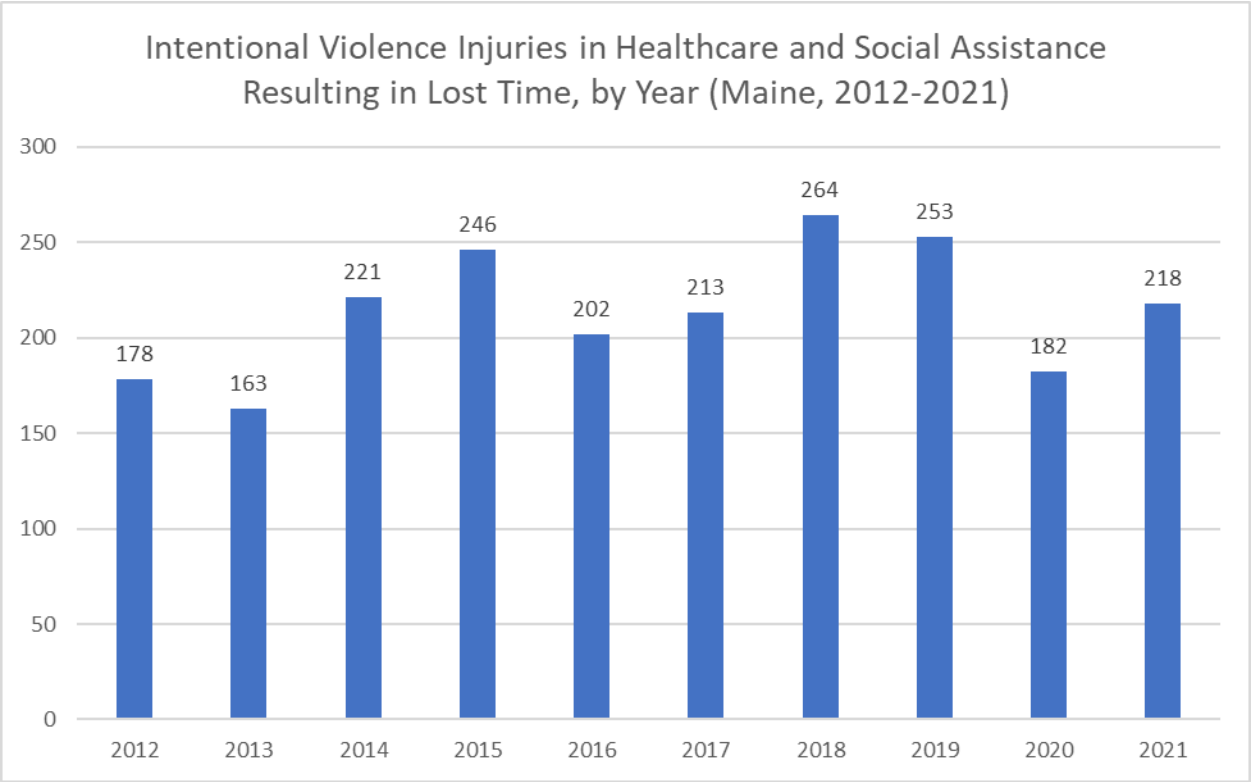
Healthcare and Social Assistance is 1 of only 2 industries for which intentional violence is a top 5 injury event, the other being Educational Services. Unsurprisingly, these two industries recorded the greatest number of intentional violence injury events. What is surprising is how long of a shadow Healthcare and Social Assistance casts over other industries.

Between 2012 and 2021, there were a total of 3,091 instances of intentional injury perpetrated by another person resulting in days away from work. Over 2 out of 3 of these claims were filed by workers within the Healthcare and Social Assistance industry. In the Public Administration industry, which includes police officers and prison wardens, intentional violence was the 13th most common reason for a lost time injury claim. Beyond healthcare, education, and public administration, all other industries combined total 268 intentional violence injury events.

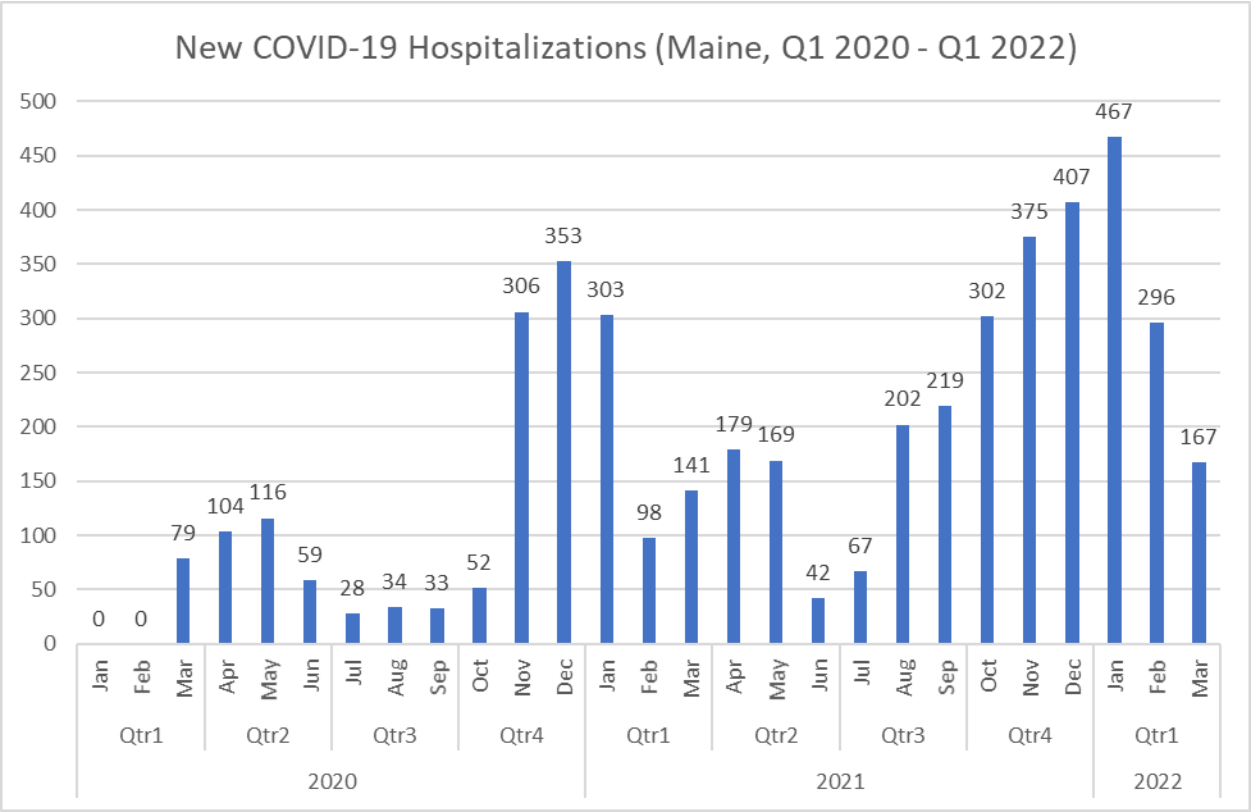


These 6 more specific healthcare segments account for 1,905 (89.0%) of the 2,140 days away violence claims we counted in the previous chart. Because the North American Industry Classification System (NAICS) uses up to 6 digits to classify industries, further breakdowns are available. However, there are diminishing returns on their usefulness, as these 4-digit codes get at the heart of the industry without bogging the reader down in minute details.

