Cal/OSHA Advisory Meeting
Workplace Violence Prevention in Healthcare
Wednesday, September 10, 2014
Oakland, CA

Welcome: Juliann Sum, Acting Chief
Meeting Chairs: Deborah Gold, Bob Nakamura
Notes: Grace Delizo, Kevin Graulich

MEETING ATTENDEES

NAME	AFFILIATION
Hector Alvarez	Alvarez Associates
Cristina Barolet Garcia, MD	Los Angeles County USC Medical Center
Jason Barry	University of California
Gail Blanchard-Saiger	California Hospital Association (CHA)
Gerard Brogan	California Nurses Association
LaChanta (Candi) Brown	Harbor-UCLA Medical Center
Alice Burston	LA County Sheriff Dept.
Jorge Cabrera	SoCalCOSH
Trina Caton	Keenan & Associates
Lt. Cindy Conner	LA County Sheriff's Dept.
Cory Cordova	SEIU Local 121RN
Ingela Dahlgren	SEIU Nurse Alliance of California
Jordan DeLano	Committee of Interns and Residents/SEIU
Steve Derman	CIHC/Medishare Environmental Health
Denise Duncan	UNAC/UHCP
Kate Durand	SFDPH, Laguna Honda Hospital
Bridget Ehiemenonye	
Jennifer Gabales	California Association for Health Services at Home (CAHSAH)
Erica Garcia Pena	EORM
Ala Garza	UCSD/ANA
Chris Kirkham	Cal/OSHA
Suzi Goldmacher	Worksafe
Lisa Hall	California Association of Health Facilities
Meleah Hall	Teacher, CTA Member
Robert Harrison	UCSF, CDPH
Marc Hernandez	SEIU Local 721
Sheri Hinkle	SEIU
Kathy Hughes	SEIU Local 121RN
Cheri Hummel	California Hospital Association
Tricia Hunter	American Nurses Association of California (ANA/C)
Rebecca Jackson	Department of Industrial Relations
Vanessa Johnson	LA County Department of Children and Family Services
David Kernazitskas	Occupational Safety & Health Standards Board (OSHSB)
Dennis King	SEIU
Jeannie King	SEIU 121RN
Mary Kochie	Cal/OSHA

Nycky Lampone	Occupational Health Nurse
Betsy Leff	Alpha Fund
Delmi Madrigal	Department of Children and Family Services, LA County
Taisha McCulloch	Alameda Health System
DeAnn McEwen	California Nurses Association/ National Nurses United
Alberto Mejia	SEIU 121RN
Rosanna Mendez	
Lynn Michels	Kaiser Permanente
Dan Mooney	Federal OSHA
Elsa Monroe	SEIU 1000
Michael Musser	California Teachers Association
Richard Negri	SEIU 121RN
Rob Newells	UCSF Benioff Children's Hospital Oakland
Steven Pitocchi	SEIU Local 1021
Angela Platzel	San Francisco Department of Public Health
Kimberly Rosenberger	SEIU
Lindsay Sandberg	
Ruby Sloan	Alameda Health System, John George Psychiatric Hospital
Kenneth Smith	Retired
Pattie Soltero	Harbor UCLA
Sarah Springer	SEIU 121RN
Kevin Thompson	Cal/OSHA Reporter
Caryn Thornburg	ValleyCare Health System
Michael Tou	Providence Health & Services
Bradley Vandersall	UCSD
Mercal Vivier	SEIU Local 221
Sandra Williams	Alameda Health System
B.J. Wilson	Alameda Health System, John George Psychiatric Hospital, Highland Hospital

Deborah Gold, Deputy Chief for Health and Engineering Services, opened the meeting and welcomed the attendees. She introduced co-chair **Bob Nakamura** and other Division and Occupational Safety and Health Standards Board (Board) staff involved in the Workplace Violence rulemaking project.

Ms. Gold explained that the Division is holding the meeting because two healthcare worker unions petitioned the Board to adopt a new standard that would address workplace violence in healthcare. Petition 538 was filed by SEIU Local 121RN and Petition 539 was filed by the California Nurses Association. Copies of the petitions, the Board and Cal/OSHA (Division) staff evaluations were made available at the meeting.

Ms. Gold stated that Cal/OSHA has been working on the issue of workplace violence for over 20 years. In 1993, Joyce Simonowitz, Nurse Consultant for the Cal/OSHA Medical Unit, had drafted the first guidelines on preventing workplace violence. Cal/OSHA has done a number of inspections on workplace violence in many different types of healthcare operations and its experience is summarized in the Division evaluations of Petitions 538 and 539.

At the June 2014 Board meeting, the Board adopted a decision which requested the Division to convene an advisory meeting on this issue and in that decision, they had determined that the necessity for improved workplace violence protection standards has been established.

Therefore, Cal/OSHA is starting this process to determine what should be included in a workplace violence standard – how workplace violence is defined, what types of workplaces should be included, and how the issue of workplace violence can be addressed in the many different environments.

Ms. Gold mentioned that a bill in the current legislative session addressing workplace violence, SB 1299, was passed and is awaiting action by the Governor. The Division doesn't know if this bill will be signed and become law or not. The purpose of today's meeting is to address issues raised by Petitions 538 and 539, and any other issues to consider in addressing workplace violence as an occupational safety and health issue.

Other handouts included Health and Safety Code sections 1257.7 and 1257.8, which apply to certain hospitals in California. These laws are not enforceable by Cal/OSHA but provide information as to how the legislature has addressed this issue in the past. Other handouts were described – possible definitions of workplace violence, types of facilities licensed by the CA Department of Public Health, Office of Administrative Law's rulemaking process chart, Dr. Lipscomb's presentation, statements by SEIU local 121 and CNA regarding workplace violence and SB 1299.

Ms. Gold described the OAL rulemaking chart and the Administrative Procedures Act that governs how agencies can adopt regulations. She pointed out that we are engaged in preliminary activities which the Act encourages agencies to do when working on something complicated. "Here we're trying to take on a pretty big issue which we have never specifically regulated before, though we have often issued citations under other regulations. So we want a chance to really develop what that regulation should say and give everybody a full chance to have input."

The Division has found that having this kind of collaborative process has been very helpful in developing regulations – everything from safety needles to aerosol transmissible diseases to safe patient handling to the ongoing process on antineoplastic drugs. If there is a proposed regulation, there will be formal public comment periods, formal public hearings, and additional chances to have input to the process.

