EXECUTIVE INSIGHTS

RESILIENCY + RECOVERY

DEVELOPING EFFECTIVE WORKPLACE VIOLENCE-PREVENTION STRATEGIES

Building a safer, healing-centric environment

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Threats against health care workers are on the rise. The federal government reports that health care workers are five times more likely to experience workplace violence than employees in all other industries. Violence against health care workers has long been an issue, but it has increased significantly during the last few years. Hospitals are working to protect their staff and patients by identifying security risks with artificial intelligence (AI)-enabled monitoring and reporting systems, modifying facilities and expanding security technologies throughout its buildings, revising entry procedures, designating areas for patients and staff, adding barrier protection and exit routes, calling in de-escalation teams, and training staff in violence prevention. This executive dialogue explores how hospitals are using technology and training to mitigate risk, redesigning facilities and workflow processes to prioritize safety and reenvisioning relationships with hospital security and others to support prevention and crisis response.

Key elements of comprehensive workplace violence prevention and intervention

1 | **Develop a comprehensive workplace violence-prevention program** that educates team members to recognize potential situations, de-escalate and manage those behaviors, when to involve security and various reporting methods. Conduct a risk assessment by a security consultant. Track and create process improvements if there's an ongoing trend. Leaders in each location need to evaluate and deploy tactics that apply to their facilities.

2 | **Equip staff with annual, nonviolent crisis-intervention training based on job code.** Staff in the emergency department (ED), behavioral health, security, and house supervision, should receive the highest level of training. Incentivize staff to participate in the training and learn de-escalation techniques. Partner with local police to educate the staff.

3 | From a design aspect, **new facilities and any renovations should go through a Crime Prevention Through Environmental Design study.** Create a scoring scale to determine what level of security is needed. Implement basic security standards in all facilities, a clear divide among the waiting area, public area and clinical area, a secure door with a badge reader, cameras in the waiting room, building entryways, stairwells and elevator lobbies.

4 | In areas with significant violence-risk factors like EDs, **evaluate and employ weapons detection systems and equip staff badges with a real-time locating system** to summon help and communicate the identity of staff members and the precise location of the emergency.

5 | Depending on the location and violence threat, **train security staff with tasers, firearms or gel pepper spray.** Offer financial incentives for security officers and develop different tiers of payment based on their training.

6 | **Assess the vulnerability of off-site locations.** Distribute wearable panic buttons to staff in off-site locations with the alarm going directly to 911 and consider boosting security rounding.

7 | **Look at autonomous security robots** for larger health care locations that don't have security personnel. These automated guards perform security tasks, combining self-driving technologies, robotics and AI. They have a designated patrol path and two-way communication so that if somebody needs assistance, the security team is able to either provide aid or call law enforcement depending on the situation.

8 | **Address the community behavioral health needs with other partners** through outpatient, virtual or other methods of intervention, rather than admitting patients into an inpatient unit with limited capacity. Leverage telehealth with behavioral health specialists to partner with primary care practices to keep patients stable, from both medical and behavioral management perspectives, and to help reduce recidivism in the EDs.

9 | **Use dogs to provide strength, comfort and emotional support** to individuals, families, communities and first responders who experience intense traumatic emotions in the aftermath of critical incidents.

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MODERATOR *(Suzanna Hoppszallern, American Hospital Association):* **What areas in your facilities present the greatest risk of exposing patients and caregivers to violence? What innovations have you deployed to mitigate this risk?**

BENJAMIN CARTER *(Trinity Health):* The emergency department (ED) is a critical concern for us, particularly with staffing shortages and long waits. We have experienced a higher level of aggressive behavior and instances of physical altercations. We've posted signs stating that it's a violation of the law to strike or in any other way abuse our staff and that violence is not permitted and will not be tolerated. In some instances, we've added security and metal detectors because the brandishing of weapons has increased somewhat, even though we have signs that prohibit weapons. In many of our ministries, we have brought in trained security dogs and have found that the dogs can, in some cases, be calming and serve as a deterrent to aggressive behavior. Staff can document concerns about aggression from a family member or a patient and add chart notes. Trinity has facilities across 25 states and while it's different everywhere and we don't mandate practices, we do share best practices. Our leaders in each ministry evaluate and deploy different tactics that apply to their respective facilities.