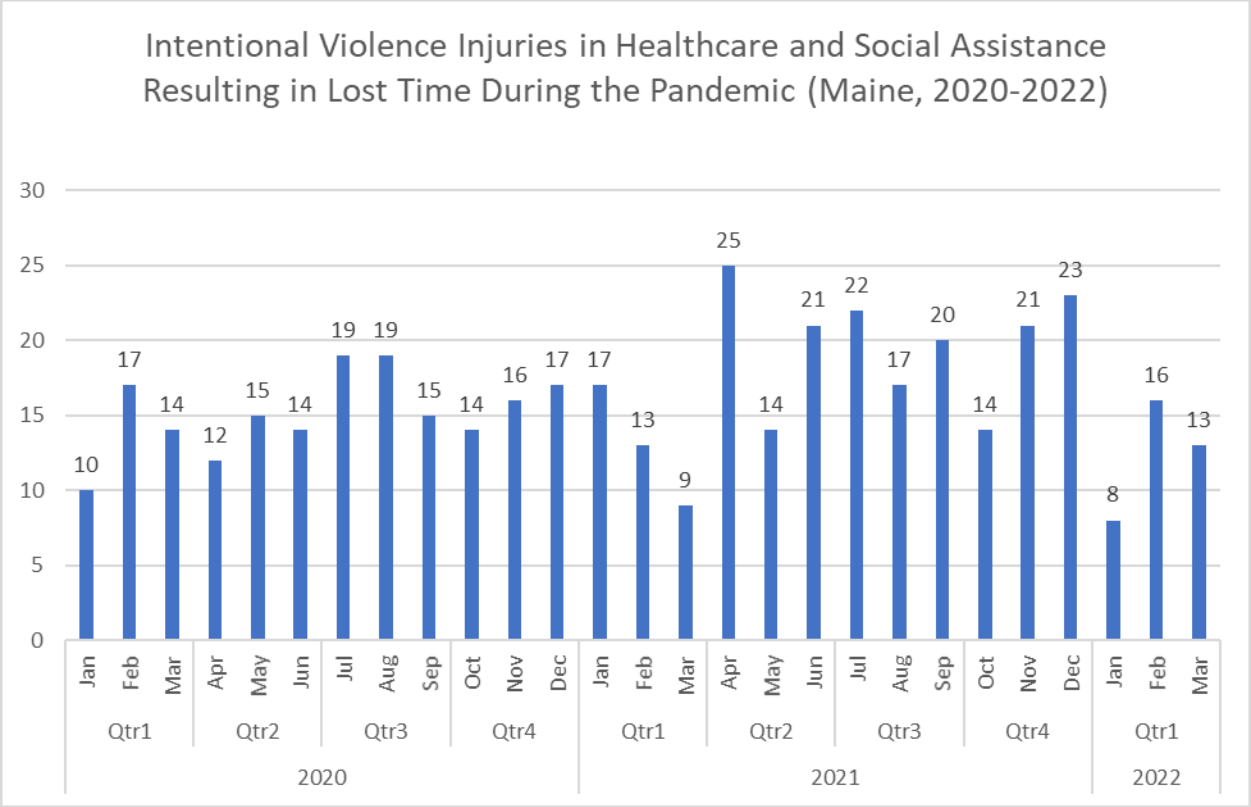
With some idea of how seriously and uniquely intentional violence effects the Healthcare and Social Service industry, we can move on to demographic splices detailing trends.

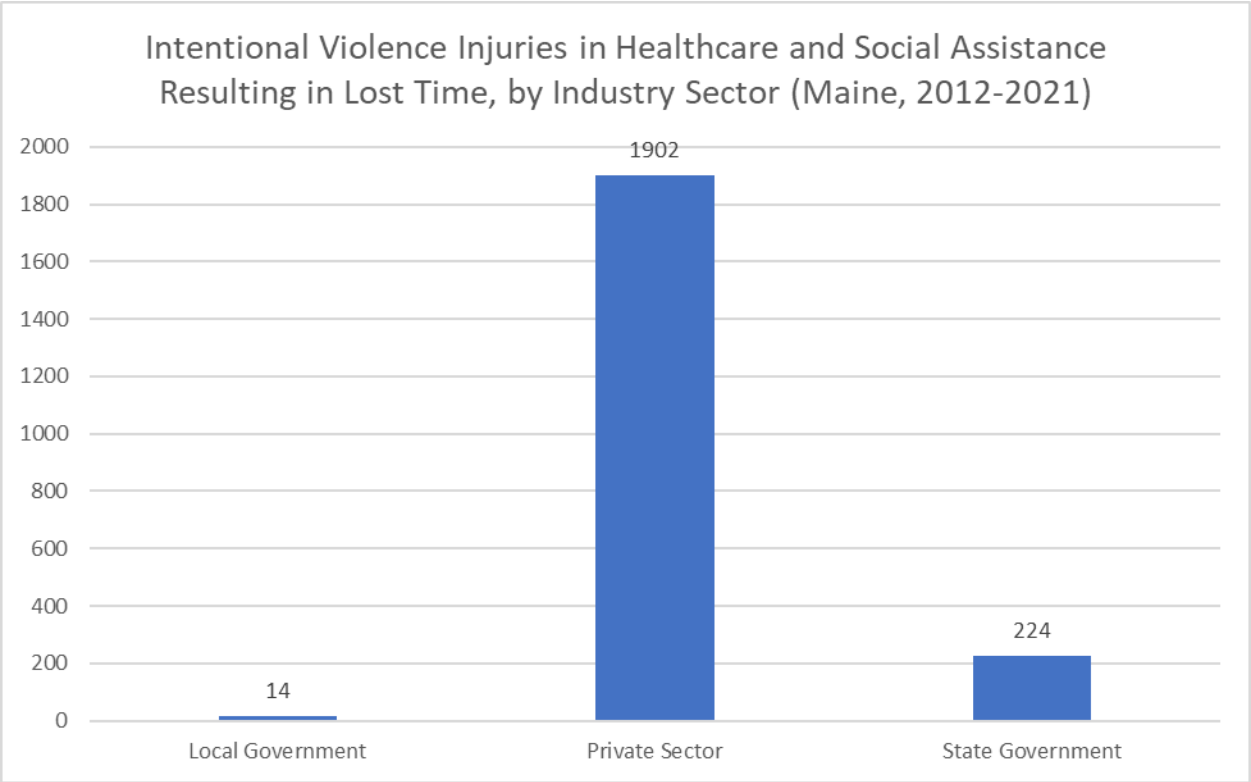


While there appears to be a slight upward trend in the data over time, it could be more easily explained by the increasing trend in total employment within the healthcare and social assistance industry than an indication of rising violence in Maine's healthcare industry. A similar increase exists in the number of individual establishments providing healthcare and social assistance services, leading to a less noteworthy conclusion that the more workers who are exposed to the workplace hazard, the more workers who are injured in violent events.