Ms. Gold went over housekeeping issues and encouraged everyone to sign-in and provide their contact information as the Division will be communicating through e-mail (send out drafts, request comments, etc.).

Ms. Gold then introduced **Jane Lipscomb**, PhD, RN, FAAN with the University of Maryland's nursing faculty. She is one of the leading researchers in the country on workplace violence. She is principal author and principal investigator on a number of NIOSH publications. She also presented at the OSHA webinar on workplace violence and is one of the leading national authorities on this issue.

Dr. Lipscomb mentioned that she resided in the Bay Area between 1984 and 1993 and worked with Joyce Simonowitz and a handful of others present at the meeting. She stated that her perspective is a national one and she will not be speaking specifically about what goes on in California. See Dr. Lipscomb's presentation (handout).

Q&As with Dr. Lipscomb

Q. Can you give us the website for online training?
A. Go to www.cdc.gov/niosh/topics and click on Violence (Occupational).

Q. Most of the studies/regulations exclude correctional or detentions nursing. Is there a reason for that and how can that be fixed?
A. I think that comes down to the scope of what the standards are going to include. That's a really high risk setting and there's been some work done on forensic hospitals, which are sort of between healthcare and corrections. It's a really important area and research has not been done in that setting to any great extent, especially intervention work. A number of Federal OSHA's recent inspections and citations have been in corrections. If you go to their website, www.osha.gov, as you get to their workplace violence page, they have the press releases along with the citations they issued. So it's informative. You can look at where they're citing a correctional institution and see what they're finding and recommending.

Q. **Cristina Barolet Garcia, MD** asked, "What is your understanding of the research, in terms of what type of training needs to be implemented? I'm a physician (psychiatrist) and work with mentally ill patients and throughout medical school and nursing and training, we do simulations around code blue to do all these codes if somebody is sick. And along with psychiatry we're the same way and I'm wondering what type of simulations we might be able to devise or implement to put into a training process so that residents and nurses might undergo this a couple times a year the same way we would run a code so that everyone is on board, everybody knows what they're doing, and there's a protocol in place. I'm not sure if there's any literature on that."
A. There's not a lot of literature on the effectiveness, but there are a lot of commercial or home-grown curriculum that focus on the de-escalation, the prevention side, but then when it comes to managing behavioral emergencies, which I think is the terminology, there is curriculum and it's usually not done by everyone in the general setting. Most hospitals give some kind of training around physical interventions. The Veterans Health Services is a leader in this area and they make the distinction between defensive moves and physical take-down type of moves. That is an important distinction for what a worker can do defensively on their own for which they're not going to be charged with assaulting a patient. I've actually done some evaluations of training. What I've heard from workers is that they are limited in terms of simulation. You can't act out the type of assault that's going to physically injure a staff. That is one problem that workers have – that it's just not realistic enough.

Q. But I wonder if we could do that, if we think in terms of law enforcement. They undergo those types of simulation.
A. Why not? There's not been a lot of attention to this and my personal bias is that if you don't train someone, completely, effectively, you could be giving them a false sense of security about their skills when it comes to trying to contain someone. There's also been a change in the way restraints, seclusion are used. There are limits on using those tools, not that there shouldn't be. I think you're right and we do need to look at other industries. I know we have someone from security. Do you (addressed Chad Thomas) want to offer anything there?

Chad Thomas, I'm probably not as thorough in the assessment of training programs out there and I find them, in one brushstroke, wacky in substance. The majority of what I have come across is they start from the point of intervening in a problem that is already occurring rather than recognizing an emerging pattern of behavior. From a security or law enforcement perspective, when we're taking somebody out in the field for the first time we can harness their intuition in recognizing a situation that's deteriorating, specifically for the purposes of

disengaging. Second from that there is a level of tactics where I anticipate what my engagement is going to get from that person. ATAP, a national association of threat assessment professionals, is on the verge of rolling out guidelines. There are a couple of people working on structured patterns of recognizing emerging aggression, not really clinical. As far as running simulations, I think it is possible to get somebody to a level of awareness. We have to take a cautionary approach towards calling it training. It goes a lot further. There are a lot of commercially available programs – some are online, some you can start and walk away from. I can get in front of somebody in an hour and a half and demonstrate some of the things to look for and how to disengage. What I also find is people recognize the warning signs before they occurred and they didn't listen to those signals, whether it's they were directed to not listen because they work by themselves or they talked themselves out of that. It's pretty unusual to talk to somebody who was assaulted and didn't recognize at some level before it all happened that it was about to occur. I think a simulation is possible and easy to structure for the level of giving somebody awareness. If there's an administrative infrastructure that can complement that and is ready to intake the staff person that says, "I've got a concern about going in there" and then that concern is supported and heard, then it's valuable. But no amount of training or awareness is going to do anything unless somebody is in a position to either stop or start a process.

Dr. Lipscomb added that a lot of training programs she's seen have techniques that require 3 or 4 people to perform them successfully and then workers report that they're never in a position to have 2 or 3 staff available to help them and that needs to be clearly stated in policies that if this 4-person hold or takedown is taught with 4 people, then don't perform it if you don't have 4 people. Workers often feel like they just have to do whatever they can do and they get injured in the process.

Q. I'm not suggesting physical training per se, self-defense is always important, but more of recognizing the aggression as it escalates and then having protocol and simulation in terms of you're acting it out with colleagues with simulating some type of behavior that would be not productive.
A. And that should be going on.

Deborah Gold asked if there were any more questions as the discussion went off to one small area of training.

Q. **Alice Burston**, LA County Sheriff Dept., RN, "you talked about police involvement and noticing the acts of aggression. When you're on the front grounds it happens quickly and you might think you have a situation under control, which I know personally, and it just flips. Then the danger, violence, attack happens and then the police come in. They're not really excited about working with you on those patients. The patients go to the hospital because they're placed on a 5150, involuntary hold because they're probably schizophrenic and also tweaking off of drugs, there's a policy in LA County that they'll be released from the hospital as soon as the labs come back. As a nurse, when I'm asked if I want to press charges against a client, if they're purely psychotic it doesn't do anything, so I don't want to. So the situation is to get no help in the end. We're talking about the middle of the process, but at the end, the client is released and because it's not necessarily with a gun, they might not even tell you that the client, who you hope is so psychotic that they don't remember you, is released and could return. I think we start talking about policies added to the prevention, control and protection.

