Health care leaders understand the tenets of the Triple Aim — enhancing the patient’s experience, improving the health of the population and reducing costs. A newly coined fourth aim adds developing a resilient workforce, thus creating the Quadruple Aim.¹ MHA recognizes the necessity of the Quadruple Aim as a framework to achieve high-quality care delivery and recently has put it into practice. MHA’s July 2019 Quality and Safety Convening engaged health care staff from Missouri hospitals for a program focused on achieving bold aims for patients in a safe care environment. Recognizing the interdependencies of the care team — the patient, their family and the caregivers — resulted in the following takeaway: We must empower and support our health care workers to engage their patients to achieve optimum health.

These interdependencies between the clinicians, patients and their families are challenged by the continued prevalence of workplace violence within the care setting. An infographic from the Advisory Board highlights the impact of violence and point-of-care safety threats that undermine nursing resiliency.² Without a resilient workforce, hospital efforts to improve the health of their patients will be diminished.

Despite efforts to mitigate violence against health care workers, incidents remain prevalent in hospitals and clinics. The 2019 MHA Preparedness and Safety Assessment found that 48 percent of hospitals (n=132) report workplace violence or violent intruders as one of their top three internal risks.³ The assessment further validates that hospitals are investing in necessary mitigation strategies, as indicated in the following table.
Mitigating Workplace Violence: Progress in Missouri

August 2017
Missouri health care workers received increased legal protection through Section 565.002, RSMo, which was expanded to include all hospital personnel in the “special victim” definition, authorizing enhanced penalties against individuals convicted of assaulting hospital staff.

November 2017

February 2018
MHA establishes a repository of workplace safety policies available to members to validate existing approaches and identify best practices.

April 2018
MHA’s Strategic Quality Advisory Committee approves Missouri’s definition of workplace violence in health care settings, developed by MHA’s S.A.F.E.R. Initiative Task Force.

September 2018
MHA’s SQAC approves metrics to frame a statewide data collection initiative.

October 2018
The U.S. Department of Health and Human Services appropriations bill includes language calling for a collaborative report from the Centers for Medicare & Medicaid Services and the Occupational Safety and Health Administration to provide protections and support safe health care environments. The report was published in August 2019.

November 2018
Executive members of MHA’s Psychiatric Network and Rural Hospital Council discuss the behavioral health crisis in rural emergency departments during MHA’s Annual Convention & Trade Show.

January 2019
Missouri hospitals begin collecting first quarter workplace violence data based on the established definition.

March 2019
MHA staff present EMTALA/HIPAA principles at the statewide Crisis Intervention Team conference.

April 2019
MHA’s Strategic Quality Advisory Committee approves Missouri’s definition of workplace violence in health care settings, developed by MHA’s S.A.F.E.R. Initiative Task Force.

May 2018
MHA convenes regional workshops throughout Missouri to address HIPAA, EMTALA and safe patient handoffs with law enforcement.

June 2019
MHA facilitates regional workshops to develop, implement and evaluate effective workplace violence prevention programs for hospitals and outpatient clinics based on the Oregon Association of Hospitals and Health Systems’ comprehensive toolkit.
While hospitals have collectively made progress in mitigation, work continues to fully achieve safe care environments. Violence against health care workers is characteristically underreported. This is because of several factors to include, but not limited to, lack of physical injury, time-consuming incident reporting procedures, lack of organizational support and the belief that violence is part of the job. Having a better understanding of where, how and by whom the violence occurs within the health care setting will inform policymakers and executives to identify the most appropriate solutions.

Beginning Jan. 1, MHA began collecting workplace violence data to quantify the prevalence of these incidents in Missouri hospitals using a definition developed and approved by the MHA S.A.F.E.R. Initiative Task Force.

Key findings from preliminary data collected from January to July indicate that the majority of incidents reported by Missouri hospitals are directed at employees by patients or visitors, with roughly two-thirds of these involving an individual with a mental health diagnosis. Emergency departments report the highest number of incidents followed closely by other patient care areas such as “the floor.” These early findings create opportunities to target or direct education and resources accordingly.