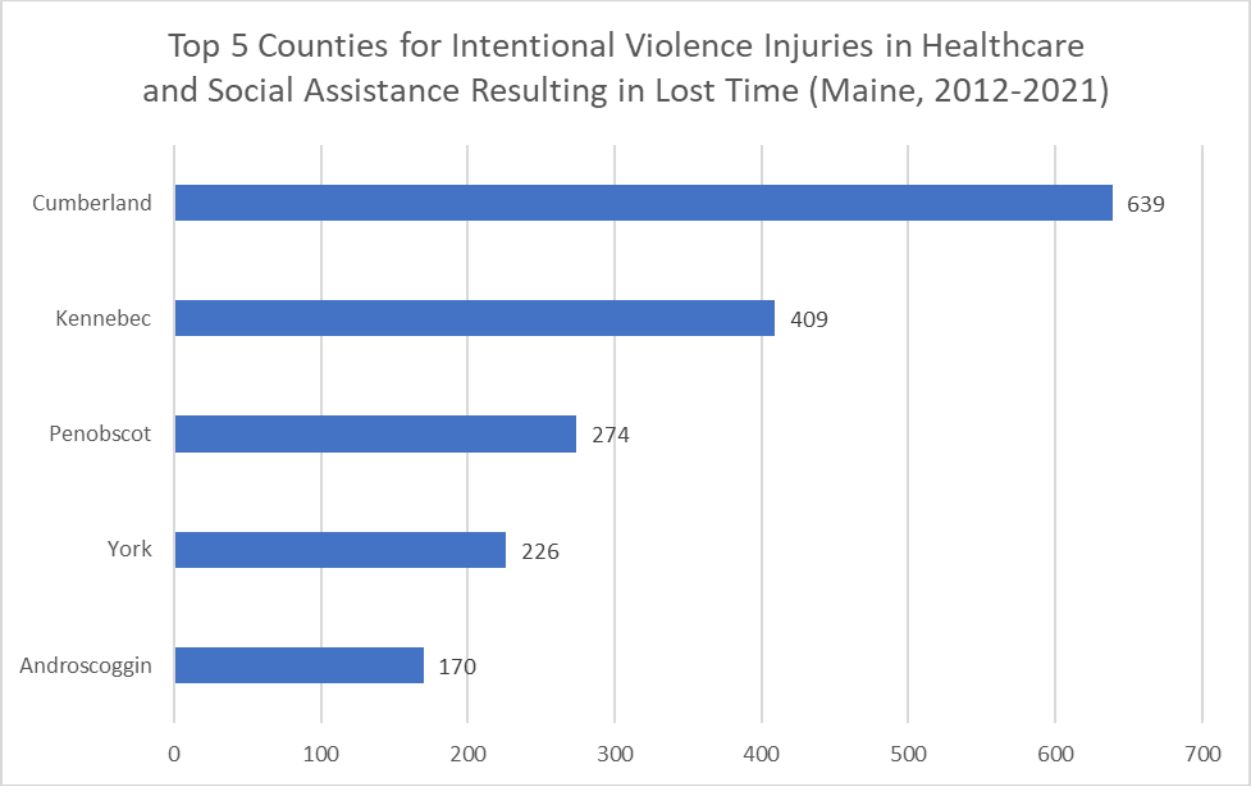


The progression of COVID-19's spread through Maine hospitals is not reflected in violence injuries





Half of Maine's largest private employers are General Medical and Surgical Hospitals, so it's unsurprising to see the private sector hosting a vast majority of these injuries. Local government includes Mayo Regional Hospital in Dover-Foxcroft before it was privatized, and the Barron Center in Portland. State Government includes Riverview Psychiatric Center, Maine Veterans Homes, and Dorothea Dix Psychiatric Center.

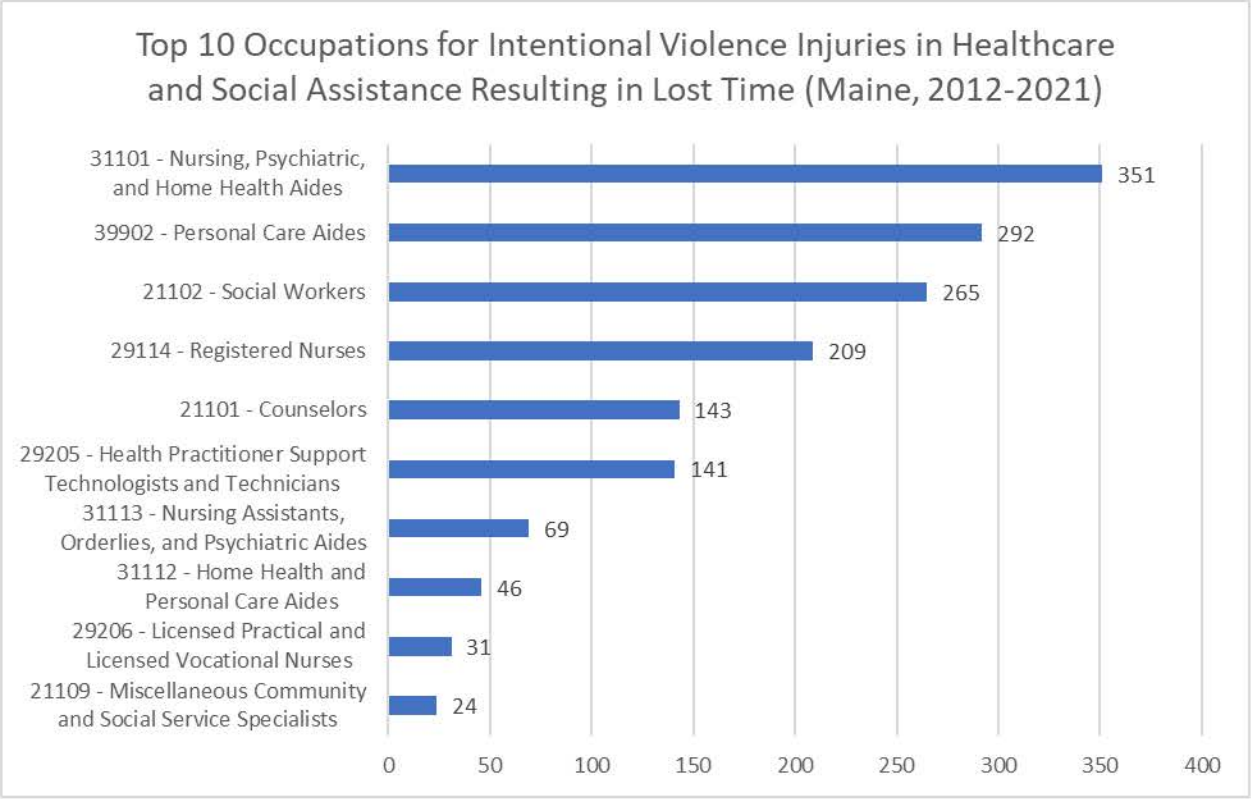


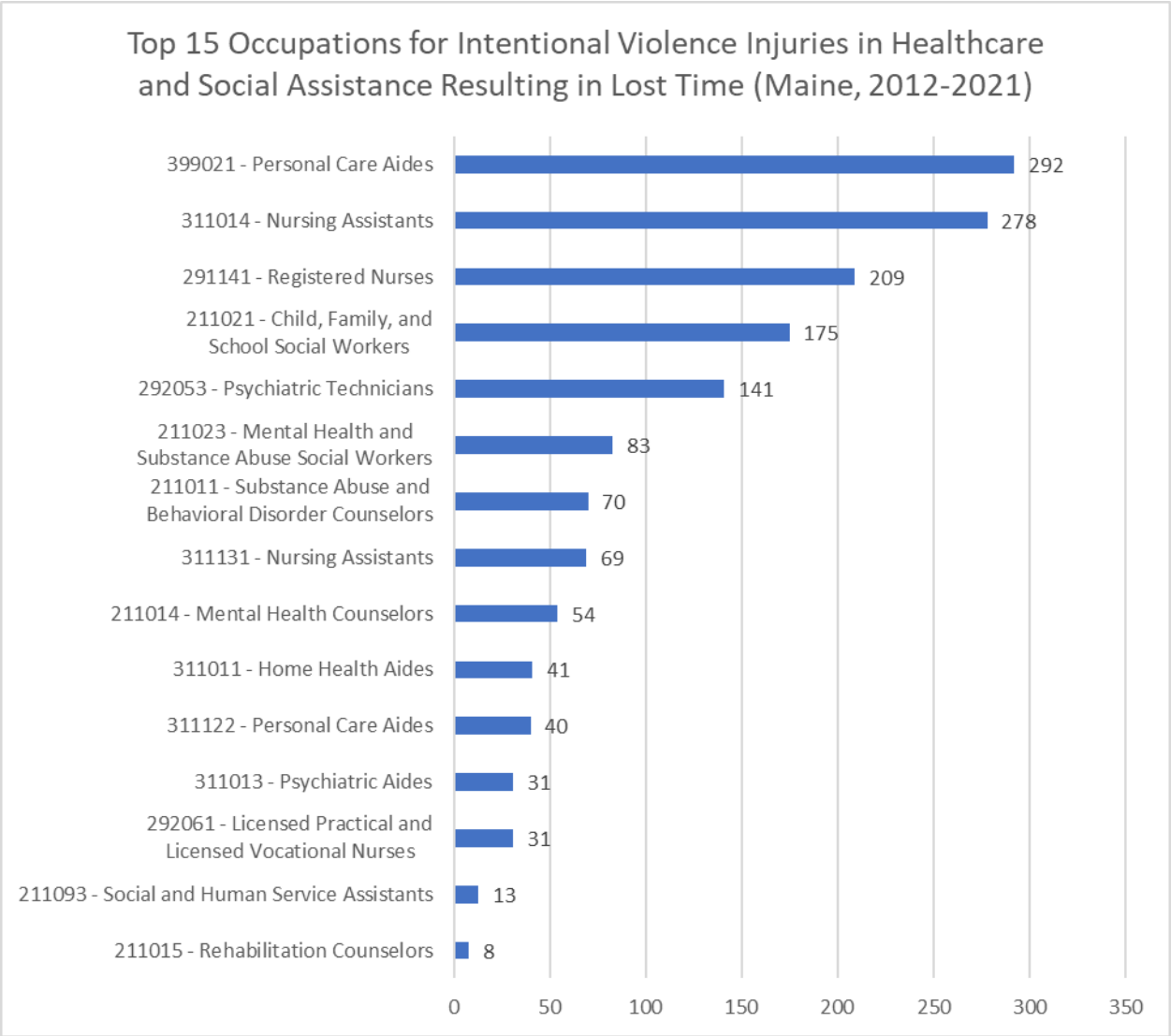
With each of the top 5 counties home to a major hospital campus employing hundreds of workers directly, and thousands of local workers in satellite offices within the hospital network, the distribution of violence cases seen above is not unexpected. For reference, Aroostook was the next highest county of incidence, totaling 90 claims over the past 10 years.