A. It's a good example of how complex the work is that all of you do. She encouraged submitting written comments when you get to that point about that specific situation because she's heard it before.

Q. **Ala Garza**, nurse manager of 50 beds. Workplace violence has increased significantly on her two units in the past 6 months, one is a cardiac unit. They have 3 incidents per month, involving knives and guns and physical attacks. She didn't know there would be a delay to developing a standard, but asked where to start if you feel things are out of control and your hospital has swung the pendulum toward patient rights. They've talked about creating flags in the EMR, but they get pushback saying they don't want to label patients. They've talked about searching belongings, but then it's their right to refuse the search.

A. Are the rank and file healthcare workers part of a union? Recommended working through them and their union to create a space and a place where you can work as a committee and use the leverage the union can bring to support the workers and bargain around this issue. She asked if the nurse unions want to give specific recommendations. It's not that uncommon to hear that. Management is often not going to take this on in addition to trying to fill beds and everything else they do. To the extent you have people that work in your units that do have the collective bargaining agreement, I'd work with them.

Q. **Gail Blanchard-Saiger** pointed out that under California law hospitals have to have safety and security assessments, and that was developed by SEIU. It's not focused on patients. The first line says you have to develop security measures to protect personnel. There is already a law and there should be a process in your hospital so if you're not getting what you need, you need to follow through on that. There should be protocols but also, this issue you identified and I'm working with my hospitals is this tension with patient care and patient rights. She had a conversation with California Department of Public Health who license hospitals, whose focus is patient safety, that there's a tension there that we're really trying to work through. She's hoping to engage CDPH in this process so we can work through those issues.

A. In working with Morgan Smith's staff in the state of WA, they got together with the consumer population too. The families of the mentally ill don't want their loved ones assaulting the staff taking care of them. The point of the coalition, industry and consumer groups, is a good one.

Q. **Katherine Hughes** stated it's amazing that a manager is here today saying that they want to protect their worker and coworkers and people that work under them. "The reality is that you're not represented by a union and you don't have the same protections as the people you supervise. It's easy for me as a union nurse to speak up and be a greasy wheel. You have to be really careful and delicate in how you do that. So working with your nurses and having a staff meeting if you're looking at the law 1257, which I helped pass the law in the very beginning of my unionism, not realizing that CDPH regulating that was basically making it ineffective. As far as I know, CDPH has not cited any facility for not having a written plan. They certainly don't have effective written plans. Your hospital probably has some kind of plan and it obviously isn't working, which is why we're here today because we're hoping that Cal/OSHA, who falls under the Labor Code, will actually be able to enforce it and force the employers to not only follow the existing law which is what the standard would expand upon."

Elsa Monroe said she worked at one time in the emergency room. She described an incident where a mother of an 8-year old was angry that they dismissed her son as being healthy without asthma. She came back into the treatment room and lit the paper towels on fire and walked away. When Ms. Monroe came into the treatment room, it was smoke-filled room and when the

sheriffs responded, the mother and child had already left and couldn't do anything more. Ms. Monroe emphasized that this is why we need to have regulation, not just the policies, not just the law.

Sandra Williams wondered if other facilities have processes in place where they are reporting incidents such as the ladies spoke of, increase in numbers in terms of violence, and detection of weapons within their environment. Are they reporting that through their current system? Are the reporting those particular incidents to their safety officers? If so, is it being discussed within their committees where they're looking at how they go about mitigating and assessing and addressing the issue to try to eliminate that. What's helpful is, as organizations are collecting the information, especially in the wake of workplace violence and active shooters, there's a heightened awareness and there may be an opportunity to escalate that so that they're aware of the potential and the impact of what is occurring.

A. It varies by organization how much reporting that gets done and what's done with the incidents that do make their way into the system. "The literature suggests that only 10-20% of incidents that meet some of these definitions actually get reported because often nothing gets done. I looked at records where hospitals basically count them, put the number that's occurring on a spreadsheet and that's as far as it goes. So the committee structure that you describe is really what we hope to see."

Cindy Conner stated that she's had the good fortune in the last four years to work within the healthcare environment in LA County and she's been astounded by the degree of the accepting culture of violence that she has seen so many have been subjected to. This clearly has sent the message to her department that they need to work on bridging the gap between law enforcement and all of the healthcare sites. They're fortunate to have the partnership with LA County DHS to increase the heightened level of training. Some of the things Dr. Lipscomb talked about they are currently doing. A lot of things they do are dictated by money, finances, time. Like HCWs who work 24/7, so does law enforcement. They're trying to develop creative means not just for DHS partners but for all of their partners within healthcare in addressing the things you're talking about because they have evidence to support the fact that although they may be red flags or precursors, most of the assaults that are occurring are unsolicited, random, and just like that. So you can have all these red flags and predictors in advance, but it's those quick, blink of an eye assaults that we're concerned about and we're working with to develop means, measure to assist you. She still considers herself in the learning curve – 27 years in law enforcement and the last 4 years working within healthcare.

Suzi Goldmacher said she was a nurse before she retired and worked for CDPH and before that worked as an occupational health nurse practitioner running the employee health department at a number of hospitals. She saw a lot of people that were injured on the job, some from violence. She was a victim of violence several times. She was involved in a study that Jane Lipscomb presented and was the one who actually went into the field and interviewed nurses in emergency rooms, psychiatric facilities and home health. In California, they see less in home care because most workers said that families protect them. One of the things she found frustrating in going to the hospitals is they were looking for recordkeeping of the incidents. "Unless it's more than a first aid, you don't see recordkeeping. Where's that floating out there if the employee gets hit and he/she doesn't really need to get treated it's sort of out there in the universe but nobody sees that and she doesn't know how many of those exist. So as Jane said a lot goes unreported. There needs to be a system that's not just through the OSHA 300 log because that's only one piece. Then there's another piece, let's say that someone fills out an incident report on the floor and where do those go? Where are those floating around? Who

gets those records – security, employee health, HR? Because there's too many different systems out there. There needs to be one system that does all the data collection."

Q. **Candi Brown** said that Harbor-UCLA Medical Center psychiatric emergency room states they have a CPI program that is mandatory once a year. She's been there 26 years and the program has been the same training and is not working. She wants to know how they can get training more often, like quarterly, and how they can get it changed. What steps do they need to take to get it changed and also keep record or a log of injuries that have occurred.