MHA continues to seek a larger representative sample to complete further analysis and causal factor attributions. Hospitals are encouraged to submit data to MHA through the HIDI Quality Portal. A user guide is available for just in time reference, or staff can assist with the submission process.

**Gun Violence in America**

Violence isn’t isolated to health care settings but certainly impacts the environment in which care is provided. Recent headlines demonstrate the vulnerable position of the U.S. as it relates to incidents of violence. These events impact the entire community, with uncertainty of where they will occur and who they may effect. An August 2019 report by the National Council for Behavioral Health reviewed existing data on mass violence, provided an analysis about its causes and impacts, and made recommendations to inform next steps. The report defines mass violence as crimes in which four or more people are killed in an event or related series of events. According to the report, “A substantial majority of mass violence occurs by shooting, and the rate of mass shooting occurrences and number of people killed are increasing.” Hospitals play a role as the first receivers of trauma victims that result from gun violence, are susceptible for gun violence to occur on their premises, and have an opportunity to influence change as communities look at broad strategies to recognize and prevent the cycle of violence. Missouri Department of Public Safety Director Sandy Karsten reflects on this critical alignment of community partners.

“In public safety, we see first-hand the heroic, life-saving work performed by Missouri hospitals in the aftermath of shootings and other tragedies.”

Sandy Karsten
Missouri Department of Public Safety Director

“‘In public safety, we see first-hand the heroic, life-saving work performed by Missouri hospitals in the aftermath of shootings and other tragedies,’ Karsten said. ‘Public safety agencies and hospitals regularly train and conduct exercises together to help make sure we can get trauma patients the best care as quickly as possible, but it’s also vitally important that hospitals plan and train team members in case anything ever happened in their own workplace. Planning, training and exercises are essential in health care facilities and anywhere people gather — and that should include how to recognize precursors and encourage all to report anything out of the ordinary. All of us must remember, ‘If You See Something, Say Something.”’
Industry Best Practice: Oregon’s Approach to Facilitate Improvement

In 2014, to address the increasing prevalence of violence in the health care setting, the Oregon Association of Hospitals and Health Systems established a Workplace Safety Initiative, including a comprehensive toolkit, to identify solutions and pilot interventions to mitigate violence in the care environment. Missouri and many other states are adopting Oregon’s model, which includes the following sequential steps of program development, evaluation and sustainment.11