These 5 occupation classes account for 1,979 (92.5%) of the 2,140 total claims filed, so there are few insights to be gained from discussing other occupations such as healthcare managers, security guards, or patient access representatives. This breakdown is based on the Standard Occupational Classification (SOC) system using the first 2 digits of the 6-digit occupational code. However, we can break down these occupation classifications further.

Every chart in the following series only lists extensions of the occupation classifications featured in the previous chart. E.G. Every 3-digit SOC code in the next chart will have either 31, 29, 21, 39, or 25 as the first two digits.

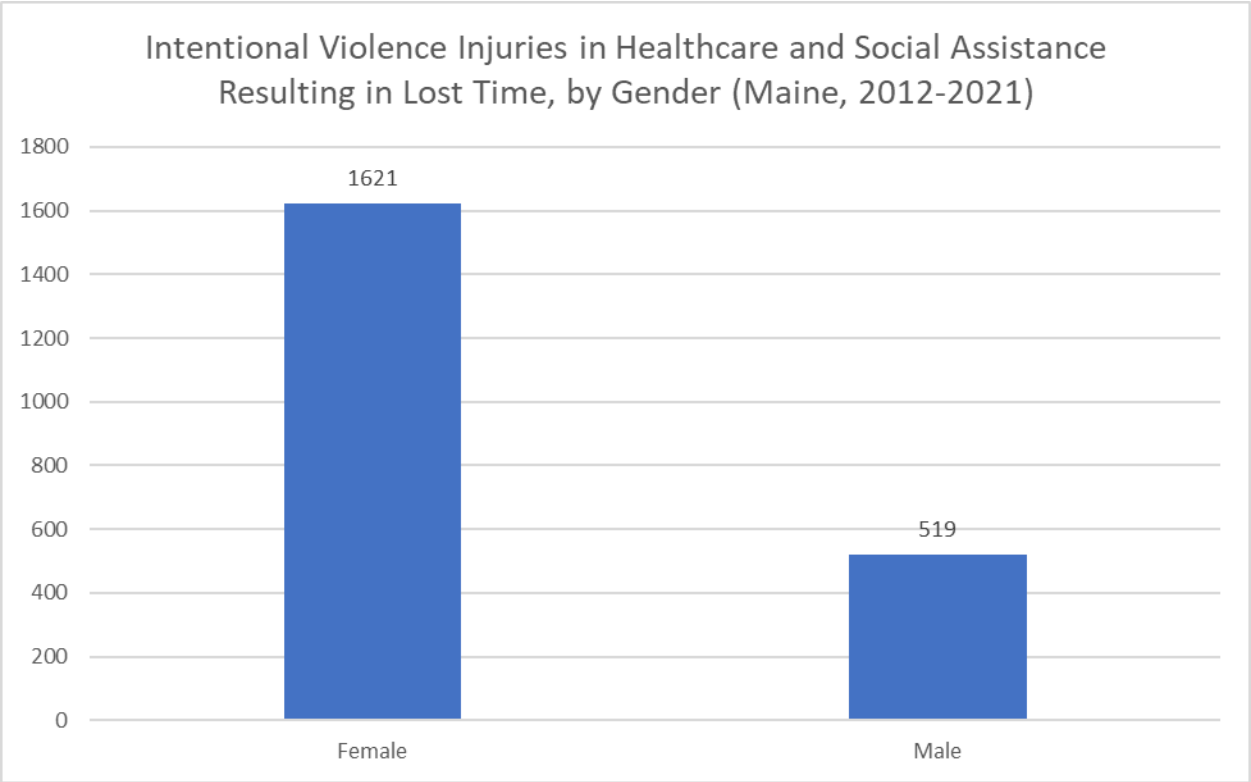

Top 5 Occupations for Intentional Violence Injuries in Healthcare and Social Assistance Resulting in Lost Time (Maine, 2012-2021)
311 - Nursing, Psychiatric, and Home Health Aides
466
211 - Counselors, Social Workers, and Other Community and Social Service Specialists
432
399 - Other Personal Care and Service Workers
349
291 - Healthcare Diagnosing or Treating Practitioners
237
292 - Health Technologists and Technicians
198
0 50 100 150 200 250 300 350 400 450 500


Top 10 Occupations for Intentional Violence Injuries in Healthcare and Social Assistance Resulting in Lost Time (Maine, 2012-2021)
31101 - Nursing, Psychiatric, and Home Health Aides
351
39902 - Personal Care Aides
292
21102 - Social Workers
265
29114 - Registered Nurses
209
21101 - Counselors
143
29205 - Health Practitioner Support Technologists and Technicians
141
31113 - Nursing Assistants, Orderlies, and Psychiatric Aides
69
31112 - Home Health and Personal Care Aides
46
29206 - Licensed Practical and Licensed Vocational Nurses
31
21109 - Miscellaneous Community and Social Service Specialists
24
0 50 100 150 200 250 300 350 400

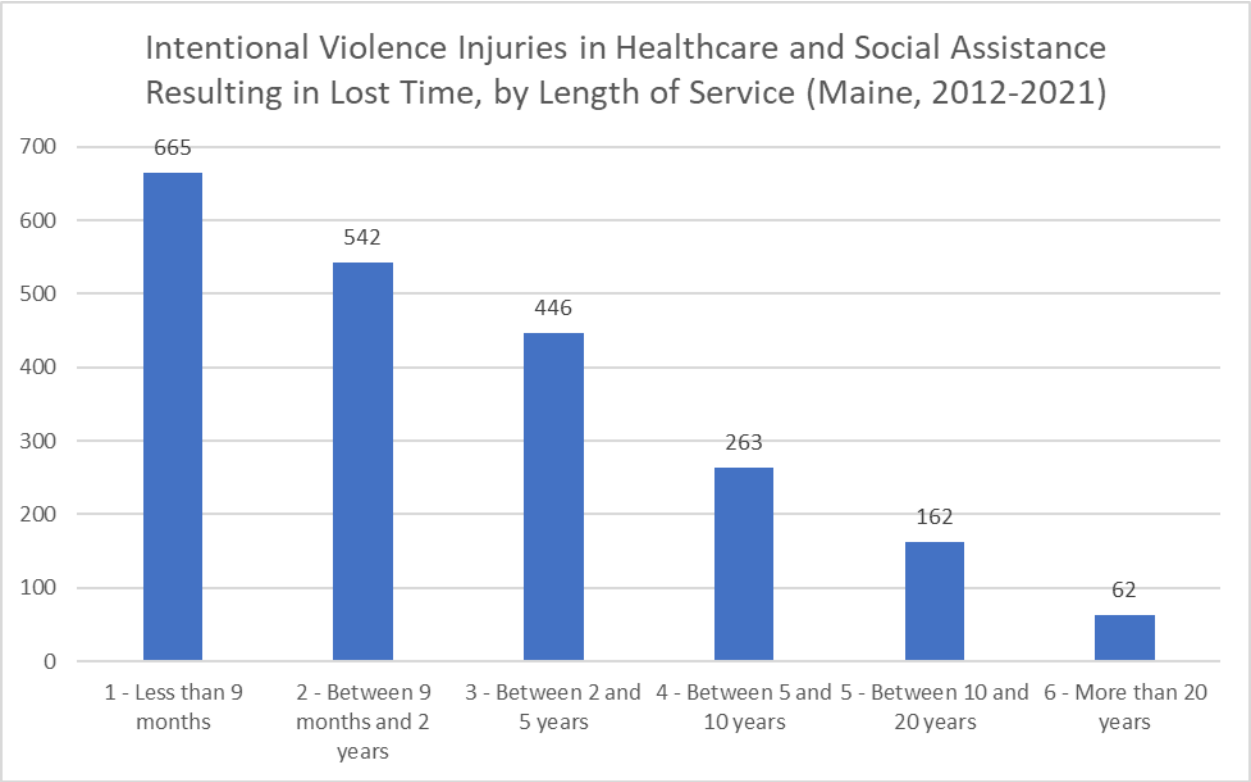


These 15 occupational classifications account for 1,535 (71.7%) of the 2,140 lost time violence claims in the healthcare and social service industry.