A. She hears Ms. Brown saying that we need a standard and enforcement because there are requirements by law and you're not seeing it on the ground. She thinks it will be the same strategy working collectively to make sure that you can exercise your rights without retaliation. It's so prevalent to hear that you're working in very high risk settings, and that you're talking about getting annual training and not really doing anything about these incidents that get filed and that's egregious.

End of Q&As with Dr. Lipscomb

Deborah Gold stated that we want to shift gears and get moving towards this regulation. What Cal/OSHA has been doing is going into situations where there has been workplace violence and issuing citations under the Injury and Illness Prevention Plan, which is something they don't have in every other state which requires employers to generally assess hazards, evaluate those hazards and take corrective measures, provide appropriate training to employees, investigate injuries and incidents. The Division cited the state mental hospitals after Donna Gross' murder and cited on the Contra Costa County nurse that was killed. The Division cited after Dr. Ursua was killed at John George well more than 10 years ago working by herself at the end of a blind corridor like what Dr. Lipscomb showed. The Division has also cited for not having effective employee alarm systems or responses to that. Special orders were issued to a number of facilities to say, "Here's the specifics of what you have to do" because the Injury and Illness Prevention Plan is a general mandate and it's not a specific mandate. What the Standards Board found and what the petitions have said is we don't have enough specifics, we're not providing enough clear guidance to employers, enough tools for employers and employees to use.

Ms. Gold explained that the Division is trying through this meeting and a couple of subsequent meetings, one focusing on the role of facility security and law enforcement, and another on non-hospital environments, in a relatively short period of time because the situation is urgent.

The Division wants to hear from stakeholders on how to address this issue and what to put in a standard like frequency of training and type of training. The Division directed the state hospitals to go out and investigate their physical plan, blind corridors and alarm systems. The state legislature eventually gave Napa State Hospital several million dollars to improve their alarm system because Donna Gross activated her alarm more than once and was not found after she had been attacked and that was a terrible tragedy. And the state hospitals are currently improving their alarm systems facility by facility as the money permits. But the issue of who is going to respond to those alarms still exists.

Ms. Gold explained that the structured for the rest of the day is to first talk about definitions for workplace violence, then discuss what facilities and operations should be included in the standard, and then talk about the elements of a standard.

Ms. Gold went over a handout of definitions that were discussed by Dr. Lipscomb. She asked for feedback if one or both definitions were fine or if there's something that should be included in the definition and isn't.

Suzi Goldmacher stated she has another definition from the World Health Organization that Dorothy Wigmore from Worksafe wanted her to present – "the intentional use of power, threatened or actual, against another person or against a group in work-related circumstances that either results in or has a high degree of likelihood of resulting in injury, death, psychological harm, or deprivation."
She stated that the definition encompasses everything and is used in countries all over the world.

Gail Blanchard-Saiger stated concern that the OSHA definition was vague – harassment, intimidation, etc. She has a longer definition that she feels is more objective – "the use of physical force against a hospital employee or other facility personnel (including volunteers) that results in or has a high likelihood of resulting in injuries, psychological trauma or stress regardless of whether the individual sustains an injury; an incident involving the use of a firearm or the use of an object ... to inflict harm or other dangerous weapon regardless of whether the individual sustains an injury; the threat of physical force or harm against a hospital employee or other facility personnel."

Rob Newells stated that the advantage of using the NIOSH and OSHA definitions is that they also include unintentional, violent acts that they are tracking versus the WHO definition that includes intentional acts. He wants to make sure that we are including as much as possible, because we're trying to prevent all workplace violence acts so that it has to include unintentional acts as well.

Sandra Williams asked if we should also explore bullying and how we define that, as well as the lateral and horizontal violence.

Gerard Brogan agreed with Ms. Williams. CNA spoke to 6,000 nurses in the last two years about this. They're equally concerned about two things – physical violence from patients, etc. and in equal measure – stress, bullying, and harassment from management. A union, experienced nurse was in a one-on-one, short staffing situation. She locked the door, put herself behind the locked door. After that, she was disciplined for doing that. She was much more traumatized by the management discipline than the potential assault because she expected a little bit of assault from psychiatric patients but what did come as a shock to her was the violence perpetrated against her in terms of deeming her safety unimportant. This is one of hundreds of anecdotes, so he wants to stress that lateral violence, bullying has to be a major part of any standard.

Meleah Hall stands in solidarity with the group. She works with adults with developmental disabilities and autism. She asked with regard to the four types of workplace violence, where do individuals fit in that are related to the student, client, or patient such as family members or in gang situations, other people who can come and actually cause violence. It's not clear where they fit in under the four categories.

Deborah Gold stated Ms. Hall was referring to a slide in Dr. Lipscomb's presentation. Type I is somebody coming in as an unknown perpetrator. Type II is the patient, client, customer where we're generally considering a visitor or family member who's related to that patient to be in a

Type II situation. Where it becomes confusing is that sometimes we have a situation in hospitals where the violence on the street has followed the patient into the hospital. And we have somebody who is kind of related to the patient in that they may be in the same grouping and there may be another grouping that they're having a conflict with and the violence is following the patient, so it is kind of Type II. It's not random violence, but it's kind of Type I-1/2.

Ms. Hall stated for that reason it would be important to clarify that because in her experience working in continuation schools and special education schools, a lot of violence has occurred because of that type of an act. If it's not written, then it's hard to follow up on that.

Hector Alvarez stated that one of the things he comes across when working with clients are complicated, wordy, lengthy regulations that he has to boil down and make useful for their organization. He hears the motivation to include everything, however they struggle to get everything in. He shared his organization's workplace violence definition – any physical assault, threatening behavior or verbal abuse occurring at a worksite.

Ingela Dahlgren said she finds part of the first definition "a person at work or on duty" troublesome because a lot of incidents happen follow you out into the community on the way home, parking garages, right outside of the hospital after you clocked out. It's important to determine more about if the violence actually follows you from work. It might be a patient or a relative that is assaulting you and that needs to be included in the definition.

Richard Negri said SEIU uses the OSHA definition. When he thinks about the worksite he thinks about the parking lot where their nurses have been followed. They're not talking about on duty vs. off duty, but the environment in which a control should be in place.