<table>
<thead>
<tr>
<th>Define the Need for, or to Enhance, a Workplace Violence Prevention Program</th>
<th>WPV Program Foundation &amp; Management</th>
<th>Hazard Identification &amp; Assessment</th>
<th>Hazard Control and Prevention</th>
<th>Develope the WPV Program Plan</th>
<th>Implement &amp; Evaluate the Program</th>
<th>Program Improvement &amp; Sustainability</th>
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<tbody>
<tr>
<td><strong>STEP 1</strong></td>
<td><strong>STEP 2</strong></td>
<td><strong>STEP 3</strong></td>
<td><strong>STEP 4</strong></td>
<td><strong>STEP 5</strong></td>
<td><strong>STEP 6</strong></td>
<td><strong>STEP 7</strong></td>
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<tr>
<td>Using the toolkit and provided resources, review best practices for assessing risk, control and prevention of workplace violence.</td>
<td>Analyze data to identify units, departments and employee groups with higher risk of exposure to workplace violence, as well as the nature, severity and cost of these injuries.</td>
<td>Enlist support of senior leadership to develop or enhance the Workplace Violence Prevention Program.</td>
<td>Identify a program champion, project coordinator and interdisciplinary committee — include behavioral health and external stakeholders such as law enforcement.</td>
<td>Educate the committee about the principles and elements of a successful Workplace Violence Prevention Program and the current environment based on data collected.</td>
<td>Determine the scope of the issue and identify key stakeholders.</td>
<td>Analyze all data collected to prioritize hazards and the needs of the program.</td>
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<td>Identifylicable regulations and legal responsibilities.</td>
<td>Begin to identify hazards, risks and specific program elements that need to be addressed.</td>
<td>Collect baseline incident/injury data through the OSHA 300 log, incident reports and associated workers’ compensation costs related to workplace violence.</td>
<td>Analyze data to identify units, departments and employee groups with higher risk of exposure to workplace violence, as well as the nature, severity and cost of these injuries.</td>
<td>Share the proposed approach to addressing violence at the facility and their role as a committee in implementation.</td>
<td>Assess the organization’s culture and readiness for change.</td>
<td>Develop the Workplace Violence Prevention Program plan.</td>
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<td><strong>STEP 9</strong></td>
<td><strong>STEP 10</strong></td>
<td><strong>STEP 11</strong></td>
<td><strong>STEP 12</strong></td>
<td><strong>STEP 13</strong></td>
<td><strong>STEP 14</strong></td>
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<td><strong>Using the toolkit and provided resources, review best practices for assessing risk, control and prevention of workplace violence.</strong></td>
<td><strong>STEP 9</strong></td>
<td><strong>Develop a communications plan, an employer education and training plan, and a workplace violence prevention policy.</strong></td>
<td><strong>STEP 10</strong></td>
<td><strong>Complete the program plan to include what, how, who, cost, return on investment, timeliness, measurement tools and how the program will be implemented.</strong></td>
<td><strong>STEP 11</strong></td>
</tr>
<tr>
<td><strong>STEP 2</strong></td>
<td><strong>Analyze data to identify units, departments and employee groups with higher risk of exposure to workplace violence, as well as the nature, severity and cost of these injuries.</strong></td>
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<td><strong>Identify a program champion, project coordinator and interdisciplinary committee — include behavioral health and external stakeholders such as law enforcement.</strong></td>
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<td><strong>Educate the committee about the principles and elements of a successful Workplace Violence Prevention Program and the current environment based on data collected.</strong></td>
<td><strong>STEP 7</strong></td>
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<td>Implementation approach and policy following leadership input.</td>
<td><strong>STEP 6</strong></td>
<td><strong>Determine the scope of the issue and identify key stakeholders.</strong></td>
<td><strong>STEP 12</strong></td>
<td><strong>Finalize the program, plan, approach, and policy following leadership input.</strong></td>
<td><strong>STEP 13</strong></td>
<td><strong>Implement the program policy, plan and hazard controls.</strong></td>
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<td>Implement the communications plan.</td>
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<td><strong>Develop a communications plan, an employer education and training plan, and a workplace violence prevention policy.</strong></td>
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<td>Educate and train employees.</td>
<td><strong>STEP 11</strong></td>
<td><strong>Obtain approval of the program plan, implementation approach and draft policy from senior leadership.</strong></td>
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<td><strong>STEP 15</strong></td>
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<td><strong>STEP 15</strong></td>
<td><strong>Plan, implement and standardize pilot processes to other departments and locations.</strong></td>
<td><strong>STEP 15</strong></td>
<td><strong>Conduct proactive audits of units and departments to identify risks for violence, and gaps in current policies and practices.</strong></td>
<td><strong>STEP 15</strong></td>
<td><strong>Develop a process to integrate security and safety design principles into facility wide building remodels and new construction.</strong></td>
<td><strong>STEP 15</strong></td>
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Current Proposed Legislation