Note: Personal Care Aides are listed twice due to a change in the coding structure. From 2012 through 2019, personal pare aides used the unique 399021 code. In 2020, they were moved into the 311 – group alongside home health aides, nursing assistants, orderlies, and psychiatric aides.

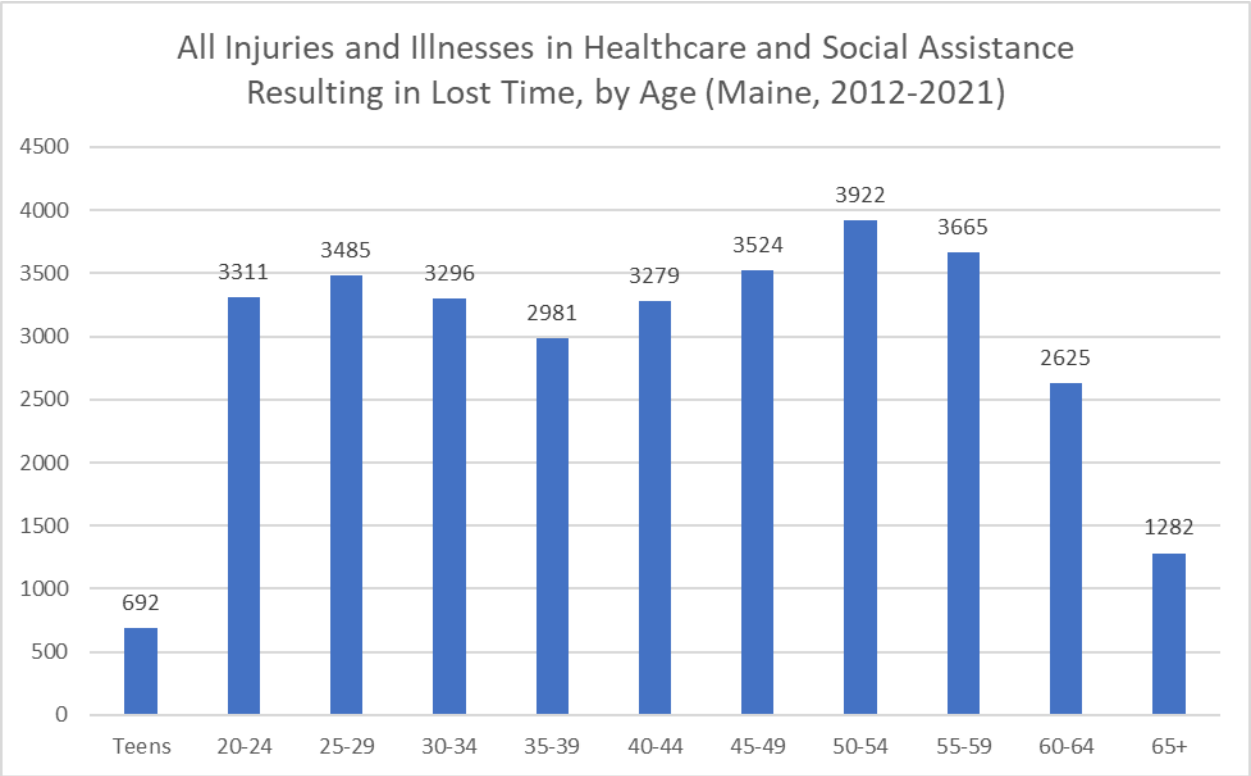


Seeing 3 out of every 4 violence injuries occurring to female workers is not surprising. This is very much in line with the overall claim spread, where 4 out of every 5 lost time injuries or illnesses in the healthcare and social assistance industry are occurring to female workers.



Typically, 1 out of every 3 lost time claims is filed by a worker who has not yet finished their first year of service with their employer. The divisions above have been chosen to display a better illustration of the steady decrease in injuries as employees become more tenured in their position. The trend seen here is typical of many industries and occupations.

The routineness of the length of service splice makes the following age demographics stand out.

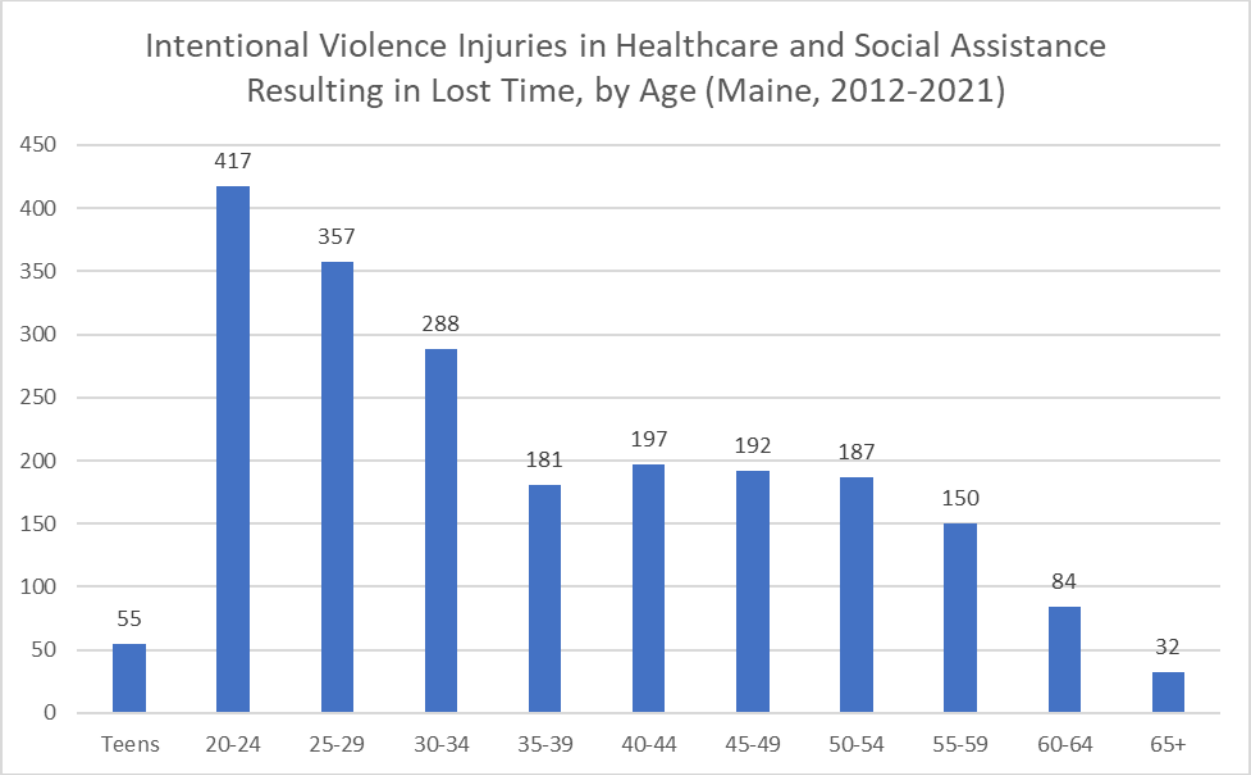


Note: Age represents the age of the worker at the time of the injury, not normalized to their age in 2022.