Ruby Sloan said she feels anxious because she has been assaulted a lot and is tired of all the meetings, and policies and procedures. She's been assaulted too many times to count – verbally, physically. She was just assaulted in May and is seeing a therapist about it. She's a 20-year employee and can't tell the number of times she's been assaulted. She's seen patients assaulted and coworkers taken out by ambulance, blood all over the place. She stated, "Please do it very fast, stop talking about it and get it done."

Elsa Monroe stated the need to include correctional systems. "When you review the language, consider that our society has a bias against this type of setting (criminal activity, murder). There's a stigma for healthcare professionals working there and she pleads adding protection in all correctional settings and detention centers."

Candi Brown said they deal with a lot of violent, combative, psychotic patients and when she was leaving work, one of the patients that had been discharged earlier that day was waiting outside. As she came out the exit door, the patient approached her and made a verbal threat. The security guard was at the door and saw the patient approach her. Ms. Brown used CPI to get the patient away from her. The patient chased another coworker and said that they were off the clock now. She feels the same type of training they take, everyone in the hospital should be informed so when they see things like this they can call the sheriffs. The security guard did not call the sheriffs. The patient chased another coworker literally around the parking lot for two minutes and it was not even reported. Something tragic could have occurred and it was frightening.

Alice Burston, LA County Sheriff Dept., RN, stated that mental health has no debriefing. "When something happens, there's no putting employees back together. When the two nurses

were killed last Easter, there was no debriefing which should have been county wide. There's no information of what to look for or how they should treat their patients. What should they do? The patients are traumatized as well. Debriefing has to be mandatory and mental health departments have clinical debriefing teams and they worry about debriefing everyone else, and the mental health professional who takes all of this home suffers greatly. "

Rob Newells advised that the workplace definition include electronic and telephone threats or intimidation (e-mail, phone calls, texts) that someone receives while at work.

Steve Pitocchi stated that there's no bite in any legislation to have an employer held accountable to have proper lighting, proper surveillance, cameras and these are things they fight with the employer and sheriff's department on. Another aspect is the level of training of the security officer. Private security systems are used so the employer says we have security, but they're not adequately trained to assist in these sort of situations. There needs to be a standard of training and a requirement of how many deputies should there be in a particular facility. He doesn't have those tools to say there's a compliance requirement and that's what he's looking for and advocates for his members.

Caryn Thornburg stated that employee-sponsored events have incidents happening so that might be something we should look at. Bullying, verbal abuse, physical, inappropriate touching are happening at outside, sponsored events such as Christmas parties, etc.

Katherine Hughes stated that when their organization and Richard Negri's organization drafted Petition 538 they used OSHA's definition of workplace violence for several reasons. It's highly recognized, fairly recent and it added credibility coming from OSHA. They liked that it has intimidation and disruption in worksites because it includes all the typologies that happen in all of healthcare facilities, services and operations. That's why they have it on their petition and position paper. It is vague and that's good because we need it to cover those kinds of things. "If I'm not intimidating you, if I'm not disrupting the workplace, then it wouldn't be covered. If it triggers those things, then we need to have policies and it needs to be part of the standard whether it's reporting, recordkeeping or training that addresses that kind of behavior because we're afraid to go to work, because someone is intimidating us, and our employers are disrupting the workplace in front of our coworkers. It makes it very difficult to return to work and be safe healthcare practitioners."

Deborah Gold asked about the issue of intentional assault and neither NIOSH nor OSHA has "intent" in their definitions. Part of that has to do with the issue of what do you do with mental health patients who may not form an intent in that way. They certainly may not be capable of forming a criminal intent, but they are capable of injuring you. She asked for comments on the issue of including intent in the definition.

Jane Lipscomb strongly recommended against using the term "intent" because not only is it an issue with the mental health population but with the geriatric population. The point is it doesn't matter if was intended or not. A worker still was injured.

Richard Negri underscored what Dr. Lipscomb stated. We've made this point over and over again that healthcare workers are patient advocates first and foremost. If you bring in the intent, it opens it up to a whole new conversation and how to have that conversation might not be something that we'd be prepared to do and get through a comprehensive Cal/OSHA workplace violence standard as soon as possible.

Jennifer Gabales, represents California Association for Health Services at Home (CAHSAH), the hospice and home health providers who are different in that they provide care so it's important that the definition be broad enough to include all of the health workforce. She also agrees that intent language should not be included in the definition. It's important to include all the unique characteristics of all the settings. She cautioned there can't be a one size fits all approach for every single health worker and all the different ways and areas that healthcare is delivered. The risk with a hospice patient is going to be different than the risk from a psychiatric patient due to the nature of their health condition and their family's awareness and the other workers that are involved in the case.

Gail Blanchard-Saiger, CHA, agrees that we shouldn't make the distinction between intentional and unintentional in the definition and had a conversation with her hospitals about that. She wonders, and defers to the researchers on this, for the purposes of determining whether it would make a difference because she doesn't know if it's relevant in that context, but for the purposes of the definition it's not relevant.

Cindy Conner stated that there are aggravated assaults and non-aggravated assaults. Verbal assaults don't exist. It's either your First Amendment rights that are being exercised or there's clear and specific intent as to how I'm threatening you. The vast majority of what she's seen in healthcare is non-aggravated where there's no physical trauma, certainly emotional trauma and complaints of pain. But there are those severe cases we've talked about and the two in LA County, by the way weren't deaths and they were debriefed unfortunately. It's those non-aggravated assaults that occur that can have long-lasting, sustainable, psychological trauma to an employee. She looks at it two ways, clear cut – systems that you have procedures in place regarding the horizontal, the bullying that needs to be addressed by leadership, but the right to feel safe against physical assault is an entirely different topic.

Suzi Goldmacher thinks we should take out intentional also. She stated that in the research with staff they would say "he was demented," but she would say "but you still got hit." To the staff, the intent mattered to them. It was very interesting. Over and over again, she would hear "he was demented" or "he was confused" or "he was drunk." She said that when we train, that's an important piece that it doesn't matter – the intent. It matters that you were assaulted or abused verbally.

Taisha McCalloch said she was a staff nurse for 38+ years spoke about how a member was killed although an unsafe work environment that had been identified by the staff at a detention facility, and the perpetrator had no prior history. She stated when unsafe staffing has been identified, a light or camera is not going to protect you. There are staffing guidelines in place, but there's a lack of enforcement because the enforcement arm and the investigatory arm of CDPH Licensing and Certification no longer investigates that. Cal/OSHA would have to look at where existing law says there should be sufficient staffing in a ratio available that would meet the needs of the patients has been violated and refer that back to that agency for investigation.