KELLY JOHNSON *(Children's Hospital Los Angeles):* We have dogs for the happiness factor in a children's hospital.

Our urban neighborhood is one of our biggest risk factors. Our amazing security force has a visible presence around our area. There's risk to our staff, who are trying to take public transportation, and that's a significant violence-risk factor over which we lack full control.

In a children's hospital, this could be the worst day in a parent's life. We always keep in mind that what families are going through has become worse post-pandemic, along with social injustice. Families are less tolerant of long waits and frustrated with trauma-informed care, as well as the desperation of having to deal with childhood terminal illness. We provide a lot of staff education to help them recognize potential situations, and de-escalate and manage behaviors before they require our behavioral health emergency response team or security to become involved.

ERIC ZELL *(Cincinnati Children's Hospital):* A security consultant has performed a risk assessment at a couple of our sites. We're using CenTrak, a real-time locating system, with all our staff at our College Hill location, which is our main behavioral health site. Staff badges, equipped with wireless call functionality, discreetly summon help via the network. During an emergency, staff simply press on their badges and the application instantly communicates the identity of the staff member and the precise location of the emergency. We're going to put in a weapons-detection system at both our EDs and in the lobbies of our College Hill location.

RACHEL FAULKNER *(Cameron Memorial Community Hospital):* We're a critical access hospital with five rural health clinics, urgent care and specialties like OB-GYN and psychiatry services, which tend to be our most vulnerable locations. All psychiatric and psychological services are provided on an outpatient basis. The ED is a place of vulnerability, as well as our OB unit, but we are hearing more from our rural health clinics and our psychiatry office, where there's a perception of the vulnerability of being off-site and not having as much security. We have distributed wearable panic buttons to staff in those areas; the alarm goes directly to 911 but, unfortunately with the older design, it ends up being alarm fatigue for our police who may not respond right away.

We have partnered with our local police to come in and educate the staff. We're also looking at alternatives for our panic alarms — applications that

can be installed on both the phone and computer to send notifications of the location where a threat might exist and panic buttons to press for different levels of response; for instance, one tap to get a response internally, two or three taps to notify the police. We've also boosted our security rounding to our off-site locations. We've implemented financial incentives for our security officers and developed different tiers of payment based on their training. They all receive de-escalation and physical tactics training, but we also provide an incentive if they earn additional certifications or receive firearms training. One officer on duty who has had firearms training is partnered with one who has not.

CYNTHIA DRY *(ScionHealth, Hospital Division):* Our two rural hospitals in Texas, Parkview Regional Hospital in Mexia and Ennis Regional Medical Center, partnered with the police departments on violence prevention. At a monthly meeting, a police officer comes in to teach different strategies to the leadership team, and now we're teaching our direct care staff as well. Staff are incentivized to participate in the training and learn de-escalation techniques.

MODERATOR: Has the rise in behavioral health needs in your communities caused you to reassess and prioritize capital project investments differently? As behavioral health services become integrated into all aspects of care delivery, have you forged new partnerships to address this demand and adopt upstream approaches?

LARISA GOGANZER *(AtlantiCare):* We see the gamut of security risks at both our urban and suburban hospitals. Our suburban hospital is surrounded by long-term care facilities, and we are seeing more behavioral issues in patients who might have dementia. Sometimes patient interactions with staff turn into physical altercations requiring help from security.

JAY FARHAT *(Baptist Health):* We're a large system with five hospitals, five satellite EDs, and about 90 primary care sites. We've taken a collaborative care approach to behavioral health with all our primary care sites. One positive outcome from COVID-19 is that we leveraged our telehealth systems. Our behavioral health providers call directly into a primary care site when one of our physicians or physician assistants (PAs) is confronted with any type of mental health crisis and needs to get the patient into our behavioral health system as quickly as possible. We also rolled that out to our EDs. We're one of two pediatric behavioral health units in the region and by far the largest.

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>
> — Rachel Faulkner —
> Cameron Memorial Community Hospital

The local law enforcement agencies bring their pediatric behavioral health patients to our EDs, regardless of whether that location is a receiving facility. We have started providing behavioral health specialists and, more importantly, the medications to those satellite EDs so that we can stabilize patients, get them the meds they need, and then transport them to our inpatient pediatric behavioral health unit. We have an adult behavioral health unit as well. We follow that same process, but we're really challenged with the increasing behavioral health needs of pediatric patients since COVID-19. We've gone to our state legislature and, luckily, we received funding to expand our pediatric behavioral health services in the Northeast Florida area. We expanded the number of beds by nearly one-third, which will be helpful in servicing the entire region.