When looking at large swaths of injury data by age, the shape of the graph above is seen frequently. Low injuries to teens followed by a sharp increase with a local maximum in the mid to late 20's is expected. Injury counts then decrease through the 30's, before starting to rise again and ultimately peaking in the early to mid-50's. Finally, there is a sharp drop off in injury counts as workers become eligible for retirement.

What we've noticed in the past is that age bears so significance on injuries; younger workers are equally likely to suffer a lost time injury in the workplace as older workers. The has allowed us to use age as a proxy for estimating the age of the Maine workforce. The chart above accurately displays the age distribution of workers within the healthcare and social service industry over the last 10 years.

We would expect this same general shape for almost any chart with a sufficient number of data points. For intentional violence in healthcare and social service, we have over 2,000 injuries, which should be more than enough to generate this distribution. However, that is not the case.

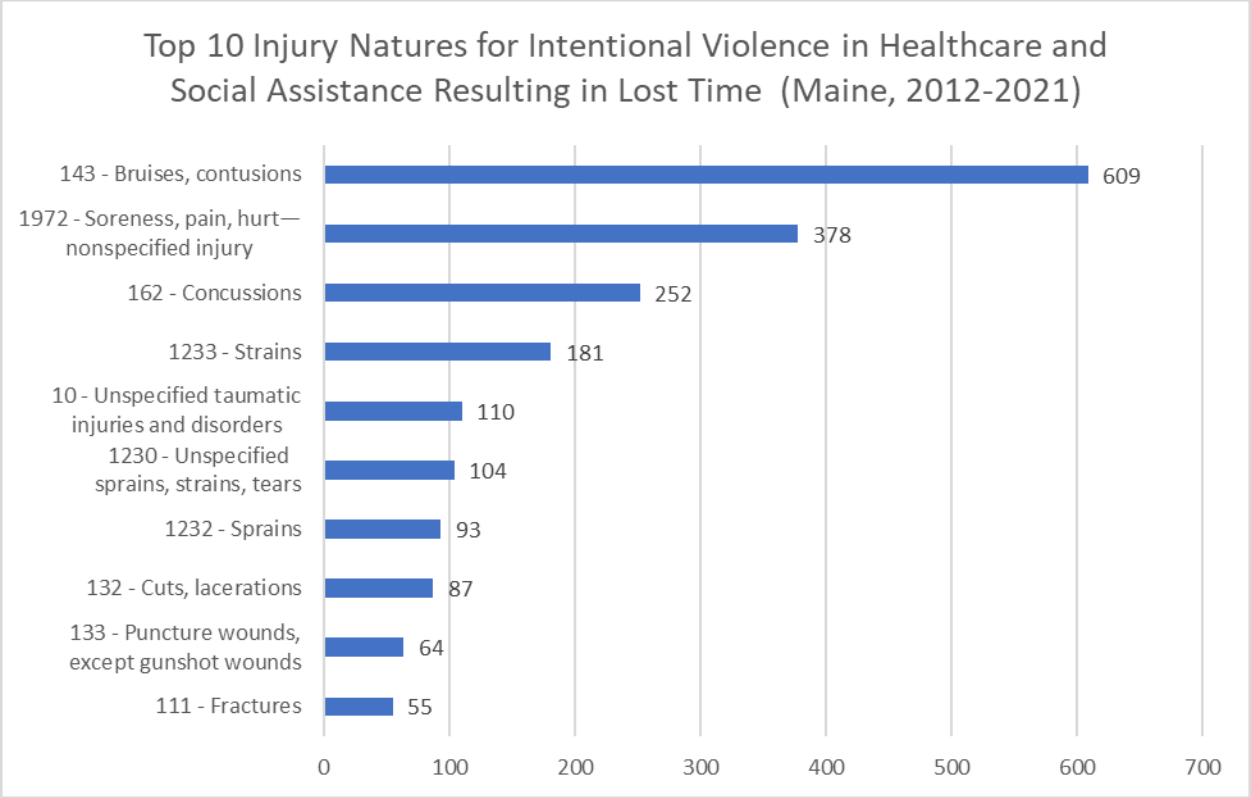


Here we see an absolute maximum in the count of injury claims for workers in their early 20's, and an almost strictly decreasing number of injuries in older workers. Given the previous demographic slices showing trends which are more-or-less regular for large datasets, the age demographic is completely contrary to our expectations.

There could be numerous reasons for this distribution, and most likely a combination of factors more easily ascertained by those working in the industry. We offer some possible explanations as a starting point to spur deeper discussions

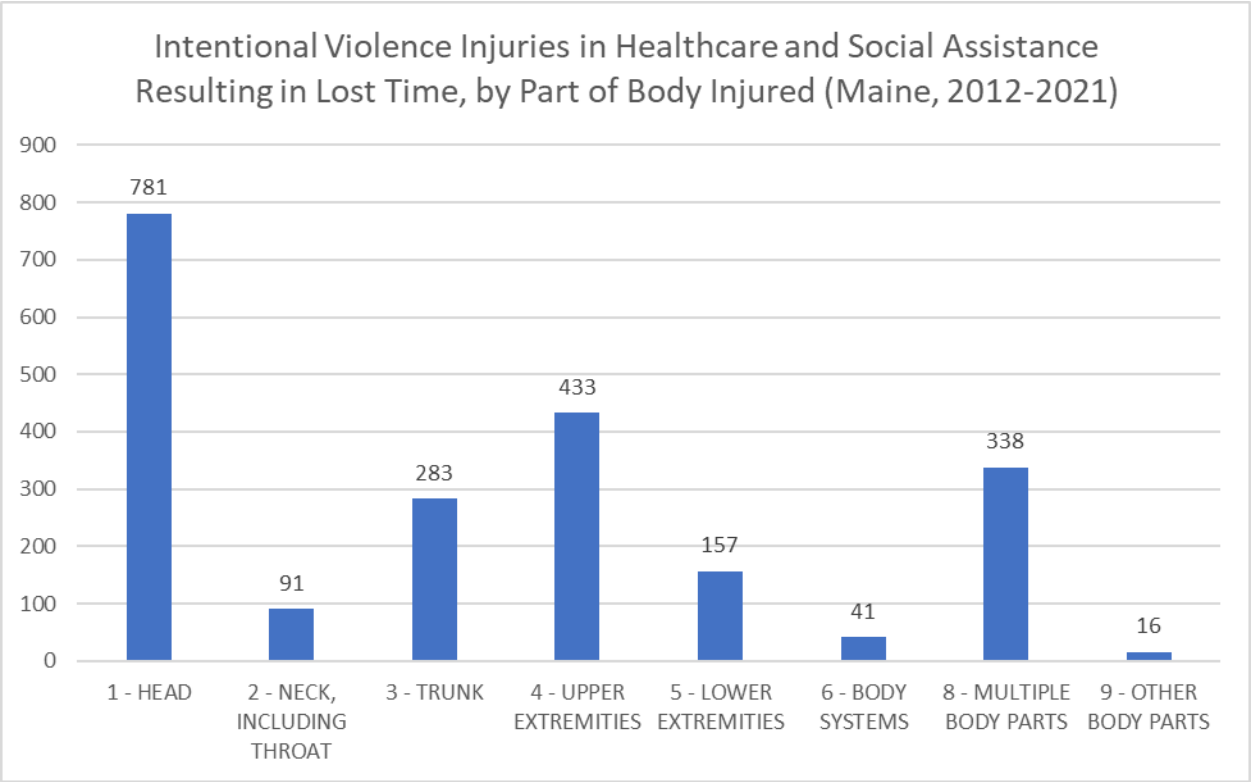
- The healthcare and social assistance industry may be seeing a significant amount of turnover, and new hires already at higher risk of injury are disproportionately younger workers
- Younger workers may be suffering violent injury events before they are able to complete their MOAB training, and are more at risk of violence due to their lack of education
- Younger workers may lack the experience or emotional intelligence to assess when a patient begins showing signs of hostility, and not act as defensively or disarmingly as older workers
- Younger workers may not be empathizing with patients appropriately, and coming off as a cold target to people who already feel disconnected, abused, or frustrated by the healthcare system
- Younger workers are systematically being put in more hazardous situations, assigned to care for patients with a higher risk of lashing out

- Patients are more likely to feel disrespected by younger workers telling them unpleasant news, and therefore less restrained in their interactions with the workers.