Deborah Gold introduced **Juliann Sum**, Acting Chief.

Juliann Sum thanked everyone for coming to the meeting and was pleased with the huge turnout and everyone's participation in this important issue. She is excited that this rulemaking is not a traditional hazard – physical, chemical, heat or radiation hazard. It's like the elephant in the room which is a huge hazard and we have to find innovative ways to deal with the human nature aspect as well as the legal, jurisdictional aspects that we'll have to grapple with. She has

a dedicated team to work with everyone with their expertise and dedication, and looks forward to hearing about and participating in this process.

Unidentified Staff RN, said over the past 3 years, they've been getting people from the jail that end up in the psych hospitals. When they come they are very violent. There's not enough staff and when they call police, they don't help and they are not taking them back to jail, and the hospital doesn't have any cells for these people. They are the cause of their problems now. They need help because it is becoming a big problem in the hospitals.

Meleah Hall feels there needs to be language about intentional and unintentional in the standards although it should not be part of the workplace violence definition. If it's unintentional, oftentimes the police department will not consider it a crime. That's what happened to her when she was attacked and suffered amnesia from a concussion that was so severe. She was told by police that because she had amnesia and the person was special needs and, although the individual confessed, no crime had occurred. She still hasn't been able to file a police report and doesn't know how many times she's called them, although her peers that work in the general education setting have a right to file a police report. She feels that it's critical that the standard includes talk about intentional and unintentional because without it means you won't have as much protection.

Delmi Madrigal said as a social worker in LA County, she hopes for the enforcement of the policies that are in place because her department has a lot of policies, supposedly to keep them safe, but they're not enforced. Recently, a client was threatening to shoot DCFS workers and none of them were informed of this and didn't know what was going on. Three weeks later, this person turned out to be her client and she was trying to contact and meet with her not knowing that this client had a long history of extremely violent behavior and had been arrested by the Sherriff's Dept. "To this day, they are trying to figure out what happened. Nobody seems to know. It's pointless to have laws and policies that are not being enforced because no one is checking to see that it's done properly and it's unfair because they are out there in the street dealing with people who have a lot of issues – mental health, drugs, and on top of that we're taking their kids away so they're not very happy with us. It's a bad situation and we really need enforcement."

Cory Cordova stated that there seems to be a disconnect between the LA County Sheriff's Department and the healthcare workers there in regards to flow of information as well as the housekeeping, security, and dietary departments which area all different companies. We need clarification about what workplace is as well as how it relates to the employer because he doesn't see it as one in the same, and agencies acting on the worksite or the jurisdiction of the employer.

LUNCH

Deborah Gold, welcomed back from lunch and asked if anyone had any further thoughts on definitions, or can we move on to scope.

Kimberly Rosenburger said SEIU strongly supports the Fed OSHA definition.

Denise Duncan said United Nurses Association of CA, seconds that.

Jorge Cabrera said SoCal/COSH also supports the definition, not only to have a good standard, but to change the culture.

Mercal Vivier said SEIU Local 221, also supports the definition.

Elsa Monroe supports the definition

Jeannie King, VP of 121 RN, supports the definition, and it's about time this moves forward.

Taisha McCulloch, said SEIU 1021, supports the definition.

Alice Burston, LA County Sheriff Dept., RN, supports the definition as well.

Candi Brown, Harbor UCLA Psych ER, SEIU 721, also supports the definition.

Deborah Gold, Clarification is needed because there seems to be support of the definition, but this morning there was considerable discussion of what a work site is. There is a need to define a worksite to include parking lots, etc. so is what everyone is saying is that they support the definition, but we need an expansive definition of a worksite is?

General room response: Yes.

Jane Lipscomb said to include patients' homes for those giving home health care.

Hector Alvarez said he could support definition if we were to change work "site" to work "setting".

Ms. Gold explained that the fine tuning of these definitions can be discussed further in the process.

Meleah Hall said that violence that originates from the work site ie. stalking, has been a concern.

Bob Nakamura explained that the main difference in the two petitions was the scope. One focused on General Acute Care Hospitals, and the other had a much broader approach to the scope of settings that would be covered. Seeking your ideas on what should be covered, and how we should decide what should be covered. When we did the ATD standard we were able to use the TB reference book that defined settings that would be included in health care. We are looking for a reference to use for this case, and to get input from the Stakeholders on what you think should be included.

Richard Negri said they are looking for a very broad, very comprehensive scope to include all health care workers, wherever they are working. Violence does not know where it is, can happen wherever we are working.

Katherine Hughes added they want to include any health care setting regardless of where. Every setting, service, and operation. It should be similar to the ATD standard.

Vicky Lim said she is concerned that SPH was focused on acute care facilities, and wants to make sure that all health care is included in this one. There has been an increase in violence in

adult care (elderly care). This is likely due to an increase in number of patients and increase in medication use with a lack of oversight.

Unidentified commenter said the increases are due to closures of facilities etc. and other factors. 1) drugs; 2) economic factors; 3) not getting help until in crisis; and 4) health care is unavailable and/or underserved population with nowhere to go.

Ruby Sloan blamed lack of community resources. Facilities are overcrowded so they are not able to effectively help. They are putting out "fires" and breaking up fights all day long.

Gerard Brogan said CNA fully supports SEIU's more comprehensive scope.

Gail Blanchard-Saiger said there is lots of information on external factors about why there is increased violence in health care. For instance, AB 109 issues.

Cindy Conner, LA County Sheriff, on AB-109 issues: prison release of low grade offenders being funneled back into your facilities. Many with 5150 hold, released into county hospitals. This is being addressed with the DA of LA because they see the impact this is having on local facilities.

Bob Nakamura said they need to focus back on what types of facilities should be included.

Denise Duncan said UNAC is looking at many ways to have healthcare options. There have been lots of changes with different ways to provide healthcare and keep patients out of acute care facilities leaving a whole group of workers uncovered.

Richard Negri said he is re-stating that the scope should cover everyone everywhere. No one worker is worth more than another worker.

Elsa Monroe agreed with the need for a comprehensive scope to include all HCW.

Caryn Thornburg said it should include ancillary services (ie. Dietary, housekeeping, EVS workers).

Bob Nakamura asked if any EMT representatives present. No response.