CHUCK PICKERING *(Children's Hospital Los Angeles):* Being a children's hospital, we are not a psychiatric facility, and we rarely struggle with young people who are going through behavioral crises and who are admitted. They often end up in our ED. Some are brought here by the police directly from a school. Often, they are admitted, because we're trying to understand what their medication issue is and whether we can get that in good balance. They may end up staying with us for a long time awaiting a bed in a children's psychiatric unit. Kelly has been supportive of getting us behavioral technicians.

GOGANZER: We had to take our psychiatric inpatient program unit and create a separate area for our pediatric patients away from the adults. Because of the limited number of children's psychiatric beds available within the state, they were staying with us for too long awaiting a bed when it should take no more than 24 hours.

We've looked into Crisis Canines to provide strength, comfort and emotional support to individuals, families, communities and first responders who experience intense traumatic emotions in the aftermath of critical incidents.

JOHNSON: We have a contract with the California Department of Mental Health, and we have a huge behavioral health program, but no inpatient beds. Our state has limited psychiatric beds, especially for pediatrics. We're looking at what we're doing with the medical/psychiatric beds — whether we should have a separate unit or put patients on the unit where they're getting their medical specialty care and try to manage the psychiatric behavioral component.

GOGANZER: We've done it both ways — having the behavioral patients who have the medical needs mixed in with everyone else and creating a separate unit. We found success with creating a separate unit along with a security presence.

We also taught the Stress First Aid model to everyone on the unit with some extra behavioral modules so that they knew how to de-escalate those patients. This program decreased workplace violence incidents across the system and decreased injuries.

CARTER: Behavioral health is a huge issue for us and, unfortunately, there's chronic underfunding for behavioral health. We're trying to raise the level of awareness of the appropriate level of funding to provide the services, or we fear that continued closures of inpatient services may be necessary.

We're looking to address the community behavioral health needs with other partners, rather than bearing them on our own. More and more, we must address the needs through outpatient, virtual or other methods of intervention, rather than only admitting patients into inpatient units because of limited capacity. In the EDs, we have isolation rooms where behavioral health patients can stay for a period with extra security, but when those rooms fill, we're in crisis mode ourselves as we try to determine what the next site of care is for these patients.

MODERATOR: How are you mitigating some of the risk with violence-prevention strategies?

TOM CARRICO *(Baptist Health Hardin):* We're a 300-bed, hospital-based health system with a lot of ambulatory and outpatient care and one of the largest EDs in Kentucky by volume. We have a well-staffed security team. In addition to de-escalation training, all our security officers are trained and certified in the use of tasers. We also have expanded our Crisis Prevention Institute (CPI) nonviolent crisis intervention training to many of our clinical staff. Nearly all our ED clinicians and caregivers are CPI-trained.

We've equipped staff with annual CPI training, and our security team partners with our clinicians, caregivers and leaders. That's been an effective strategy for us, especially on the inpatient side where we routinely see an increase in violence and threats. Post-pandemic, hospitals are no lon-

ger seen as the heroes so, for many reasons, we're seeing those increases.

On the ambulatory side, we have a Grow Our Own program. We have two full-time psychiatrists who are training advanced practice registered nurses (APRNs), and even a few PAs to become behavioral health specialists. Those behavioral health specialists, APRNs and PAs work in concert with our primary care practices across the region. They have been effective in keeping these patients stable, from both a medical and a behavioral management perspective. These partnerships are starting to take off and are helping us reduce the number of recidivism patients that come through our EDs.

KATIE CHIEDA *(Fisher-Titus Health):* We're a 99-bed acute care hospital, but we also have a long-term care facility, assisted living facility and multiple ambulatory sites across the system. We provide all our team members with the same tools, whether it's de-escalation training or the panic button. Depending on the site of care, we consider several factors. We are seeing people come to different venues in different states of minds, where before we primarily saw that in the ED.