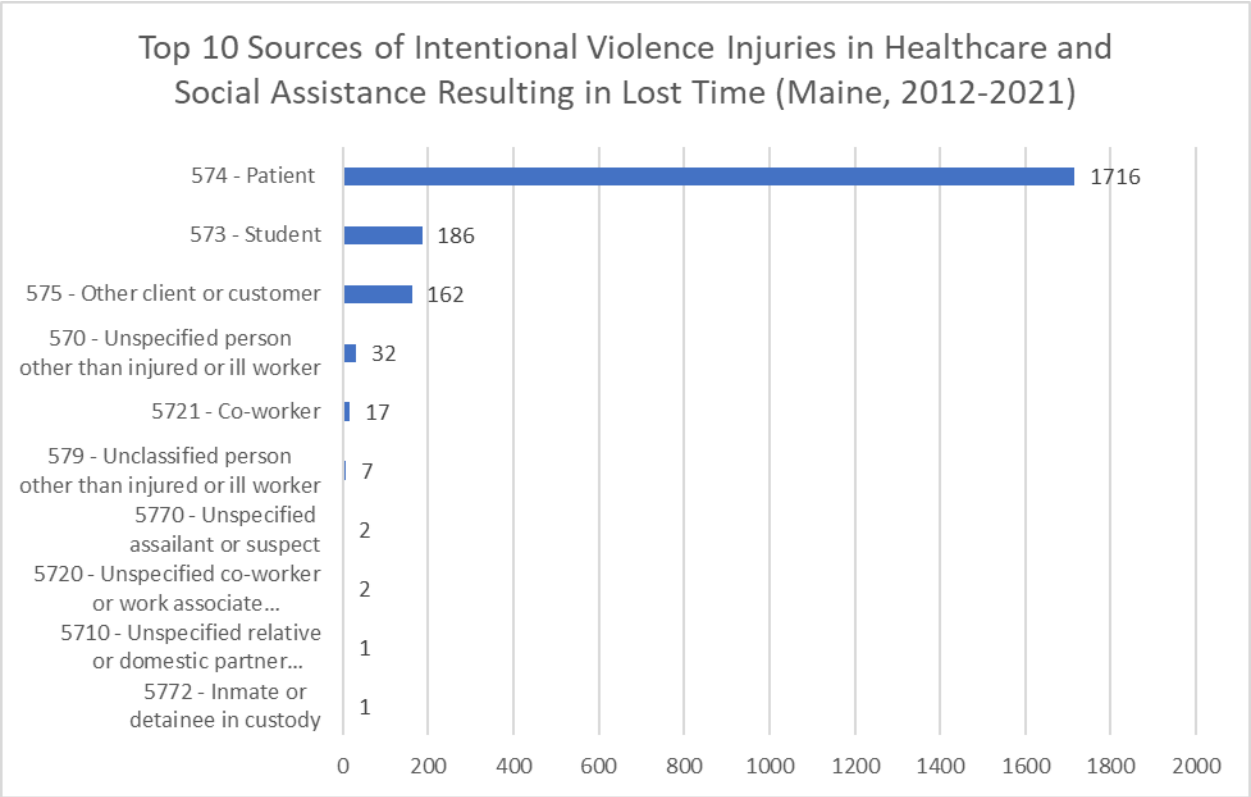


"Soreness, pain, hurt – nonspecified injury" represents injuries where there is not enough information in the claim to assign a more specific medical diagnosis. This nature having the second highest frequency is a sign that these types of injuries are more lacking in detail compared to other injury events. Given the higher level of specificity and medical jargon typically seen in the narratives for this industry, it's odd that vague terms of Hurt, Sore, or Injured would appear without more descriptive language. Two possible explanations are below.

- There may be some reluctance to talk about these types of injuries in detail, to protect patient confidentiality for instance
- The full extent of the attack is unknown at the time the FROI is filled out and submitted



Any time the nature of injury is a concussion, the Brain will always be selected as the part of body injured. While that explains some of the disproportionate head injuries resulting from violent attacks, it doesn't fully explain the tendency for aggressors to go for the head.



The person who commits a violent act is classified according to their relationship to the injured worker. There should be no surprise that a vast majority of violent injuries are committed by patients. The Student and Other Client/Customer classifications are specific to a select few occupations within the industry and are used due to the employee and the other person not having a traditional provider/patient relationship.

APPENDIX E

Maine Judicial Branch Data on §752-C

Adult Assault on an Emergency Medical Care Provide 17-A M.R.S. § 752-C (1)

The below data represents the number of charges filed and manner of disposition by calendar year 2017 through 2021 and are based on the number of counts filed in adult criminal cases. In addition, the data do not represent the number of defendants charged as an individual defendant may have had more than one count filed in a single complaint or may have more than one case in any given year or years.

Number of charges filed:

DISTRICT	2017	2018	2019	2020	2021
1	1	4	2	2	3
2	3	2	2	4	3
3	3	1	1	2	2
4	1	0	0	4	1
5	3	0	7	3	5
6	2	1	1	5	5
7	0	5	0	3	0
8	2	1	1	2	1
CY TOTAL	**15**	**14**	**14**	**25**	**20**

Number of convictions:

DISTRICT	2017	2018	2019	2020	2021
1	0	0	0	0	1
2	0	1	0	0	1
3	0	2	0	0	0
4	0	0	0	0	1
5	0	0	2	2	0
6	0	0	0	0	0
7	0	0	0	0	0
8	1	1	0	0	0
CY TOTAL	**1**	**4**	**2**	**2**	**3**

ASSAULT ON AN EMERGENCY MEDICAL CARE PROVIDER 17-A M.R.S. § 752-C (1)

Sentencing/Fine details

DISTRICT	CASEID	FILING DATE	FINDING DATE	FINDING	JAIL	TOTAL JAIL DAYS	BASE FINE AMT	SURCHARGES	SUPERVISION	RESTITUTION	RESTITUTION AMT
1	YRKCDCR202000109	9/10/20	12/17/21	GUILTY	3 YEARS ALL BUT 7 DAYS SUSPENDED	1,095	$300.00	$35.00	PROBATION 2 YEARS	F	-
2	CUMCDCR201801245	7/15/17	3/5/18	GUILTY	6 MONTHS ALL SUSPENDED	180	$0.00	$35.00	PROBATION 2 YEARS	T	$1,391.00
2	CUMCDCR202100182	3/5/21	8/9/21	GUILTY	18 MONTHS ALL BUT 6 MONTHS SUSPENDED	540	$0.00	$45.00	PROBATION 2 YEARS	F	-
3	ANDCDCR201702375	10/3/17	7/19/18	GUILTY	1 YEAR ALL SUSPENDED	365	$300.00	$35.00	-	F	-
3	ANDCDCR201703288	12/5/17	12/5/18	GUILTY	4 YEARS ALL SUSPENDED	1,460	$0.00	$35.00	PROBATION 2 YEARS	F	-
4	KENCDCR202002399	4/22/21	9/15/21	GUILTY	3 YEARS ALL BUT 111 DAYS SUSPENDED	1,095	$0.00	$45.00	PROBATION 2 YEARS	F	-
5	PENCDCR201900769	6/26/19	8/12/19	GUILTY	1 YEAR ALL BUT 90 DAYS SUSPENDED	365	$0.00	$35.00	PROBATION 2 YEARS	F	-
5	PENCDCR201900769	6/26/19	8/12/19	GUILTY	90 DAYS ALL SUSPENDED	90	$0.00	$35.00	-	F	-
5	PISCDCR201900233	7/25/19	7/7/21	GUILTY	18 MONTHS 4 MONTHS SUSPENDED	540	$0.00	$35.00	PROBATION 1 YEAR	F	-
5	PISCDCR202000249	10/29/20	7/9/21	GUILTY	1 YEAR ALL SUSPENDED	365	$0.00	$45.00	-	F	-
8	AROCDCR201720191	7/24/17	10/31/17	GUILTY	2 YEARS ALL BUT 101 DAYS SUSPENDED	730	$0.00	$35.00	PROBATION 2 YEARS	F	-
8	AROCDCR201840143	5/11/18	12/21/18	GUILTY	299 DAYS ALL SUSPENDED	299	$0.00	$35.00	-	F	-

APPENDIX F

Proposed Legislation

AN ACT TO PROTECT HEALTH CARE WORKERS FROM WORKPLACE VIOLENCE

Sec. 1. 17-A MRSA §752-C is amended to read:

752-C. Assault on an emergency medical ~~care provider~~ services' person.