House Resolution 1309 Workplace Violence Prevention for Health Care and Social Service Workers Act was introduced to the 116th Congress on Feb. 19, by Representative Joe Courtney. Its companion, Senate Bill 851, was introduced by Sen. Tammy Baldwin on March 14. The bill requires the Department of Labor to address workplace violence in the health care and social service sectors by promulgating an occupational safety and health standard that requires certain employers in the health care and social service sectors, as well as employers in sectors that conduct activities similar to the activities in the health care and social service sectors, to develop and implement a comprehensive plan for protecting health care workers, social service workers and other personnel from workplace violence. In addition, those employers must investigate workplace violence incidents, risks or hazards as soon as practicable; provide training and education to employees who may be exposed to workplace violence hazards and risks; meet record keeping requirements; and prohibit acts of discrimination or retaliation against employees for reporting workplace violence incidents, threats or concerns. Nine states — California, Connecticut, Illinois, Maine, Maryland, New York, New Jersey, Oregon and Washington — have passed local legislation to require hospital workplace violence prevention programs. While companion bills were introduced in the 2019 Missouri legislative session, no action was taken. The 41 states without specific mandates must comply with OSHA's General Duty Clause, and are encouraged to develop prevention plans reflective of OSHA's Guidelines for Preventing Workplace Violence.

Critical Next Steps: Five Things Hospitals Can Do to Foster Safe Care Environments

To generate state and federal support for hospital-driven improvement related to workplace violence plans and policies, hospitals must implement and maintain strong workplace violence prevention programs. Violence against the workforce impacts all organizational operations and as such, requires a comprehensive program to manage strategies for prevention.

1. Engage Executives

Leadership involvement and support for the violence prevention initiative is critical to the success and sustainment of the program. In addition to identifying an executive champion of the program, hospitals should prioritize establishing or refining administrative huddles to include a safety/security report. This provides an excellent opportunity to proactively communicate timely requests for additional resources during high-risk cases, as well as responsive staff support following an assault.

2. Analyze Risks and Threats

Program staff must understand the risk to the environment to allocate their staff and training resources accordingly. This includes, but is not limited to, identifying staff most at risk for point-of-care violence, understanding the higher risk areas within the hospital or higher risk hospitals within a health system, and using historical data to educate staff on the necessary triggers to request timely assistance. An excerpt from Katherine Eyestone, Chief Transformation Officer with HSS Inc., further describes how data can be used to support safety and security resource allocations.

"HSS Inc., a national health care-specific workplace violence prevention training and contract security company, is a leader in utilizing data to design and run effective onsite security programs in health care settings. HSS invested in statistical modeling and benchmarking capabilities to understand the drivers of
security incidents and has shared key findings at recent industry events. These findings assist health system and security leaders in designing effective security programs that can help address problems like turnover in emergency department staff and hospital staff workers’ compensation claims due to assault. ‘Security program’ refers to the combination of security personnel, technology and training in place to protect the people and property of a location.

Utilizing a variety of sources, HSS examined data from more than 100 HSS-secured health care facilities to determine what factors are statistically significant drivers of security incidents. Initial modeling validated that the crime index of the community and the annual ED visit volume are statistically significant predictors of security incidents as either the crime index or ED visit volume increases, the number of security incident rises. The analysis also showed that certain aspects of a security program have a statistically significant impact on security incidents, including the average tenure of the team of officers at a location, and whether TASERs or a magnetometer are present. (TASERs and magnetometers generally are utilized only at facilities in higher crime areas.)

Security leaders can utilize this information to analyze the effectiveness of a security program and to make improvements. These findings provide an initial evidence base for security leaders to compare outcomes (security incidents, hospital staff workers’ compensation claims due to assault, etc.) across secured facilities, segmented on the basis of risk by crime index and annual ED visit volume. They also suggest what program modifications — security officer tenure, for example — a security leader can leverage to reduce adverse outcomes like assaults. By working to create a safer environment for hospital staff and patients, security leaders can contribute to a hospital or health system’s goals to improve quality of care and safety.