"We're looking to address the community behavioral health needs with other partners, rather than bearing them on our own. More and more, we must address the needs through outpatient, virtual or other methods of intervention, rather than only admitting patients into inpatient units because of limited capacity."

— Benjamin Carter —
Trinity Health

FARHAT: From a security standpoint, every Baptist Health team member goes through at least some level of CPI training based on their job code. However, staff in behavioral health, security, house supervision and the ED receive the highest level of CPI training as well as hands-on training in how to take a patient down to the ground without harming the patient or themselves. This is in addition to a comprehensive workplace violence-prevention program, which educates our team members to identify workplace violence, various reporting methods and then track and create process improvements if we determine there's a trend. Members of the security staff lead the way on the front end of behavioral health. When patients are brought in, security inventories their property, documents all their belongings and ensures that they possess nothing that can harm themselves or anyone else.

Unfortunately, we've started arming our security staff due to the uptick in health care violence that we're seeing; however, the response from our team members has been positive because they have an added sense of safety. All armed officers are retired law enforcement officers with 10 years or more of service. We've also implemented the Evolv weapons-detection system in all our EDs, whether it's a hospital-based ED or a satellite. It specifically detects firearms and explosives as well as large knives, but it doesn't detect the little things. We are especially concerned about weapons that will cause extensive damage in a matter of seconds. It's an expensive program, but our CEO and chief operating officer fully support this initiative, which has been successful.

CRYSTAL LOSING *(Logan Health–Cut Bank):* In a 20-bed critical access hospital, we have experienced several issues in the ED related to substance abuse and behavioral health. Our local police department is our security, but they are short-staffed and have abbreviated hours. Between 3 and 7 a.m., our police officers are on call. We have a panic button in a couple of locations in our ED and at our nurse's station, which connects to police station dispatch to deploy officers.

We have purchased Reflex Protect, a gel pepper spray that's highly targeted, so it will not take out

our entire ED, and is readily reversible with an antidote. Once we finish training and put policies in place, it will be ready to use.

We also have completed Aegis crisis-intervention training focused on mental and behavioral health care, which is comparable to CPI.

OSCAR GARCIA *(Methodist Hospital):* Methodist Health System has four hospitals, more than 30 clinics and a nursing and allied health college. I manage the main hospital. In terms of security, we're also looking at the Evolv weapons-detection system. My security team of 14 officers is unarmed. I'm the co-chair on the Workplace Violence Committee at my facility, and we meet monthly and review the trending and reporting.

We are about to roll out a program called RISE (Resilience in Stressful Events), developed at The Johns Hopkins Hospital to provide timely, peer support to health care workers who are second victims and/or who encounter stressful, patient-related events. We're not counselors per se, but it's a group of volunteers who are available to talk with employees in the moment to see if they're OK. If they need anything outside of that scope, we will refer them to the employee assistance program (EAP).

MATTHEW GRIFFIN *(Trinity Health Livonia Hospital):* We're a 300-bed hospital with a 30-bed inpatient behavioral health unit as well as a behavioral health residency program. An area of our ED is set aside for behavioral health patients. We could triple its size and fill it every day.

We have pediatric and adolescent patients who are sometimes with us for weeks, if not months, because we can't place them. The other challenge is that geriatric psychiatry resources are minimal, if any. Patients who are somewhere in the geriatric psychiatry continuum may be too disruptive to be at the next site of care, but they don't need to be on an inpatient side.

Families or the local facilities bring in these patients, but it's taxing on families. Either the patient is not safe, or the patient is threatening or hurting them. We also have staff members who are being assaulted. We have resources, we have a phenomenal team and we have a teaching team and yet we still can't keep up with the behavioral health needs. We have many more patients than we can see on any given day.

MODERATOR: What are you doing for staff after they go through the trauma of some of these workplace violence incidents?

CARTER: Trinity Health is a faith-based organization and, in each of our ministries, we have colleague care teams. They are all trained and respond to a variety of our colleagues' needs and crises. The colleague care teams round through the hospitals, talk to our colleagues, and whenever we have had an incident, they respond on the spot and support our colleagues. That's been effective.

We also offer personalized mental health services through Spring Health that have been responsive in assisting colleagues when they've either experienced a crisis or are feeling that they need support.