Jennifer Gabales asked a question regarding referral agencies, in that they are not employers. Regional centers that provide services such as infusion pharmacy, long term care, home health, EMT. She believes that physicians' offices should be included. Many have several types of physicians at one location.

Delmi Madrigal said Child protective services and social services should be included.

Meliah Hall said schools have medical staff and nurses that should be covered.

Bob Nakamura asked if any School nurses, homeless shelter, or community clinics present. No response.

Nisaa Mayun believes that case managers, social workers even clerical should all be covered because they all have the same exposure.

Jorge Cabrera said it should include Community clinics, mobile services that go door to door in challenging neighborhoods.

Sandra Williams said it should be as inclusive as possible. People enter the environment in different ways. Both direct and indirect health care work should be included.

Katherine Hughes said it should include public health nurses and community home health.

Hector Alvarez said he questions types of facilities vs. types of activities. Said he wants to see less focus on types of facilities and more on types of activities.

Rob Newells said it should cover all hospital and non-hospital employees, not just patient care providers.

Gail Blanchard-Saiger said what about dentists and therapists? How do we define the scope?

Deborah Gold said the problems lie with Health Care Facilities, Services and Operations. The initial thought was that retail pharmacies would not be covered, however with current minute clinics and similar operations, we are not sure. How about School nurses? What do we do when the main operation is not healthcare, but it has a health-care element?

Richard Negri said if they are providing the service then they should be covered.

Meleah Hall said they have Special Education Services; they have staff that provides tube feeding, physical therapists, occupational therapists, etc. They are employees of school districts.

Gerard Brogan said service provided should be covered equally. They agree with SEIU that it should be based on the services provided. Cover all health care workers.

Bob Nakamura said part of our job is to write this regulation up in terms of justification of who is and who is not to be covered. We have to show what employers are going to have to follow and apply this regulation to their employees. We have to demonstrate in writing that there are either no differences among exposures to all health care workers to workplace violence, or identify what groups are at most risk, etc. We are not looking to exclude employees, but trying to see what other groups should be included.

Katherine Hughes said there are different hazards for home health vs. acute care vs. social work, etc. The question is how to apply the standard. So we agree that everyone should be covered, but the difference is how to apply to each type of health care worker.

Sandra Williams agrees. Cover the individual healthcare worker, and the environment in which they work; including traveling in relation to work settings.

Caryn Thornburg said for consistency, look at the ATD standard and use that as a base or a reference point.

Denise Duncan said she is concerned about minute clinics. They are new ground and are vulnerable. They are doing far more than just giving injections, and have been successful.

Bob Nakamura moved to close scope and move on to Key Components of a standard.

Deborah Gold said we described what the key components of the standard would be. Hazard identification: where do the hazards come from; evaluation: what is going to work as far as control measures; incident response: evaluation and follow-up; debriefing; and a way to move forward. Recordkeeping is a critical component to allow for your annual review process etc. What are the problems and what is the structure. For example, with home health- how we evaluate the patient and home environment. And what are the issues with intake, etc. She described the process and what to expect. Any missing elements other than the six we just mentioned?

Sandra Williams in regards to the communication component of the standard, there are two types of debriefings. The Employee Assistance Program (EAP) to deal with the wellbeing of the worker, and the Root Cause Analysis (RCA) to help learn from what happened. Both are important.

Ruby Sloan said we can't even get to these key components because first the facility has to admit that something happened. Employees are threatened to return to work. There needs to be a non-retaliation clause to avoid discrimination cases.

Deborah Gold said that typically the issues of discrimination and retaliation are handled by DLSE and we work to improve the response to these types of complaints. Represented employees have recourse through their Union.

Elsa Monroe said EAP should not be part of this. That program is set up for outside stresses and should not be used for work place violence.

Richard Negri said if there is a WPV incident, the nurse is sent for drug screen testing. There are barriers blocking incident reporting. Workers don't want to go through the hassle of reporting. There is a culture of non-reporting.

Gail Blanchard-Saiger said if the employee is injured at the workplace it should be covered under workers comp, not under EAP. As for retaliation and discrimination, she echoed that there are systems to address that problem.

Rob Newells said there should be a designated person at each facility to lead the program. Let the employer choose how they do this as long as they do. As for workers comp, that is helpful if you have actually been injured, but it doesn't kick in if you have been threatened.

Lisa Hall said EAP allows one to three visits for home based issues such as divorce or financial issues. Employer can bring in representatives (counselors) to help for these issues.

Katherine Hughes said it was mentioned but not listed, that there needs to be mployee involvement throughout the process. Part of the solution, part of the evaluation, recordkeeping, reporting, etc. They indicated that there is retaliation and discrimination going on. Many different types of retaliation. Workers comp is another issue. The workers' comp doctor says what the hospital wants them to say. I.e. modified duty instead of off duty.

Caryn Thornburg said there should be a program Designated Person with multi discipline input for assessment and follow up. This needs to involve senior administration as well to achieve executive buy in. Another useful thing would be sample tools on how to do the assessment/risk assessment templates.

Deborah Gold asked for existing examples of assessment tools, please submit to Bob Nakamura. Blank out confidential information because this is a public process and will be public record. These may give us good examples of threat assessment tools that could be included.

Bradley Vandersall said they taught assaultive behavior response training in behavioral health. They must be aware of environment, surroundings. Violence involves two parties. Any post incident evaluation needs to be done quickly and the perpetrator has to be involved in evaluation to help prevent future occurrence. They need to know that it is not ok what they did, but how do we prevent it in the future.

Ruby Sloan had issues with workers comp, however, she had a very good experience with the WC doctor. No single thing is most important in this process, It is all important. That being said, the debriefing is critical. Gives time to breathe and gather yourself.

Hector Alvarez said that currently the American Society of Industrial Security does have, by way of health care, many resources on line. Need to include definitions for Risk Assessment, Threat Assessment, and Vulnerability Assessment. They are all different and need clarity the three terms are not interchangeable.

Nisaa Mabyun said she was brutally attacked in her job. After, the first thing the supervisor said was "what could you have done better?" they blame it on the employee. There needs to be a lot of training, because that is a form of immediate retaliation. Second question, "what are appropriate control measures"? How can you control a risk when you work in a volatile situation?