~~1.~~ A person is guilty of assault on an emergency medical ~~care provider~~ services' person if that person intentionally, knowingly or recklessly causes bodily injury to ~~an emergency medical care provider a~~ person licensed under Title 32, section 82, while the ~~emergency medical care provider~~ person is providing emergency care regardless of where the treatment is provided.

~~2. As used in this section, "emergency medical care provider" includes hospital personnel assisting in an emergency and emergency medical services persons, defined in Title 32, section 83, subsection 12, but does not include a firefighter as defined in section 752-E, subsection 2.~~

~~3~~2. Assault on an emergency medical ~~care provider~~ services' person is a Class C crime.

Sec. 2. 17-A MRSA §752-F is enacted to read:

752-F. Assault in an emergency department

1. A person is guilty of assault in an emergency department if that person intentionally, knowingly or recklessly causes bodily injury to a person employed or contracted by a hospital licensed under Title 22, chapter 405 if the injury occurs in the hospital's designated emergency department.

2. Assault in an emergency department is a Class C crime.

Sec. 3. 17-A MRSA §1604, sub-§5, ¶B is amended to read:

B. If the State pleads and proves that, at the time any crime~~, excluding murder,~~ under chapter 9, 11, 12, 13, 27 or 35~~, excluding section 853-A~~; section 402-A, subsection 1, paragraph A; ~~or~~ section 752-A; ~~or~~ section 752-C or section 752-F was committed, or an attempt of any such crime was committed, the individual had 2 or more prior convictions under chapter 9, 11, 12, 13, 27 or 35, excluding section 853-A; section 402-A, subsection 1, paragraph A; ~~or~~ section 752-A; ~~or~~ 752-C or 752-F, or for an attempt of any such crime, or for engaging in substantially similar conduct in another jurisdiction, the sentencing class for the crime is one class higher than it would otherwise be.

(1) In the case of a Class A crime, the sentencing class is not elevated, but the prior record must be assigned special weight by the court when imposing a sentence.

(2) Section 9-A governs the use of prior convictions when determining a sentence, except that, for the purposes of this paragraph, for violations under chapter 11, the dates of prior convictions may have occurred at any time.

This paragraph does not apply to murder under chapter 9 or section 853-A. This paragraph does not apply to section 210-A if the prior convictions have already served to elevate the sentencing class under section 210-A, subsection 1, paragraph C or E or any other offense in which prior convictions have already served to elevate the sentencing class.

SUMMARY

This bill makes assault in an emergency department against a person employed by a hospital a Class C crime. It clarifies that assault against an emergency medical services' provider while that person is providing emergency care is a Class C crime regardless of where the assault occurred. It allows elevation of the crime of assault in an emergency department and makes other nonsubstantive changes to 17-A MRSA §1604, sub-§5, ¶B.

APPENDIX G

Letters Sent By the Task Force

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

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

Commissioner Jeanne M. Lambrew
Department of Health and Human Services
11 State House Station
Augusta, ME 04333-0011

Dear Commissioner Lambrew,

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. This study was prompted by the increase in violence experienced by hospital employees at the hands of patients and families. The Health and Human Services Committee broadened the focus of the original bill to include violence in other health care facilities and settings.

During the task force's deliberations, it became apparent that there is a dearth of standard data collection around incidents of violence against health care workers. There is anecdotal evidence from behavioral health providers, group homes and long term care facilities that incidents of violence against front line workers has increased. Some nursing facilities are collecting some information on violent incidents. We know that providers take the issue seriously with respect to training in de-escalation techniques and other prevention activities. However, task force members believe that there should be a systematic and comparable system for data collection. Standardized data would allow for actions and solutions that are grounded in data rather than anecdote.

We are requesting that the Department of Health and Human Services convene a group of health care providers, other than hospitals, to develop a system of data definitions and data collection to identify violent acts experienced by health care staff. (The task force has requested that the Maine Hospital Association coordinate a group of hospital representatives to develop a standard dataset and terminology that is applicable to hospitals.) Data collection could include data such as incidents of violence, near misses (for example, a patient throws a chair but misses the employee), what type of facility (including residential or community), location of the violence within the facility, type of employee injured, perpetrator (patient or family; age), type of violence, calls to law enforcement and any data that makes sense. We are requesting a report 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 your assistance. We know that you share our concern for the safety of our health care workers who undertake their work on behalf of serving others. They are critical to the health of Maine's people and 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
Molly Bogart, Government Relations Director, DHHS

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

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Department of Health and Human Services
11 State House Station
Augusta, ME 04333-0011

Dear Commissioner Lambrew,

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. This study was prompted by the increase in violence experienced by hospital employees at the hands of patients and families. The Health and Human Services Committee broadened the focus of the original bill to include violence in other health care facilities and settings.

Although violence against health care workers is not an appropriate or justified response to frustration, it nevertheless appears to us to be partly a response to the shortages of services. We believe that the shortage of services, both residential and community, and in all areas including long term care, intellectual disability and autism, and behavioral health, is a primary root cause of the number of individuals stuck in hospital emergency departments. These individuals no longer need emergency medical treatment but lack placement for the appropriate therapeutic environment for effective treatment. We also know that there are facilities with empty beds but insufficient staff to staff those beds and so they remain empty.

We know this a complex issue with multiple causes. One of the causes is reimbursement rates that do not always account for costs in certain areas. We understand that there is a new and much-needed rate system review process that was encapsulated in Public Law 2021, chapter 639. However, there are costs that are not currently included and we are requesting that the following topics could be considered outside of that regular review process:

- *Bed hold days payments.* The task force understands that there are federal restrictions on the level of payments to nursing facilities and PNMIs for days in which the occupants of those beds are in hospital. For example, Appendix C and F facilities are reimbursed for up to 30 bed hold days but only for the room and board portion and not for the direct care portion; for facilities the reimbursement amount is not sufficient to maintain staffing levels. Appendix B, D and E facilities are not directly compensated for bed hold days but the department states that the rates include occupancy rates to support a period of time when

members are out of the facility (for B and D facilities, that results in approximately 30 days). We are asking that the Department might consider how best to reimburse for bed hold days to allow the facility to keep the bed available for the occupant while in the hospitals while retaining staff.

- *Days awaiting placement payments for hospitals.* Current law in Title 22, §3174-AAA allows for reimbursement to hospitals other than critical access hospitals for each day after the tenth day that a MaineCare eligible individual is in the care of a hospital while awaiting placement in a nursing facility. There is an annual maximum funding cap of $500,000 per year for this purpose and the law has a sunset date of December 21, 2023. We are requesting that days awaiting placement payments to hospitals be broadened to allow for payment for any MaineCare eligible person, including children, rather than only nursing facility eligible individuals. (Representative Anne Perry, chair of the task force, submitted a bill to achieve this purpose.)
- *Behavioral add-ons in reimbursement rates.* The task force requests that the Department of Health and Human Services review reimbursement rates to allow for additional reimbursement for PNMIs to provide services for individuals with co-occurring behaviors.
- *Security costs.* Hospitals have increasingly hired or contracted for security personnel without a means of recouping those costs; we request that the Department investigates the ability for MaineCare reimbursement to include a portion of security costs.

Thank you for your assistance. We know that you share our concern for the safety of our health care workers who undertake their work on behalf of serving others. We also know that you share our concern about the lack of placements for individuals who are stuck in emergency departments awaiting a more appropriate placement.

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

Anne Perry

Rep. Anne Perry
House Chair

cc: Task Force members
Michelle Probert, Director, Office of MaineCare Services
Molly Bogart, Government Relations Director, DHHS