FAULKNER: We have done critical incident stress debriefs and used our on-site social workers to do that. There are a couple of individuals who are certified to do this. We also have used chaplains before. After a traumatic event adversely impacted the community this year, we learned that our EAP program would dispatch someone on-site. It takes a day or two, but we did bring someone in. We also have partnered with other entities in the community when it's something that has a wider impact, like our fire department.

JOHNSON: We have an internal EAP staffed by seven mental health practitioners, mostly clinical social workers. They offer an immediate response because they know the culture and the environment and, if

employees need additional services, we have the external EAP. This has been empowering and effective. Our internal EAP conducts critical-incident debriefings and other programs that we've developed.

MODERATOR: Are we designing our facilities to increase safety?

FARHAT: Over the past several years, the safety and security of our patients, visitors and staff has become a hot topic, and we're diverting considerable time and money toward this effort.

From a design aspect, all our new facilities and any renovations go through a Crime Prevention Through Environmental Design study. We're looking at the outside demographics of the facility area we're constructing or renovating and the internal numbers as well. What events have we had at these locations? We've created a scoring scale to determine the level of security needed. We also have standards that we've implemented at all facilities, so there's always a clear delineation among a waiting area, public area and clinical area. What we mean is that there will be a secure door with a badge reader. At a minimum, at least one camera will be installed in the waiting room and in our entryways into the buildings, our stairwells and elevator lobbies. If your facility is extremely large, you may not see every square inch, but at least you'll be able to track movement throughout the facility, whether they're inside or outside, floor to floor, unit to unit.

We've also implemented more security at our SG2 modeling, such as adding access control devices in our smaller facilities, which historically haven't had the benefit of much security. We're ensuring that all those facilities now have badge readers and cameras at our main entryways.

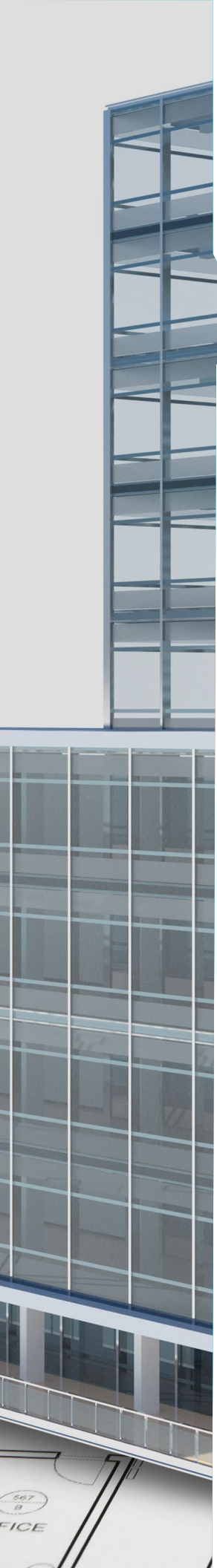
"We are about to roll out a program called RISE (Resilience in Stressful Events), developed at The Johns Hopkins Hospital to provide timely, peer support to health care workers who are second victims and/or who encounter stressful, patient-related events."

— Oscar Garcia —
Methodist Hospital

We may not be able to provide a physical security presence with an officer, but we're looking at robotics for some of our larger health facilities that don't have security personnel. These autonomous devices look like a trash can on wheels with a suite of onboard cameras and artificial intelligence. It has a designated patrol path and two-way communication so that if someone needs assistance, our security team is able to provide aid, call law enforcement or call our mobile security team depending on the situation.

The robot also has analytics that can determine if someone falls, if they're walking and they fall, or they're hurting themselves. It would alert our team and we'd be able to send people to assist. It can even differentiate whether someone has purposely gone to the ground and crawled beneath a car. It also can alert us to say, 'Hey, there's a potential theft in progress.' The robot is a force multiplier. It's not meant to take the place of individuals, but it provides AI coverage that we can implement at our larger facilities that don't have a physical security presence.

We are constantly educating our team members: 'If you see something, say something. Be aware of your surroundings. Don't use your cellphone when you're walking to and from.' We added an additional feature to our mass communication system — Everbridge, a module called Safety Connection. It's optional, but any team member can download an app to a cellphone with two-way communication capabilities to acknowledge receipt of alerts, confirm their safety or request additional assistance. It also has a panic button option. We design our facilities with purpose to provide the maximum amount of protection possible, within reason, but still be accessible to the public.



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