Ms. Gold agreed that is an issue, so let's say you've identified that part of the risk is that there is no way to get to someone that has been injured because the configuration of the door is such that you can't get in if the assaulter is blocking the door. So then you need to look at that and see if you need to re-configure the door, or change how help is going to get there etc. This is how Cal/OSHA looks at things. First we look to see if there is a problem, then we have to decide what to do about that problem.
If the problem is not enough people to respond and to do the job that needs to be done than maybe you have to look at how the work and/or staff is assigned. Cal/OSHA is not the agency that will dictate staffing levels, but employer has to make decisions about if there is sufficient staffing to do the job you need to do.

Ruby Sloan said Clinical Risk Management in her organization is charged with solving these problems; however, they are not dealing with the Cal/OSHA issues.

Ms. Gold said that is part of our job, to structure a standard so that employers know what it is we want them to do so we can move forward. Sometimes, Clinical Risk Management is patient centered, so they may need to bring other departments, ie. Bring in Environmental Risk Evaluation etc. That is why we need definitions so we all know how terms are to be used and there is some consistency in how terms are being used.

Cory Cordova said in his experience, instructors are typically not involved in the hazard identification, debriefing, or site evaluation, so it is difficult for them to teach to that portion of the program. Also there needs to be a way for the employees to evaluate how well the program is working and give feedback to the organization.

Kimberly Rosenberger said SEIU wants to raise the issue of tracking. Something along the lines of the Sharps log from the Blood Borne Pathogens standard that requires you to record the needle stick regardless of the outcome. Right now there is no consistency with how incidents are recorded or tracked.

Ruby Sloan suggested a standardized log and questionnaire as well. The questionnaire for BBP asks for employee input right on the form and should also be something similar that goes out on an annual basis that gives employee a chance to give input. Also, agrees that we need definitions to go with Threat assessment, and environmental risk and hazards.

Elsa Monroe wants to comment about the awareness factor. Employees should be aware of their surroundings, but often attacks come from behind you where alarms may not be useful. Must have employee involvement, and the Employers should be evaluated as well. Perhaps a daily checklist/pre-shift briefing that includes staff and security to make sure everyone is on the same page to help prevent violence.

Rob Newells said they are seeing more employee verses employee violence, not just patient verses employee. Agrees there needs to be an annual assessment and update requirement.

Gail Blanchard-Saiger advised to remember to be consistent with the Health and Safety code so there are no conflicts or confusion.

Surit Goldmacher said from studies that they did, environmental approach was often the least developed portion of the plan. For example, no windows, blind hallways, etc. This needs to be included in the standard.

Ruby Sloan said the cost of workplace violence is more than the cost of prevention. We need our employers to listen to the employees.

Meleah Hall said there needs to be a time limit within which the evaluation has to be done because the patient may leave. Secondly, be aware that concussion and amnesia can affect the ability to evaluate and is hard for them to assist in the evaluation.

Richard Negri said the group should consider some form of workplace violence labor/management committee. Employer/Union/Employee involvement. The logs need to be maintained regardless of whether or not the incident would be logged on the log 300. The logs need to be accessible to affected parties for review and assessment.

Jorge Cabrera agreed with Mr. Negri's comment above. There needs to be involvement of victims and potential victims. Documentation will help to establish the patterns to help better address the hazards.

Gail Blanchard-Saiger noted that union involvement in committee, is already required by 1257.7, at least in hospitals, so no issue with that, but as for union being able to select the committee members, they have concerns about that. That is a function of the employer.

Jeannie King said she doesn't see a problem with the employer selecting who is on the committee, because there is already a requirement for 50% of the "acuity" committee be made up of bed side nurses, union nurses so no difference.

Ingela Dahlgren said she believes it is a bad idea to have a committee run by management with management. Must have employees pick committee representatives. Gave workers more of a voice and helped in employee buy-in with the results since they all had an opportunity to vote in the representatives.

Rob Newells said they welcome all front line staff to all our meetings, and do our best to have union representatives on all committees, but if Union is to dictate who is going to be involved in the meetings, it makes it very difficult to schedule meetings because they would have to try to schedule around everyone's schedules. He believes that it is totally appropriate to ensure that someone from the union is involved, but not dictate who from the union is involved. As for access to the logs, there needs to be a way to be sensitive of confidential information, and have a method to observe privacy issues.

Kathy Hughes has a concern about how a supervisor may be considered a bed-side nurse because they approached a bedside. So there is a need to make sure that workers select the committee members. Not the union selecting who, but the employees selecting who.

Pattie Soltero wants to echo what Gail said. In their facility, both employees and managers participate.

Ms. Gold discussed where we go from here. There will be two sub-committee meetings in the next few months, followed by another general meeting prior to which a discussion draft should be proposed. Please send any comments, suggestions and questions to Bob Nakamura.

Meeting adjourned.

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ATTENDANCE ROSTER

MEETING NAME: WORK PLACE VIOLENCE PREVENTION IN HEALTH CARE ADVISORY **DATE:** September 10, 2014

CHAIRPERSONS: Deborah Gold/ Robert Nakamura **LOCATION:** Elihu Harris Bldg 1515 Clay Street Room 1 Oakland

NEW ATTENDEES: PLEASE BE SURE TO WRITE YOUR NAME, AFFILIATION, AND E-MAIL ADDRESS CLEARLY

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ATTENDANCE ROSTER

MEETING NAME: WORK PLACE VIOLENCE PREVENTION IN HEALTH CARE ADVISORY **DATE:** September 10, 2014

CHAIRPERSONS: Deborah Gold/ Robert Nakamura **LOCATION:** Elihu Harris Bldg 1515 Clay Street Room 1 Oakland

NEW ATTENDEES: PLEASE BE SURE TO WRITE YOUR NAME, AFFILIATION, AND E-MAIL ADDRESS CLEARLY

NAME AND AFFILIATION	E-MAIL ADDRESS (for notices of future meetings)	PHONE & FAX NUMBERS	MAILING ADDRESS
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Jennifer Gabales CAHSAH	jgabales@cahsah.org		

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Lisa Hall CAHF California Association Health Facilities	Lhall@CAHF.org	916-432-5201	2201 K Street Sacramento, CA 95816
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LaChanta (Candi) Brown Harbor UCLA	MSCANDIB525@ATTNET	3105674095	P.O Box 470594 L.A CA 90047
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Jessica Hunter ANA/C	thunter930@ aol.com	916-837/620 858-225-0227 fax	1121 L St Suite 508 Sac 95814
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