3. Provide Staff With Tools to Recognize Agitation

Training programs must highlight modules on recognizing and verbally de-escalating aggressive behaviors. This approach empowers staff to proactively assess and implement the appropriate interventions based on resources available to them. Physical interventions should be trained to a level of competence but used as a solution of last resort. With training and experience, staff will gain confidence in recognizing the signs and symptoms of agitation in their patients and visitors. Symptoms of agitation include but are not limited to the following:

- clenched fists, jaw
- change in body language
- pacing/fidgeting
- protruding chest
- change in verbal tones — yelling, bullying
- defiance in following established rules

With the advancements of electronic medical records and the ability to retrieve prior medical histories, some health systems have elected to flag records of patients who have a history or propensity of violence for internal use. This approach supports the effort of providing the care team with the necessary information to adequately and appropriately provide informed care to the patient. Alerting the care team to a propensity for violent behaviors provides situational awareness and allows staff to make informed decisions throughout the patient visit.

4. Centralize Reporting

As hospitals develop or refine their reporting procedures related to workplace violence, it is suggested that a centralized reporting platform be developed for employee health, security incidents and injury reports. Early efforts to quantify and address violence against caregivers have been characterized as isolated and disjointed. For example, security staff often track incidents requiring their assistance, while human resources and risk management track those incidents resulting in injury.

5. Engage Locally With External Partners

Externally, hospitals must engage with law enforcement to facilitate safe patient care transitions. This is a necessary step for all hospitals. However, these interactions will look different depending on the hospital security program. Hospitals with employed security need to foster a shared understanding of procedures, while hospitals without formal security programs need to proactively identify triggers to notify law enforcement in a timely manner. All hospitals are encouraged to foster strong partnerships with their local Crisis Intervention Team councils to proactively foster relationships with community partners. More information on Missouri’s CIT program is provided.
The Missouri Crisis Intervention Team program is a partnership of law enforcement and other first responders, behavioral health providers, hospitals, courts, individuals with lived experience, and community partners who are dedicated to implementing the Missouri Model of CIT.

**Goals of CIT:**
- Promote more effective interactions between local law enforcement and other first responders and individuals in crisis through a 40-hour training centered on behavioral health education and de-escalation skills.
- Help individuals in crisis by connecting them with appropriate community resources in an effort to divert involvement with the criminal justice system.
- Improve the safety of the first responder and individual(s) in crisis.
- Reduce stigma.
- Expand and sustain CIT across the state.

**CIT COORDINATOR**
Missouri’s CIT program is led by the state CIT Coordinator with direction from the CIT Council. The coordinator provides overall leadership of the program, including the facilitation of the council, statewide expansion efforts, leveraging of partnerships, training, education and advocacy.

**LOCAL CIT COUNCILS**
Local CIT Councils are comprised of local law enforcement and other first responders, behavioral health providers, courts, hospitals, community partners, and individuals with lived experience. Each council works to identify and address local structural barriers to individuals receiving the services they deserve to achieve greater stability. Council members also provide updates on any changes in resources in the area. CIT Councils are encouraged to provide CIT trainings to local law enforcement and other first responders, focusing on local resources.

**MISSOURI CIT COUNCIL**
The Missouri CIT Council is a network of representatives from each established local council across the state, Community Mental Health Liaisons, state agencies and associations, and those with lived experience. The council works to address any structural barriers at the state level, and advocates for policy and legislative changes that may be necessary to support health and wellness. The council also provides direction and support on the CIT curriculum, training, expansion and implementation of the program. The council also hosts an annual CIT Conference.

The Missouri Department of Mental Health, in partnership with the Missouri Coalition for Community Behavioral Healthcare, provides administrative and financial support for the coordinator and the council.
Conclusion

MHA continues to shape a more structured program through its S.A.F.E.R. Initiative to engage members, and provide resources and guidance to assist hospitals with workplace violence prevention resources. Monitoring the legislative and regulatory environment, facilitating key partnerships, and sharing evidence-based practices are the three areas MHA staff have dedicated their attention to achieve results. Workplace violence prevention must be addressed through a comprehensive mitigation program. Our focus going forward will be on health care workforce training and resiliency, in addition to outcome measures to assist in the evaluation of security and safety programs.

References


Suggested Citation